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(Volume 1 of 6)

104th Congress
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THE POTENTIAL ROLE FOR EMPLOYERS, ASSOCIATIONS, AND MEDICAL SAVINGS ACCOUNTS IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MAY 25, 1995

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THE POTENTIAL ROLE FOR EMPLOYERS, ASSOCIATIONS, AND MEDICAL SAVINGS ACCOUNTS IN THE MEDICARE PROGRAM

THURSDAY, MAY 25, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 9, 1995
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearings on Increasing and Improving Options for Medicare Beneficiaries

– Private-Sector Lessons to be Sought –

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings to explore increasing and improving options for Medicare beneficiaries, with a focus on private-sector successes.

The hearing dates and subjects are as follows:

Tuesday, May 16, 1995:	**Experience in Controlling Costs and Improving Quality in Employer-Based Plans**
Wednesday, May 24, 1995:	**Medicare HMO Enrollment Growth and Payment Policies**
Thursday, May 25, 1995:	**The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program**

The hearings on May 16 and May 24, will be held in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing on May 25 will be held in room B-318 of the Rayburn House Office Building, beginning at 10:00 a.m.

Oral testimony at these hearings will be heard from invited witnesses only. Witnesses will include health policy experts, representatives from the health care industry, and employer groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the HI trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require, in the absence of spending restraints, an immediate 44 percent increase in the payroll tax rate. As a result, taxes on a person earning $20,000 would be increased by $260 annually and a person earning $30,000 per year would see their taxes hiked by $390 a year. Those who make $75,000 a year would pay an additional $975 in taxes every year.

In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

(MORE)

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last 5 years."

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed-care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations. According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65 percent of people with employer-based health insurance plans were enrolled in some form of managed-care arrangement, according to the KPMG Peat Marwick Health Benefits in 1994 (October 1994).

Moreover, managed-care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2 percent, according to GHAA.

Some private employers have also begun to offer their employees Medical Savings Accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed-care arrangements, but, due to certain features of the program, managed-care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries enrolled in managed-care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of Medical Savings Account.

FOCUS OF THE HEARINGS:

The hearings will focus on successful private-sector approaches at controlling costs and improving quality and an exploration of how such approaches can be made more available to increase choices for Medicare beneficiaries.

The hearing on Tuesday, May 16, 1995, on "Experience in Controlling Costs and Improving Quality in Employer-Based Plans" will review the approaches employers have taken to improve the cost-effectiveness and quality of their coverage for their employees, the issues and problems encountered as these approaches were implemented, the effectiveness of these approaches, and lessons the Federal Government can learn from these private-sector experiences.

The hearing on Wednesday, May 24, 1995, on "Medicare HMO Enrollment Growth and Payment Policies" will investigate the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methods.

The hearing on Thursday, May 25, 1995, on "The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program" will explore issues involved in enabling employers and associations to offer Medicare coverage to former employees and members, respectively, and the potential role Medical Savings Accounts could play in the Medicare program.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, June 8, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

** *NOTICE -- CHANGE IN LOCATION* **

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 17, 1995
No. HL-11-Revised

CONTACT: (202) 225-3943

Thomas Announces Change in Location for Health Subcommittee Hearing on the Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the potential role for employers, associations, and medical savings accounts in the Medicare program, which was originally scheduled for Thursday, May 25, 1995, at 10:00 a.m., in Room B-318 of the Rayburn House Office Building, **will be held instead in the main Committee hearing room, 1100 Longworth House Office Building.**

All other details for the hearing remain the same. (See Health Subcommittee Advisory No. HL-11, dated May 9, 1995.)

*****

Chairman THOMAS. The Subcommittee will come to order.

I want to welcome all our friends to our hearing on the potential for employers, unions, and medical savings accounts to add to the Medicare Program. As I said yesterday at the Subcommittee hearing, this Subcommittee is going to undertake a major effort to make Medicare a better program, both to improve its insolvency and to provide better choices for beneficiaries.

Today we will examine how we might provide options through former employers and through medical savings accounts. In addition to that, labor unions, I believe, are a very fruitful area of new endeavors.

Last week we heard from a series of employers about their successful efforts to control their health care costs and improve the quality in the coverage they provided for their workers and families. For instance, the Pacific Business Group on Health reported a successful effort in negotiating a nearly 10-percent reduction in HMO, health maintenance organization, premiums for their members in 1995.

I would like this Committee to explore how we can tap into that kind of creative energy by employers on behalf of Medicare beneficiaries and the Medicare Program. I believe we must find a way to allow employers to play a more defined role in Medicare coverage so that beneficiaries can stay with the plan they had as workers, and if they like it and it is cost effective for the program.

Clearly, this kind of change raises many questions: What would be the payment rate for Medicare in that situation? How would we define an employer's retirees? What would we do about retirees who want to stay in the Medicare fee-for-service program?

I am pleased that the list of witnesses in our first two panels, who will address the concept of an employer role in Medicare, have a background that will allow us to ask the kinds of questions that I just outlined and more. I am also pleased that our last panel will address an equally exciting concept, and that is the medical savings account for Medicare beneficiaries.

Clearly, one very promising approach to cost control and quality health care is medical savings accounts. With medical savings accounts, MSAs, as they are called, a person has the protection of a very high deductible for significant health expenses. They also have the freedom to make wise choices with their money in a medical savings account because it is their money and their choice.

This option is apparently working very well already for one company, the RCI Corp. of Michigan. We will hear from that company's director of benefits about how they have successfully instituted a MSA Program for their workers, and I believe Members of the Subcommittee have already been enrolled in that particular health program by virtue of the cards that we have received.

We need to explore how we might make a MSA option available to Medicare beneficiaries as well. There are some serious questions that must be answered before we proceed: What is likely to be the premium for the high deductible coverage for an average senior beneficiary; how much would that leave in an account for medical expenses each year; in addition to a number of other questions. Who would sponsor MSA accounts and high deductible insurance and who would regulate it? Should all Medicare beneficiaries be

given this option or just those beneficiaries entering into the plan? Should this be a one-time option for beneficiaries? Should they be allowed to disenroll at some point from the MSA and reenter traditional Medicare?

I look forward to hearing from our distinguished witnesses about the MSA concept for Medicare and how we might answer some of these questions as well as the role of employers and unions. Today, this Subcommittee, is to look at new and novel ways to create a better Medicare for all seniors.

And I would yield to the gentleman from California, the Ranking Member.

Mr. STARK. Thank you, Mr. Chairman, and I am sure we are going to hear some very novel ideas today. I understand the purpose of the Chair's hearing is to assess the potential of various ideas to improve the Medicare Program.

While it may or may not be the Chair's intention, I am afraid we could head down a troublesome path for Medicare and its beneficiaries. If I were going to create the short title, I would call it the Medicare Beneficiary Partition Act. It reminds me a little bit of what is going on in Eastern Europe. Unless we are careful, we will end up carving up the Medicare beneficiary pool with retirees in plans sponsored by the former employees, young, well seniors in HMOs, the healthiest in medical savings accounts, and the sickest staying in the traditional fee-for-service coverage.

Yesterday, the chairman of the Prospective Payment Assessment Commission said that Medicare was beginning to run the risk of becoming a very different program, depending upon where a beneficiary happens to live. I think we are asking for trouble if we attempt to divvy up the Medicare population beyond our ability or willingness to adjust the per capita payments to correspond to the health care needs of the various beneficiary groups.

If we go down the road of subdividing the Medicare population before we know how—and we do not—to adjust the Medicare capitated payment appropriately, we can just mess up the one good system that works in this country. I would urge my colleagues, while they have the votes and the will to do whatever they choose to Medicare, it is fragile and could easily literally be destroyed by capricious experiments when we do not have either the data or any experience in trying some of these areas.

I have no problem with capitated payments or providing beneficiaries with additional health options, but I do have a concern that we are already losing an average of 6 percent for every Medicare beneficiary that enrolls in an HMO and the percentage of retirees with employer-provided health insurance has been declining from over 60 percent today to 40 percent. Why in heaven's name would employers want to take on the whole liability of the over 65 population? Only, I suspect, because they can make some money and help pay for the under 65 population.

As has happened with HMOs, the bucks to be made are not necessarily from efficient operation, but from cherrypicking the healthiest beneficiaries or denying services to the very sickest.

A more extreme example is medical savings accounts, but I think that any empirical evaluation and any reasonable disinterested study will show that it benefits, to a small percentage, I think it

is 6 or 8 percent, the young healthy people, and adds tremendously to the costs of those who are sicker and need to spend more in the medical delivery system.

It is not fair. It flies in the face of any kind of social insurance or commercial insurance. It robs money from the insurance pool, which the Chair is already complaining is going broke, and is an idea that is right up there with sun spots.

I want to ask, or I want people to keep in mind that in the Chairman's budget the Medicare growth will have to be limited to meet the budget projections to under 4 percent, perhaps 3.7 or 3.8 percent. I would like these companies who suggest that they might like to continue operating their retirees' programs to tell us today if they could survive if the increased payments that they could make was limited to under 4 percent—3.8 or 3.9—if we do not have to adjust for adverse selection. I don't think they can do it.

I think if they combine the idea of continuing to maintain Medicare beneficiaries in their retirement plans, with the budget reductions that are being discussed, and very likely to happen, that the idea will lose its attractiveness.

I hope they will have a chance to review that today for us as we hear the ideas being presented.

Thank you, Mr. Chairman.

[The prepared statement follows:]

The Honorable Pete Stark

May 25, 1995

Hearing on the Potential Role of Employers, Associations, and Medical Savings Accounts in the Medicare Program

Thank you, Mr. Chairman.

I understand that the purpose of today's hearing is to assess the potential role of various parties, and certain insurance products, in the Medicare program -- a benign enough topic for a hearing.

While it may or may not be the intention of the Chairmen, I am afraid that we are heading down a troublesome path for the Medicare program. We seem to be looking for ways to break-up the Medicare population into numerous sub-groups. If I were creating a short-title for legislation, I would call it "The Medicare Beneficiary Partition Act." Unless we are careful in how we proceed, we may very well end-up carving up the beneficiary pool with retirees in plans sponsored by former employers; young, well seniors in HMOs; the healthiest of Medicare recipients selecting medical savings accounts; and the sickest remainder in whatever is left of traditional Medicare coverage.

Yesterday, in the Subcommittee's hearing on Medicare HMO enrollment, the Chairman of the Prospective Payment Assessment Commission said that Medicare was beginning to run the risk of becoming a very different program depending upon where a beneficiary happens to live.

We are asking for trouble if we attempt to divvy-up the Medicare population beyond our ability or willingness to adjust the per capita payments to correspond to the health care needs of the various beneficiary groupings. If we go further down the road of sub-dividing the Medicare population before we figure out how to adjust the Medicare capitated payment appropriately, we will make the adverse selection problem worse.

For example, a proposal is floating around that would have retirees remain in their former employers' plans and receive a capitated payment from Medicare. I have no problem with capitated payments, nor with providing beneficiaries with an additional health coverage option. But I do have a concern that we are already losing an average of 6% for every Medicare beneficiary that enrolls in an HMO. The percentage of retirees with employer-provided health insurance coverage has been declining dramatically -- from over 60% in 1985 to under 40% today. Why would employers now want to take on the whole liability of the over-65 population? I suspect because there are big bucks to be made. And as happened with HMOs, the bucks to be made are

not necessarily from efficient operation, but from being able to cherry-pick the healthiest beneficiaries.

A second and more extreme example is medical savings accounts. The potential for adverse selection posed by injecting an MSA option into Medicare is enormous.

A study just released by the American Academy of Actuaries found that, for the under-65 employer-covered population, the selection effect as a result of adding an MSA option to employees' health insurance choices could end-up increasing the standard, low-deductible premium by 60%. For the Medicare population, where high health care costs are even more concentrated in a small percentage of the pop-ulation, the adverse selection problem will be even greater.

These are only projections, though. MSAs today are a theoretical concept without foundation. The few insurers that offer any sizable number of MSA-like plans will not let me, or the American Academy of Actuaries, take a look at what they are actually offering.

Medicare is a social *insurance* program, not a social *experimentation* program. We should take extreme caution when using the Medicare population to prove or disprove some economist's latest theorem.

Providing Medicare beneficiaries a range of options is something I continue to favor. And as we know, there is no employer in the country today that provides the range of health insurance options to the range of Americans in the variety of locations as does the Medicare program. But every potential option we may provide beneficiaries is not necessarily a healthy one.

Just some words of caution as we work to make a better Medicare. Thank you.

Mr. MCCRERY [presiding]. Thank you, Mr. Stark.

We would like to call the first panel to the witness bench: Mr. Van Bell, Mr. Maher, Mr. Salter.

Gentlemen, thank you for joining us today. We have Richard J. Van Bell, president of John Deere Health Care, Inc.; Walter B. Maher, director of Federal relations for Chrysler Corp.; Charles G. Salter, director of employee benefits for GenCorp, Fairlawn, Ohio.

Thank you for joining us today, gentlemen, and any written statements that you have, if you would like to present those to the Committee, they will be included in the Committee in their entirety. We would ask you to summarize your testimony in about 5 minutes.

So, Mr. Van Bell, if you would start we would appreciate it.

STATEMENT OF RICHARD J. VAN BELL, PRESIDENT, JOHN DEERE HEALTH CARE, INC.

Mr. VAN BELL. I would like to thank the Chairman and other members of the House Ways and Means' Subcommittee on Health for the opportunity. My name is Richard Van Bell and I am president of John Deere Health Care, which is a wholly-owned subsidiary of Deere & Co., better known in the marketplace as John Deere.

Deere provides health care coverage to approximately 110,000 employees, retirees, and dependents. In 1994, Deere spent $222 million to provide coverage for this group. In this group there are approximately 17,000 retirees, of which 9,000 are Medicare eligible, and over half of this group elects to be covered through the company's managed care plans.

Over the last 3 years, 2,100 Deere retirees have reached age 65, of which 95 percent elected to remain in the company's managed care plans. Overall, John Deere Health Care provides managed health care services to over 300,000 enrollees through its two HMOs, Heritage National Health Plan and the John Deere Family Health Plan. Eighty percent of these enrollees are non-Deere commercial clients.

The John Deere Family Healthplan, a primary care staff model health center, was established through a strategic alliance with the world renowned Mayo Clinic, and with the endorsement and full support of the United Auto Workers.

Our success has been built on three basic principles: High quality health care is the most cost effective care; costs can be lowered when employers, providers, government, and managed care organizations create partnerships that utilize a market-based approach; patient satisfaction and education are of utmost importance.

Our overriding priority has been the development of high quality delivery systems. We focus our efforts on the primary care physician to coordinate the care. Working with Mayo physicians, we are implementing disease management strategies, a series of practice guidelines to best treat high frequency, high cost diseases. We are also deploying an electronic medical record which will provide our physicians an important tool to track all patient care and specifically these chronic diseases.

These tools, along with data, provide the physician greater control of care which we believe will enhance the quality of care. Em-

ployers, hospitals, physicians, and MCOs are responding to the need to manage cost while enhancing the quality of care.

Some examples: Deere health costs, which include supplemental costs for retirees, increased 2 percent in 1994. Deere costs equate to approximately $2,000 per covered person per year, which we believe is the only true method to measure cost. In 1994, we tripled the number of Iowa counties in which we served the Medicaid population. This program began in 1986 and now has 23,000 clients.

Our quality improvement program, such as the asthma disease management strategies, are being used with this population. We are encouraged by our recent success with the asthmatic population enrolled in our health centers. With overall success of the program, according to the Iowa officials, we are saving the State $500 per year per enrollee, and we voluntarily returned $3.5 million to the State last year.

These changes could not occur without patient satisfaction. Three years ago our enrollees rated our service the best in the country, according to a leading consumer magazine. In 1994, the Gallup organization researched our patients. Gallup compared us to 64 other health plans. Our patients scored us significantly higher than the national composite in key areas of patient satisfaction. Enrollee satisfaction in our staff model center was at 94 percent, or 6 percent higher than our IPA model. This suggests to us that we are able to offer choice, and yet see satisfaction levels above 90 percent in our most tightly managed care model. We believe we are adding value.

I would like to briefly speak to the issue of the Medicare insured group demonstration project we have been working on with Health Care Financing Administration, HCFA. Our involvement began when I chaired the OHMO National Industry Council in the late eighties. Former Secretary of Health and Human Services, Richard Schweiker, created the council to foster the development of HMOs.

The Medicare Insured Group, MIG, would be a 5-year demonstration project which would provide a savings to the Medicare Program by enrolling Deere retirees in our managed care programs. The post-65 retiree would continue to have a choice of plans but there would be incentives to move to the managed care programs. John Deere Health Care, through our health plans, would manage the care, paid for by Medicare, and we would also manage the supplemental benefits Deere provides this group.

While there have been many delays, we believe this concept can work and we are hopeful that the demonstration project can move forward. By utilizing some of the tools I have already mentioned, such as Disease Management Strategies, DMS, and Electronic Medical Record, EMR, we believe we can add value in managing the care and cost of this important population.

In closing, we believe that many of our programs can be made to work in the general Medicare population. Our experience with the Iowa Medicaid Program suggests it can work. Quality improvements in cost savings continue in that group. Current Deere employees, upon retirement and becoming eligible for Medicare, by and large, remain in our managed care programs. We also continue to see high levels of patient satisfaction.

With the emerging tools of care for physicians, DMS and EMR, we believe our managed care efforts are moving from the traditional component management of care to managing the continuum of care. This is the real value added.

We are confident after nearly 20 years of working to improve our managed care programs that they have proven their value in providing enhanced quality while managing cost. We believe the Medicare population will embrace managed care as they learn the value added, as have many Deere retirees. By encouraging choice within the Medicare population, we can build on one of our key principles: High quality health care is the most cost effective care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF RICHARD J. VAN BELL
JOHN DEERE HEALTH CARE, INC.

I would like to thank the members of the House Ways and Means subcommittee on health for this opportunity. I am President of John Deere Health Care, which is a wholly-owned subsidiary of Deere & Company. Deere & Company, of course, is best known for manufacturing John Deere farm machinery.

Deere & Company currently employs approximately 34,000 individuals worldwide. Health care benefits are provided to these employees, 17,000 Deere retirees and the beneficiaries of both groups. In 1994, Deere & Company spent $222 million to provide health and accident coverage to employees and retirees.

Twenty years ago, the company decided the cost of health care services provided to its employees and retirees could be better managed and the quality of care could actually be enhanced. After successfully starting two small Health Maintenance Organizations for our own employees, we were approached by other employers that they too would like to use the same techniques to impact the quality and cost of their own health care benefits.

Today John Deere Health Care offers health management services and managed care programs to Deere & Company, other companies and government agencies in Illinois, Iowa, Wisconsin and Tennessee. We serve the needs of over 300,000 members through two subsidiaries - Heritage National Healthplan and John Deere Family Healthplan.

We have gained considerable experience with government programs and with the Medicare population. Of the 17,000 Deere retirees for whom we currently provide health care benefits, more than 9,000 are Medicare-eligible. Just over half of those individuals choose to be covered in our managed care programs. We have 2100 retirees who reached age 65 in the past three years. Of those in managed care, 95 percent of them choose to remain in our managed care programs.

In addition, we provide health care coverage to approximately 40,000 Medicaid recipients. More than half of those are enrolled in the state of Iowa. There we have gained considerable success in providing quality health care at lower costs for patients in this population. We hope to see similar success in the TennCare project in Tennessee.

We have traditionally offered our managed care products through an Independent Physician - Model HMO named Heritage National Healthplan. In the past two years, Deere has opened three staff model health centers and will open four more by the end of 1995. These health centers are managed as a primary care, staff-model HMO named John Deere Family Healthplan. The health centers were opened as part of a strategic alliance with the Mayo Clinic. We received the endorsement and full support of the United Auto Workers to open these centers.

The number of employers using our managed care services has grown from 290 just two years ago to over 700 today. Deere employees and retirees now represent about twenty percent of our total enrollment.

Our success has been built on three basic principles. We have applied these principles to other government programs with great success, and no doubt they could be applied to Medicare as well.

- We believe that high quality health care is the most cost effective care.
- We believe that costs can be lowered significantly when employers, providers, government and managed care companies create partnerships that utilize a market-based approach.
- We believe that patient satisfaction and education are of utmost importance.

High quality health care is the most cost effective care.

Our overriding priority has been on the development of high quality delivery systems. We have found that by emphasizing the quality of care, we can also lower costs. This quality control is obtained by focusing on the primary care physician. That physician can direct all of the care of an enrollee and the enrollee's family. Coordinating this activity helps the physician to improve the consistency of care given each patient.

We emphasize quality of care in many ways. Here are some examples:

- As we started our health centers, Deere & Company developed an alliance with the Mayo Clinic for the continuous improvement of Disease Management Strategies, a series of clinical practice guidelines used by physicians in the health centers. These important guidelines allow health care professionals to create the best treatment protocols for certain high frequency, high cost diseases. These guidelines help the physician to deliver consistently high quality care but do not mandate the treatment plan.

  We have three strategies already in use at our health centers. They include guidelines for asthma, diabetes and high blood pressure. A total of 11 have been designed and will be implemented.

  Other diseases targeted include heart disease, depression, chronic headaches, lower back pain, breast cancer, gallstones, abnormal uterine bleeding and abnormal Pap smear.

- We are now deploying an Electronic Medical Record system which allows our physicians to track all key aspects of the care given to a patient. The system assists the physician in coordinating the care of each patient. The use of technology allows physicians to identify chronic disease patterns and act to prevent health care problems. This technology provides a tool for more consistent care.

- In our staff model health centers, Deere & Company handles the management and administrative functions. This frees the physician to focus on patient care. We provide data about each physician's practice that can be used by the physician to improve the quality of care provided.

- In choosing physicians, we review more than a dozen indicators to assure that the physician will practice medicine with a program and patient philosophy consistent with our own.

The success we have experienced at Deere in managed care comes from our practical, day-to-day recognition that the highest quality health care is also the most cost effective health care.

Partnerships which take a market-based approach can impact cost.

Employers, hospitals, physicians, community alliances and managed care companies are responding to the need to control health care costs while not compromising quality of care. For instance, Deere health care costs increased by two percent in 1994 which includes the cost for retiree supplemental plans with a slightly older workforce. Our cost last year was approximately $2000 per covered individual. We believe this is the only meaningful way to measure this cost since a cost per family can vary significantly because of family size. We also know there currently is no meaningful data available nationally on a per covered person basis.

We have not removed choice to achieve these results for enrollees from Deere, other companies and in our government programs. Employers have told us they prefer to give employees a choice

in health care plans, to allow the individual employee to choose the health care plan best suited to their specific situation. This system works when pricing of the various plans is reflective of the real market situation. We believe partnerships create plans which allow the interests of patients and employers to be met.

Partnerships also work in government programs. In 1994, we tripled the number of Iowa counties where we serve the Medicaid population. In this program, government served as a catalyst for change. Because of concerns by the State of Iowa, private sector alternatives were sought and developed. We first became involved with this project in 1986. Today 23,000 Medicaid enrollees in Iowa receive health care coverage through our managed care program. The history of our project is as follows:

- When the State identified the need, we first worked with local providers to create a partnership that was committed to meeting the challenge.

- We believed in one concept then that we maintain today. All patients are part of the mainstream in our system. Our quality improvement initiatives are targeted to improve the care provided to all patients. Our managed care programs and services are used with all patient populations.

  As an example, this year we are targeting children with asthma with our Disease Management Strategies. Our intervention with these patients will aim to improve the child's health status. Children in our Iowa Medicaid population will be included in the project. We will most likely provide financial savings to the State of Iowa by ensuring that a consistent and proper treatment plan is in place for this chronic illness.

- Annually, the State of Iowa pays five percent less than they would outside our program. In addition, two years ago we voluntarily returned an additional $3.5 million to the State of Iowa. According to Iowa officials, our program is saving the state $500 per year per enrollee.

We also are gaining valuable experience in state-mandated reform by participating in the TennCare program in Tennessee. We currently have 17,000 enrollees in the plan and have put in place some of the same strategies used in our Iowa experience.

In addition, we have 10,000 members enrolled through a Medicare cost contract and are working on development of a Medicare Insured Group (MIG) demonstration project with the Health Care Financing Administration.

Our involvement with the MIG project started when I chaired the OHMO National Industry Council in the late 1980s. This council was created by Richard Schweiker, former Secretary of Health and Human Services. The Council met to enhance and encourage the development of the managed care industry. Through this council, Deere & Company, along with others, envisioned a program to encourage more post-65 retirees into managed care.

The five-year demonstration project would provide for a five percent savings to the Federal Medicare program for each enrolled participant in our managed care network. The post-65 retiree would continue to have a choice in plans. But we believe there would be strong incentives for the post-65 year old retirees to move to managed care programs.

This concept continues to be of interest to us and we are moving forward to put this demonstration project in place. We believe the MIG project will provide better value to the Medicare enrollee and allow us to work more effectively with the providers.

In all of this experience, I would underscore the importance of all patient care being delivered in the same manner. No group of patients should be treated differently than another.

Patient satisfaction and education is an important emphasis.

Change cannot occur if patient satisfaction is not maintained. Three years ago, our enrollees rated our services as the best in the country, according to research by a leading consumer magazine. This rating came after many of our enrollees had seen dramatic change, moving to managed care programs for the first time in their life. We managed this change with educational programs and open communication. When you introduce more choice to Medicare participants, we believe you must target patient education as a top priority.

In late 1994, we commissioned the Gallup Organization to do research with our patients. Gallup compared us to a national composite database of 64 other health care plans. Our patients score us significantly higher than the national composite in key areas of patient satisfaction. These include:

- Overall Satisfaction
- Satisfaction as compared to their previous plan
- Satisfaction with Customer Service
- Courtesy with Physician Office Staff
- Overall Quality of Physician Care
- Thoroughness of Physician
- Satisfaction with the time the physician spends with the patient

There is a significant finding in this research. Overall enrollee satisfaction in the staff model health centers was six percent higher than in our Independent Physician Model HMO. Both scores are very favorable. However, the 94 percent ranking in our staff model managed care program means that a population can be moved to a more tightly managed plan without decreasing patient satisfaction. We have focused on improving the primary care physician's relationship with patients in this model and it appears to be adding value from the patient's perspective.

We also believe strongly in education of all enrollees. We have developed many programs aimed at specific groups to improve their health care. We have a New Generations program for women who will soon be new mothers. In this program we have improved the rate of pregnant women who seek care in the first trimester. We have also had significant success with other educational programs targeted at diseases such as diabetes, cervical cancer and breast cancer.

Can these same principles be applied to Medicare?

We have focused on quality of care in all of our programs. We believe in partnership with all of the stakeholders in the health care industry. We know patient satisfaction should not be jeopardized. These principles draw more people into managed care programs, even when they are given a choice. We believe these same concepts can work in the Medicare population:

- Our experience with the Medicaid program in Iowa clearly suggests it can work. Quality improvements and cost savings continue in that program. As we develop new strategies to improve the quality of care, we are having an additional favorable impact on health care costs for that population.

- We can keep current employees in managed care programs as they become Medicare eligible. Deere retirees report high levels of satisfaction with their care and with the administration of the managed care programs.

- Education of patients can attract other retirees not now in managed care. Our retiree population continues to grow in our managed care programs. This education must be focused on the quality of care provided.

- Mainstreaming Medicare beneficiaries with other patient populations is clearly possible and beneficial. Managed care plans have proven their value in providing lower costs and higher quality. Managed care is, however, only one tool among an array to manage health care cost and enhance quality.

There are important considerations in introducing more choice into the Medicare program, especially when the choices will include managed care programs. Here are some final thoughts about our current strategy for the MIG project.

- The MIG does not contain any monetary inducements for retirees to enroll in one of the managed care programs. However, we have designed the project to encourage enrollment in the MIG.

- We will closely parallel our current options to enrollees. The Medicare eligible will be automatically enrolled in the MIG.

- We believe retirees who currently enjoy the benefits of managed care will want to enroll in the MIG project. Our provider panels, our facilities, our commitment to quality, our enrollee satisfaction and our benefit levels have served as inducements in the past and will continue to be attractive under the MIG.

- Retiree participation in HMOs has increased over time. This appears to be because of the growth in the participation of active employees. As our employees retire, they stay with the benefits and delivery systems to which they have grown accustomed. And as the Gallup Survey showed, they are very satisfied with their current plans.

Deere has traditionally supplemented the Medicare benefit to cover virtually all medical expenses, and provided it at little or no charge to retirees. Because of this, there are only subtle reasons to choose managed care Retirees have nevertheless chosen the HMO options. We believe this increasing success is based on their perception of the quality of care, the coverage for preventive measures and the freedom from paperwork.

Encouraging choice in the Medicare program is important. Designing the choices to encourage high quality, cost effective health care will be a foundation for success.

Mr. MCCRERY. Thank you, Mr. Van Bell.
Mr. Maher.

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, CHRYSLER CORP.

Mr. MAHER. Thank you, Mr. Chairman and Members of the Committee. My name is Walter Maher. I am director of Federal relations for Chrysler Corp., and we appreciate the opportunity to be here today to discuss this important issue.

Chrysler firmly believes that anyone sponsoring a health plan, whether an employer or a government, can achieve savings without sacrificing quality if those benefits are delivered by selective managed care plans as opposed to traditional fee-for-service indemnity plans. And as such, we commend the Committee for examining all the options that are available to increase substantially the number of Medicare beneficiaries enrolled in such plans.

Now, given the current low rate of enrollment of Medicare beneficiaries in managed care plans and the potential savings inherent in increasing that number, real opportunities exist to achieve Medicare savings and help reach balanced budget objectives.

Increases in Medicare managed care enrollment will also help strengthen the hand of employers as they seek to achieve greater efficiencies from the health care system. In short, working in tandem, the public and private sectors can bring about reduced health care costs for our country, help bring those costs more in line with the costs prevailing in other leading countries, and in the process enhance American living standards, American competitiveness, and free up funds to help our country meet its other pressing needs.

Prior to 1989, I was Chrysler's director of employee benefits. With the cooperation of the unions representing many of our employees, we had put into place a series of successful innovative managed care programs designed to reduce the cost of the health care programs covering our employees and our non-Medicare retirees. During the latter half of the eighties, we entered into a cooperative research project with Health Care Financing Administration, HCFA, to determine whether Medicare and employer retiree health costs could be controlled, enrollee satisfaction enhanced, while maintaining quality of care.

Based on the recommendations of Health Data Institute, which conducted the study for us, in 1989 we decided not to pursue a demonstration project at that time. We were in the relative infancy of this concept, the number of unknowns were legion, and the risks to any company sponsor were great. More specifically, the parties were unable to satisfactorily resolve questions concerning risk selection and other uncontrollable risks.

The issue of the demonstration project's administrative cost was a significant one. To achieve lower operating costs would require significant investments amortized over long periods and large enrollments, neither of which were ensured.

We were also unable to secure an agreement with HCFA to permit the demonstration project to use Medicare's favorable provider payment arrangements.

Finally, if additional benefits were to be provided to spur enrollment, the demonstration project would have to generate efficiencies

great enough to exceed the combined cost of the additional benefits, Medicare's 5-percent retention, and the additional cost of administration if it were to reduce the cost for the sponsor of the demonstration.

Now, to say the least, much has transpired since 1989 insofar as health care financing is concerned. One major change in today's environment is the reality of financial accounting standard 106 regarding retiree health expensing. Employers providing retiree health benefits are more than ever acutely sensitive to such costs. They now have an even greater incentive to reduce those costs, but they also have incentives to avoid taking on new risks and liabilities: Witness the decline in the number of employers providing retiree health coverage.

Nevertheless, for employers who continue to provide coverage, it is clear that both they and Medicare have an interest in reducing the cost of retiree health care. Now, whether this will translate into employer interest in entering into risk arrangements with HCFA will depend on a number of factors, not the least of which is the company's aversion to doing anything likely to increase its retiree health cost or risk.

Now, in this regard, forecasted Medicare cost escalation and Part A shortfalls during the post-2002 period, portend further Medicare cost reduction efforts which may deter employers from participating in a demonstration where they assume the risk. Now, while such cost reduction efforts will undoubtedly be required, we would hope the primary focus will be on assuring that providers of care are committed to a continuous quality improvement process eliminating all semblances of waste in the system. The goal should be to reduce the cost of health care for all payers, public and private, rather than shifting costs from the public to the private sector.

Despite all of this, opportunities do exist for employers and Medicare to work together to realize retiree health care savings. For example, many employers offering managed care options offer plans developed by Blue Cross/Blue Shield, commercial insurance companies, and well-recognized HMOs. These plans, in turn, contract with providers. HCFA could negotiate risk arrangements directly with the managed care plans covering Medicare benefits, while the employer could negotiate an arrangement with the plan covering employer-provided complimentary benefits; and, by doing that, meet the combined objectives of Medicare, the employer, and the beneficiaries share.

In conclusion, Mr. Chairman, reforming the Medicare Program to incorporate an extensive offering of managed care options available to the employee population is a long overdo means to reduce the rate of growth in Medicare spending. Both our Federal budget deficit and our high rate of national health spending pose a major threat to sustained economic growth in the future. While solving either or both problems will not solve all of our country's economic and social problems, they are interrelated and solving them will be essential if we are to offer future generations of Americans the opportunities we all have enjoyed.

Thank you.

[The prepared statement follows:]

TESTIMONY OF WALTER B. MAHER
CHRYSLER CORPORATION

Mr. Chairman and members of the Committee, my name is Walter B. Maher. I am the Director - Federal Relations for Chrysler Corporation. Thank you for inviting me to appear here today to discuss employers and the Medicare program, and specifically the provision of Medicare coverage to former employees.

Chrysler Corporation produces cars, trucks, minivans and sport-utility vehicles for customers in more than 100 countries. It has been in business for seventy years. We employ over 120,000 people worldwide, almost 100,000 of whom work in this country. Chrysler provides health benefits for its employees, retirees and dependents of both groups. In 1994, we spent over $800 million for this coverage.

Chrysler firmly believes that anyone sponsoring a health benefit plan, whether it be an employer or a government, can achieve savings, without sacrificing quality, if those benefits were delivered by selective managed care plans as opposed to traditional fee-for-service indemnity plans. As such, we commend this Committee for examining all options to increase substantially the number of Medicare beneficiaries enrolled in such plans.

We also believe that, as Congress sets about the essential task of balancing the federal budget by a date certain, it is most appropriate that action be taken to reduce the rate of growth of federal Medicare expenditures. Given the current low rate of enrollment of Medicare beneficiaries in managed care plans, and the potential savings inherent in increasing that number, real opportunities exist to achieve Medicare savings and help reach balanced budget objectives. Increases in Medicare managed care enrolment will also strengthen the hand of employers and other private sector health plan sponsors as they seek to achieve greater efficiencies from the health care system. In short, working in tandem, the public and private sectors can bring our country's health care costs more in line with costs prevailing in other leading countries, and in the process enhance American living standards, enhance America's competitiveness, and free up funds to help our country meet its other pressing needs.

Medicare Insured Group Feasibility Study

Prior to June of 1989, I was Chrysler's Director of Employee Benefits. While in that position, one of my responsibilities was managing Chrysler's health care plans. As is the case today, controlling health costs was of the highest priority to Chrysler. Due to the highly competitive nature of the global automotive marketplace, and the significantly lower health costs in all other auto-producing countries, controlling health costs is critical to our competitive success.

Prior to 1989, with the cooperation of the unions representing many of our employees, we put into place a series of innovative managed care programs designed to reduce the cost of the health care programs covering our employees and non-Medicare retirees. This included not only traditional HMO's and PPO's, but also PPO's designed specifically for certain coverages, such as mental health and substance abuse cases, as well as programs to reduce the cost of our fee-for-service indemnity plans. As a result of these efforts, Chrysler kept its rate of health cost growth well below that of business in general.

For retirees eligible for Medicare benefits, Chrysler provides coverage for services not covered by Medicare that are covered by our plan for active employees. During the latter half of the 1980's, as part of our overall effort to better manage health plan costs, Chrysler, in cooperation with the UAW, sought to develop a feasible strategy to provide cost effective care for Chrysler retirees eligible for Medicare benefits. It was hoped that it would be possible to demonstrate that a single, integrated Medicare Insured Group (MIG) program would work better than two separate Medicare and Chrysler complementary programs. Consistent with the framework provided by the Omnibus Budget Reconciliation Act of 1987, a cooperative research project was

undertaken with the Health Care Financing Administration (HCFA) to determine whether Medicare and employer retiree health costs could be controlled, enrollee satisfaction enhanced, while maintaining quality of care.

Following a lengthy analysis by Health Data Institute (HDI), in 1989 Chrysler and the UAW concurred with HDI's recommendation not to pursue a MIG demonstration at that time. Several matters contributed to this decision, not the least of which was that we were in the relative infancy of this concept, the number of unknowns were legion, and the risks to MIG sponsors were great.

More specifically, given that the demonstration was to be voluntary for retirees (i.e. the retiree could choose to opt in to the MIG program or retain traditional Medicare coverage), Chrysler and HCFA were unable to satisfactorily resolve questions concerning risk selection and other uncontrollable risks.

Further, the issue of MIG administrative costs was a significant one. The cost to Medicare to administer its fee-for-service plan is significantly less than the costs an employer must incur to administer a comprehensive managed care plan, even for a very large group. Not only were ongoing MIG administrative costs anticipated to be higher, but since Chrysler was not in the health insurance or HMO business, significant start-up administrative costs were projected. To achieve lower operating costs would require significant systems investments amortized over long periods and large enrollments, neither of which were assured. Chrysler and HCFA were also unable to resolve this issue.

Given Medicare's favorable provider payment arrangements, we sought to enable the MIG to have the same terms available to it. We were unable to secure such an agreement with HCFA.

Another issue we confronted was the fact that certain managed care initiatives, to the extent they impacted the number of participating providers, could impact MIG enrollment and risk selection. If benefits over and above those provided by the combined Medicare/Chrysler benefits were to be provided by the MIG to spur enrollment, Chrysler would have to bear the cost of such benefits with no assurance of offsetting savings. In this regard, it should be noted that Medicare was to retain 5% of the cost of an experience rated capitated payment. Accordingly, if additional benefits were to be provided, the MIG would have to generate efficiencies great enough to exceed the combined cost of the additional benefits, Medicare's 5% retention, and the additional costs of administration, if it were to reduce costs for the MIG sponsor.

There were also several uncertainties in 1989, including uncertainties about the then recently enacted Medicare catastrophic coverage law and how it might impact the MIG, and uncertainties about future Medicare cost containment initiatives, including the 1989 recommendation by the Physician Payment Review Commission to change the way Medicare reimbursed physicians.

Current Environment

To say the least, much has transpired since 1989 insofar as health care financing is concerned. Medicare has continued to tighten its provider reimbursement policies to the extent that, for a comparable MIG project to save money today, it must rely almost exclusively on utilization-related savings. Further, some progress has been made to achieve utilization reductions within indemnity plans, so some of the "low hanging fruit" has already been plucked. Nevertheless, managed care still presents savings opportunities for Medicare and for employers providing Medicare complementary benefits.

Another difference in today's environment compared with 1989 is the reality of FAS 106. Financial Accounting Standard 106, which went into effect in 1993, requires

companies providing retiree health benefits to accrue the cost of such benefits during the years employees provide services. Prior to FAS 106, the expense recognized for these benefits was based primarily on the cash expenditures for the period during which the benefits were provided. It is clear that FAS 106 sent a wake-up call to corporate America on the future cost of retiree health benefits. Employers providing retiree health benefits are, more than ever, acutely sensitive to such costs. They now have an even greater incentive to reduce these costs, as well as ample reason to avoid taking on new liabilities.

According to a 1994 study released by KMPG Peat Marwick, Retiree Health Benefits: The Uncertainty Continues, employers' offering of retiree health benefits continues to shrink, even among the largest firms. According to this study, "Corporate America is against the wall on retiree health coverage, and firms are taking dramatic measures in response." It goes on to say, however, that employers are not necessarily out of options:

> ".. there are considerable opportunities for decreasing the burden of retiree health coverage on a firm's balance sheet. Managed-care plans, flexible benefit plans, and defined contribution health plans are just a few of the ways employers may be able to significantly reduce their retiree medical liabilities while still providing some level of retiree health coverage."

It is clear, therefore, that both Medicare and employers have a shared interest in reducing the cost of retiree health care. However, whether this will translate into employer interest in entering into risk arrangements with HCFA will depend on a number of factors, not the least of which is a company's aversion to doing anything likely to increase its retiree health costs or its risk. In this regard, employers must take cognizance of the fact that, according to recent testimony earlier this month before the Senate Budget Committee by Henry J. Aaron , Director of Economic Studies, The Brookings Institution, budget projections indicate that while Medicare outlays, absent change, are scheduled to rise from $176B in 1995 to well over $300B in 2002, they are scheduled to rise further to over $400B by 2005. Likewise, trust fund projections for Medicare Part A indicate that while the cash flow deficit is expected to hit $50B in 2003, it will grow to $100B in 2008. Given such forecasts, continued Medicare cost reduction efforts will likely be required if the federal budget is to remain in balance without resorting to tax increases. This prospect may deter many employers from participating in a MIG like arrangement Further, as efforts continue to reduce Medicare outlays, a primary focus should be on assuring that providers of care are committed to a continuous quality improvement process, eliminating all semblances of waste in the system, and meeting best practice benchmarks. The goal should be to reduce the cost of health care for all payers, public and private, rather than shifting costs from the public to the private sector.

Alternatives

Notwithstanding the above, opportunities exist for employers and Medicare to work together to realize retiree health care savings. For example, many employers offering managed care options, offer plans developed by Blue Cross Blue Shield, commercial insurance companies, and well.recognized HMOs. These plans, in turn, contract with providers. While these managed care plans often incorporate benefit administration techniques developed in concert with the employer, HCFA could seek to negotiate a risk arrangement directly with the managed care plan covering Medicare benefits, while the employer could negotiate an arrangement with the plan covering employer provided complementary benefits. In this way, the retiree would be able to remain in the same health system, subject to the same or similar cost containment rules applicable during pre-Medicare years, free of the administrative hassle retirees coping with both Medicare and a former employer's claims processing procedures must endure, and both Medicare and the former employer could realize health care savings.

In this regard, it should be noted that it has been the existence of ERISA which has facilitated the growth and development of high quality, cost effective employer sponsored health plans, the very plans you seek to enlist to help control the rate of growth in Medicare outlays. For this reason, both the federal government and employers have a mutual interest in preventing the adoption of anti-managed care proposals.

In addition, to assure Medicare does realize savings from the expansion of managed care enrollment, it appears that, in addition to revising the program to provide a reason for a Medicare beneficiary to want to enroll in a managed care plan, Medicare must also develop a risk adjusting technique to guard against risk selection. Based on testimony this Committee received earlier this year from Bruce Vladeck, HCFA Administrator, the Adjusted Average Per Capita Cost (AAPCC) method HCFA uses to pay Medicare risk contractors (not MIGs), is not adjusted for the health status of the enrollee. As a result, managed care currently costs the Medicare program rather than achieving savings, as these plans appear to attract the healthier members of the Medicare population. While negative for Medicare, beneficiaries enrolled in some of these plans receive additional benefits at no cost to them (which often serve as the incentive for them to join the plan in the first case). If Medicare wishes to achieve savings and increase enrollment in managed care plans, this cannot continue.

Conclusion

Mr. Chairman, reforming the Medicare program to incorporate the extensive offering of managed care options available to the employed population is a long overdo means to reduce the rate of growth in Medicare spending. Efforts to achieve Medicare savings which rely mainly on constrained provider fees, and which ignore the savings opportunities presented by managed care, often end up shifting costs to private sector payers and doing little to reduce overall national health spending. Both our federal budget deficit and our high rate of national health spending pose a major threat to sustained economic growth in the future. While solving either or both problems will not solve all of our country's economic and social problems, they are interrelated, and solving them will be essential if we are to offer future generations of Americans the opportunities we have enjoyed.

Mr. MCCRERY. Thank you, Mr. Maher.
Mr. Salter.

STATEMENT OF CHARLES G. SALTER, DIRECTOR, EMPLOYEE BENEFITS, GENCORP, FAIRLAWN, OHIO

Mr. SALTER. Mr. Chairman and Members of the Subcommittee, my name is Charles G. Salter, director of employee benefits of GenCorp. I am also pleased to serve on the board of directors for the Association of Private Pension and Welfare Plans, an association I am sure each of you are familiar with, with their constructive and thoughtful assistance in legislative matters affecting pensions and health care.

GenCorp is a technology-based company in Fairlawn, Ohio, with positions in aerospace/defense, automotive and polymer product markets. We cover approximately 26,000 employees and dependents in our employee medical plans and approximately 21,000 retirees and dependents under various retiree medical programs.

As a representative of a plan sponsored by a self-insured employer and an employee benefits professional, my intent today is to encourage you in your further exploration of the ways in which employers can participate constructively in the Medicare Program.

Like many other emplyers, we are engaged in examining the feasibility of contracting with HMOs that have risk-sharing contracts with Medicare. Briefly stated, I wish to encourage you in the following specific areas:

Congress should encourage the expansion of managed care within the Medicare Program. Managed care should be positioned to enhance the quality of health care delivered to Medicare beneficiaries. Congress should seek to attract more HMOs to participate in the Medicare risk-sharing program. Congress should encourage the participation of employer groups in the HMO risk-sharing program.

First, the experience of employers like GenCorp indicates that the strategy of managing health care produces better results than the passive use of the unmanaged fee-for-service system. Working with health care providers and network managers, such as HMOs or insurers, employers have driven the employee group health marketplace in the direction of organized systems of care that focus on the course of a patient's treatment, the coordination of necessary care, and attention to the overall allocation of scarce resources. The extension of these advances to Medicare beneficiaries should be encouraged and expanded.

Many managed care concepts and innovations have been developed and honed in the marketplace for active employees. Requiring health care providers and managed care networks to be responsive to the needs of plan participants and the employer/payers has literally transformed the marketplace for private employer groups in the last 7 to 10 years. It is not merely an economic phenomenon. Most successful employer managed care programs are focused on improving the quality of health care delivery. Good financial results typically follow efficient delivery of quality health care services. This model has much to offer the Medicare population, particularly in the areas of disease management, wellness, care of chronic health conditions, and the continuity of care.

Next, one of the hallmarks of the movement of employer plans toward managed care has been a focus on improved quality in the health care system. Among the lessons we have learned in manufacturing, as well as in delivering health care benefits to our employees, is that illusive concepts such as health care quality can be reduced to identifiable elements. The relative presence or absence of these elements can serve as indicators of the quality of network management and ultimately the quality of health care delivery.

The coalescence of health providers, network managers, insurers, and other professionals around such benchmarking activities as the HEDIS, Health Plan Employer Data and Information Set, measurement tool and the collaborative efforts of employer-led initiatives like the Cleveland Health Quality Choice program are evidence of marketplace activity that is having success and positive impact on improving the quality of care and reducing cost.

Both, the government and the private sector have substantial financial obligations with regard to retiree medical coverage. Approximately 40 percent of all Americans receive their health care benefits from self-insured employer-sponsored plans. It is clear that both parties have a significant interest in seeing that quality improvement continues to be a hallmark of managed care as it is introduced to the Medicare population.

My message to you today, simply put, is that quality costs less. Incorrect diagnoses, improper treatments, unnecessary service, and the inappropriate setting for care are, by definition, not quality. The key is identifying a reasonable consensus view on quality indicators, communicating that view to managed care organizations, and then driving the change.

Today, less than 10 percent of Medicare beneficiaries are enrolled in managed care for the receipt of their benefits. Despite increased efforts by HCFA and the HMO community, the level of participation is far below the level of participation in the pre-65 population. At GenCorp, the figure in managed care is close to 80 percent.

I will leave it to the HMO community and managed care networks to identify technical factors that may need to be revisited in order to increase managed care enrollment under Medicare. Generally, however, I would call your attention to one significant characteristic of the current Medicare risk-sharing program.

Under the HMO risk-sharing program, HMOs contract with HCFA on a capitated basis to provide at least the full Medicare benefit package, usually along with additional supplemental benefits. This has led, however, to the development of an HMO Medicare product focused on individuals rather than on groups.

The individual nature of the product contributes to the labor intensive way in which HMOs must market, enroll, and administer their Medicare members. It also leads to the final suggestion I wish to offer to you today. Increased employer involvement in enrolling retirees in Medicare risk-sharing HMOs can help bring greater group related efficiencies, greater retiree acceptance as well.

Increased employer participation in the Medicare risk-sharing marketplace has several benefits to the beneficiaries, employers, and the government. Current and future Medicare beneficiaries will be more willing to enroll in Medicare risk-sharing HMOs if

their employers are actively involved in reviewing and monitoring those plans.

Employees are also able to negotiate and improve plan designs from risk-sharing HMOs by seeking supplemental benefits and improve pricing arrangements for employer groups. Experience with enrolling active employees in managed care has also taught employers what needs to be communicated to participants in order for their decisions to be well informed and for a managed care program to be successful.

At GenCorp, we are currently participating in an employer coalition lead by a national benefits consulting firm, Towers Perrin. This coalition of over 70 employers is exploring the offering of selected risk-sharing Medicare HMOs to over 1.5 million Medicare-eligible retirees. We recently completed the first phase of analysis in which we identified the areas where our retiree population, combined with others in the coalition, have a geographic match with current risk-sharing HMOs. The response of HMOs so far is encouraging. We are hoping to negotiate and approve meaningful supplemental benefits on favorable terms in addition to the required Medicare package.

We believe that employer involvement in the process will contribute to higher than average retiree enrollment and satisfaction with the selected HMOs involved. This is a developing example of the positive role that employers committed to the benefits of managed care can play in connection with the Medicare Program.

I thank you for the opportunity to testify today, and I would be pleased to respond to any questions you might have.

[The prepared statement follows:]

TESTIMONY OF CHARLES G. SALTER
GENCORP

Mr. Chairman and members of the Subcommittee, my name is Charles G. Salter, Director, Employee Benefits of GenCorp.

GenCorp is a technology-based company located in Fairlawn, Ohio, with strong positions in aerospace/defense, automotive and polymer product markets with net sales of $1.7 Billion in 1994. We cover approximately 26,000 employees and dependents in our employee medical plans and approximately 21,000 retirees and dependents under various retiree medical programs.

As a representative of a plan sponsored by a self-insured employer and an employee benefits professional, my intent today is to encourage you in your further exploration of the ways in which employers can participate constructively in the Medicare program. Like many other employers, we are engaged in examining the feasibility of contracting with HMOs that have risk sharing contracts with Medicare. Briefly stated, I wish to encourage you in the following specific areas:

- Encourage the expansion of managed care within the Medicare program.

The experience of employers like GenCorp indicates that the strategy of managing health care produces better results than the passive use of the unmanaged fee-for-service system. Working with health care providers and network managers, such as HMOs or insurers, employers have driven the employee group health marketplace in the direction of organized systems of care that focus on the course of a patient's treatment, the coordination of necessary care and attention to the overall allocation of scarce resources. The extension of these advances to Medicare beneficiaries should be encouraged and expanded.

Many managed care concepts and innovations have been developed and honed in the marketplace for active employee group health benefits. Requiring health care providers and managed care networks to be responsive to the needs of plan participants and the employer/payers has literally transformed the marketplace for private employer group health coverage in the last seven to ten years. This is not merely an economic phenomenon. Most successful employer managed care programs are focused on improving the quality of health care delivery; good financial results typically follow efficient delivery of quality health care services. This model has much to offer to the

Medicare population, particularly in the areas of disease management, wellness, the care of chronic health conditions and the continuity of care.

- Use managed care to enhance the quality of health care delivered to Medicare.

One of the hallmarks of the movement of employer plans toward managed care has been a focus on improved quality in the delivery of health care benefits. Among the lessons we have learned in manufacturing, as well as in delivering health care benefits to our employees, is that elusive concepts such as health care quality can be reduced to identifiable elements. The relative presence and/or absence of these elements can serve as indicators of the quality of network management and ultimately the quality of health care delivery. The coalescence of health providers, network managers, insurers and other professionals around such benchmarking activities as the HEDIS measurement tool and the collaborative efforts of employer-led initiatives like the "Cleveland Health Quality Choice" program are evidence of marketplace activity that is having success and positive impact on improving the quality of care and reducing cost.

Both the government and the private sector have substantial financial obligations with regard to retiree medical coverage. Approximately 40% of all Americans receive their health care benefits from self-insured, employer sponsored plans. It is clear that both parties have a significant interest in seeing that quality improvement continues to be a hallmark of managed care as it is introduced to the Medicare population. My message to you, simply put, is that quality costs less. Incorrect diagnoses, improper treatments, unnecessary services and inappropriate settings for care are, by definition, not quality. The key is identifying a reasonable, consensus view on quality indicators, communicating that view to managed care organizations and then driving the process in our roles as payer through continual quality improvements.

- Attract more HMOs in the Medicare risk sharing program.

Today, less than ten percent of Medicare beneficiaries are enrolled in managed care programs for the receipt of their Medicare benefits. Despite increased efforts by HCFA and the HMO community, this level of participation is far below the level of participation of the pre-65 population in managed care. Among active eligible employees, more than 50 percent are enrolled in some type of managed health care system. At GenCorp this figure is closer to 80%. The employers who moved in this direction, some of them many years ago now, have enjoyed the benefits along with the risks of being pioneers. In similar fashion -- that is, to drive marketplace change for Medicare beneficiaries -- I suggest you focus on those policy changes that will

continue to attract HMOs in all regions of the country into the risk sharing program.

I will leave it to the HMO community and managed care networks to identify those technical factors that may need to be revisited in order to increase managed care enrollment under Medicare. Generally, however, I would call your attention to one significant characteristic of the current Medicare risk sharing program. Under the HMO risk sharing program, HMOs contract with HCFA on a capitated basis to provide at least the full Medicare benefit package, usually along with additional supplemental benefits. This has led, however, to the development of an HMO Medicare product focused on individuals, rather than groups. The individual nature of this product contributes to the labor intensive way in which HMOs must market, enroll and administer their Medicare members. It also leads to the final suggestion I wish to offer you; increased employer involvement in enrolling retirees in Medicare risk sharing HMOs can help bring greater group-related efficiencies and greater retiree acceptance to this aspect of the Medicare program.

- Continue to encourage the participation of employer groups in the HMO risk sharing program.

Increased employer participation in the Medicare risk sharing marketplace can have several benefits for Medicare beneficiaries, employers and the government. Current and future Medicare beneficiaries will be more willing to enroll in Medicare risk sharing HMOs if their employers are actively involved in reviewing and monitoring these plans. No amount of HMO marketing and advertising can compete with the positive effect of a communication from the retiree's former employer introducing the managed care concept and the potential benefits of participating in a managed care network or HMO. As I indicated earlier, approximately 80% of our employees are already participating in managed care programs; therefore, continuation of managed care into retirement will be anticipated and considered the norm.

Employers also are able to negotiate improved plan designs from risk sharing HMOs by seeking supplemental benefits and improved pricing arrangements for employer groups. This existing flexibility in the risk sharing program is sometimes not even fully understood by HMOs that have risk sharing contracts with Medicare. As sophisticated purchasers of health services, employers involved in this market place can bring about product innovation by HMOs and greater value to retirees.

Experience with enrolling active employees in managed care programs has also taught employers what needs to be communicated to participants in order for their decisions to be well informed and for

a managed care program to be successful. Success in these programs is measured by participant understanding and acceptance, not by coercion. Employer involvement in enrolling retirees in risk sharing HMOs that the employer endorses can lead to lower disenrollment by retirees from risk sharing HMOs.

At GenCorp, we are currently participating in an employer coalition led by a national benefits consulting firm, Towers Perrin. This coalition of over 70 employers is exploring the offering of selected risk sharing Medicare HMOs to over 1.6 million Medicare-eligible retirees. We recently completed the first phase of analysis in which we identified the areas where our retiree population, combined with others in the coalition, have a geographic match with current risk sharing HMOs. The response of HMOs so far is encouraging; we are hoping to negotiate improved and meaningful supplemental benefits on favorable terms in addition to the required Medicare package. We believe employer involvement in this process will contribute to higher than average retiree enrollment and satisfaction with the selected HMOs involved. This is a developing example of the positive role that employers committed to the benefits of managed care can play in connection with the Medicare program.

Thank you for the opportunity to testify today. I would be pleased to respond to any questions you may have.

Mr. MCCRERY. Thank you, Mr. Salter, and thank all of you for your excellent testimony.

Now I am going to ask Mr. Ensign if he would like to inquire of the witnesses.

Mr. ENSIGN. Thank you, Mr. Chairman.

I want to explore some of these ideas you talked about. Mr. Van Bell, you talked about saving $500 per year. I think that all of you, through a lot of the innovations you have done through your companies and with some of the coalitions, have been able to bring the costs down in some cases, in some cases slowing the rate of growth similar to what we are talking about doing with the Medicare population.

In Mr. Stark's opening testimony, he talked about severe cuts in Medicare spending. I want to address that issue because I think it is a very important issue. The other day we had a person that was in charge of the University of California health care systems, and they talked about savings, over $650 per year per enrollee. Because of the innovations they had done, they actually had savings that much per year.

I asked the question, and I am asking you the same question, do you consider the savings through innovation, and all of you mentioned that you had improved quality and not decreased the level of satisfaction from your enrollees. Do you consider those cuts?

Mr. VAN BELL. I would certainly be happy to try to respond to the question. I don't believe that our retirees or the Medicaid eligible in the State of Iowa that are in our program would look upon our innovations as cuts. I believe that they would look upon them as enhancements to the quality of the care we provide.

In a number of initiatives surrounding our disease management strategies with the asthmatic population, we are beginning to see some real benefits through the education process, teaching these patients how to use peak flow meters and manage their own conditions so they are not needing to run to an emergency room at 3 o'clock in the morning. These kinds of innovations, we believe, are going to clearly enhance the quality of care.

People have told us that they feel they are in control and they are managing their care much more efficiently with the primary physician that they are now a part of, in a relationship.

Mr. ENSIGN. What Mr. Stark said this morning, though, you just cut their benefits because you are spending less money. You are saving money by not going to the emergency room. That is a cut. Just because you are giving them better care, that doesn't mean anything, I guess. That is a cut.

Mr. VAN BELL. Well, I can't really represent what was said earlier. I can only say what we are doing, and I look upon it as a way to improve the quality of care, and that is really one of my missions. If I am saving money in the process that can be used for other types of care or other services in this country, then that is a positive that flows from this activity.

Mr. ENSIGN. Mr. Stark also mentioned in his testimony about maybe these companies getting involved with the retirement population do not have the purest motives at heart when they are trying to get involved with this type population.

Could you, anybody on the panel, address some of the reasons that you would want to be involved with the retirement population, the Medicare population?

Mr. MAHER. I think the only reason a company would want to get involved is the same reason that the government wants to get involved, and that is to have a win-win situation. For that reason, a company is not likely to want to get involved if they think the deck is stacked against them and they are going to lose money, very clearly for the reasons in my testimony. I would submit that Medicare, likewise, should not enter into an arrangement if it would lose money.

I happen to believe that, as you go down this path, which makes an awful lot of sense in terms of trying to get more people in managed care plans, that the current methodology that is used to pay for these beneficiaries appears to be working against the government. The last thing you want to do is to worsen the budgetary situation.

So, I would encourage the Committee to look into how the government pays to make sure that it is a good deal for the government. The only way this is going to work is if it is a good deal for both parties, and, frankly, it can be.

Mr. ENSIGN. Well, not as far as the rhetoric up here is concerned. It is one or the other. I would agree with you. We need to change our paradigm. We need to change our mindset, similar to what business is doing in the United States with labor unions and management.

There are ways to have both parties win. I think the best way for us is to design programs where the Medicare population and the government both win.

Mr. VAN BELL. I would just add that in our health plans, on the boards of our health plans, labor is represented and has been represented for 15 years. So, we have an ongoing dialog with labor.

As we look at managing the costs of our parent company, that is one of our missions within John Deere Health Care. Our retirees are an important part of that, as I mentioned. We believe that it is important to manage all the supplemental benefits that we provide.

Beyond Medicare, we provide the pharmaceutical benefit, drug benefits, vision, hearing, dental. All of those are components of cost that we have to bear as a corporation, and we need to work on managing those costs and that is part of our responsibility.

Mr. ENSIGN. My time is up. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Ensign.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. Let me thank all three of our witnesses, not only for their testimony, but for the ways in which you have managed your health care for your respective entities. Very impressive testimony and very impressive results.

One of the purposes for today's hearing is to explore the feasibility of looking to private employers to assume more of the responsibility in Medicare, if we were to look at your employees once they reach the age of Medicare eligibility, all remaining in your health care plans.

The Republican-passed budget in the House provides for an annual increase in Medicare over the next 7 years of 5.4 percent. Now, if you adjust that for the demographic changes that are anticipated, that would be approximately a 3.9 percent per capita increase over the next 7 years.

The question that I would like to focus on, would you be willing to assume the responsibility of all of your retirees who have reached the age of Medicare eligibility, and assume full responsibility for their health care costs with the Federal government paying to you the current per enrollee federal cost for Medicare, adjusted annually by 3.9 percent? Can that work?

One of the difficulties we have on optional plans is, we run into the problem of potential adverse selection or cherrypicking, however you want to refer to it, and there is a tendency for the more disabled seniors to stay in fee-for-service under Medicare and not to come into a managed care environment.

So, my question is, if the system were so designed that every person that is in your plan remains in your plan on reaching Medicare eligibility, and the Federal Government were to pay you that sum of money, is that a feasible alternative? Understanding, of course, that we would require that the benefit levels not be reduced or the cost to the seniors increased as one of the ways of bringing the plans into balance.

Who wants to tackle that? Are you willing to assume that responsibility?

Mr. MAHER. I will start. Mr. Cardin, there are a lot of employers, including our company for a sizable number of our retirees, that have already taken the step the Congress is trying to take, that is, by trying to limit our future liability for cost by just assuming that we are going to pay *x* dollars, perhaps inflated each year by some amount, and, in essence, the risk gets transferred, in this case to beneficiaries. For a lot of the reasons set forth in my testimony, I think that you will find a lot of apprehension in the employer community about the proposal that you mentioned.

Let me get to the larger question, and that is businesses in this country today, if they are going to succeed in a global economy must operate with a continuous improvement mentality, setting breakthrough objectives and then, hopefully, meeting them; and setting new breakthrough objectives. The objective should not be whether it is reducing the rate of growth or cutting Medicare costs, it is trying to get the job done as efficiently as possible.

Given all of the indicators of excess in the health care delivery system in this country, I am not prepared to say that 3.9 percent is not doable.

Mr. CARDIN. The question is would you be willing—how would you feel if legislation were crafted that required you to assume this responsibility without diminution of benefits to the seniors or without additional cost to the seniors, guaranteeing you the funds that I said? How would Chrysler feel about that? Would you support that legislation?

Mr. MAHER. Well, first off, I think you saw the attitude of the great bulk of the employer community in the last 2 years when the subject was taking on the risk for active employees on a mandated

basis. I suspect that if you are talking about, all right, we are going to therefore mandate everybody to take on not only——

Mr. CARDIN. I will do it voluntarily. Will you step forward and volunteer to take——

Mr. MAHER. I think my testimony makes clear all of the reasons why you would find a lot of apprehension in the employer community for the employer to assume that risk.

Mr. CARDIN. I understand that.

Mr. MAHER. I think I have set some alternatives here. There are people in the business called HMO plans who are in the business of assuming risk, and there is no reason why HCFA and employers cannot contract with them.

Mr. CARDIN. The difficulty is that unless you take the full group, you run into the——

Mr. MAHER. Selection problem.

Mr. CARDIN. The selection problem. We know that is one we have not been able to come up with a satisfactory solution for. Maybe, you all have the answer to that. We welcome your suggestions. We are still trying to figure out how to deal with selection.

The bottom line is this: Can the business community, which has been successful in dealing with health care by better educating your enrollees and developing better ways of offering additional choice to your employees, can you take on more of this responsibility, at a 3.9 percent annual growth, without diminution of the benefits or additional cost?

I think the answer is—and you were pretty direct—you would be pretty reluctant to accept that kind of responsibility.

I don't know if either of the other two witnesses want to comment or not.

Mr. VAN BELL. I would quickly add that I don't believe we know the answer to the question. There are so many variables when you look at our population versus, say, Chrysler's or anyone else, trying to understand how you would do it. We as an HMO are looking into seeking a risk contract as we speak. Some of the work we are doing with a MIG addresses——

Mr. CARDIN. That doesn't assume all your employees.

Mr. VAN BELL. Pardon?

Mr. CARDIN. That doesn't assume that everyone will join the risk contracts.

Mr. VAN BELL. No, I am talking about the commercial aspect of John Deere Health Care. The risk.

Mr. CARDIN. I'm sorry.

Mr. VAN BELL. There are so many variables that we would have to understand, plus the administrative activities. Seeking a risk contract, as I understand it, is probably a year's proposition at the very best. So, there are a lot of things that go into that decision, and it is very difficult. The variation from different parts of the country. It is so difficult to answer that question.

Mr. CARDIN. Thank you.

Mr. SALTER. I can say that at GenCorp we certainly believe this whole issue is a national issue; probably needs to be spread in some form over the economy as a whole.

What I think each one of us, independently, has said is that managed care has worked at our companies. If you have a level

playingfield, there is absolutely no reason why it cannot work nationally. When we talk about cuts, we are really talking about cuts in waste, cuts in inefficiency.

Our companies are not in the position to continue to invest in waste. Quite the opposite. We are trying to cut that. That, in turn, relates to improved service and improved quality, and so forth.

So, I believe what we are really saying is that quality costs less and the only way you get to quality is to begin to measure what you do. Right now we are not doing that in our health care delivery system.

Mr. MCCRERY. Thank you, gentlemen. Thank you, Mr. Cardin.

Since, Mr. Cardin's questions are always so penetrating and elicit such enlightening information, and because he has no help on his side today, I allowed him to go further than we normally would.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Let's just go over some Medicare facts in terms of the spending per senior citizen this year and in terms of medical benefits received. Currently, we are spending $4,800 per Medicare recipient. In year 2002, we are going to spend $6,400 per Medicare recipient in terms of medical benefits received. That is a $1,600 increase.

Listening to Mr. Stark speak, it would seem as if we are bringing an end to Medicare as we know it. These "Mediscare" tactics that have been promulgated by the liberals in this House is really disgusting, and we keep hearing it from our friends on the left. It doesn't help us get to a solution of the Medicare problem.

Clinton's own trustees, as you know, have stated that Medicare goes bankrupt in the year 2002. It is growing at a 10-percent growth rate. We are going to slow it down to 6 percent. But yet, to listen to Mr. Stark and others speak, innovative and novel ideas are not what we need at this time.

My question would be regarding the Democrats' big government experiment with health care last year that was soundly rejected by the American people. Where were each of your companies on this approach to solving health care last year? And then I have a follow-up.

Mr. VAN BELL. We followed the legislation throughout the process and we felt very strongly that the private sector held many of the solutions. We were very concerned about the creation of alliances and more government intervention with our programs.

We felt very strongly that we should continue to work to unleash the private sector in health care. We felt a number of the innovations that we had embarked on and invested in to improve the quality of care would probably not continue if we moved in that direction. So we were terribly concerned with the direction of legislation last year.

Mr. MAHER. Our company believes that the health cost in this country and the cost shifting that is inherent in this country will really never be fully resolved until you get all people in this country covered. As a result, there were many aspects of the Health Security Act, including the goal of getting everyone in this country covered that we supported.

To the extent the country decided that it wanted to continue with a public-private system as opposed to a fully tax supported system,

if we were going to rely on employers to provide coverage for people who worked, the great bulk of people do that, we did support the fact that all employers should be required in some way to contribute to the cost of health care in this country.

We supported reliance on competition in terms of health plan design as opposed to a fully rated regulated system. Because we think that competition, in terms of solving the cost problem, if it is competition versus full rate regulation, you are better to have some blend of both rather than having a fully rated regulated system. Because, clearly, the marketplace has shown that you can get efficiencies in the system. We are starting to see the introduction in some European countries experimenting with HMOs, and so forth, even within their budgeted systems.

We did support a requirement that all employers in some way participate in the system, because my company, for example, and the manufacturing sector in general, is paying about 28 percent additional in health costs because of cost shifting. A great deal of that is because people in our industry, in manufacturing and other large industries end up not only paying for their employees, but also spouses of their employees who have jobs elsewhere. It is just, in our sense, not a fair way of distributing costs.

Mr. CHRISTENSEN. Mr. Salter, also, I would like you to address whether your company has experimented with MSAs at all?

Mr. SALTER. No, we have not. I have a comment on that, though. I think it is interesting, I had a chance to explore the issue as far as allowing individuals through MSAs, for example, to purchase their own health care. It gets to the subject or the topic of innovation in health care.

It is interesting. It is not very innovative if you look at somebody who is selling an appliance in a store. They have a price tag, and they even have a consumer report that will rank all the quality. I think what we have said today is that we really would like to see the force of the markets unleashed at producing efficiencies in the system.

There is no consumer report on health care. Quality is assumed in the system. That is dangerous because we have already recognized we have measured some. There is a large variance in quality within even communities. Price is very difficult to obtain. Therefore, if you are purchasing based upon value, and value typically is some tradeoff between quality of a product and the cost of that product, that is not available in the health care system.

So, really, consumers today cannot go out there and, quote, shop for their health care. I think if we had something like that, it would perhaps go a ways toward helping with MSAs.

Mr. CHRISTENSEN. You are exactly right, and we had a panel yesterday, including, among others, Stuart Altman, who summed it up perfectly about the HCFA and the health care system delivery we have now for the Medicare. His quote was, we are talking about efficiency here. That, unfortunately, sums up our system.

Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman. Just a couple of questions, one specific and one a little broader.

Specifically about John Deere. Is this correct, that you give retirees the same health care coverage if they go outside the managed care arrangements?

Mr. VAN BELL. Their benefit offering provides that they have basically the same package. There would be some enhancements through our managed care program, effective case management, some education in preventive medicine, and things like that. They are very much the same plans.

Mr. HOUGHTON. OK. Now, the more general question really is, the difference between the approach that Chrysler and John Deere are taking as far as retirees.

If I understand it, Chrysler rejected the concept—working closer with HCFA—to be able to blend the Medicare and the non-Medicare expenses. It somehow did not work out. John Deere was willing to do that, assuming, of course, that the whole push would be more toward the managed care area, and you thought that that was a good sort of common denominator. Why the difference in the two approaches here?

Mr. VAN BELL. I will let Wally answer that and then I will try to respond, too.

Mr. MAHER. Two things. First, the time period. Our involvement was 1988 and 1989. In addition to the uncertainties that I mentioned in my oral testimony today, my written testimony talks about a lot of the other things on the table then. For example, at that time the Medicare Catastrophic Act had just passed. The question was how in the world is that going to impact our negotiations with HCFA? The Physician Payment Review Commission had just recommended to Congress a total overhaul in the way Medicare paid physicians, which was probably going to be implemented, and indeed was. How was that going to impact our arrangements? Probably the biggest factor is that we are not in the HMO business; John Deere is in the HMO business. They have been working on this project with HCFA for 5 years and will likely start it, as I understand it, next year, 1996.

Being in the health plan business eliminates from consideration a significant amount of the investment in administrative systems. In other words, to a certain extent there is some sunken cost already there in an ongoing HMO that we don't have, and we are in the car and truck business and not in the HMO business.

So, the question to our management at that time, do we want to make an additional investment in this type of system which, to make sense, would have to be amortized over a long period of time and over a large enrollment? The question: Are you going to be in this demonstration for a long enough period of time and get enough people in it to make it worthwhile? And those questions were just not satisfactorily resolved.

Mr. HOUGHTON. OK.

Mr. MAHER. Conceptually, what I think is important, is we continue to believe that both companies offering complimentary benefits and Medicare, both can gain if that Medicare beneficiary is enrolled in a good, efficient health plan. The question is: Who is going to bear that risk?

I think one suggestion we have is there are businesses out there in that business of managing health plan delivery. I suggest that,

in terms of accountability, it may be best to have the health plan, the accountable health plan, be the one bearing that risk. Indeed, that is the business that John Deere Health Care is in, to be an accountable health plan.

Mr. VAN BELL. There clearly are differences. First of all, we feel very strongly that health care is local. Our environments are very different, where Chrysler would be located and maybe where Deere is located with a number of its facilities. I also need to preface any remark by indicating it has been 5 years and that is not really a problem because of HCFA, it has been a combination of a lot of things that had to be dealt with.

We believe with health care being local that we can work with those providers very effectively. We know that most of our retirees domicile in the community in which they work when they retire. We have been in this business for about 20 years. We have a database of retiree costs, at least supplemental costs. The situation was significantly different looking at Chrysler and John Deere.

Now, there are applications, I am sure, very similar to ours in other parts of the country where a MIG might very well work.

Mr. HOUGHTON. Mr. Chairman, could I just ask one more quick question?

Gentlemen, since you are not willing to accept the succulent offer of Mr. Cardin here on the 3.9 percent, I must assume, therefore, that you are going to be able to control your costs over the next 5 years below that. Is that right?

Mr. VAN BELL. I don't know as anyone really knows what is going to happen with costs over the next 5 years. I know we will negotiate additional labor contracts in that period of time. I have no idea what might be envisioned in labor negotiations that might impact retiree costs. I have no idea what might happen at the State or Federal level. It is very, very difficult to try and forecast what those costs are.

What I try to do is to manage those costs as well as I possibly can with a quality thrust. Our whole effort, we really believe that enhancing the quality of care is going to reduce the cost of that care. Everything we do, our physicians that are on staff in our centers, our work with Mayo, all are directed to do that. We believe the payoff is in managing that cost. The peripherals out there, many things I cannot control.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Houghton.

Mr. Van Bell, if you can, let us explore some of the negotiations that have been taking place with HCFA over the last several years. I am going to try to characterize the interests of HCFA and the interests of John Deere and you tell me if it is a proper characterization and then let us expound on it.

HCFA, I assume, is concerned that if they give you a capitated rate for folks in your HMO that you will get the low-cost employees into your HMO and the high-cost employees will stay in the fee-for-service and Medicare will have to reimburse them on a fee-for-service basis.

Your concern, I would assume, is that if you accept a capitated payment, you don't want to get all the high-risk patients in your

HMO under a capitated rate and have the better risk stay in fee-for-service.

Is that the tug and the pull that has been taking place?

Mr. VAN BELL. I don't know it is fair to characterize it as a tugging and pulling, but I would say that trying to understand what the rate ought to be is the question. We have been working with HCFA in very positive ways to try to determine what the appropriate rate is, looking at the Deere experience, looking at the county experience, looking at national experience.

We have engaged the help of Deloitte & Touche as we work through this and in attempting to come up with what is appropriate. Obviously, the MIG has a 5 percent savings right off the top, on whatever rate you establish for the beginning of the demonstration for the Medicare Program. There also is a cap on what we would be able to retain if, in fact, we do generate the savings that we believe are there through local involvement, local control.

I believe that the rate setting will be established. I think it is a question of making sure that we have the appropriate risk and reward relationship put together.

Mr. MCCRERY. And where are you right now?

Mr. VAN BELL. We are really in the final stages of reviewing where we are on rates. We have had some dialog in the last few weeks. We expect that we will be sitting down with HCFA very shortly.

Our goal would be to do that, to continue to visit with the UAW, United Auto Workers. We have brought them along as this process has evolved over the last several years. It has been in phases, if you will. Factfinding, rate setting, and education. Our goal would be that we would start that MIG sometime the end of this year or January 1, 1996. That is at least the objective set in place.

Again, I will assume that we can work through the rate-setting issues. I assume that we will have continued endorsement from the UAW to do the demonstration.

Mr. MCCRERY. Well, are you basing your assumptions on a normal or average group or are you trying to get more specific than that and analyzing who your participants are going to be?

Mr. VAN BELL. The work that we have been doing is a demonstration in one community where Deere has a major presence. It is in the quad city, Moline, where our corporate office is located. About 350,000 people reside in that community and we have a good concentration of retirees that live there.

We are trying to understand the experience of that population, which is data that HCFA has. We would only have supplemental data. What the county rates are versus national rates and trying to understand how the Deere population stacks up in there so we can set the rate that is appropriate and HCFA then in fact is incented with their 5 percent and we are incented to perform the kinds of things I mentioned earlier we are working to do.

Mr. MCCRERY. Will all of your retiree population participate?

Mr. VAN BELL. In that community they would be placed in the MIG, but could elect to opt out of that program if they so elect. It is my understanding that that is acceptable as to how we would do it.

We would have to go into an exhaustive education process. Keep in mind, a lot of our retirees already are in our managed care programs in that community.

Mr. MCCRERY. But if they have that option to get out of the HMO, isn't HCFA concerned that their high risk beneficiaries will opt out and go for the fee-for-service?

Mr. VAN BELL. I have not personally been in a discussion where that was mentioned. It may be that that is an issue that they will raise with us, I don't know.

Mr. MCCRERY. OK. One last question for Mr. Salter. If you want to entice your retirees to join a Medicare HMO, how would you do it?

Mr. SALTER. Well, probably the easiest way is an evolutionary approach. We have, for example, close to 65 or 70 percent of our active employees on the West Coast in HMOs now. Our biggest challenge, obviously, is the challenge of change, and it takes some time to get people used to the managed care concept.

I think any time that you run parallel systems where you are allowing essentially two delivery systems to operate side-by-side, one that allows, "total freedom of choice to go anywhere you want on a fee-for-service basis and another, managed care system that has restrictions on utilization, people with higher risk will tend to opt for the fee-for-service system."

The way we have expressed it at GenCorp, is that we are on a continuum of care and we are moving from fee-for-service toward full managed care. So, where GenCorp will ultimately spend its money is in the managed care environment. It will become, I believe, prohibitively expensive for employees and then, later, as retirees, to go into the fee-for-service system, if that is provided as a choice at all.

I think you do it in an evolutionary manner. In the short term your biggest problem is with change, changing purchasing behavior and having confidence that the care that is delivered in the new setting, the managed care setting, is equal to and, in fact, better than the care that can be obtained by self-referral.

Mr. MCCRERY. So, I am inferring that when you say if they choose to stay in fee-for-service it would become prohibitively expensive, that you are going to either reduce their benefits or increase their coinsurance if they choose to stay in that form of service?

Mr. SALTER. I believe that is necessary just as in other areas of our business. Remember part of my message here today is that the phenomena of having a price on an item with a quality indicator, is not unique in this country, it is only unique that it is absent in the health care delivery system.

Our company purchases a number of things on a wholesale basis. When we do that, we are also allowed to set higher specifications for the production of the services and products that we receive. So, what we are saying is that if the company has determined after a period of time that it can produce, it can purchase rather, a higher quality product at lower cost, it only makes sense, then, if someone chooses to continue to purchase retail, that the company charge the differential.

Mr. MCCRERY. So, the answer is yes.

Mr. SALTER. Yes.

Mr. VAN BELL. Mr. Chairman, one additional comment I would make. It may sound a little unusual, but it is really to our benefit if we can get the people with the greatest illnesses in our plan, because we then can more effectively manage that care and the supplemental benefits that we provide, the pharmaceutical, the drug costs, if you will.

So, it may sound a little unusual, but trying to encourage the sickest, if you will, into our managed care program would be beneficial to Deere in managing its supplemental cost.

Mr. MCCRERY. Thank you, gentlemen, for your comments. We appreciate your testimony.

We now call up the second panel. Matthew Stover, president and chief executive officer of NYNEX Information Resources Corp., and he is here on behalf of the National Association of Manufacturers and accompanied by Sharon Canner, vice president, human resources policy department, National Association of Manufacturers; James S. Ray, counsel, National Coordinating Committee for Multiemployer Plans, and he is accompanied by Judith Mazo, counsel.

Thank you for joining us today, and like the previous panel, any written prepared remarks that you have will be entered into the record and we would ask you to summarize your testimony in 5 minutes. When the yellow light comes on, you will have about 1 minute to conclude. When the red light comes on, if you would just attempt to reach a conclusion.

Mr. Stover.

STATEMENT OF MATTHEW STOVER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NYNEX INFORMATION RESOURCES CORP., ON BEHALF OF NATIONAL ASSOCIATION OF MANUFACTURERS, ACCOMPANIED BY SHARON CANNER, VICE PRESIDENT, HUMAN RESOURCES POLICY DEPARTMENT, NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. STOVER. Thank you, Mr. Chairman, Members of the Committee. I am Matthew Stover, president and chief executive officer of NYNEX Information Resources Corp., the information services subsidiary of NYNEX Corp. NYNEX employs 67,000 active individuals and we have 63,000 retirees, for all of whom we provide approximately $640 million in annual medical coverage. I am also a member of the board of directors of the National Association of Manufacturers and chair the NAM's employee benefits committee.

NAM would like to thank you and your colleagues for taking a leadership role in the Medicare debate. The NAM agrees the present Medicare system needs to be restructured and we are pleased to be given the opportunity to participate in your search for the best restructuring solutions.

Your concept of seamless coverage in which the Federal Government would make payments to employers who retain their Medicare-eligible retirees in their health plans is an innovative response to the crisis in the Medicare system. Employers would have the option to assume the risk of these retirees and manage their care with the same tools that we have been using to successfully manage the care of active workers.

In summarizing my written statement today, I would like to discuss the NAM's principles for Medicare reform, highlight several trends in employer-sponsored health coverage, and conclude by noting several specific concerns of beneficiaries, government, and employers.

The NAM urges this Committee to consider the following principles as it modifies Medicare: That any modification should: (1) provide incentives for greater use of managed care; (2) maintain quality health care for employees, retirees, and Medicare beneficiaries; (3) seek solutions that reduces escalation of medical costs for the Nation as a whole; (4) avoid initiatives that result in cost shifting; and finally, continue to pursue market approaches to ensure access to quality medical care for all Americans.

Consistent with these principles, the NAM board of directors adopted a resolution on Medicare and Medicaid in February of this year. Within that resolution, the NAM supports efforts to reduce our Nation's budget deficit, however, we believe that unilateral across-the-board reductions in the Medicare and Medicaid Programs should be avoided because they are likely to exacerbate cost shifting to the private sector and individuals. The challenge for business individuals and the government is to reduce the total cost of health care, both public and private.

Specifically, the NAM supports restructuring Medicare with an emphasis on greater use of quality managed care, which delivers higher value by encouraging more efficiency and the wiser use of services. Cost containment is important to all Americans and it is very important to many NAM companies that provide broad medical benefits and are forced to compete internationally with companies that do not incur similar expenses.

Consistent with this, the NAM commends you for proposing ways to restructure Medicare and for exploring opportunities to increase the use of managed care for Medicare beneficiaries. As you consider a role for employers in the Medicare system, it is important to note a few facts. While 97 percent of NAM members provide health coverage to active workers, only 61 percent of all working age Americans receive employment-based coverage. In addition, 52 percent of employers surveyed provide early retiree benefits, in 1992, down from 64 percent in 1987. So, there is a trend downward in the coverage of retirees.

According to the Health Care Financing Administration, 75 percent of Medicare beneficiaries have private insurance to supplement Medicare while 38 percent have employer-sponsored coverage. So, we see that employers are disengaging themselves from the retiree health system. In fact, between 1987 and 1992 it reduced from 57 percent down to 46 percent.

In considering the creation of a seamless health care option for Medicare beneficiaries, the benefits and costs of Medicare-eligible retirees, the Federal Government, and the employer community must be considered. Medicare-eligible retirees would benefit from greater access to quality managed care plans offered by former employers, particularly if this allowed them to remain in their current managed care plan. However, Medicare-eligible retirees may have some geographic difficulty gaining access to employer-sponsored plans because they may not be located where the retiree is living.

The Federal Government may overestimate savings from this concept, particularly if the only employers who choose to participate are the ones with, "healthier retirees." Greater savings would result from moving the less healthy Medicare populations into managed care arrangements, not the healthier ones. The solution to this issue may, unfortunately, not be found without more government regulation, looking at risk adjustor systems and also looking at increased government regulation and review to monitor the solvency of employer's health plans and the proper use of payments.

Employers will insist that the seamless coverage concept be voluntary for both the employer and the retiree. Clearly, any mandate to shifting cost from government to business would be unpopular and would not address the fundamental issue of reducing the overall rate in the growth of health care costs. It is of note that some employers already are trying to increase retiree participation in managed care plans by encouraging their retirees to join risk contract HMOs. These are HMOs that contract with HCFA to treat Medicare-eligible retirees.

NYNEX and seven other large employers are participating in Florida in a Medicare Risk Coalition which is designed for employers with large retiree populations in Florida. The employer members of the coalition, which began on January 1 of this year have approximately 27,000 Medicare-eligible retirees in Florida and we have contracted with four Florida HMOs to provide a voluntary conversion to managed care. So far, a few hundred of these retirees have elected to make the switch this year.

Let me conclude by saying again how pleased the NAM is that you and your colleagues are exploring ways to restructure and improve Medicare. The NAM commends your efforts. Our comments today are offered to be helpful and highlight issues that will need to be considered in developing a seamless coverage option. NAM agrees more retirees should be covered by cost-effective and quality managed care plans. Of course, there will be, as with any major restructuring of a system, technical issues that must be considered in the final approach, but the overall concept of employers and government working together to reduce waste and inefficiency in our Nation's health care system is one with which the NAM very much agrees. Thank you.

[The prepared statement follows:]

TESTIMONY OF MATTHEW STOVER
NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. Chairman and members of the Subcommittee, I am Matthew J. Stover, President and Chief Executive Officer of NYNEX Information Resources Corporation, an information service company which is a subsidiary of NYNEX Corporation. NYNEX has 67,000 employees and 63,000 retirees worldwide. I am also a member of the National Association of Manufacturers Board of Directors and I chair NAM's Employee Benefits Committee. I am testifying today on behalf of the NAM. I am accompanied by Sharon Canner, Vice President of NAM's Human Resources Policy Department.

The NAM would like to thank you and your colleagues, Mr. Chairman, for taking a leadership role in the Medicare debate. The April 3 report of the Board of Trustees of the Federal Hospital Insurance Trust Fund concerns us all. As you know, the Trustees essentially told you that Medicare Part A, if left unchanged, would be insolvent by 2002. The NAM agrees that the present Medicare system needs to be restructured and we are pleased to be given the opportunity to participate in the debate.

Your concept of "seamless coverage," in which the federal government would make payments to employers who retain their Medicare-eligible retirees in their health plans is an innovative response to the crisis in the Medicare system. Employers would assume the risk of these retirees and manage their care with the same tools employers have been using to successfully manage the care of their active workers. The NAM urges this committee to consider the following principles as it modifies Medicare:

- Provide incentives for greater use of managed care;
- Maintain quality health care for employees, retirees and Medicare beneficiaries;
- Seek solutions that reduce the escalation of medical costs as a whole;
- Avoid initiatives that result in cost-shifting;
- Continue to pursue market approaches to ensure access to quality medical care for all Americans.

Today, I would like to discuss the following matters with you. First, I will provide a general background on employers and retiree health coverage. I will then discuss the NAM principles for Medicare reform. I will conclude with a discussion of the issues that will concern Medicare beneficiaries, the federal government and employers should the Congress move forward to develop the seamless coverage concept.

I. Background - Employers and Retiree Health Coverage

A. Early Retiree Coverage. Many employees retire before they are eligible for Medicare. To understand how Medicare might be integrated with employer-provided coverage, it is important to examine health care coverage for this group of retirees.

In 1992, slightly over half -- 52 percent of employers surveyed by the benefits consulting firm A. Foster Higgins, provided health care benefits to their retirees under age 65. This figure was down from 64 percent in 1987. Manufacturers, according to the Employee Benefits Research Institute (EBRI), provided the bulk of this coverage with approximately 64 percent (in 1991) of manufacturers making health insurance available to retirees aged 51 to 61.

Firm size is the major predictor in determining if a firm provides retiree health benefits. A 1993 survey, reported by EBRI in its most recent Databook on Employees Benefits, showed that in firms of 10 to 49 employees, only 8 percent provided health insurance coverage to retirees under age 65. By contrast, in firms of 20,000 or more employees, 84 percent provided health insurance coverage to such early retirees. Given these statistics, it seems likely that larger employers would be the employers most interested in participating in a seamless coverage system. Most firms (68 percent) that provided health coverage for retirees under 65 require that the retiree pay the entire premium. Only eleven percent of responding firms shared the cost with the early retiree.

B. Medicare-Eligible Retirees. Medicare is the primary payer of benefits for retirees aged 65 and over. Employer benefits are secondary. In 1993, 10 percent of employers surveyed by A. Foster Higgins provided health insurance to their retirees aged 65 and older. Only 22 percent of those employers paid the entire cost of this coverage. The most common type of coverage was a Medicare coordination of benefits (COB) plan. Under the COB method, the private plan pays the difference between the Medicare payments and the total charge, as long as that difference is less than the total amount the private plan would

have paid in the absence of Medicare.

In 1991, the Health Care Financing Administration (HCFA) found that approximately 75 percent of Medicare beneficiaries had some form of private insurance to supplement Medicare. Approximately 38 percent supplement Medicare with employer-sponsored private insurance.

It is important to note that the number of Medicare beneficiaries with employer-sponsored supplemental coverage declines with age. The 1991 Medicare beneficiary survey showed that employer-sponsored coverage is at its highest among beneficiaries ages 65 - 69 (41.5 percent). The number drops steadily until reaching a low point of 15.5 percent covered under employer-sponsored plans for beneficiaries 85 or older.

This trend is troubling. We are here today to discuss the potential role for employers in the Medicare system. At the same time, employers are disengaging themselves from the retiree health care system. As the number of Medicare beneficiaries with employer-sponsored health coverage continues to decline, due to forced reductions by many large employers and business decisions to reduce retiree benefits, creating a role for employers in the Medicare system will be more challenging.

C. Managed Care and Employer Health Care Costs. Many employers have found managed care to be a crucial component in their efforts to control their health care costs and provide quality, cost-effective health care to their employees. More than 90 million Americans are now enrolled in some form of managed care. In fact, HMO enrollment alone has nearly doubled since 1986 to 50 million people in 1994. The Congressional Budget Office reports that the most effective HMO's -- group and staff model HMO's -- can reduce employers' health care costs by 22 percent compared to typical indemnity plans. In contrast, approximately 8 percent of Medicare beneficiaries -- 2.3 million -- were enrolled in HMO's as of December 1994.

II. NAM Principles

In February 1995, the NAM Board of Directors approved a resolution on Medicare and Medicaid. The NAM supports efforts to reduce our nation's budget deficit; however, unilateral across-the-board reductions in the Medicare and Medicaid programs should be avoided because they are likely to exacerbate the cost-shifting to the private sector and individuals. The challenge is for government, business, and individuals working together to reduce the total costs of health care, both public and private.

Specifically, the NAM supports restructuring Medicare with an emphasis on greater use of quality managed care, which delivers higher value by encouraging more efficiency and wiser use of services. Strategies to accomplish this goal should include reducing barriers to managed care, promoting innovation, and fostering competition among program providers.

Given our Board's resolution, we commend you, Mr. Chairman, for proposing ways to restructure Medicare and for exploring opportunities to increase the use of managed care for Medicare beneficiaries. Current health care expenditures by the government, businesses and individuals cannot be sustained. The United States devotes a much larger portion of its GNP to health expenditures than do other industrialized nations. The NAM supports a reduction in the rate of growth in overall health care costs for all payers. Cost-effective purchasing and management of care will be critical. At the same time, any solution must maintain quality health care for employees, retirees and Medicare beneficiaries. The solution should not shift costs. It is in the nation's best interest if the solution reduces the rate of growth in all health care spending without resorting to cost-shifting.

Further, as background, long-standing NAM policy suggests the following guidelines: Public programs (Medicare and Medicaid) should be structured to distribute the burdens equitably between the public and private sector and among consumers, payers, and health care providers. Cost-conscious consumer behavior should be encouraged through greater cost-sharing and other incentives. Cost-conscious provider behavior should be encouraged through measures such as prospective payment systems and at-risk arrangements.

III. Issues to Consider in Creating a Seamless Coverage System

In considering the creation of a seamless health care system for Medicare beneficiaries, the benefits and costs to Medicare-eligible retirees, the federal government and the employer community should all be considered.

A. Considerations for Medicare-Eligible Retirees. Medicare-eligible retirees

would benefit from greater access to quality managed care plans offered by their former employers, particularly if this allowed them to remain in their current managed care plan. They could remain with the same doctors they had before they became Medicare-eligible, and they would be familiar with the plan's procedures.

Medicare-eligible retirees may have some difficulty gaining access to employer-sponsored managed care plans. First, to make educated decisions about their health care, employees need to be adequately informed of their options. Providing this information to retirees may place an increased administrative burden on the former employer. There may also be geographic issues to consider. The former employer's managed care plan may not be located where the retiree now lives. In this situation, remaining with the former employer's managed care plan would not be a viable option.

Retirees who are "snowbirds" -- that is, they live in one, usually warm place for some or all of the winter and elsewhere for the rest of the year -- often cannot enroll in "closed panel" HMO's. This model HMO does not cover the cost of care outside the HMO. Using a provider outside the network is prohibited. These individuals could enroll in their employer-sponsored open panel HMO's, which permit visits to a provider outside the HMO, but the cost of using a non-network provider may be prohibitive.

B. Considerations for the Federal Government. If the former employer who successfully manages the Medicare-eligible retirees' care is allowed to retain any savings, employers with healthier retiree populations are more likely to be attracted to this seamless coverage concept. These employers could expect to successfully manage their retiree's care. This trend will leave the higher-cost retirees in traditional Medicare plans. As a result, the federal government would save less than anticipated because greater savings would result from moving the less healthy Medicare populations into managed care arrangements, not the healthier ones.

The solution to this favorable selection issue may unfortunately be more government regulation, which runs counter to the expressed philosophy of many members of Congress and the NAM. The solution may be a risk adjustor that incorporates some measure of health status. Such a system would pay employers accurately for the risk that their retirees represent, thereby bringing government costs down. However, implementing such a risk adjustment may be prohibitively expensive and administratively burdensome for many employers and their health plans. As a result, it may fall on the government to bear the cost of a risk adjustment system.

Another factor to consider is that Medicare enjoys lower administrative costs, as a percentage of total spending, in administering fee-for-service payment than the private sector does in administering managed care plans. According to HCFA, in 1988, the administrative costs of the Medicare program were 2 percent of total program costs, but were 5.5 percent for the large group market -- firms with more than 50 employees. Employers who provide expanded coverage to their retirees may require additional funding to cover their higher administrative costs.

Increased government regulation and bureaucracy may be needed to monitor the solvency of an employer's health plan and the proper use of payment from the government to the employer. This raises both a jurisdictional and a cost-benefit issue. Under the Employee Retirement Income Security Act (ERISA), the Department of Labor has general oversight of how private employee benefits plans are administered, but the Health Care Financing Administration (HCFA) administers Medicare. No matter which agency monitors such a process, regulations would be needed to protect Medicare beneficiaries whose former employers stopped providing health benefits or became insolvent. Monitoring the transactions and solvency of private plans, although necessary, would create additional government regulations and costs. The costs and benefits of this additional regulation would need to be further analyzed.

C. Considerations for Employers

1. Seamless Coverage Must Be Voluntary. The concept of seamless coverage raises a number of issues for employers. First, a seamless coverage system should be voluntary for both the employer and the retiree. Since 1974, the Employee Retirement Income Security Act (ERISA) has given employers the ability to structure their benefit packages according to the needs of their employees and retirees. The voluntary ERISA-system has been crucial to the ability of employers to find innovative and creative ways to provide cost-effective, quality health care benefits. Clearly, any mandate or shift in costs

from government to business would be unpopular and would not address the fundamental issue of reducing the overall rate of growth in health care costs.

It would be administratively difficult for self-insured employers to accept payments directly from the government for the provision of health care benefits. A more attractive arrangement from the perspective of employers may be for the government payments to go directly to the managed care plan, which would then bear the risk.

2. FAS 106. Another issue to consider is Financial Accounting Standard 106 (FAS 106), which went into effect for most companies in 1993. This standard requires companies that sponsor retiree health plans to record unfunded liabilities for future expenditures on their balance sheets. The standard increases balance sheet liabilities for corporations that have large retiree populations and/or generous health benefit plans. To the extent that any payment did not adequately compensate employers for their retirees' health care costs, the FAS 106 rule would make these employers appear to be less attractive investments and adversely affect their competitiveness.

3. Continued Budget Cutting. The environment of government downsizing and deficit reduction may make many employers leery of participating in this concept of seamless coverage. Congress may decide to reduce payments to employers in future years. Such a reduction would leave employers with a costly and unsustainable burden as more of their employees become Medicare-eligible. This would induce fear among employers who have volunteered to participate and may lead to many leaving the program. In fact, anticipation of the budget cuts that are being considered by Congress may be enough to discourage many employers from participating in this new seamless system in the first place.

4. Employers and Risk-Contract HMO's. Some employers are already trying to increase retiree participation in managed care plans by encouraging their retirees to join risk-contract HMO's. These HMO's which contract with HCFA to treat Medicare-eligible retirees usually have a special expertise with Medicare beneficiaries. Under Medicare risk contracts, an HMO receives 95 per cent of the average per capita rate reimbursed under conventional Medicare coverage for each of its Medicare members, and it must absorb any losses if its costs to provide care to those members exceed that rate. The few employers that have successfully led more of their retirees to enroll in risk-contract HMO's have lowered their supplemental premiums and often provided their retirees with more comprehensive coverage, all within the construct of existing law.

For example, NYNEX and seven other large employers are participating in the Florida Medicare Risk Coalition, which is designed for employers with large retiree populations in Florida. The employer members of the Coalition, which began January 1st of this year, together have 27,000 Medicare-eligible retirees in Florida.

The Coalition contracted with four Florida HMO's to promote a voluntary conversion to managed care. So far, only a few hundred of the retirees have made the switch. For each retiree that has switched, his or her former employer will save from $500 to $2,000, depending on how much the employer had been spending on supplemental coverage. If the government redesigns the HMO payment formula in the risk program, it too could save money from the current Medicare risk contract program.

IV. Conclusion

Mr. Chairman, let me conclude by again saying how pleased the NAM is that you and your colleagues are focused on the Medicare system and exploring ways to restructure the program. The NAM commends you for your efforts. Our comments today are offered to be helpful and highlight issues that will need to be considered when developing a seamless coverage system.

The growth in the rate of health care expenditures cannot be sustained, particularly in our public programs. Restructuring of the Medicare system needs to be a top priority for this Congress, particularly in light of the Trustee's report on the looming crisis.

The NAM agrees that more retirees should be covered by cost-effective and quality managed care plans. There will be, as with any major restructuring of a system, technical issues that must be considered but the overall concept of employers and the government working together to reduce waste and inefficiency in our nation's health care system is one the NAM very much agrees with.

Again, NAM urges this Subcommittee to consider the following principles as it

reforms Medicare:

- Provide incentives for greater use of managed care;
- Maintain quality health care for employees, retirees and Medicare beneficiaries;
- Seek solutions that reduce the escalation of medical costs as a whole;
- Avoid initiatives that result in cost-shifting;
- Continue to pursue market approaches to ensure access to quality medical care for all Americans

We look forward to working with you in the months ahead and congratulate you on your vision in seeking innovative ways to remedy the Medicare crisis. Mr. Chairman, I would be happy to answer your questions or those of any other member of this subcommittee.

Mr. MCCRERY. Thank you, Mr. Stover.
Mr. Ray.

STATEMENT OF JAMES S. RAY, COUNSEL, NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS, ACCOMPANIED BY JUDITH F. MAZO, COUNSEL

Mr. RAY. Thank you, Mr. Chairman. I am accompanied by Judy Mazo, who is also a member of the NCCMP's professional staff, and by Jack Curran, the NCCMP's long-time legislative director. On behalf of our chairman, Bob Georgine, let me express our appreciation for the opportunity to participate in this discussion.

For 20 years now, the NCCMP has been representing the interests of the more than 10 million workers and families who obtain their health coverage through joint labor-management multiemployer plans established by collective bargaining under the Taft-Hartley Act of 1947. I should note, Mr. Chairman, that our population of plan participants and beneficiaries is defined by coverage under a collective bargaining agreement and not by health status. So, there is no cherrypicking with regard to our plans.

Mr. Chairman, the multiemployer plan community is interested in exploring cost-effective means by which Medicare-eligible employees, retirees, and their spouses, covered by our health and welfare plans, can look to those plans for both their Medicare benefits and other health, disability, and death benefits that our plans may provide. We believe that arrangements for multiemployer plans to deliver such seamless coverage, as workers move through active employment into retirement, can be worthwhile for all parties: Medicare beneficiaries, multiemployer plans, and taxpayers alike.

We would appreciate the further opportunity to submit to the Subcommittee at a later date a proposal for such "one-stop shopping" for multiemployer plan participants and beneficiaries.

In developing a proposal, we are guided by a fundamental principle: They must be designed to help, not hurt, our plan participants. This means Medicare-eligible participants and beneficiaries must be assured of coverage at least as good as what the current Medicare Program delivers, and the program must not imperil the plan's ability to continue providing other participants with good health coverage at a moderate cost. We believe that this is doable under certain conditions.

Financing is the key, however, both for the government and for our plans. In managing multiemployer plans, the trustees are not running a business in which they are free to take big risks in the hope of achieving big gains. They are nothing more and nothing less than fiduciaries of a fund that must be administered in a way that maximizes the benefits of those it covers.

Because Medicare has provided the lion's share of health coverage for the over 65 population for so long, multiemployer plans, like other private sector payers, do not have reliable independent bases of experience from which to estimate the potential cost of following that age group back into their basic coverage.

Initially, a fair amount of trial and error will be needed to cost out these programs. To attract multiemployer plans to such voluntary arrangements, various concerns relating mostly to financial risk will have to be addressed. Among those are, number one, the

pricing. How much will Medicare pay to the plan? To what extent, if any, do cost sharings or do cost savings from favorable experience have to be shared with the government?

Design. To what extent will plan trustees have flexibility to design the benefit package and delivery system for Medicare eligibles as well as our other participants?

And regulation. To what extent will plans be required to comply with Medicare regulations on top of ERISA's regulatory scheme?

We believe that there is much to be gained for all parties, Medicare eligibles, multiemployer plans and their participants as a whole, and the Medicare Program itself, if an arrangement that satisfactorily addresses these concerns can be designed.

Mr. Chairman, we thank you, and Judy and I are prepared to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS (NCCMP) AS PRESENTED BY JAMES S. RAY AND JUDITH F. MAZO

Mr. Chairman and Members of the Subcommittee:

On behalf of the National Coordinating Committee for Multiemployer Plans (NCCMP), its affiliates, and its Chairman, Robert A. Georgine, we are pleased to have this opportunity to share with you the interest of the multiemployer plan community in exploring cost-effective means by which Medicare-eligible employees, retirees and their spouses who are covered by multiemployer health and welfare plans can look to those multiemployer plans for both their Medicare benefits and any other coverage -- supplemental, for retirees, or primary for active workers -- that the health and welfare plan provides. We believe that arrangements for the multiemployer plans to deliver that kind of "seamless" coverage can be worthwhile for the beneficiaries, the plans and the U.S. taxpayers. We would appreciate the further opportunity to submit to the Subcommittee at a later date a more detailed proposal for such "one stop shopping." In considering the specifics, we have a fundamental guiding principle: its must be designed to help, not hurt, our plan participants. This means that Medicare-eligible participants and beneficiaries must be assured of coverage at least as good as what the current Medicare program offers, and the program must not imperil the plans' ability to continue providing the other participants with good health coverage at moderate cost. We believe this to be do-able.

To assist you in understanding the perspective from which we approach this question, let us first describe the NCCMP, the nature of multiemployer plans, and the concerns of multiemployer plans and the millions of families they cover with regard to the current health care system.

The NCCMP

The NCCMP is a non-partisan, non-profit organization of multiemployer pension, health and welfare plans and their labor-management sponsors. The NCCMP was established in 1975 to represent the legislative, regulatory, and legal interests of the multiemployer plan community -- a community composed of thousands of plans, more than ten million American workers and their families, and tens of thousands of labor-management sponsors.

The national, regional and local benefit plans affiliated with the NCCMP cover workers in a variety of industries including building and construction, food and commercial, transportation, service, clothing, textiles, bakery and confectionery, entertainment, and maritime.

Since the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), the NCCMP has provided guidance to Congress, the Labor Department, the Internal Revenue Service, the Pension Benefit Guaranty Corporation, other government agencies, and the courts on a wide variety of legislative, regulatory and legal issues of concern to the multiemployer plan community. The organization's contributions to the development of employee benefits law with regard to multiemployer plans has been publicly recognized on many occasions by Congress, by administrative agencies, and by the Supreme Court.

The retirement, health, and income security of millions of Americans depends upon the continued existence and well-being of multiemployer plans -- an express legislative finding of Congress itself.[1/]

The Nature of Multiemployer Health & Welfare Plans

Among the proudest achievements of collective bargaining is the decades-old nationwide system of joint labor-management multiemployer health and welfare plans that provide more than ten million Americans workers and their families with medical,

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1/ *See Multiemployer Pension Plan Amendments Act of 1990, Public Law 96-364, Section 3(a).*

hospital, sickness, death, disability, and related benefits.[2/] Workers covered by multiemployer plans are employed throughout the Nation in industries as diverse as building and construction, retail, food, clothing, textiles, transportation, service, mining, entertainment, hotel and restaurant, and maritime.

But for multiemployer plans, most of these millions of Americans would be uninsured and at risk for financial ruin in the event of a serious illness. The seasonal, intermittent, and mobile employment patterns that characterize these industries would prevent the workers from obtaining health benefits coverage absent a central pooled fund through which portable coverage is provided to workers as they move from one participating employer to another. In addition, most employers in these industries are small and would not maintain their own employee health plans, particularly for transient or short-term workers.

For example, a building tradesman may be employed by a particular employer for only a day, a week, a month or a few months to work on a specific project, and then move on to work on another employer's project, and thereafter another, etc. Between jobs, he or she might be off work for a day, a week, a month, or longer. A building tradesman might work for scores of different employers over his or her working life, with periods of unemployment between jobs. Most construction employers would not maintain their own employee health plans, particularly for transient workers, if they did not participate in our multiemployer plans. In fact, very few non-union contractors maintain health plans for their employees. The non-union segment of the building and construction industry is among the worst of all industries in terms of health care coverage. In contrast, virtually all union workers who are employed on jobs covered by collective bargaining agreements have health care coverage for themselves and their dependents.

For several decades now, our multiemployer health and welfare plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to workers as they move from one participating employer to another. In effect, all of the participating employers -- scores, hundreds, and even thousands of employers -- are treated as a single employer for purposes of providing health and welfare benefits coverage to workers and their families.

Multiemployer health and welfare plans are financed, in reality, by covered workers through their labor. Collective bargaining agreements typically require signatory employers to contribute to a particular health and welfare plan at a set dollars-and-cents rate for each hour worked by a covered worker. While the law

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2/ *A multiemployer health and welfare plan, often referred as a "Taft-Hartley plan," is:*

- *a trust fund established through labor-management collective bargaining and pursuant to the Labor Management Relations ("Taft-Hartley") Act of 1947 by one or more labor unions and more than one employer of the union-represented workers;*
- *administered by a joint board of trustees with equal labor and management representation;*
- *providing medical, hospitalization, and other health-related benefits, as well as death, disability and sickness benefits, to covered workers and their dependents; and*
- *financed by employer contributions which are collectively-bargained between the sponsoring union(s) and the participating employers.*

These structural requirements are imposed by Section 302(c)(5) of the Taft-Hartley Act [29 U.S.C. §186(c)(5)]. Multiemployer health and welfare plans are also regulated by the Employee Retirement Income Security Act (ERISA) as employer welfare benefit plans. A multiemployer plan is not a "multiple employer welfare arrangement" or a "MEWA" within the meaning of ERISA.

considers these to be "employer contributions," the reality is that the employer's contributions are substitute wages for labor received. Instead of putting this money into the worker's paycheck, the employer pays it to the health and welfare plan to finance benefits coverage for the worker and his family. Covered workers are well aware of the cost of health care coverage; they pay the cost by accepting employer contributions in lieu of cash wages. They know that they are paying the full cost of their health care coverage. They do not need a new law or tax to motivate them to hold down health care costs to the extent possible.

For example, the nature of collective bargaining in the building and construction industry is that the total compensation package cost is negotiated with the employers, and the workers, through their union, decide how to allocate the total hourly rate among cash wages, pensions, health and welfare, apprenticeship and training, and other beneficial programs. An increase in the contribution rate for the health and welfare plan means less in wages, or less in pension plan contributions, or less in contributions to another benefit plan. This process makes the workers very sensitive to increases in the cost of health care coverage.

From the plan's perspective, financing depends upon the level of covered work, as well as the collectively-bargained contribution rate. That is, the plan generally receives employer contributions only for hours worked in employment covered by a collective bargaining agreement. If the level of covered work declines, plan income declines. The per hour contribution rate set by the collective bargaining agreements usually cannot be increased unless and until the labor-management parties negotiate a new or modified agreement. A multiemployer plan cannot simply reach into the corporate treasury of an employer, in contrast to single-employer corporate plans.

Over the years, the labor-management boards of trustees of our plans, with professional assistance, have designed health and welfare programs that balance the benefit needs and wants of the covered workers with the financing that can be provided by the collectively-bargained contributions. To balance these factors, the trustees have developed various eligibility rules, benefit packages, and operational practices tailored to their particular circumstances. For example, plans have developed various systems for continuing coverage during gaps in employment and into retirement. These systems include "hours-bank" arrangements under which a worker's hours of covered employment are "banked" and used to pay for benefit eligibility during periods of unemployment. Other systems use eligibility periods during which a worker's covered employment builds credit towards benefit eligibility in a future period (e.g., covered employment in the first quarter earns the worker benefit eligibility for claims incurred in the second quarter).

By pooling the contributions of many employers into a central fund, multiemployer health and welfare plans enjoy economies of scale in administration as well as enhanced purchasing power in dealing with health care providers and insurers. Multiemployer plans are prototype purchasing cooperatives. Many of our plans are self-funded. Many others insure some or all of their benefits with commercial carriers or other health insurers. Some of our plans have in-house administration, although most use professional third-party administrators who answer to the plan's labor-management board of trustees.

Participating employers are advantaged in that they are required to do little other than submit their periodic contributions to the plan with verifying information. The employers need not become involved in plan administration or plan design. These functions are the responsibility of the plan's labor-management board of trustees and the professionals they hire.

These financial advantages are even greater for the many multiemployer plans that are multi-state in coverage. Many multiemployer health and welfare plans cover workers, dependents, and/or retirees in multiple States. Some multiemployer plans are national in coverage. Fortunately, because of federal preemption under the Employee Retirement Income Security Act (ERISA), most of our multi-state plans are not subject to regulation by the States; although ERISA preemption is being dangerously diluted by recent court decisions, some of which have narrowly construed ERISA to allow State taxes relating to plans, and some of which have read ERISA too broadly to strike down State laws that Congress intended to preserve. The cost and operation of multiemployer plans, if not their very existence, would be adversely affected if the plans were subject to multiple, inconsistent regulation by the States in addition to Federal regulation. Indeed, even intra-state plans would be adversely impacted if the State could regulate and tax them. Every dollar spent by a plan on regulatory compliance and administration is a worker's dollar, and a dollar that cannot be returned to covered workers in the form of benefits.

Among the unique characteristics of multiemployer plans is the involvement of the covered workers in their health coverage. The plan's financing is the subject of collective bargaining between the workers' union and their employers. And, the design and operation of the plan is, by law, controlled by a board of trustees, half of whom represent the covered workers. As mentioned above, the workers' influence is reflected in the benefit packages provided by plans, which are typically custom-designed to meet the needs and wishes of the workers, within the confines of what the particular plan can afford with the collectively-bargained contributions generated by the covered workers' labor.

Many multiemployer plans provide health benefits coverage to retirees and pay all or a substantial portion of the cost from contributions generated by the active workers' labor. This retiree health coverage reflects the reality that many covered workers are engaged in heavy physical labor that wears down their bodies and drives them from the workforce earlier. These members have earned a secure retirement without fear of financial catastrophe if they become ill or are injured without health benefits coverage.

Beyond health benefits coverage, multiemployer health and welfare plans provide an array of other valuable employee benefits such as disability, sickness, and death benefits. But for multiemployer plans, most covered workers and families would not have access to such benefits for all the same reasons that health benefits coverage is effectively available only through multiemployer plans.

Problems With The Current Health Care System

Our system of multiemployer health and welfare plans is a proud achievement in self-reliance and labor-management cooperation. We are most reluctant to invite additional government regulation that would unnecessarily disturb our successful system by injecting more costs. But, there are forces in the current health care system that are beyond our control and threaten the security of our participants' health and welfare coverage. Only action by the Federal Government can effectively address these forces.

Inflation in the cost of health care and insurance has cut severely into wages. Labor-management bargainers have had to shift increasing amounts of wages into health and welfare contributions to offset cost increases. In many cases, cash wages have been frozen, with negotiated increases being redirected into the health and welfare plans to keep them adequately funded. In some areas, pension plan contribution rates have been reduced by the bargaining parties, and the "savings" rechanneled to the health and welfare plans. Many health and welfare plan boards of trustees have been

compelled by cost pressures to cutback benefits, tighten eligibility rules, and increase out-of-pocket payments by covered workers. Workers are less secure about their coverage, especially if they have been unemployed for a period, as many have.

The economic recession in some industries, like the building and construction industry, itself is a product, in part, of health care cost inflation. As health care costs consume ever-increasing portions of government budgets and private sector resources, less money is available for investment in public and private building and construction projects. This means fewer jobs for our covered workers and less income for our health and welfare plans.

While we have struggled with these pressures to maintain responsible health coverage for covered workers, our non-union competition has gained an unfair competitive advantage. Non-union employers have found a way to shift the cost of medical treatment for their employees and families onto the backs of our health and welfare plans and covered workers; a way to cut their costs and increase ours.

Most non-union employers against whom our employers compete do not provide health plan coverage for their employees or their employees' families. If the employer provides any, it is inadequate coverage. This social irresponsibility gives the non-union employer an immediate cost advantage over responsible union employers who contribute to our multiemployer health and welfare plans.

This unfair competitive advantage is multiplied when the employer's uninsured worker or his family needs medical treatment. Lacking insurance coverage, they have no regular doctor, but rather go to hospital emergency rooms for treatment of minor and major ailments; the most expensive place to get treatment. And, when the worker is unable to pay for the treatment, the cost is passed onto our multiemployer health and welfare plans in the form of higher hospital bills, higher insurance premiums, or State uncompensated care taxes and assessments.

In other words, our covered workers are being compelled by the current system to pay twice for health care: once for themselves and their families, and a second time for the non-union workers who take our jobs and their families. Government statistics show that the vast majority of the millions of uninsured Americans are workers or dependents of workers. The cost of health care for these millions -- and for millions more who are underinsured -- is being unfairly shifted to employers and workers who do maintain adequate health plans, penalizing us for being socially responsible.

Government -- at the State, as well as the Federal, level -- is a major player in the cost-shifting game that unfairly inflates the cost of health care and health plan coverage. Concern about State regulation and taxation increasing the cost of maintaining a multiemployer plan is at the core of our longstanding support for ERISA preemption of State and local laws relating to employee health, welfare and pension plans. As recently observed by the United States Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 63 U.S.L.W. 4372 (April 26, 1995), the

> "basic thrust of the [ERISA] preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.
> ...
>
> [Congress intended] to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of

> complying with conflicting directives among States or between States and the Federal Government to prevent the potential for conflict in substantive law requiring the tailoring of plans and employee conduct to the peculiarities of the law of each jurisdiction..."

63 U.S.L.W. at 4375.

Despite this recognition of the essential protective purposes of ERISA preemption, the Supreme Court created a large loophole in these protections by its decision in the *Travelers* case. The Court ruled that ERISA does not preempt New York State's law requiring hospitals to impose surcharges (amounting to up to 24%) on the bills of patients covered by commercially-insured health plans, even though the State law exempts from those surcharges patients who are insured by a Blue Cross/Blue Shield plan and certain other patients. The imposition of such surcharges on self-funded health plans is at issue in the case on remand to the lower courts.

The *Travelers* decision appears to have cleared the way for States to impose discriminatory surcharges -- taxes, really -- on hospital and other provider bills to shift the cost of uncompensated care for uninsured workers to insured workers, and to control such fundamental plan decisions as whether to insure (and, if so, with what insurer) or whether to self-fund benefits. The impact of the *Travelers* decision will be to drive up the cost of health care even further as States seize on health plans as a source of public revenues and as a dumping ground for the cost of care provided to uninsured persons in the State.

State officials do not want the political heat created by general tax increases to pay for charity health care for uninsured workers and families. So, they impose hidden taxes on workers who do have health plan coverage -- an approach that discourages health plan coverage and exacerbates the uninsured and cost-shifting problems.

The *Travelers* loophole was preceded by another Court-made loophole in the protections which ERISA preemption was designed to provide. In *Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985)*, the Supreme Court ruled that ERISA does not preempt States from dictating what benefits must be included in every health insurance policy, including policies sold to ERISA-covered plans. In effect, States can -- and do, extensively -- mandate the benefits and services to be provided by any insured health plan. Hundreds of State laws so mandating health benefits and services have been enacted under the authority of the *Metropolitan Life* reading of ERISA preemption. And, in response, many multiemployer plans and employers alike have dropped insurance coverage and undertaken to self-fund benefits to avoid the costs and governmental control imposed by mandated benefit laws. The *Travelers* decision may provide States with the means for retaliating against these plans and employers -- through taxation; indeed, discriminatory taxation.

The Federal Government, too, plays a major role in the cost-shifting aspects of health care cost inflation. Changes in the Medicare and Medicaid programs often have an indirect, but predictable and costly, impact on multiemployer health and welfare plans. Congress has a record of achieving savings in these public programs by shifting a portion of their costs to private sector plans like ours. Reimbursement rates for hospitals and doctors who treat Medicare and Medicaid patients have been reduced by congress with the realization that these care providers tend to recoup such reductions by raising their rates for private, insured patients -- workers with multiemployer plan coverage. Another example of cutting public program costs at the expense of private health plans is the Medicare Secondary Payor program that requires private plans,

including multiemployer health plans, to provide primary coverage for Medicare eligible workers.

This government cost-shifting is particularly troubling because it taxes only those of us who have health insurance or other health plan coverage. And, this tax discourages health plan coverage, driving more people into the ranks of the uninsured whose health care costs, too, are shifted to the shrinking pool of persons with health plan coverage. This effect is directly opposite of the direction in which national policy should be traveling. Clearly, Medicare and Medicaid costs need to be contained, but not through taxation of only persons with health plan coverage. A fairer means of financing-- that also reaches those employers who do not provide health plan coverage for employees -- needs to be found.

In short, our workers and their families are generally pleased with their health and welfare plans; plans which have been custom-designed for them and which they control through collective bargaining and through the plans' boards of labor-management trustees. But, health care cost inflation and cost-shifting beyond our control is undermining the plans and our workers' standard of living, while placing them at an unfair competitive disadvantage.

Retiree Benefits and Medicare

As mentioned earlier, the majority of multiemployer health and welfare plans provide some coverage for participants who are retired and drawing retirement benefits from a related multiemployer pension plan. Practice varies by industry, geographic area, and plan size. Most often, this coverage applies to all retirees (and their dependents) -- under age 65 as well as Medicare eligibles. Some plans limit coverage to early retirees as a bridge between coverage as an active worker and Medicare eligibility. Coverage for Medicare eligibles is designed to supplement Medicare coverage.

Retiree coverage is usually financed (subsidized) at least partially by the collectively bargained contributions generated by the labor of active workers. Employers are not required to contribute to multiemployer plans on behalf of retirees, but only for the work performed by active workers covered by a collective bargaining agreement. However, a portion of these contributions is used by the plan to finance coverage for retirees.

In addition, most plans require a retiree to make a contribution (self-pay) towards the cost of his or her coverage as a condition of maintaining the coverage. Of course, coverage is voluntary for retirees.

Inasmuch as retiree coverage is subsidized by current collectively-bargained contributions, declines in contribution-generating work by active workers creates financial pressures on retirees' coverage -- as well as on actives' coverage. Cutbacks in retiree coverage or increases in retiree contributions may result from reductions in covered work. Such necessary changes are harder on early retirees who are not yet eligible for Medicare.

Multiemployer plans would much prefer to expand retiree coverage -- if they could work it out financially. There is a strong feeling of commitment and loyalty to long-service members, and a desire to maintain their affiliation with the union that sponsors the plan. There is a sense that they have earned health coverage in their retirement years because contributions made during their work careers helped to fund coverage for earlier retirees.

Financing is the key, however. Multiemployer plan trustees must maintain a proper balance between the beneficial needs and wants of all participants, on the one hand, and the available funding to backup benefit promises on the other hand.

An arrangement under which the Medicare program provides funding to a multiemployer plan for Medicare-eligibles' benefits may provide the means for more plans to maintain and expand retiree coverage. Such an arrangement would give retirees the advantage of a "one-stop shop" for all of their health care benefits -- a shop with which they are familiar and which is familiar to them, and which may also be providing them with life insurance and other types of benefits. Most importantly, of course, a retiree's or older worker's multiemployer plan is an organization over which the covered population, through their union representatives on the board of trustees, have an equal say in plan management, and which, under the joint stewardship of the labor and management trustees, is dedicated exclusively to serving the interests of its participants and beneficiaries. Coverage could be seamless as the individual moves from active employment into retirement. Savings from efficiencies could be used to fund early retiree coverage, and to ease the pressure on active workers to generate contributions to finance retiree coverage.

Financing is, of course, a key concern, both to the government and to the plans. In managing multiemployer plans, the trustees are not running a business in which they are free to take big risks in the hope of achieving big gains. They are nothing more, and nothing less, than fiduciaries of a fund that must be administered in a way that maximizes the benefits of those it covers. Because Medicare has provided the lion's share of health coverage for the over-65 population for so long, multiemployer plans -- like other private sector payors -- do not have a reliable independent base of experience from which to estimate the potential cost of folding that age group back into their basic coverage. Initially, a fair amount of trial and error will be needed to cost out these programs and, as noted, plan trustees do not have much room for error!

To attract multiemployer plans to such a voluntary arrangement, various concerns (mostly relating to financial risk) will have to be addressed, including:

- Pricing -- How much will Medicare pay the plan? Will the amount vary by location and demographics of the eligible group? On what basis will Medicare's payments to the plans increase? To what extent, if any, do cost-savings from favorable experience have to be shared with the government? To what extent, if any, will Medicare provide guarantees against plan losses?

- Design -- To what extent will plan trustees have flexibility to design the benefit package and delivery systems for Medicare eligibles as well as other participants? To what extent can the plan link Medicare benefits and supplemental benefits? Will plans be free to cutback benefits if Medicare benefits are cutback? Could a plan use Medicare funding to finance early retiree coverage?

- Regulation -- To what extent will plans be required to comply with Medicare regulations on top of ERISA's regulatory scheme? Does the plan gain Medicare law protections (e.g., limit on physician charges)? How, if at all, would the Medicare Secondary Payor program apply with respect to the plan's active workers who are Medicare eligible?

We believe that there is much to be gained for all parties -- Medicare eligibles, multiemployer plans and their participants as a whole, and the Medicare program -- if an arrangement that satisfactorily addresses all of these concerns can be designed.

Thank you.

Mr. MCCRERY. Thank you very much for your testimony.

We have a vote on the floor, and since I am the only one who has not voted, I am going to recess the Subcommittee for just a few minutes. If you will just stay where you are, someone will be back to open the Subcommittee for questions. Thank you.

The Subcommittee is in recess.

[Brief Recess.]

Mr. ENSIGN. It is just us.

Mr. RAY. Is it something we said, Mr. Chairman?

Mr. ENSIGN. I happened to be the only one left walking over here.

Let's start off by talking a little bit about one of the problems associated with Medicare costs. Most of the medical expenses are expended in the last months of a person's life; and the problem there is that a lot of the expense is not for the benefit of the patient. I mean, when a lot of the care is given, it is totally hopeless care. The chances of the outcome being positive are virtually nil; and we know a lot of that money and services that could be going to help healthy patients is not there because the resources are taken up by those kinds of situations.

If employers were involved with the Medicare population, how would you foresee—because hospice care is something that is done so well in this country, and sometimes it is the best thing that people would choose for themselves if they had the capacity to make that decision for themselves. A lot of times these patients are on life support systems, or they do not have the ability to make those kinds of decisions for themselves.

How would you design a system that would, allow for or encourage people to set up living wills, or whatever it is, so that at that point we aren't spending the bulk of the health care dollars in this country on patients that, first of all, wouldn't want it spent on themselves?

Mr. STOVER. You know, there are a couple of ways to approach that question; and one way verges on the theological, and I am not going to take that approach.

I think the other one is to really look at the experience we have had over the last few years and say, it is more an issue of how do we give people more choices. I think a lot of the outcomes from a standard way of dealing with people toward the end of their lives has been, well, there has been one system and there has been one set of expectations and that is sort of what the overall health care system has allowed.

When you speak of hospices, I think what we have seen over the last—you want to say 4, 5, 6 years, is there have been more HMOs, as there have been more alternative ways of looking at how medical care can be delivered, and then you get some different answers. It really gets down to individuals having a choice in how they would like to manage things and becoming more involved in defining for themselves what they view value to be in terms of their medical care. That is not always a price issue, and it is not always a "how many tests can you run" issue, but a sort of "how do you feel about the care that you are receiving," "how does that relate, not just to you, but the involvement of your family members and where they are living" and so on and so forth.

So, I think that, clearly, if we have some more flexibility for people to select some options——

Mr. ENSIGN. When would they select those options, when they are signing up for their particular plan, or on an annual basis?

Mr. STOVER. I think this is—really, when it comes to medical care, it needs to be a lifelong education process. I think that is something that a lot of us as employers or certainly with group plans do a lot of education; and increasingly, we are providing background on medical care so people can make informed choices on a much better basis instead of just having, some faith as you go into it that the system is going to take care of me.

Ms. MAZO. Of course, we are all working on a program, so we can identify what is the last month of a person's life. Until that time—another feature, by the way, this is an equal problem from the point of view of employer-funded plans at the beginning of life, a major cost is enabling families to make decisions about damaged babies and how far they go.

I think one of the things that a fund that has been involved with the person following them all along—and the John Deere people and the Chrysler people talked about this—is when you get into individualized, major case management, which is delivered by an institution that the person and the family trust, it can help the choices that have to be made at the ultimate point. Choices and advice are given at an early point, but finally someone has to decide, yes, this is what we believe is hopeless. This is what we believe is not true life.

There always has to be an individual decision, and when it is coming under the guidance and through a payer who has a personal involvement in the way—the way a union does, the way an employer does with the person and their family, I think it may be a little more credible and a little more useful than when it is just coming from the government or from an insurance company.

Mr. ENSIGN. We—obviously, are in a situation where we don't have a choice about Medicare going on as it has in the past because of the findings of the trustee report. Do we think that the Taft-Hartley plans may be one of the answers to more efficiently delivering health care to the elderly than the Medicare Programs?

Ms. MAZO. Not all of them but some might be. I have to say that the Taft-Hartley plans are not as far advanced, in general, as the major corporations represented by NAM in their sophisticated use of managed care, but they are moving in that direction; and they capture a population which can't be captured by the large corporations, and so they provide a useful supplement.

Just as business is in a position to do it now, I think the Taft-Hartley plans, in fact, perhaps given the added incentive of the opportunity to maintain the connection with their retirees—in a sense this option might also be an incentive to move them along generally down the managed care path.

Mr. STOVER. I might just add to that, I think what we are finding in common is both the issues of portability and continuity that we come back to. The Taft-Hartley plans allow them some continuity. If we had more portability vis-a-vis the other kind of private plans that are tied to a specific employer now, that would also help ensure more continuity, which we think is a positive.

Mr. RAY. Mr. Chairman, if I could underscore that comment, one of the unique parts of our Taft-Hartley plans is, we do have portability, by definition, with a group of employers who are signatories to collective bargaining agreements. You get seamless coverage as you move from job to job with different employers who are bound by the collective bargaining agreement to contribute.

Mr. ENSIGN. One of the other aspects I would like to explore just a little bit, and that is when you are getting into a situation of assuming too much risk, the risk where you are getting the patient populations that are going to jump on board and potentially bankrupt your company; the Medicare population as a whole obviously is a very large population. It can be spread out over a very large population.

How do you avoid the cherrypicking, but also avoiding the potential massive risk if you get a higher percentage of AIDS cases or diabetic cases or whatever; to stop cherrypicking results when you have a system set up in its totality that has incentives and disincentives to do things that would otherwise make the system work?

I think the earlier panelists have talked about the issue of quality as being very important, and if we set up options in which people can select quality care in a number of different ways, so that there is not a perception that the value for me as an individual for getting medical care from this provider is less than it is going to be over here, then you are not going to drive to cherrypick situations like that.

So, I think that it is not an either/or, employers or the government—let's look at how we set up something with the flexibility so that positive outcomes can come from individuals either way.

Ms. MAZO. You obviously have put your finger on the hardest question and that is why I think it has to evolve over a period of time. We are also not cherry picking because we are working with a population we know that we have been taking care of up until age 65. Often their health traits and the problems of their family are—they may be sort of linked to the industry in which they have been working.

Just as we can begin to get a sense of what the costs are going to be once people reach age 55 and 60 from what the costs have been when they were 35 and 40 and 45, over—I can't say that the first 3 years of this program we are going to have excellent predictors. Within some period of time we will begin, and we will be building on a base of knowing how they have been operating up until this date.

Mr. ENSIGN. I would like to thank the panel very much for your excellent testimony and call the next panel forward.

We have Tom Erhart, vice president, human resources for RCI Corp. from Brighton, Michigan; Peter Ferrara, senior fellow, National Center for Policy Analysis; Jane Orient, a medical doctor, executive director of the Association of American Physicians and Surgeons, Inc.

Mr. Erhart, why don't you proceed. You have 5 minutes. When there is 1 minute to go, the amber light will appear; and if you could keep your remarks around 5 minutes, we would appreciate it. Thank you.

STATEMENT OF TOM ERHART, VICE PRESIDENT, HUMAN RESOURCES, RCI CO., BRIGHTON, MICHIGAN

Mr. ERHART. Thank you. I am Tom Erhart, vice president, human resources, for RCI, an automotive specialty manufacturer in Brighton, Mich. I would like to relate to you the terrific experiences our company and employees have enjoyed with medical savings accounts, MSAs.

One year ago we replaced our traditional employee insurance program, which offered a very high level of benefits and was fully company paid, with the medical account program. MSAs are an extremely cost-effective way to offer health care benefits to employees because they put the consumer, the employee, back in the process.

Employees are free to choose where they want to go for their medical care. They make choices based on the quality of care provided and the cost of such care. Even though employees have a higher level of benefits with the MSA than our previous health program, our annual health benefit costs were reduced from $4,800 to $4,200 per employee, a 14.3 percent savings. For a business with 200 employees, this amounts to an annual savings of $120,000 per year; and we don't even anticipate a premium increase for the second year of our program.

The MSA program at RCI works very simply. An employee with dependents receives an MSA of 1,700, a single employee receives 1,200. This MSA is provided by the company. RCI then purchases a health insurance policy with a $2,000 deductible for employees with dependents and $1,500 for single employees.

This insurance policy pays 100 percent of all covered medical expenses after the deductible is met, no employee copay. Employees' maximum amount of out-of-pocket expense is $300 per year, the difference between the MSA and the deductible, and employees only have this out-of-pocket expense after their MSA is expended.

At the end of the year, employees receive any money remaining in their MSA or carry over to next year's MSA. Since there is currently no tax advantage to rolling the remaining money over, most employees elect to take the cash option. This is an incentive to be conscientious consumers of health care.

Our employees use only one MSA health I.D. card to pay for all their medical, prescription, dental and vision expenses. We find that our employees shop around for their health care needs; and what better way to control costs than through free enterprise? A managed care system is an added feature that our employees may choose to utilize to lower their medical expenditures.

Our employees are proud to point out that they have saved money by comparing costs. They often save $50 to more than several hundred dollars on routine procedures. One employee even bragged that he saved $2.59 on a prescription by comparing costs.

After the first year of our MSA Program, nearly 75 percent of our employees received money back and the average amounted annually to over $1,000 per employee. Employees are enthused and excited about MSAs because they have the freedom to go to the provider they would like. They have the opportunity to receive a significant amount of money back at year end or build up a pool of money in their MSA to pay for health care, retirement, or when they are out of work. They can control how their health care dollars

are spent, and MSAs provide employees with the financial incentive to stay healthy.

Our company is pleased with MSAs because we are able to offer an increased level of benefits and are reducing costs at the same time. By putting the consumer back in the loop, health care expenses are kept to a minimum. Paperwork is significantly reduced. Payments are not subject to the scrutiny of reasonable and customary determination, preexisting conditions and other administratively burdensome reviews. I know of no other program that presents such a win-win situation for both employer and employee.

Companies from across the country call me daily to seek information about MSAs and how well they work. Workers—I should say organizations—such as Crown Northrop, Quaker Oats, Danville, Ohio schools, United Mine Workers of America now provide MSAs and hundreds of others are considering the program.

At RCI we envision a great future for MSAs. If the Federal Government authorizes medical savings accounts and grants them tax deductible status, these programs will thrive. MSAs would be offered by a greater number of insurance companies, allowing for more competition, better pricing, greater portability and more widespread savings on the part of employees for their future health care needs. Paperwork expenses would be slashed drastically because employees and retirees could use their MSA card like a universally accepted credit card. The MSA credit card-type system will reduce paperwork costs from 30 cents of every dollar to 6 cents of every dollar spent on health care.

MSAs would be a natural replacement for Medicare. Individuals accumulate their MSA nest egg through the years and, by age 65, could have $200,000 or more, assuming an average accumulation of $1,000 a year since age 21 at a 6 percent interest rate. That individual could then purchase a super MSA from an insurance company with a $200,000 deductible for the remainder of their life at a very economical rate.

The challenge in acceptance of medical savings accounts nationally is merely getting the public to understand the concept and advantages of a program and for the government to implement MSAs. I envision the education process to explain what MSA means as being no different than the evolution of HMO. Ten years ago that was an unknown. Today HMO is a household word, and that is the kind of growth and potential we could expect to see from MSAs.

Based on my firsthand experience with medical savings accounts at RCI and exhaustive research on health care alternatives, I can tell you that MSAs work. I strongly believe not another health insurance program offered compares with the MSA concept. MSAs can and should play a major role in reducing health care costs nationally. If the Federal Government authorizes tax deductible status for MSAs, we will see them flourish. Now is the time to expand MSAs as the choice for providing health care to all Americans.

Thank you.

[The prepared statement follows:]

TESTIMONY OF TOM ERHART
RCI, BRIGHTON, MICHIGAN

Medical Savings Accounts at RCI

I would like to relate to you the terrific experiences our Company, RCI and its employees have enjoyed with Medical Savings Accounts (MSA's)

RCI is an automotive specialty manufacturer located in Brighton, Michigan. One year ago we replaced our employees traditional health insurance program which offered a very high level of benefits and was fully Company paid, with a Medical Savings Account program. MSA's are an extremely cost effective way to offer health care benefits to employees because they put the consumer, the employee, back in the process. Employees are free to choose where they want to go for their medical care. They make choices based on the quality of care provided and the cost of such care. Eventhough employees have a higher level of benefits with the MSA than our previous health insurance program, our annual health benefit costs were reduced from $4800 to $4200 per employee, a 14.3% savings. For a business with 200 employees, this amounts to an annual savings of $120,000 per year! We do not even anticipate a premium increase for the 2nd year of our program.

The MSA program at RCI works very simply. An employee with dependents receives a MSA of $1700 and a single employee receives $1200. This MSA is provided to employees by the Company. RCI then purchases a health insurance policy with a $2000 deductible for employees with dependents and a $1500 deductible for single employees. This insurance policy pays 100% of all covered medical expenses after the deductible is met - no employee copay! Employees maximum out-of-pocket expenses $300 per year, the difference between the Medical Savings Account and the deductible. Employees only have out-of-pocket expenses after their MSA is expended.

CLAIM EXAMPLES

(Assume a $1700 MSA and $2000 Annual Deductible)

Annual Medical Claims less than MSA amount	
MSA	$1700
Medical Expenses (doctor visits, prescriptions, x-rays, hospital charges)	-$ 500
MSA payout at year-end	$1200
Annual Medical Claims greater than MSA amount	
Medical Expenses (doctor visits, prescriptions, x-rays, hospital charges)	$5000
Paid from MSA	-$1700
Employee out of pocket expenses	-$ 300
Paid by Health Insurance	$3000

At the end of the year, employees receive any money remaining in their MSA or carry it over to next year's MSA. This is the incentive to be conscientious consumers of health care. Employees have a direct role in seeing that their health care dollars are spent wisely. This also provides employees the incentive to take care of their health and utilize preventative health care to avoid costlier procedures.

Employees use only one MSA health ID card to pay for all of their medical, prescription, dental and vision expenses.

We find that our employees shop around for their health care needs and what better way to control costs than through free enterprise? A managed care system, PPOM, is an added feature our employees may choose to utilize to lower their medical expenditures.

Our employees are proud to point out that they have saved money by comparing costs. They often save $50 to several hundred dollars to routine procedures, and one employee even bragged that he saved $2.59 on a prescription by comparing costs.

After the first year of our MSA program, **nearly 75% of our employees received money back, and the average amount returned annually is over $1000 per employee**. Since there is currently no tax advantage to rolling the remaining money over to next year's MSA, most employees elect to take the cash option. Since the average employee only spends approximately $1000 on health care annually, the majority of employees will have a surplus in their MSA.

Employees are enthused and excited about MSA'a because:

- They have the freedom to go to any doctor, hospital or pharmacy they would like.
- They have the opportunity to receive a significant amount of money back at year-end.
- They control has the health care dollars are spent.
- They can build up a pool of money in their MSA to pay for health care at retirement or when they are out of work.
- MSA's provide employees with a financial incentive to stay healthy.

RCI is pleased with MSA's because:

- We were able to increase the level of benefits to employees while reducing our health insurance by nearly 15%.
- Putting the consumer back into the loop keeps health care expenses to a minimum.
- Paperwork is significantly reduced - Since 75% of our employees don't spend more that the amount in their MSA, these payments are not subject to the scrutiny of reasonable and customary determination, pre-existing conditions and other administratively cumbersome reviews. The expenses are simply paid out of the MSA!
- Future premium increases will be reduced because the premium base is lower with the higher deductible.

I know of no other program that presents such a **win/win** situation for employer and employee!

Companies from around the country call me daily to seek information about the Medical Savings Account concept and how well it works. Numerous organizations including Crown Northrop, Quaker Oats, Danville, Ohio Schools, United Mine Workers of America and Forbes Magazine now provide MSA's to their employees and hundreds of others are considering the program.

Our Vision for MSA's

At RCI we envision a great future for MSA's. If the Federal government authorizes Medical Savings Accounts and grants them tax deductible status, these programs will thrive. MSA's would be offered by a greater number of insurance companies allowing for more competition, better pricing, greater portability and more widespread savings on the part of employees for their future health care needs. Participants will accumulate large nest eggs in their MSA to be used for health care upon retirement.

I envision a dramatic reduction in health care expenses nationally with MSA's, mainly because the consumer is involved in cost control. Additionally, administrative/paperwork expenses would be slashed drastically because employees and retirees could use their MSA card like a universally accepted credit card. Use of the MSA "credit card system" will reduce paper work costs from $.30 of every dollar spent on health care to $.06 of every dollar.

Providers would be paid on a monthly basis, with the insurance company merely debiting their account and sending them one statement. Participants would also only receive one consolidated statement from the insurance company showing their activity for the month.

MSA's will also help eliminate the very costly government programs of Medicare and Medicaid Concerning Medicaid, the government would give an individual on welfare an MSA voucher which could be taken to an insurance company of his or her choice to get an MSA/insurance policy. If that individual has money coming to them at the end of the year, it will be held until they find a job, providing them with another financial incentive to seek work.

Eventually MSA's would be a natural replacement for Medicare. Individuals accumulate their MSA nest egg through the years and by age 65 could have $200,000, assuming an average of $1000 is accumulated per year since age 21 at 6% interest. That individual could then purchase a "super MSA" from an insurance company with a $200,000 deductible for the remainder of their life at a very economical rate.

The major challenge to implementing Medical Savings Accounts nationally and gaining acceptance from employees, employers and Medicare/Medicaid participants is merely getting the public to understand the concept and advantages of such a program and having the government implement MSA's. This can be readily addressed. I envision the education process to explain what MSA means as being no different than the evolution of the HMO. Ten years ago it was an unknown, today HMO is a household word. That's the kind of growth and potential we can

expect to see from MSA's.

Conclusion

Based on my first-hand experience with the Medical Savings Accounts at RCI and exhaustive research on health care alternatives, I tell you that MSA's work! I strongly believe there is not another health insurance program offered that compares to the MSA concept when it comes to providing a high level of employees benefits, employee satisfaction, cost control, freedom of choice, and administrative efficiency.

MSA's can and should play a major role in reducing health care costs and improving health care delivery nationally. It's time to expand MSA's as the choice for providing health to all Americans. If the Federal government authorizes tax deductible status for MSA's, we will see them flourish for employees, employers, individuals, Medicare and Medicaid.

Chairman THOMAS [presiding]. Thank you very much, Mr. Erhart.

Mr. Ferrara.

STATEMENT OF PETER J. FERRARA, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. FERRARA. Thank you, Mr. Chairman. My name is Peter Ferrara, and I am a senior fellow at the National Center for Policy Analysis.

We all know why we are here. We are here because the Medicare Program is not only going bankrupt; it is finally collapsing in a most disastrous manner. President Clinton's own trustee's report shows, if you study carefully the data that is published, that in order to pay all the promised benefits by the time today's young workers retire, under current policies if the benefits are not changed, you would require at least tripling the payroll tax under Medicare, increasing the deductibles paid by the elderly under Medicare to the equivalent of $4,000 per year per elderly couple and you would still be running a deficit of $250 billion in the Medicare Program in today's 1995 dollars, which is bigger than the entire Federal deficit.

I would submit to you that this effectively is Mr. Stark's plan, Mr. Gephardt's plan, Mr. Clinton's plan, the plan of anyone who says they are not going to make any changes in Medicare benefits. Their plan is to triple the payroll taxes, raise the deductible premium to $4,000 per couple and run a deficit in the Medicare system bigger than the entire deficit. That is what is going to happen according to President Clinton's own report if changes aren't made.

I am here today to present a proposal which—to address this problem, which I think can address it in a very appealing way. The proposal I am presenting that is advanced by my organization, the National Center for Policy Analysis, has broad support from many other groups that many of you worked with in the past, including the Cato Institute, the United Seniors Association, the Seniors Coalition, the National Taxpayers Union. Citizens For a Sound Economy is helping me with this and many other groups you all have worked with in the past.

Let me try to explain how this works. The broad concept is encaptured by medical choice. Elderly recipients under Medicare would have the freedom to withdraw their share of funds of Medicare from Medicare each year and use it to buy anything in the private sector that they want. They could buy an HMO, coverage from an HMO. They could buy coverage from a current or former employer plan. They could buy traditional insurance, but also they could buy a medical savings account to receive their coverage. The amounts they could withdraw from Medicare would be risk adjusted, based on age, geographic location, health status, so those who are relatively younger and healthier would take less if they left for the private sector. Those who were older and sicker would take more and the system would be protected from any adverse problems because people are just taking the share of funds that are represented by the risk that they present.

This proposal is designed to meet the budget targets, without question. The amounts that people withdraw from Medicare each—

have the right to withdraw from Medicare each year would be targeted to grow no faster than the budget target, whether it is 5 or 6 percent or whatever. So, everyone who exercises this option and leaves Medicare for the private sector would take an amount each year that grows no faster than the budget target.

In addition, we are advocating that for people who stay in Medicare that an automatic up front deductible be added to the Medicare benefit structure each year of sufficient magnitude so the rest of Medicare does not grow faster than the budget target of 5 or 6 percent or whatever it is.

So, here you have a plan that is guaranteed to meet your budget targets regardless of any other factor.

Now what is intriguing about this, from our perspective, is the medical savings account option, because that will enable people to meet these budget targets while still getting better benefits than even Medicare offers them today. Let me explain how that would work.

We have had actuaries estimate this for us and what they have indicated is that if you take the amount of funds that can be withdrawn from Medicare through this program each year, the amount the elderly are already spending out of pocket for medical expenses and for health care, private supplemental health insurance, the amount they are already spending on average, there is enough in that pool to buy an insurance policy covering all expenses above a deductible of $3,000 to $4,000 and still put $3,000 to $4,000 in an account; and they could use the funds in that account to pay for medical expenses below the deductible of $3,000 or $4,000. So, they are entirely covered by either insurance or savings in the medical savings account. Whatever they don't spend by the end of the year, they could then withdraw and use for any purpose.

I think that is very important to protect that freedom of control. That provides the most powerful incentive because now people have the money; it is their money. They now have great incentives to control costs, like you have heard from the prior witness. In fact, what is fascinating about this—and this was a perfect example, employers across the country are already adopting these medical savings accounts. They are achieving bigger reductions in their cost increases than is targeted in the House budget from Medicare. They were doing more than reducing growth from 10 to 5 percent. They are often reducing growth from 15 percent down to zero percent and even less.

What that shows is that, with the MSA option, people can achieve the targeted cost reductions while still maintaining their benefits. Under this medical savings account structure that I have defined, they have better benefits than under Medicare. They have unlimited catastrophic coverage for all expenses over the coverage, over $4,000. They have a cap on out-of-pocket expenses. If they have the MSA, they only have to pay up to the deductible and also they get money from Medicare in that account to help pay those expenses below the deductible. All they have to pay out of pocket is the difference.

Actuaries have estimated for us that would be about $1,900 a year today. So, in other words, the MSA option is offering people a cap on out-of-pocket expenses they don't have under Medicare,

unlimited catastrophic coverage, yet while achieving the budget targets.

So, let me just make one more point. I heard Mr. Stark present what I have to insist is a very uninformed presentation of what medical savings accounts are. Under our proposal, anyone from these private sector options would have to accept everybody from Medicare that wanted to join. You could not just come in and say, we will only take a few healthy people; you have to accept everybody who would come.

My estimate of the number of people—ultimately, the potential for MSAs is—I will put my number out; it is 90 percent, I estimate, is where the people—based on how people are choosing MSAs in the private sector.

The last thing I want to say is, let me suggest to you that you should not be in the business of, increasing managed care enrollment in Medicare or reducing costs by greater use of managed care or emphasizing managed care over anything else. There must be a level playingfield. All the options should be out there, and the emphasis should be on freedom of choice; and I think in terms of appealing to the grass-roots who are—try to support what you are doing here, MSAs, which really appeal to the idea of greater power of the people, what we are really doing here by this proposal is taking control of the program, and the funds, away from just the government, the doctors and the hospitals that control it today and shifting the power back to the people, to the elderly recipients themselves.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF PETER J. FERRARA
NATIONAL CENTER FOR POLICY ANALYSIS

The government's own latest annual report for Medicare established beyond contention that the program must be fundamentally reformed. As has been widely noted, the report indicates that Medicare will likely run short of funds to pay promised benefits within 7 years, by 2002. But what has not been as clearly reported is how big the financial gap becomes. Without change, paying all promised benefits to today's young workers would require:

- Tripling the current total Medicare payroll tax of 2.9%;
- Increasing the annual Medicare premiums paid by the elderly relative to income to the equivalent of almost $4,000 per elderly couple per year in today's terms;
- And still running an annual deficit in the program of over $250 billion in constant 1995 dollars, larger than the entire federal deficit today.

For those who say they oppose any change in Medicare benefits, this effectively is their reform program for Medicare.

And all of this is just under the so-called intermediate projections in the report. Under the so-called pessimistic projections, which many top experts think are more realistic or at least more prudent, the problem is much worse.

This financial disaster will occur even though Medicare is already effectively rationing health care for the elderly to reduce costs. Medicare pays doctors and hospitals only about 70% of the costs of the services provided under the program. This is leading to lower quality care and reduced access to care for many patients. In addition, Medicare pays the same fees, regardless of the quality of care provided. This encourages lower quality, less expensive care. The Medicare payment system also allows hospitals to make more net income by discharging patients earlier, regardless of health condition. Evidence suggests that resulting premature discharges have harmed some patients.

Medicare is also slow to approve new medical technologies, leaving the elderly without the latest and best treatments and care. For example, Cochlear implants are far superior to previous technology for treating some types of hearing loss. But the elderly under Medicare are stuck with hearing aids because Medicare doesn't pay for the more costly implants.

All of this is apart from the problems of the general federal budget, and the need to reduce the total federal deficit. But unlike Social Security, Medicare is already running deficits contributing to the federal deficit. This year, Medicare alone will add over $50 billion to the federal deficit, about one-fourth of the total deficit. By 2000, Medicare will be increasing the federal deficit by over $100 billion in today's dollars. By 2010, Medicare alone will be running a deficit almost as large as the entire federal deficit today. And, again, this is all just under the intermediate projections. Clearly, we cannot bring the total federal deficit under control without controlling these deficits under Medicare.

Indeed, by the year 2000 Medicare alone will constitute 13% of the entire federal budget. If Medicare is exempted from spending restraint along with Social Security, interest on the national debt (which is constitutionally protected), and the defense budget as proposed by Clinton (which has already been cut sharply), then about two-thirds of the total budget in that year would be shielded from spending reductions. The rest of the government would then have to be cut by one-third to balance the budget.

But how can Medicare spending be restrained? Fortunately, a Medicare reform plan with true popular appeal that would accomplish this has already been developed by free market and conservative organizations, led by the National Center for Policy Analysis in Dallas. This proposal was designed so that it would be assured of achieving the cost control targets for Medicare included in the budget resolution adopted last week by the House. That resolution calls for reducing the annual rate of growth of Medicare from 10% to 5%.

Under the proposal, the elderly would each be free to withdraw their share of Medicare spending each year and use it to purchase private coverage of their choice instead, including an MSA option, HMO plans, employer plans, or traditional insurance. The share each retiree could withdraw from Medicare would be risk rated to reflect the retiree's age, geographic location and

health status. Consequently, those who are older and sicker would receive more from Medicare to purchase private coverage. Those who are younger and healthier would receive less, reflecting the lower amounts they would be charged for such coverage. This would prevent adverse selection problems, since retirees who leave the program would only take the share of funds that actuarially reflects their own risks.

The key is that these amounts that could be withdrawn from Medicare each year would be restricted to grow by no more than 5% per year. So for those who chose the private options, Medicare spending would grow no faster than the budget targets.

Another provision would ensure that for anyone who chose to stay in Medicare, spending would also grow no faster than budget targets. An upfront deductible would be added to the Medicare benefit structure. The deductible would be set at whatever amount necessary each year to ensure that the rest of the program for those staying in the current system would not grow faster than 5% per year.

Consequently, Medicare overall would be assured of growing no faster than 5% per year, meeting the budget targets.

The MSA Option

The MSA option in the above reform plan would enable the elderly to get even better benefits and health care than under the current Medicare system, while staying within the budget targets. That is because the powerful incentives of the MSAs would control costs while other features of the MSA option would actually improve benefits and the quality of care.

Under the MSA option, the retiree would use part of the funds from Medicare to purchase insurance covering all expenses over a high deductible, say $3,000 - $4,000 per year. The remaining funds would be saved in the MSA and used to pay medical expenses below the deductible. The retiree could then withdraw any remaining MSA funds at the end of the year and use them for any purpose.

Health insurance actuaries have estimated for the NCPA that the amounts the elderly could withdraw from Medicare, plus the amounts they are already paying out-of-pocket for health care and supplemental Medigap insurance, would be enough to pay for the insurance and put $3,000 - $4,000 in the MSA for expenses below the deductible.[1]

Under this structure, the elderly choosing the MSA option would effectively be spending their own money on health expenses below $3,000 - $4,000 per year. This would make them fully cost conscious consumers of health care for such expenses. They would consequently seek to avoid unnecessary or overly costly care, or any care where the costs exceed the benefits. Perhaps more importantly, because of this new consumer cost concern, doctors and hospitals would compete to reduce costs to attract consumers trying to preserve their funds.

Several studies show that for those who used the MSAs, these incentives would quite likely produce savings more than sufficient to hold costs within the 5% per year growth rate targeted under the budget for Medicare:

- The prestigious Rand Corporation conducted a rigorous scientific study of the health expenditures of 2,500 families from 1974 to 1982. The families were each provided with one of four different insurance plans, ranging from a zero deductible and all health expenses paid, to 5% of the first $1,000 in expenses paid, and 100% after that. The families with no deductible incurred 53% more in hospital expenses, and consumed 63% more in doctors' visits, drugs, and other health services, than the families with the highest deductible. Yet, the study also found no difference between these families in health outcomes.[2]

- Overall, these Rand studies indicate that families today with a deductible of about $3,000 would consume 30% less health care than families with no deductible — with no adverse effects on health.

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[1] See Peter J. Ferrara and John C. Goodman, "Medical Savings Accounts for Medicare," Brief Analysis No. 160, National Center for Policy Analysis, Dallas, Texas, April 17, 1995.

[2] Joseph Newhouse, et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, December 17, 1981.

- The Congressional Budget Office estimates that Medicare enrollees with private Medigap insurance shielding them from Medicare deductibles and co-payments use about 24% more services than those who do not have such coverage and face the cost-saving incentives of these deductibles and co-payments.[3]

  A 1992 study by the National Center for Policy Analysis estimated that if the public generally switched from traditional third party insurance to MSAs, the resulting cost control incentives and competition would reduce health spending by about 30%.[4]

- Another study by the health consulting firm of Milliman and Robertson estimated that the cost control incentives and competition created by MSAs, if generally adopted in the private sector, would reduce national health care spending by $600 billion over 5 years.[5]

- A recent Cato Institute study estimated that if MSAs were generally adopted, leaving traditional third party payment insurance to cover 25% of total health costs, the cost incentives and competition created by MSAs would reduce health costs by about 40% per year.[6]

- Another Cato Institute study examined the experience of employers across the country who were already adopting MSAs. The resulting cost-savings for those employers would be more than enough in the case of Medicare to hold program costs within targeted growth limits. Indeed, cost-growth for almost all of these employers was zero or even negative.[7]

Such cost savings would result for the elderly who used MSAs for their Medicare coverage, enabling them to obtain their benefits within the growth-capped payments they could withdraw from Medicare.[8]

Indeed, such an MSA structure would offer improved benefits and quality for the elderly:

- The MSA catastrophic insurance would provide unlimited coverage for all expenses over the deductible, unlike Medicare benefits, which are limited in duration and do not provide full catastrophic coverage.

- The above MSA model would cap all annual out-of-pocket expenses, unlike Medicare, which does not cap out-of-pocket payments. Indeed, the estimates from the actuaries indicate that the MSA could cap out-of-pocket contributions and expenses from the elderly at less than $2,000 per year.

- Through the MSA, the elderly could avoid the increasing rationing under Medicare, which is reducing the quality of their care and their access to care.[9]

This proposal achieves the targeted cost controls for Medicare, essentially by giving the elderly direct control over the program's funds. Retirees can consequently profit by wise use of those funds. By avoiding unnecessary expenses, they can each pay themselves a large rebate each year under the MSA option. When they get sick, this reform would also allow them to escape the increasing rationing of health care under Medicare. Instead, they would be free to choose the doctors, hospitals, treatments, and benefits they want. Moreover, the MSA actually offers better benefits than Medicare. These and other benefits of the reform for the elderly would make the necessary reductions in program expenditures politically possible.

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[3] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," Washington, D.C., February, 1995, p. 287.
[4] John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," NCPA Policy Report No. 168, National Center for Policy Analysis, Dallas, Texas, January, 1992.
[5] Litow, Milliman and Robertson, "Financial Impact of Medical Savings Accounts on Health Care Spending in the Federal Budget," Council for Affordable Health Insurance, October, 1993.
[6] Stan Liebowitz, "Why Health Care Costs Too Much," Cato Institute, Washington, D.C., Policy Analysis No. 211, June 13, 1994.
[7] Peter J. Ferrara, "More Than a Theory: Medical Savings Accounts at Work," Cato Institute, Washington, D.C. Policy Analysis No. 220, March 14, 1995.
[8] Note, however, that even if such savings were somehow not fully achieved, that would not affect whether the necessary budget savings were achieved, as those savings would result from the 5% growth cap on the funds that could be withdrawn from Medicare in any event. The only result would be that the withdrawn Medicare funds would buy less in private benefits than otherwise.
[9] See Peter J. Ferrara and John C. Goodman, "Medical Savings Accounts for Medicare," Brief Analysis No. 160, National Center for Policy Analysis, Dallas, Texas, April 17, 1995.

Other Reform Features

Other features of the reform proposal would include the following:

- The private plans offered as an alternative to Medicare would have to cover the same medical services and treatments as Medicare.

- The private plans would have to accept anyone from Medicare for coverage to participate in the system.

- Those who chose a private plan could go back to Medicare after one year, but not before. The could switch to another private plan that would accept them at any time, but those plans again would not be required to accept them from another plan.

Chairman THOMAS. Thank you very much, Mr. Ferrara.
Dr. Orient.

STATEMENT OF JANE M. ORIENT, M.D., EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

Dr. ORIENT. Mr. Thomas, I am executive director of the Association of American Physicians and Surgeons. Our association thanks you for the opportunity to participate in this discussion.

We will not claim to have a plan to save Medicare, because it is a serious offense to lie to Congress. The fact is that the handwriting is on the wall. You can read it for yourselves in the 1995 Report of the Medicare Trustees. Medicare has been weighed in the balance and found wanting. Next year, it will be wanting about $30 billion. The gap between income and expenditures will increase progressively, and the HI, Health Insurance, Trust Fund will be exhausted long before baby boomers retire.

In 1967, Frederick Exner, a former secretary of our association, wrote, "Medicare can never be sound. The projected tax increases when the plan was adopted should be enough to scare us even though they failed to scare the Congress; but actually they will provide only a fraction of what the expenses are sure to be." In 1966, the maximum Medicare HI tax was only $46.20 a year.

The truth is that Medicare was built on an unsound foundation and straddles a major fault. The foundation is crumbling and the building is about to be hit by a major earthquake: the demographic dislocation of baby boomer retirement.

The structure cannot be fixed by remodeling the executive suite and hiring a new management team. If all Medicare patients were forced into HMOs, the structure would still collapse and the private sector would be blamed. Medicare HMOs would also help to destroy the rest of the medical system. In the appendix to our written testimony, physician's assistant Jim Morris, from his position as an insider selling HMO products, describes the deception and the rationing forced on employers, patients and physicians.

Medicare is a pyramid scheme founded on deceit. Seniors think that they have paid for their benefits, but in reality current workers are paying for them and, in addition, must bear the brunt of the cost-shifting and price inflation caused by Medicare.

It is time to admit that we cannot repair the Medicare building and to shift our attention to the people who are trapped inside.

Medicare traps patients and those who care for them into government dependency. We must immediately allow people who are able to do so to escape from Medicare. This will help to unload the stresses on the system.

To unstop the safety valve provided by the private market, we should encourage private contracting outside the system for which no Medicare claim is filed.

We must also repeal price controls and allow balance billing so that the marketplace can compensate when Medicare reimbursements do not cover the cost.

The long-term solution is to phase out taxpayer-financed medical insurance for retirees. This requires fixing the problem in the rest of the medical system.

What Congress must do and can do without cost to the Federal Treasury is to reform the basic inequity in the Federal Tax Code.

The Tax Code should not punish Americans for paying for medical care at the time of service or for buying individually owned, portable, true insurance. Because of the Tax Code, most Americans prepay for medical care through tax-favored employer-owned arrangements which arrangements cannot even be transferred to a different job much less into retirement. It diverts a large fraction of the medical dollar to the pockets of middlemen and leads to inflated prices and overutilization.

Medical savings accounts and individually owned catastrophic insurance should receive the same tax treatment as employer-owned comprehensive coverage, which is really a tax-free substitute for wages. Medical savings accounts allow patients to benefit from their cost-saving decisions because when patients are spending their own money, they consider costs, and this type of market pressure tends to drive down the price paid per service rendered. Companies that have tried medical savings accounts have found that their medical costs have actually decreased.

In contrast, managed care can, at best, claim to contain expenditures by reducing both quality and quantity of services. The patient bears the cost of rationing, inconvenience, poorer care and loss of choice, but receives none of the benefits of savings.

Patients own their medical savings accounts; managed care companies own patients.

Medicare is socialized medicine. We must replace socialism with free enterprise. Because free enterprise works, all Congress needs to do is to remove the impediments, the most important of which is that Americans have to earn about twice as many dollars after taxes to wrest control of their medical care from employers and third parties.

The long-term cure for American medicine, including Medicare, is tax equity. The short-term symptomatic treatment for Medicare is, let the people go.

The Medicare experiment provides one more demonstration that socialism doesn't work. We have no choice but to replace this failed and unjust system. If we act promptly, we can ease the transition to free enterprise and minimize the pain for those who are trapped in this misguided social engineering project.

You have heard about the financial foundations of the system. Let me say one word about the moral foundations. Free enterprise is morally right; socialism is morally wrong. Money given in Medicare benefits is first taken from those who earned it. That—in the words of a former Congressman named David Crockett—money is not yours to give.

[The prepared statement and attachments follow:]

TESTIMONY
of the

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC

to the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Presented by: Jane M. Orient, M.D.
Executive Director

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The Association of American Physicians and Surgeons thanks you for the invitation to participate in this discussion. We cannot, however, in good faith, propose a plan to save Medicare. That's because we understand it is a serious offense to lie to Congress.

The fact is that the handwriting is on the wall. You can look at the figures yourselves, or you can read the 1995 report of the Medicare Trustees. Medicare has been weighed in the balance and found wanting. Next year, it will be wanting around $30 billion. The gap between income and expenditures will increase progressively, and the trust fund will be exhausted long before the baby boomers retire.

In 1967, Frederick B. Exner, M.D., a former Secretary of the Association of American Physicians and Surgeons wrote: "Medicare can never be sound...The projected tax increases when the plan was adopted should be enough to scare us even though they failed to scare the Congress; but actually they will provide only a fraction of what the expenses are sure to be." [In 1966, the maximum Medicare HI tax was only $46.20 per year.]

The truth is that Medicare was built on an unsound foundation and straddles a major fault. The foundation is crumbling, and the building is about to be hit by a major earthquake: the demographic dislocation of baby boomer retirement.

The structure cannot be fixed by remodeling the executive suite and hiring a new management team. If all Medicare patients were forced into HMOs, the structure would still collapse, and the private sector would be blamed. Medicare HMOs would also help to destroy the rest of the medical system. The reasons are graphically described by physician's assistant Jim Morris in the appendix to our written testimony. From his position as an insider, selling HMO product, he describes the deceptions and rationing forced on employers, patients and physicians alike.

The dreadful truth is that Medicare is a pyramid scheme founded on deceit. Seniors think they have paid for their benefits. In reality, current workers are paying for them, and in addition, must bear the brunt of the cost-shifting and price inflation caused by Medicare.

It is time to admit that we cannot repair the Medicare building and shift our attention to the people trapped inside. Medicare traps patients and those who care for them into government dependency.

We must immediately allow people who are able to do so to escape from Medicare. This will unload the stresses on the system to some extent, to the benefit of those who remain trapped.

The first step, which would actually save money for the Federal Treasury, is to unplug the safety valve provided by the private market:

> (1) **Encourage private contracting outside the system.** For such services, no Medicare claim is filed.
>
> (2) **Repeal price controls.** This means to allow balance billing so that the marketplace can compensate for Medicare reimbursements that do not cover costs.

The long-term solution is to phase out taxpayer-financed medical insurance for retirees. This requires fixing the problem in the rest of the medical system.

What Congress must do, and can do without cost to the Treasury, is to reform a basic inequity in the federal tax code.

The tax code should not punish Americans for paying for medical care at the time of service or for buying individually owned, portable insurance. Because of the tax code, most Americans prepay for medical care through employer-owned insurance. Such insurance cannot even be transferred to a different job, much less into retirement. It diverts a large fraction of the medical dollar to the pockets of middlemen and leads to inflated prices and overutilization.

Medical savings accounts and individually owned catastrophic insurance should receive the same tax treatment as employer-owned comprehensive coverage, which is really a tax-free substitute for a wage increase.

Medical savings accounts allow patients to benefit from cost-saving decisions. Because patients are spending their own money, they consider costs in their decisions. This type of market pressure tends to drive down the price paid per service rendered. Companies that have tried medical savings accounts have found that their medical costs have actually decreased.

In contrast, "managed care" can at best claim to "contain" expenditures by reducing the quality and quantity of services. The patient bears the costs of rationing (inconvenience, poorer care, and loss of choice) but receives none of benefits of saving.

Patients own their medical savings accounts. Managed care companies own patients.

Medicare is socialized medicine. We must replace socialism with free enterprise. Because free enterprise works, all Congress needs to do is to remove the impediments. The most important impediment is that Americans have to earn about twice as many dollars, after taxes, to wrest control of their medical care away from their employers and third parties.

The two word description of the long-term cure for American medicine, including Medicare, is "tax equity."

The three-word description for the short-term symptomatic treatment for Medicare is: "let people go."

The Medicare experiment provides one more demonstration that socialism doesn't work. We have no choice but to replace this failed and unjust system.

If we act promptly we can ease the transition to free enterprise, and minimize the pain for those who are trapped in this misguided social engineering project.

SPEECH

Presented by

Jim Morris

to the

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC

Regional Conference in Boise, Idaho

May 6, 1995

I'd like to start with a little history about myself: I have been a physician's assistant for about 20 years. For part of that time I was in the military, which obviously has the worst type of socialized medicine. I took care of runny noses and sore throats at all hours of the day and night. I was awakened one morning about 2:00 a.m. for a gentleman who presented to the Naval Emergency Center for acne. So, as all cases, I got up and saw him and suggested that he take some tetracycline and so forth.

Then I said, "I have a question for you."

"What's that?" he responded.

"Have you ever heard of terminal acne?" I asked.

"No, is this terminal?"

"Wake me up at 2:00 o'clock again and it will be."

One of my past positions was as part of an HMO team. I was one of those people that went out and sold the program to companies, to doctors, to hospitals. This was a real eye opener. I'd like to tell you the methods we used to sell HMOs.

First, we were instructed in how to talk to employers. The first thing you talk to employers about is reduced cost. We told them that their employees were paying $320.00 a month for insurance for their families and that we could do it for $90.00 a month. When employees went to the doctor, it would only cost a $10 copayment.

Well, we just happened to forget to tell the employers that since it only cost them $10.00 to go to the doctor, they'd probably go more often, losing more time on the job. The other thing is that we forgot to tell them that people were going to snap the program up, and after that they would be ours.

If I came to any of you and told you the bottom line was that instead of $320.00 a month to take care of your wife and two kids, it's only going to cost you $90.00 a month, which program would you sign for? Of course, the program looks great on paper.

We talked to the employers about how they could sell the program to the employees so that the company could save money. We'd help.

Usually we would go into plants that made wood products or were involved in agriculture. It's very easy to sell to their employees. They're working for minimum wage or not

much more. They are also young. They have had no experience in the health-care market. They sign up, and the company says we'll provide health care. They didn't care what kind of plan, as long as they knew they had health care for their family. They went from paycheck to paycheck. Their educational level was low, they had no economic background, they weren't inclined to ask questions, and we certainly didn't tell them anything they didn't want to know.

From the managed-care company's standpoint, the more people we could sign up, the better. Every person enrolled means more revenue generated. So we went in and sold this program as quickly as we could. Some of you may have long dissertations with your insurance man or with your attorney. Our average appointment with a management team was one hour.

We wanted to present everything and get out of there before they had time to ask any questions. And as long as a CEO was looking at the bottom line, it was a go. We probably sold between 85 and 90% of the plans we approached.

I look back on that and I think I resembled a used-car salesman. This runs great, looks good, here it is, take the keys, gimmie $100.00, it's yours, your outta here. The problem is, I didn't tell you that it's probably only going to get you about three blocks down the road, you're lucky.

When we sold to physicians, our point was to join now or somebody else would. We said we've only got slots for four family practice docs in our list of physicians here so you know if you don't sign, Dr. Jones down here will and of course if he signs and you don't and you have patient that all work for John Doe company over here, he gets all of those patients automatically. It doesn't make any difference whether they want to go to him or not, that's where they are going to go if they want their services paid for.

We preyed upon poorly educated employees. If they were hesitant at all, we'd go out on the factory floor as we were walking out and say "Wait a minute, if you're really not sure this is a plan for you, let's ask this guy over here running this mill." We'd pull the guy off the mill and say, "Listen young man, how much do you pay for health insurance for your family? How would you like to pay 1/3 of that? Oh, and you pay 20% on top of that? Oh, well, how would you like to pay $10.00?"

Now, you only have to hit one man on the floor or possibly two, and the word would go through that company. There is a health insurance plan available that is only going to cost one third of what people are paying now and $10.00 a visit. The plan is sold. They will not dare turn your plan down because they will have a revolt from the employees if they do.

We gave people limited information concerning the panel of physicians. People would ask, "Well, is my doctor on the panel? Could I go see my family doctor?"

"Well, we are currently negotiating with a number of physicians to join our panel and actually we are talking to Dr. Jones, your physician, and he has shown some interest."

I hadn't even been to see the man yet. That's the way the system works. Don't answer any question up front, and don't answer them straight. Make a quick sale to the employer, and do it by selling it to the employees first, if necessary.

Then I changed jobs. I went from selling HMOs to working in a private office in which the physician I worked with signed up for a number of HMOs. He got caught in the crunch: "If you don't sign, the doctor down the street will. You've got 4000 patients, we own 1200 of those, can you afford that loss in income with three kids in college?" Those were the types of things that were told to the physicians. When the physician I worked for refused to sign up for an HMO, we lost 300 patients overnight. That's a pretty good chunk out of a single physician family practice group. That's a significant cut in income.

Now, what happens when you do sign up for an HMO and the other doctors don't? You get all their patients. Then you have more patients than you can handle. People can't get in to be seen. We started losing patients because they couldn't get appointments. We had patients that had been members of that practice for eight and nine years who were now seeking physicians further and further out of town because they could call and be seen that week. Our patient load got to the point that we were scheduling patients two and three months in advance.

Another selling point for doctors is the capitation. The idea is to get 300 patients on your panel, knowing that only 5% of the population is really ill. Well, I'm not sure who has worked in family practice, but let me explain what actually happens. If you tell 400 patients that they can come to the doctor and be seen for $10.00 or less, you can bet that a good portion of those are going to show up-far more than 5%. It makes it harder and harder for the sick patient to get in to be seen. So they start going outside the system. What happens if they go outside the system? They don't have any insurance.

"Well, that was on page 42 in the fine print that said that if you didn't see your family physician first, then you have to pay for the service out of pocket."

"You mean you didn't call us and ask? Oh, well I'm sorry that's on page 43, it says call this 800 number" (which of course is always busy).

If a patient goes outside the system and to a (please pardon the terminology) doc-in-the-box, and he says, "Well, look, you've got this bad heart murmur and you should go see the cardiologist," the patient generally makes an appointment to see the cardiologist. But he wasn't referred by his family practice doc, and he has no coverage. So now he's faced with a bill for $1200 - $1500, and no coverage.

We had patients go through this. We had a doc-in-the-box next door, two doors down from our office. We had people go in there. They would walk into our office, and our receptionist would say "I'm sorry Mrs. Jones, our next opening is next Thursday."

"Well, I'm sorry, but I need to see somebody today."

The patient could walk right out in the parking lot and see the sign that says "M.D. on duty" and walk in. She doesn't know any better, she doesn't care at that point, not until the bills start rolling in. And the insurance company doesn't care, the HMO doesn't care. They say, "I'm sorry-you didn't follow the guidelines, and we're not paying for anything." And they don't. The next thing you know, I have to see Mrs. Jones in the office with chest pain because she just got this $1200 bill from the cardiologist. She thought she had insurance, so she called the insurance company, but they refused to pay. She's down to her last $5 fixed May, 1995, income after she pays her rent and her groceries.

One of the other problems we had was with patients who had to travel a long distance. One of the HMOs we signed up for was in Reno. We worked in Gardnerville, Nevada, which is about 65 miles south. We were one of the first family practice docs to sign up with this HMO, so we had people driving 65 miles for their routine office care when there were obviously a large number of family practice doctors in an area like Reno or Sparks that were more than willing to see them.

Many of these patients were elderly. Some were sick children who cried for 65 miles on their way to see us. If the patient wanted to see somebody other than the family doctor on the panel, or wanted to go to the ER, he had to get prior approval. Try to get approval after 5:00 at night or on a weekend. It doesn't happen. Any number of HMOs, including the one that I was involved with, had five or six operators on during the day, but only one operator at night and on

weekends. That 800 number would ring incessantly. I have even called it myself and let it ring 60 times and not had an answer. That's what happens to your patients.

Now, what about transporting a patient by ambulance? Suppose Mrs. Jones calls you says "My husband fell down the stairs, and I think he broke his hip." You can't just say, "Okay, we'll call the ambulance, and we will see him in the emergency room." They have to call and get that approval for that ambulance, and you have to be sure they have done it. And many HMO's don't cover ambulance transportation, so it's an out of pocket expense.

Specialists care. Now we get down to what gets into the physicians pocket. Your capitated, you've got 400 patients in your panel, your capitated at $5.00 a piece and so you've got this set income that's going to come in, $2000.00. Okay now, we forgot to tell you though that we are going to keep 10% of that off the top for a catastrophic fund, that's in case somebody has to have a bypass or something like that. So, we are going to withhold that amount of money.

This is a true story. You go in to see your physician, I had an 18 year old girl who came in with acute onset of a heart murmur and chest pain. She came in, I said "look we ought to send you to see the cardiologist". Well, we had to call and get approval to send her to the cardiologist. Not a major problem with this one HMO, worked pretty well. The only problem was that we paid for the cardiologist, it comes out of our capitation fund.

I was lucky, the doctor I worked with didn't look at dollars, he looked at patients, he took care of her, he sent her.

There were other doctors I know that worked in the same area that did not refer patients because they had to pay for it. If you have somebody that does not have a life threatening condition, we had a 35 year old female with new onset seizures who we attempted to refer. We had to try, according to the HMO panel, at least three anti-seizure medications before she could be referred to a neurologist. They would not pay for an EEG, they would not pay for a neurosurgeons evaluation or neurology evaluation until she had been tried on at least three clinical drugs.

And then you run into the panel. If you have a patient (the same May, 1995 lady with the seizures) who we did try three drugs on and then we attempted to get an EEG because it was "expensive" and that is determined by each individual HMO (how costly a test is) it has to go before the approval panel. You have to submit a form to go to the panel.

Well, if you're lucky, the panel meets weekly. Unfortunately, ours met monthly to begin with, because it was small. So you submit a consultation form to the panel with the clinical information on it and request permission to send this lady to an out-of-panel neurologist and have an EEG done.

Unfortunately, on the panel you have one physician (who we were lucky was an internist, who was fairly well versed), you have an accountant and you have a CEO or CFO of the HMO. Well, he doesn't care. She's not related to him and he is not married to her, so, as far as he is concerned that's another body and he is looking at expenses. So, each person has a vote on whether or not that person gets that test done.

You have an accountant and a CEO that votes no and an M.D. that votes yes. Even in good conscious this guy is losing. It happened three times before we got this lady transferred. These are honest stories on a stack of bibles people - I swear.

Again, strict criteria for patient care, you have to meet certain criteria before you can transfer a patient. I worked in a cardiology group for awhile at a large hospital in Nevada. It was near the State line. We used to get patients over from a large HMO out of Sacramento. They would come over, they'd had an angiogram done. They did have chest pain, they had been

admitted to their hospital to their HMO facility and evaluated. Their chest pain was calmed down, they were doing fairly well on their nitrates, they went ahead and did an angiogram.

One gentleman in particular had two 75% lesions and one 70% lesion and was 76 years old. His HMO said, "Gee, we don't do anything under 80% lesions for starters and secondly we don't do anybody over 70 either". Well it doesn't make any difference if this gentleman chronologically looked like he was 60 and not 75 or 76, but "we just don't do those lesions, so, you know, sorry".

It's kind of like socialized medicine in Canada. These people would come over to our area, Reno, and they would check in the Emergency Room to see how busy things were, go across the street to the park and run up and down in the park in three piece suits until they had chest pain and then walk back across the street and get admitted in the emergency room.

Since they crossed the State line, they were out of their service area, they could be admitted on an emergent basis and treated as necessary without prior approval. I've seen it more than once. I can give you three names. I mean, this is not, out of the ordinary, this is common. It's common practice.

When you talk to people that are trying to sell HMO's to physicians, the first thing they sell the physician is, especially on a capitation program, is that this is a get rich quick scheme, as I eluded to earlier "we are going to sign up 400 patients for you because this guy down the street won't sign up with us and we are going to capitate you at $5.00 to $10.00 to $12.00 a piece, whatever it takes to get you to sign up. So -you are going to get this 2, 3, 4, $6000.00 a month no matter if you only see one of these people off this panel." Well again, since it only costs them $10.00 to come in, you are going to see a lot more than 1 or 2%. We signed up a 400 patient panel, we averaged 120 of those people a month.

The people that get rich off HMO's is the management. As the Wall Street Journal stuff was demonstrated recently, those are the people taking home the money, not the physicians in the street. Initially you think you are going to get paid for doing little or nothing - doesn't work - you get beat into the ground.

You are no longer a patient advocate. You start having to protect yourself. You start having to protect your income because you've got kids in college. You've got a house to pay for and all at once, you're not thinking about the patients well-being, you start thinking about your pocketbook and as Dr. Goltry alluded, that is the wrong direction to head.

Patients lose their choice. If you send a patient to a cardiologist or to a neurologist and you have a neurologist assigned on the panel who you really have some doubts about. Well, maybe he's not quite as aggressive as you would like and so forth, doesn't make any difference, if he is on the panel that's where your patient goes - once you get approval.

It happens many times. The problem you run into is that you may have 20 family practice docs on a panel and one neurologist. Even though there are five or six in town, there is only one on the panel. So, again, try and get a patient in.

It was not uncommon to call for cardiology or neurology services and find out that it was a three to six month wait to get an appointment and then that's an initial evaluation appointment - that's not for any services. Then they have to turn around and reschedule again three months later to get in to be seen for their follow-ups. It happens commonly. You get in medicine by proxies.

I alluded to panel choices. The panel decides what's going to happen to your patient, not you. As Dr. Goltry said, I am a physician assistant, I work with M.D.'s, D.O.'s and so I turn my choices over to the physician to make the ultimate choice in how the patient is treated and where they go, I assist in that care. But, I was trained basically to take care of the patient the best way I

know how and to use all of the knowledge that I have and I have been at this for 20 years. So, for me to turn around and fill out a form to send and let two financial people and one doctor decide what's going to happen to the patient goes against my better well-being and it definitely causes some ulcers.

There is some question in HMO panel programs now where a panel decides on medical care as to whether or not you are open for litigation. Whether you have not exercised your medical knowledge to the best care of that patient. There are two cases pending in California, that I am aware of, where a doctor is being sued because he did not refer a patient because the panel told him he couldn't.

Referral fund, as I allluded to earlier. A certain percent of your capitation goes back into referral fund. Again, this is dependent upon the contract you sign, but the ones I was exposed to this is what happened. That money then comes out of that referral fund, if you send a patient to a cardiologist, or so-forth for further care. Dependent upon whether or not that care exceeds that fund, it may or may not come out of your capitation fees.

So, instead of us getting a $3000.00 a month check, it was common for us to get $1500.00 or $1700.00 from the HMO because we spent more than what we were supposed to spend for specialty care. Again, the doctor I worked with was more concerned about his patients than his checkbook. There is something called a catastrophic fund. That is a certain percentage of your income that goes into a fund to cover those patients that need a bypass or that have to have chemotherapy or a transplant, etc.

What happens to those doctors involved in the HMO when there is no money left. What happens if you happen to be in that unlucky group that has three five vessel bypasses and a kidney transplant that year? There is no money left.

The question is, who is responsible? The physician I worked with in Nevada had a case where we just happened to be the unlucky people. We were involved with a group of family practitioners that grossly exceeded our funding because we have two five vessel bypasses out of our group and a renal transplant and so did a couple of the other physicians. That doctor ended up paying, even though he signed out of the HMO, even though he quit, because those expenses were incurred while he was still a member. He ended up paying for five years after that because those expenses he was liable for.

If any of you really contemplate joining an HMO, read your contract very carefully. There is something in there about how long you are liable for expenses and also how long for patient liability. If you are de-selected, if you should be so lucky if you happen to make the error of signing up, and find out whether or not you are still liable for expenses, even though you have been de-selected, how long the contract period goes.

I have worked in family practice and in a cardiology group which were both HMO involved. I have been involved with four HMO groups as a provider and one HMO corporation and it is the worst thing that I have ever done in my life. As Dr. Goltry alluded to, it's perverse, it's inhuman, it takes away physician choice, it takes away patient choice and it ruins what we were all taught to do.

AAPS news
The Voice for Private Physicians
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

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CAN MEDICARE BE SAVED?

Speaker Gingrich is setting the agenda, and Medicare is at the top for the next few months. With great political astuteness, Gingrich lobbed the ball into Bill Clinton's court. With equal savvy and lightning speed, Clinton slammed it back.

They both know where the "third rail in American politics" is, and neither wants to touch it. What politician could survive the credit for bringing down the federal building of Medicare, the great shining showcase of the Welfare State and government-funded medicine?

On the other hand, everyone wants credit for saving Medicare—including physicians. And something must be done.

If a building is in trouble, one needs to send in men in hard hats to examine the foundations.

Let's set aside the various Reports, Plans, Bills, Opinion Surveys, and Trial Balloons—and take a hard look at the foundations of Medicare. Here are the rock-solid indisputable facts that every American needs to know:

- **Medicare Part A is built on a first-dollar tax on wages.** Out of every dollar an American earns, 2.9 cents goes to Medicare Part A. No one may lawfully earn money to buy milk for the children, a train ticket to work, or insurance for himself, without paying that tax first. Americans who earn $20,000 pay $580; those who earn $200,000 pay $5800 to Medicare Part A.
- **Medicare Part *B* premiums are about 75 percent subsidized by general tax funds.** Uninsured working Americans are paying part of the premiums of wealthy retirees.
- **The tax is not enough; bankruptcy is inevitable.** Receipts from the payroll tax already fall about $22 billion short of covering current Part A outlays.
- **The tax *cannot* be increased enough to keep politicians' promises.** Increased longevity plus decreased fertility yields a demographic bomb. By 2040, the Medicare payroll tax *alone* would consume between 10.6 and 20.26 percent of all wages to maintain present benefits. Long before tax rates rise that high, capital and labor will move to places where they can earn a decent return. If forced to remain, their productivity will be minimal.

The dreadful truth is that Medicare is a pyramid scheme founded on deceit. It is like a poorly constructed building that straddles a major fault.

The answer to the question in the title is simply "No, Medicare in its present form cannot be saved." That is simply a fact, not a wish or a statement of political philosophy.

The next question is what to do about it. One approach is to deny the magnitude of the problem and offer a palatable nostrum. Appealing but dangerous "solutions" include changes in the top management along with schemes that paper over the cracks with price controls.

Those in power know that they cannot repair the problem, but they hope to postpone the day of reckoning so that it does not occur on their watch. Or they simply wish to delegate the responsibility so that someone else will be blamed for the debacle. "Private" entities, namely "managed" care, are popular candidates. Let them skim a fat share of gross receipts from the top for playing the heavy and taking the heat.

"Managed care" may be called a "market-based" or "private" solution, but those terms are in Orwellian Newspeak. As documents of the Clinton Health Care Task Force acknowledge, enterprises that exercise powers belonging to government, or that are under pervasive government control, are private only in name or form. Medicare HMOs are funded by the government and act as an arm of the government. But their failure will be construed as a failure of the marketplace and as a reason for frank government takeover.

Another approach is to call for the outright, immediate repeal of Medicare. This would be about as irresponsible as dynamiting an unsound building while people are inside.

The humane and rational approach is to shift our attention from saving the building to saving the people who are trapped in it.

The first step is to avoid further damage from loading on additional costly regulations. The second is to unload the counterproductive stresses that already exist (the Clinical Laboratory Improvement Act, restrictions on balance billing, claims filing when no reimbursement is expected, etc.). Next is to protect as well as possible the most vulnerable patients who cannot find assistance outside the system. Most important is to evacuate in an orderly manner those who are willing and able to leave—and simultaneously to allow the development of sound structures to replace the failed Medicare system.

Persuading people that they *should* leave a heavily subsidized program will not be easy—especially when they themselves have been taxed to provide the subsidy. Persuading young persons that they should not enter is somewhat easier. Finding the means for them to do so, given present levels of taxation, is the difficult part.

Under politics as usual, Congress will study plans to remodel the top floor. The health-care management interests will try to block the front exits, while fashioning policy that must inevitably hasten departures via the morgue.

Meanwhile, the real support for the structure is crumbling—the support of workers. Their ability to produce is drained by taxes and regulations, and their anger grows as they see the legacy that awaits them.

The choices are stark: we can tell the truth and rescue the people—or we can lie and do nothing to mitigate the inevitable collapse.

Chairman THOMAS. Thank you very much, Doctor.

If it was not said previously, any written statements that you have will be made a part of the record, without objection; and if you will entertain some questions, I will call first on the gentleman from Louisiana, Mr. McCrery. He is someone who is very interested in medical savings accounts.

Mr. MCCRERY. Thank you, Mr. Chairman. You are right, I am very interested in medical savings accounts.

Chairman THOMAS. Not that the others of us aren't. You just show exceeding interest.

Mr. MCCRERY. Well, I wouldn't say so, but I think appropriate——

Chairman THOMAS. Appropriate.

Mr. MCCRERY [continuing]. Interest. In fact, a bill that I introduced last year would have done, I think—well, wouldn't have done exactly what Mr. Ferrara recommended, but it—in fact would have gone further because it would have given tax-favored status only to medical savings accounts, high deductible options and managed care arrangements so that the traditional, first-dollar-type insurance policy would no longer be tax favored. That is how radical I am in trying to shift the population into some arrangement that, in fact, does encourage personal responsibility and involvement of the patient in his own care. That was only for the non-Medicare population.

Today we are talking about the Medicare population, which is, I must admit, a different situation, and it is one that I have not given a whole lot of thought to, frankly, until now. I am interested in the observations of all of you with regard to the Medicare population.

Is it not true that the Medicare population is far different from the rest of the population in terms of their likely medical needs? It seems to me that we must analyze the effect of medical savings accounts on that population separate from the rest of the population because of those differences.

I gather you disagree with that. Tell me, if you do disagree with that, why it is not true.

Mr. FERRARA. Well, I—the elderly have higher average costs, but in other respects, I think it is the same. The higher average costs, that just reflects the price of coverage. That is—and it seems to me that is—all the actuarial principles and all the market principles and everything else is the same. It is just that you have a somewhat higher incidence and you need somewhat more funds to cover the actuarial risk.

That is accounted for in everything I said. Medicare is already paying for that. So, the money—there is already money in the system to cover that.

The elderly are already paying for a lot of out-of-pocket expense. A lot of them are buying additional insurance out of pocket. The actuaries have looked at this and indicated to us that for what Medicare is already spending and what the elderly are already spending, you can fund the medical savings account that would produce all these benefits I described.

Mr. MCCRERY. Yes. It is your opinion that the effect on total expenditures would be the same as the effect on the non-Medicare population?

Mr. FERRARA. Yes. I think if you look at the cost distribution, as a matter of fact, under Medicare, you will find that most people—say, you had a deductible of $4,000 in the medical savings account, the great majority of people would not go above that every year—and HCFA has these numbers; if you look at that distribution, I bet it is on the order of 80 percent probably never go above that—and you would have the same incentive effect that you have got with the non-Medicare population. People are spending their own money; they don't want to waste it.

There is another factor that comes into play here that people often overlook. Because the people are concerned about not wasting money, the doctors and the hospitals for the first time really compete on cost. Today, they don't compete on cost because the patient is not choosing them on the basis of cost; the patient is choosing them only on the basis of quality. The patient doesn't care about cost because Medicare or the insurance company is paying for it.

When the patient starts choosing on the basis of cost as well as quality, they will compete on cost as well as quality; they will come up with ways to tell the patient, here is how you can do it for less.

Mr. MCCRERY. You think that principle holds true with the Medicare population?

Mr. FERRARA. Yes.

Mr. MCCRERY. Dr. Orient, have you thought about this difference between the Medicare population, the non-Medicare population and the effect of MSAs on each?

Dr. ORIENT. Well, the Medicare population is an artificial distinction caused by the existence of the government-funded program past the age of 65. Otherwise, they are human beings and they have a continuum of needs as younger people do.

Mr. MCCRERY. But they are elderly folks. When they are over the age of 65, they do have, on average, greater demands for health care; is that not correct?

Dr. ORIENT. Yes, that is correct. Mr. Ferrara, I think, has addressed that question.

Mr. MCCRERY. So, it is not an artificial distinction exactly. It is obviously an arbitrary distinction at 65, but it is not an artificial distinction, it is a real distinction. I am just curious, have you given any thought to the effect of medical savings accounts on the population, the universe of people above 65? Would it be the same? Would it act the same as those under 65? Is it more dangerous because of the greater health care demands?

Dr. ORIENT. I think clearly it would work the same way; and people over the age of 65, they are adults, they are capable of making prudent decisions about their medical care and, in fact, they do take cost into consideration when they know that there will be an out-of-pocket cost that they themselves have to pay.

Yet they also are extremely interested in their health, and I think they make wise decisions and it has been shown, certainly in younger population with MSAs that they may, in fact, tend to obtain more preventive care when it is their own money they are spending, or saving if they get the care at a propitious time.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you Mr. McCrery.

The gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

First of all, I would like to compliment whoever your employer is, Mr. Erhart. He has just done a terrific job on this, his foresight and forward thinking on choosing this option for your employees.

I would like to address Mr. Ferrara, first; you mentioned the risk assessment. Who would do the risk assessment? How often would that be done? And I guess whoever would do it, are they capable of doing that?

Mr. FERRARA. Well, this would be—HCFA would determine how much there—each individual is going to withdraw.

Mr. ENSIGN. I was afraid you were going to say HCFA, but go ahead.

Mr. FERRARA. They would do it on the basis of a few objective factors. I am not expecting them to examine each elderly person and give them a number. They have a lot of data about distributional cost by age, distributional cost by geography, and they would look at a few objective factors for health status, whether the person is—a cancer patient or a heart patient would have a different risk profile than someone who doesn't have cancer or hasn't had a heart attack in the past year or something like that—disabled. There are a few other major things. They could advise us as to the—as to the factors to be considered.

Last year it was suggested by the Clinton administration that they could—they were going to risk-adjust every health plan in America. So, they seem to think that they had some technology to be able to do that.

Now, this is different, because then, that proposal—because here the government is paying for it already, it is a matter of how much the government is going to pay in each circumstance. So, it doesn't involve the same complications as the one they were proposing last year. By their own implication, by what they were proposing to do last year, they were suggesting that they could have the technology to do this.

It doesn't need to be precise, down to the *n*th percentile. If you do some risk adjustment to get relatively close, then you will avoid the adverse selection problem.

People say, what if all the healthy people leave? If this is done right, then that wouldn't present the same risk. It wouldn't present a problem because they would take money that reflects their risk and enough would be left for the people who are remaining in Medicare.

Mr. ENSIGN. The other problem that I have—because the concept sounds great. As a practicing veterinarian, we operate basically with medical savings accounts because we operate in a free market where people are paying out of their pocket, and that is the concept that you are trying to bring in here, bringing the consumer back into the marketplace.

Veterinary medicine is incredibly competitive. We do well. We still make a decent living, but our costs have been way below inflation for 20 to 30 years, providing better and better service every year. I support the concept.

I do have another concern that a lot of the costs are consumed in the last few months of a person's life. It is difficult to determine when those last few months are going to be, but, Dr. Orient, I am sure you would agree there are times when you have a very high probability that what we are doing here is useless treatment, and if the person was able to make that decision, would probably deny the treatment in a lot of those cases. How do we, with these medical savings accounts as an option, develop systems where people are empowered to make those decisions prospectively about those last few months of their lives.

Mr. FERRARA. We have some ideas to try and address that aspect of the problem, but they are not really in this—in this proposal we are offering you today and how to basically extend the medical savings concept to more catastrophic illnesses. They reflect the idea that insurance will pay a certain percentage or a certain amount of cost, and you determine if you want to spend more or if you want to pay less.

It gets to be—it is a pretty complex thing, and we really haven't advanced that. There are ways to try to address that, but what I want to submit to you is the medical savings account, the way it is designed, is getting big cost reductions that are more than big enough to do the job that you have got before you now, when you are talking about reducing the rate of growth from 10 percent to 5 percent. Even without this more advanced version that we are still exploring to try and address the problem you are talking about, where employers have been adopting this, they are getting cost reductions reducing 15-percent growth to zero-percent growth or cutting the cost by 20 or 25 percent.

I think the emphasis should be, let's get these cost savings that are on the table and achieve what we can. That will is very large and addresses the immediate problem.

Let me say one more thing about the risk adjustment. The same kind of concept was advanced in the report that the Committee, led by Mr. Shays, released at the time the House Budget Committee report was released. They have a report on Medicare. Representative Miller, Representative Largent, Representative Shays—there was a fourth one in there—they had a system: age, demographic location, disability and ERD status. They had a way of approaching this.

So, I would submit, with a few objective factors, you can get a workable system that gets you close enough so that it will function; and then any—when you are dealing with large numbers of people, some of them will cost far more than were risk assessed, most of them will cost less, and on average you get enough numbers that it will work out for both Medicare and the insurers.

Mr. ENSIGN. My time is up, I see.

Thank you, Mr. Chairman.

Chairman THOMAS. You are welcome.

The gentleman from Nebraska, Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Thank you for this panel. I am also a strong supporter of MSAs. Dr. John Goodman, with the NCPA, has been out there in the forefront for some time leading the discussion on this, and now this year they are in al-

most everybody's plan in one form or another. I would like to see them as part of the solution.

I want to thank Mr. Erhart for being here. I am not surprised that your company is using MSAs in leading the innovative decisionmaking process here with health care reform. As most of the people in this room know, RCI is one of the leading companies in terms of producing police cruisers and electric car batteries for the 21st century.

This is a company owned by our colleague, Richard Chrysler, who has been on the forefront; and Dick, I want to thank you. I appreciate your leading the charge in this area.

Dick was kind enough to present all of us with our own medical savings account card, and I think it is a process that we need to look at very closely. Michigan has done something with your innovative Governor up there to help the process along with MSAs and maybe, Mr. Erhart, could explain what Michigan and Governor Engler have done that we might try on a national basis.

Mr. ERHART. Yes, thank you.

Michigan has authorized medical savings accounts to be tax deductible, and it has helped very much, although it is just a part of the puzzle. We feel that, more importantly, if we can do the same thing at the Federal level it will have much greater impact.

Now, at the State level, for businesses or individuals that have medical savings accounts established, the funds that they pay out for medical benefits from these medical savings account programs are tax deductible and, in fact, if they—if the individual chooses to roll over their remaining MSA at the end of the year, then those funds remain tax deductible. I think because of that, in the long run that is where we feel the role of Medicare would be satisfied, because the individual over the years would build up this large nest egg of funds.

That is how we would address—we would call it the super MSA, for example, and as I mentioned, the individual would be able to purchase this high deductible insurance program, a high deductible insurance policy that would protect them and it would be extremely economical if they built up $100,000, $200,000 or more throughout the years. We feel that that would handle the Medicare issue and the various cost concerns that are being brought up today.

Mr. CHRISTENSEN. You came to that $200,000 in your written testimony figure by an employee entering the market at age 21, at 6 percent interest, putting $1,000 away in their medical savings account over their working life?

Mr. ERHART. Yes. That is based on our experience and what we have seen with our employees in the relatively short time that we have had the program, but we feel that is very representative of what will be accomplished in the future.

Mr. CHRISTENSEN. So, your employees have been able to put money away, you found. You found your costs have been reduced. Do you really believe that we could transfer this type of innovative thinking into the Medicare field?

I mean, I know that my colleague from Louisiana, who I agree with on almost everything, didn't mean to infer that people still aren't cost conscious at age 65, because I truly believe they are very cost conscious and very careful in how they spend their dollars

and they want to save as much as anybody at age 65. Wouldn't a program like this be able to be transferred to solving a lot of our problems in the Medicare arena?

Mr. ERHART. There is no question about it. In addition to Medicare, Medicaid, the Medicaid Programs could also be addressed with the government giving Medicaid recipients who are on welfare a voucher where they would actually go out and purchase an MSA policy from an insurer of their choice; and in fact at the end of the year, if those Medicaid recipients are still not at work, then they would not be entitled to the Medicare—or the MSA balance that might be in there. We see it as possibly another way to encourage people to go back to work, another financial incentive where they wouldn't have access to their remaining MSA funds until they had a job.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. The gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you. I appreciate the good testimony of the panel on a subject that is really very important to all of us. I do have a concern about the application of this approach to the senior population and let me describe it. There has been some discussion in other sessions of structuring the medical savings account approach to take into account my concern, but I do want to share it with you.

The average income among American seniors is $25,000 but, the median income is just under $18,000. I can't tell you how many seniors have come to me with anguish in their faces because they have gone to the doctor, but they can't afford the prescription. We have a lot of seniors who use going to the doctor as a substitute for care, because what the doctor tells them to do they can't afford to do.

Now, they are making the choice, day in and day out often, not to buy medication that they know will get them well because they have to buy food. If you take any public employee in Connecticut who is retired on a municipal pension or a teacher's pension before the time when those pensions also had Social Security, these people are living on extremely small incomes.

Now, this kind of person could be lured into a medical savings account very easily and they would use that money as a salary expander. They would not use it for health care; they couldn't afford to. The big thing in Medicare now for those who have tried to micromanage from this Committee, the big frustration is that it doesn't cover prevention. It doesn't cover the very services that could lower our costs overall, and improve the quality of health care for seniors. I worry about making this available without some strings attached that in order to be eligible you have to have paid for a basic physical or something like that; or if prescription medications are prescribed by your doctor, you must demonstrate that you actually bought them and took them. I mean, at some point you have to be accountable for spending this money in a way that is prohealth, not just an income expander. This is an aspect of the medical savings account in terms of its application to the senior population that troubles me.

I wonder if you have given that any thought, and have you any proposed solutions?

Mr. FERRARA. Well, Congresswoman, let me suggest that the proposal, the way I described it, addresses this concern in the most powerful way and that all other micromanagement is not necessary.

Look, if the person only has an option to take out of Medicare the funds that will buy an insurance policy covering everything over $4,000, and then $2,100 is put in their funds, which is—in their MSA, which is what actuaries are telling me could be done, basically that $2,100 could be used for prescription drugs, can be used for medical—for checkups, for preventive care.

You are addressing their problem. You are having people who are saying I am going to the doctor, he is prescribing these drugs, I can't afford to pay for them.

Mrs. JOHNSON. The problem is, Mr. Ferrara, if you allow them to withdraw at the end of the year what is left, you are not doing that. If they preserve that money, then the next year they get that and they can use it for whatever they want.

Mr. FERRARA. Right, but listen—I am sorry, what I am trying to say is, if you give people a savings account of $2,100 that they can use to buy prescription drugs, you are giving them a big advantage over the current system. They will then have the money available.

Now, as—but apart from that, you have to leave them the freedom of choice to make their own decisions. The government should not be telling them, you have to use it for this or you have to use it for that. They make their own decisions about their own priorities; and you are going—if you limit what they can use the funds on, you will undermine the incentive to control cost, because——

Mrs. JOHNSON. I think you are missing my point. If the government is going to actually give people money for the purposes of health, we have some responsibility to see that that money is used for health. If a senior uses that money for other than health purposes, just because they are on a very low income and they are desperate, then they get sick, they will go to the hospital and we will take care of them.

Now, since the taxpayer ultimately has the obligation to pick up the cost—and we do, we are a humane society; we are not going to turn them away because they spent their medical savings account on something else. So, I don't think you can take quite as casually as you are taking the fact that people might choose to spend the medical savings dollars in other ways and, particularly, refuse to spend it in health prevention ways that would minimize their costs in the future.

Then, the other thing, the numbers that you use, $4,000 catastrophic and we are going to give them $2,100, that means they are exposed to a $1,900 expenditure. For a person on a $7,000 or $8,000 income—and there are lots of them out there; any public school retiree in Connecticut who is about 70 is retired on $500 a month; that is what they are retired on—and no Social Security.

My understanding is—well, you say that is not right. I have had a teacher stand there and say my husband taught Latin in the local high school all those years. Maybe they couldn't.

Mr. FERRARA. It is a better benefit than under Medicare. They are better off with that proposal than they have got under Medicare, because you have got a cap on out-of-pocket expenses here of $1,900. On Medicare now, there is no cap on out-of-pocket expenses.

Mrs. JOHNSON. What do you spend down to Medicaid?

Mr. FERRARA. Apart from Medicaid, this is a better benefit structure than you have under Medicare on the cap of $1,900. Under Medicare there is no cap. According to AARP, the average person is spending about that much in out-of-pocket expenses already.

You have a better benefit structure under the MSA than you have under Medicare because you are giving them a cap on out-of-pocket expenses and unlimited catastrophic under $4,000, and a lot of people are paying out of pocket today to get those benefits from medigap insurance. You are offering them a better benefit package with the MSA and an opportunity to actually benefit if they use those funds wisely.

Let me suggest that what you are offering people by letting them spend the money on what they want at the end of the year is a reward for saving both the government and themselves health costs.

Mrs. JOHNSON. I don't differ with you that it is a better benefit structure if you are going to max out. I do differ with you that it is necessarily a better benefit structure under some circumstances; but my primary concern is that there is an obligation on the part of the Federal Government, if we provide subsidies, to see that the subsidies create the behavior that we are requesting, and the behavior that we are requesting is that you spend the money on health and you do it in a way that minimizes cost.

Mr. FERRARA. But the whole purpose——

Mrs. JOHNSON. I think you have to take into account in a medical savings approach some obligation on the part of the medical savings accountholder to assure that they take certain health care actions that we know are necessary to prevention.

Mr. ERHART. I believe your concern could be easily addressed merely by restricting the MSA expenditures for health care expenses only. I wouldn't see any problem with that. The money remaining in the person's account at year end is still theirs, but they must leave it there to pay for medical expenses in future years; and I think that handles that approach.

Mrs. JOHNSON. That would go toward the $1,900 exposure next year.

Mr. FERRARA. Excuse me, as a matter of economic analysis, that won't work. If you can only spend it on health care, that won't work. It gives you no incentive to save on health care. As a matter of economic analysis, that doesn't work.

If you want to do this the way—as a matter of sound economic analysis, you must allow an even playingfield choice between health care and nonhealth care. That is the choice as a matter of economic analysis you want to allow because what—what happens now is people are overspending on health care because they are not taking advantage of cost. They are not weighing cost against benefits.

To get the full weighing of cost against benefits, you have to allow them the freedom of choice to spend it on health care, as unlimited as possible at the end of the year. Any way you restrict that, you are undermining the economic incentive to try to weigh costs against benefits. You are reducing the rewards they get for not spending money on health care.

The whole idea behind MSAs is to give people incentives not to spend money on health care, and it is not to give people more money to spend on health care.

Mrs. JOHNSON. I do understand the economic analysis, Mr. Ferrara, but my time has expired so I can't pursue this any further.

Chairman THOMAS. Thank you.

I believe Mr. McCrery wants to speak but before he does, Mr. Ferrara, one of the things that we do around here is look at economics in terms of not only real-world context but also, in terms of a political-reality context. I understand your argument about weighing health care costs versus other uses for the money. I found out a long time ago that one of the first things you have to do around here is get a program started before you have a program. I was on the floor, not able to be with this Subcommittee for a portion of the time, as we were in the process of moving toward a conference committee with the Senate on Medicare Select. You cannot imagine what was said on the floor on such a modest little program.

Your example that you just gave would allow me, unfortunately, in a political context to say what Mr. Ferrara wants to do with the taxpayers' money, with the Medicare Program is to give the senior the choice between an RV or necessary medical attention. We know that is a phony argument. That, in essence, is what you are setting up in terms of an open-ended MSA account to be expended for whatever purpose someone wishes to expend that money for in an attempt to equate, in a pure economic sense, health care costs.

I found out a long time ago that you don't legislate in a vacuum and you do have to legislate in political reality. So, one of the things that we will be looking for as a Committee moving forward is a medical savings account program which not only creates an option or a choice for an individual from other structured programs, but has a modicum of a chance to pass. We have to deal with political realities as well as all other things being equal economic reality.

So, I guess what I am politely trying to say to you is that your colloquy with my colleague from Connecticut, although it may score points in terms of an academic argument over economics does not advance our cause of finding a politically salable approach to medical savings accounts.

So, we are going to have to examine Mr. Erhart's comment very carefully about saying if you do carry over money, what you are in essence doing is moving toward self-insuring yourself by the accumulation of funds in an MSA to be spent only for medical purposes; and that may very well be the best world that we can reach, because to do otherwise would be not to have any medical savings account option, and I believe that the former is a better choice than the latter.

Mr. FERRARA. May I address that?

Chairman THOMAS. Sure.

Mr. FERRARA. Let me make this suggestion as to political realities.

Surely it will be more politically appealing to say to people they can take the remaining funds at the end of the year and spend it on whatever they want, rather than say to them, you can take the funds and only spend it on these few things that the government says you can spend it on. So, the——

Chairman THOMAS. I understand your argument. I have carried it out in a number of different forums. That may be appealing in one context; it is a political anathema in another context.

All I am saying is that the vigorousness with which you argue your position, I understand it, but it may not be a possibility of creating a system, one step that allows you to spend it only for medical purposes.

And, for example, one of the questions that I was going to ask Mr. Erhart is, what happens if someone accumulates and rolls over the surplus funds in their MSA and does it year after year after year; and if one is as healthy as a horse and never expends their money from their MSA and they then die in an automobile accident or otherwise, is that money theirs? Does it go into their estate?

Mr. ERHART. That is how I would envision it, yes. It would go into their estate, possibly it could be used for their beneficiary's health care, it could be designated for that use only; or I think that is something that could be explored further.

Chairman THOMAS. OK, Mr. Ferrara, there is an area that we can work on. You and I will work together to try not to have an intergenerational requirement on a carryover on MSA to be spent only for medical purposes, so we can break this chain at least on the generational level and we may then be able to bring it back from that generational level.

What we are doing is trying to simply respond to you in a shorthand way the concerns that we might have about a theoretical approach which would be granted in a theoretical environment. Unfortunately—perhaps fortunately—we do not operate in a theoretical environment.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Ferrara, let me try to clarify what we are talking about here in terms of the availability of money in an MSA for expenditure by the holder of the MSA. You are saying that the person would get how much in cash?

Mr. FERRARA. What I have seen from actuaries estimating this, you can—one thing you could do is buy a policy covering all expenses over $4,000 and have about $2,100 left——

Mr. MCCRERY. How much cash would they get?

Mr. FERRARA. I don't know. It is either looking at the amount you withdraw from Medicare, on average, but what they are telling me is, the amount they can get out of Medicare would be enough to pay for a policy covering everything over $4,000 and put about $2,100 in the account each year.

Mr. MCCRERY. $2,100 in cash?

Mr. FERRARA. Each year.

Mr. MCCRERY. To use for common, everyday health expenditures?

Mr. FERRARA. Right.

Mr. MCCRERY. Do they get that cash in hand or is it in an account somewhere that they draw on, or how do you envision this?

Mr. FERRARA. Say they want to do this with XYZ Insurance Co. The account and the insurance—it goes to the insurance company. For the first year, they can only use it on health expenses. So, if they have a health expense, they send the form to the account and they will pay them back for it. What we would do is have that health expense be as broad as medical expenses are defined under the Internal Revenue Code.

Mr. MCCRERY. You would not allow those folks to spend that cash on nonhealth care expenses in the initial year.

Mr. FERRARA. Right. Right.

Mr. MCCRERY. OK. I think Mrs. Johnson may have been thinking that they are able to spend that money on going to the movies and whatever during that year.

Mr. FERRARA. Right.

Mr. MCCRERY. You don't envision that?

Mr. FERRARA. No, no, no, no.

Mr. MCCRERY. You are saying at the end of the year, if they have any money left, then they can spend it on going to the movies or whatever they want, because they get another $2,100.

The mechanics, though, we would have to figure out, because if you give somebody cash——

Mr. FERRARA. You don't give them cash. The insurance company holds it until the end of the year. At the end of the year, you would say give me a rebate on the remaining funds.

Mr. MCCRERY. So, you are with us there. We would have to figure that out.

I disagree with Mr. Thomas' analysis of the politics of this. In the old Congress, I think he may have been right; in the new Congress, I think there is a distinctly different flavor of philosophy that might lend itself to passing something like this. It depends upon the intelligence of the individual, and the individual operating in his own self-interest rather than some government plan that directs the individual in certain ways.

So, I disagree with him, but as a compromise, what we might consider is allowing the individual to get any money over and above the amount of the deductible, or the out-of-pocket cap, as long as that individual has sufficient money in his account to cover the deductible. He could use any excess at the end of the year. That might be a compromise that would help.

Mr. FERRARA. I think that would work. I think it is important—it is very important not to say you can only spend it on health care. It is not going to work. It would be worse than doing nothing.

Mr. MCCRERY. I am in total agreement with you there, except with the under 65-year-old group. Frankly, I think it is possible to tell them you must keep any excess in that account until you reach age 59 1/2, or whatever. At such time you can then withdraw it for any other purposes. Until that age you would have to spend it on health care only and it would accumulate, tax free, in that account, like an IRA, individual retirement account.

For the elderly, for folks over 65, I agree with you. I think you have to let them spend it at the end of the year. Maybe we could work a compromise that would satisfy Mr. Thomas' socialistic leanings and the realities of the new Congress at the same time.

Dr. ORIENT. It is interesting that you object to the senior citizen being able to buy an RV, but no one objects to the HMO pocketing the profits.

Mr. MCCRERY. I don't object. You are talking to Mr. Thomas.

Chairman THOMAS. Obviously, I am not going to advance a third party argument anymore. I was trying to offer options in terms of political realities.

I also find it somewhat interesting, Mr. McCrery, that you do fall back on the usual IRA argument, where it has to be included for a specified reason to spend out only, otherwise there are various penalties, loss of interest, time-certain amounts, which are the old-fashioned IRAs.

When you talk about a medical savings account, I think most people would examine that and say that it is an account to be used for a particular purpose, and you named it a medical savings account for that purpose, when, in fact, it is not a medical savings account, as you have described it, except for the first year, which you are now going to require them to keep it for a medical savings account. After that, I don't know exactly what it is, since you can spend the money for anything you want.

We will have to get into the Tax Code and what that means and how it is reported. It gets a bit more complicated if, in fact, you are going to create a one-way street one year and a two-way street the next year; and somebody gets married to someone else who has a new MSA, which is a one-way street MSA the first year and they exhaust their money. Can they borrow it? I am just trying to get practical when you get in the real world with people who live real lives. We have been dealing in a very neat, singular economic world about a theoretical discussion.

It is more complicated than we are currently making it out to be. Not so complicated that it is not a very attractive alternative to any other program out there right now.

Mr. MCCRERY. For those of us, Mr. Chairman, who have thought about this for a long time, there are answers to all those objections. In fact, I agree with Mr. Ferrara, that when you put those kinds of economic interests in play, you are going to get the desired result; that individuals operating in their own self-interests will accomplish the desired results.

Chairman THOMAS. I have no doubt that there are answers to questions, whether they are good answers.

Mr. MCCRERY. Oh, yes.

Chairman THOMAS. Sufficient answers.

Mr. MCCRERY. Yes.

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. Mr. Ferrara, I agree with your economic analysis as far as incentives go. As a free market believer I think that is the correct way to go.

Mr. Erhart, you suggest that the money should stay within the medical savings account for medical purposes only and not be used for other purposes. Would you tend to agree or disagree, then, with

Mr. Ferrara's analysis that that would take away the incentive, or what is your perspective on that?

Why or why not would it not take away the incentive to keep it within the health care purchasing only?

Mr. ERHART. Well, I would tend to believe that it would not take away the incentive to still be a conscientious consumer of health care. Because the end idea is to have this built as a nest egg, as an account for future health care. And, again, we are aiming at a long-term solution for Medicare. I think that people would see that, certainly, that it is going to benefit them in the long run in the same way that they are putting money into IRAs these days to be able to prepare for the future.

If they know that that is the way that their Medicare is paid for, that their long-term health care needs are met is by accumulating this amount, I think there would still be that incentive to save and for this program to be effective and successful.

Mr. CHRISTENSEN. Have you experienced any of your employees' foregoing preventive measures to put money in their own pocket that should have gone through the preventive measures, that ended up with a long-term illness or a catastrophic health care situation that could have been prevented earlier because of your plan?

Mr. ERHART. We have experienced exactly the opposite of that. I have had a number of employees approach me and say that they are going for a routine physical exam; they have not gone for one in years because their traditional insurance program does not pay for preventive health care. So, I have experienced exactly the opposite of that.

Mr. CHRISTENSEN. Do you think that would be true of the Medicare population? Do you think preventive health care would also take place there like you have experienced in your company?

Mr. ERHART. Absolutely. Especially through the years, as this thing builds, and as people become more familiar with the concept of it and how it works, that is how they are brought up through the system, and I think that it would definitely be the case.

Mr. CHRISTENSEN. What about my penny pinching, conservative, frugal mom who does not go to the doctor for a sniffle or a cold and ends up deathly ill. Can't you foresee something like that happening with the senior citizens?

I am playing devil's advocate to some degree, because, believe me, my colleague from California, when he comes in here he is not for profit or he is not for any good innovative new ideas, like he said earlier. He is content with letting the system go bankrupt. We are going to try to fix it and come up with a system that is better for everybody.

I am just trying to think through all the arguments that we will see here later as we get closer to a decision on this.

Where do you see this, Dr. Orient?

Dr. ORIENT. I think physicians sometimes present to you an exaggerated sense of their powers. It is perfectly rational for a senior citizen or anybody not to go to the doctor when they have a cold. There is nothing I can do to cure their cold or keep it from turning into pneumonia.

Really, these preventive measures, in most instances, do not save money for society. They are good for the individual because they

help to prevent you from getting a serious illness, but not because they save money. Most senior citizens really are quite sensible and prudent. They didn't live to be 65 years of age by not taking care of their health.

Mr. CHRISTENSEN. You are with the physicians and surgeons. I have heard some people in Omaha talk about the fact that the specialists are not happy with a managed care approach to solving Medicare because they are going to see the gatekeeper theory; the primary care physician lock them out of seeing that patient that they need to see.

A lot of specialists have complained to me they don't want to go to a managed care solution with Medicare. Do you see that with your membership or have you experienced that personally?

Dr. ORIENT. Well, forget about what the specialists feel about it. Think about the patients. The patients are being locked out of seeing a physician who can solve their problem for them, and they are given the runaround and have to go to committees and go to the primary doctor who cannot help them over and over again as a means of rationing.——

Mr. CHRISTENSEN. So, you think there is some truth to that.

Dr. ORIENT. Oh, I think there is. I think you should look at it from the patient's perspective. They are the ones who are being deprived of the services that they could benefit from.

Mr. CHRISTENSEN. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Erhart, I am a new employee. I have just received my medical savings account card. There is some writing on the front that I am not completely familiar with, and I turn the card over and there is the well-known fine print on the back side. Explain to me what the fine print means.

On the front side there is a PPOM, and there is Claims Pro. The fine print says, see certificate for exclusions and other terms of coverage. Managed care services program requirements. Medical precertification is required at least 7 days prior to admissions, surgery, or home health care.

Now, PPOM is the Preferred Provider Organization of Michigan. Do you have a contract with them? The company has a contract with them?

Mr. ERHART. Yes, that is correct. I appreciate your bringing that issue up because that is one of the features of our program that we have integrated into the MSA merely as an option, where if employees do choose to go to one of the PPOM providers, they are assured of a negotiated rate that is very, very competitive.

Chairman THOMAS. Because you do have a non-PPOM provider contact point on the back of the card as well. So, the employee has a choice to go into a preferred provider structure or stay outside of it?

Mr. ERHART. That is correct.

Chairman THOMAS. Are you familiar with International Paper's program? I sat in the other night with the Speaker discussing it with them just very roughly. International Paper examines the doctors in the area and develops a fee schedule that they believe is an appropriate one. They provide a lot of background information on the doctors, their degrees, number of years they have practiced, the number of times they perform certain procedures, and so forth.

They then tell the employee that they will pay 100 percent of what they believe to be an appropriate fee, if they would go out and tell the doctor that, well, this is what we believe is the appropriate fee.

They used to have a health care benefit where the employee would pay 20 percent, and if they worked hard they would save the company 80 percent and they would save themselves 20 percent. By talking about, in essence, a voucher of 100 percent, the employee feels a little more strongly about negotiating that price, since they don't pay anything if they are able to get it at that price.

The company then spends about a half an hour with the employee on a video talking about how you are supposed to discuss this with the doctor and the rest. It is basically using the company as an information base to empower the employee to get a good price.

Do you do anything working with the employee to empower them a little bit about information, beyond I guess what the normal employer would do in terms of informing employees; that would kind of give you an argument as to the fact that the company is assisting them in getting the best possible price with their medical savings account moneys?

Mr. ERHART. Well, certainly. I have conversations with employees on a formal and informal level on an ongoing basis, and really, that is what the MSA is all about, is educating people to know how to be wise and conscientious consumers; how to shop for the best medical care, both from a quality and cost standpoint. We see that as the concept becomes more widespread and well-known, that that education process is going to become even easier.

Chairman THOMAS. Obviously, you now have empowered every single employee to go out there and get the best deal possible. Some people will, frankly, do a better job than others. Do you have any kind of a clearinghouse for information, so that someone who is looking for a lead, or does not feel they have gotten a good price, and can get a feel for what others have gotten?

Do people tend to brag about the fact that they got a good price on something? Is there a way to disseminate that information among employees that would make all of them better shoppers?

Mr. ERHART. Well, people do brag about the fact that they have achieved a cost savings. There is no question about that.

As far as a clearinghouse, that is not something we have established at this point, but it is an excellent suggestion that I think would be very worthwhile.

Chairman THOMAS. I just think the key is sharing information. When someone has had a real world experience, that kind of information needs to get around.

Mr. Ferrara, in your testimony you talked about risk——

Mr. FERRARA. Yes, sir.

Chairman THOMAS [continuing]. Adjusting and MSA. There was some discussion there but I don't completely understand this. I have two people, two males, widowers, same age, next door to each other, both former steelworkers, one has a very serious health problem, the other one does not.

Now, we are going to give the one who has a serious health problem more money; is that how we are going to risk adjust on individuals?

Mr. FERRARA. Let me explain how that would work. It is not just the MSA that is risk adjusted, it is the whole private option. In other words, what we are proposing is people each get to take a share out of Medicare each year. They have the freedom to choose that and buy anything in the private sector they want: HMOs, MSAs or anything. That share they get to take is what is risk adjusted.

In other words, if you are younger and healthier, there is less you take to go and buy either an HMO, an insurance policy, or an MSA. If you are older and sicker, you get to take more because it will cost you more anyway to go out and buy and pay for that. Then this helps to avoid any adverse selection problem, because people are taking with them the money that reflects the risk that they are taking with them.

Chairman THOMAS. So, basically, it is going to be distributed to each according to their need?

Mr. FERRARA. According to their risk, is how I would put it. Distributing to each according to their risk.

Chairman THOMAS. But risk is, in essence, need; isn't it? The risk of what?

Mr. FERRARA. Of health expenses.

Chairman THOMAS. Of health expenses. Health expenses for two people if they are different, one needs more money than the other; that is why you are risk adjusting.

Mr. FERRARA. But risk may not be the same as need in all circumstances, and it really is risk that you are adjusting for here. The key thing is this avoids the adverse selection.

Chairman THOMAS. So, to each according to their risk?

Mr. FERRARA. Yes.

Chairman THOMAS. From each—it is a payroll tax, right? So, people who make more will pay more into it?

Mr. FERRARA. During their working years, yes. During their working years.

Chairman THOMAS. From each, according to their ability, in terms of making money. Then it will be distributed to each according to their risk, which is need.

Mr. FERRARA. That is what Medicare is doing today. This is Jane Orient's point.

Chairman THOMAS. I can think of all the people filing out there. Somebody probably recalls the phrase from each according to their ability, to each according to their need.

Mr. FERRARA. But that is what Medicare does today.

Chairman THOMAS. That is what you are proposing in your concept.

Mr. FERRARA. Well, no, that is what Medicare does today; it takes from each according to their tax payments and gives to each according to their need. It pays them for the health expenses that they need.

So, we are devising a program that is within the Medicare context. Of course, it addresses those issues, and that enables you to say to your elderly constituents, we are still fulfilling the function that you are looking to fulfill with Medicare.

Chairman THOMAS. I am just saying that I may lose the battle with my friend from Louisiana not on a socialist argument but on

a political argument about letting seniors spend their money, but I think you are going to have a very difficult time on a political argument telling two seniors that one is going to get a whole lot more money on a risk-related basis than someone else.

That may be the case today, but when you strip it from all of the various levels of discussion and you simply say *y* gets this and *x* gets this, plus a factor on the risk selection, once again it is relatively easy to conceptualize and create a structure which seems to be equitable, but to take that and attempt to put it into political reality is a much, much more difficult thing to do.

So, when you just sit there and say we are going to take the MSA and MSA is going to be risk adjusted——

Mr. FERRARA. Well, it is not the MSA that is risk adjusted. It is the voucher amount that you would draw from Medicare.

The reason why I think that this would not be a political problem is because the amount each is withdrawing is reflecting what they would have to pay to buy coverage in the private sector. A person who has a serious illness has to pay a lot more to buy this coverage than a person who does not have an illness. So, that is why I think that this would be seen as equitable and that they would not create——

Chairman THOMAS. Would the illness be treated differently and in a different expense in a different health care structure?

Mr. FERRARA. Would it be treated differently? I don't think so. The point is, if you are dealing with one person who does not have the illness and one person who does, the person who does not have the illness can buy insurance a lot more economically than the person who does have the illness. So, what I was suggesting——

Chairman THOMAS. But if the person who has the illness, and it is going to cost more for in a fee-for-service program than it would, for example, in an HMO program, shouldn't we have the right to say you should go to where it is the cheapest to get the service?

Mr. FERRARA. He can go to an HMO under my proposal, if that is what he wants. He can go to anything he wants. He can take the risk-adjusted voucher out of Medicare; he can go to a current employer plan, a former——

Chairman THOMAS. Is the risk adjusted to the lowest possible health plan cost out there?

Mr. FERRARA. No, no, no, it reflects the costs that are going to be incurred by the plan that takes him. So, that it is an actuarial estimate based on his expected health costs, and you look at factors like——

Chairman THOMAS. So, one plan will take him for $3,000 and another plan will take him for $4,000. Which is the amount that should be paid?

Mr. FERRARA. You don't pick the amount based on what the plan charges. You pick the amount that he takes in his vouchers based on his expected health costs. He then takes the voucher amount and sees what can I buy on the market. An HMO will come along and say, we can take that and give you better benefits. The MSA says, we can take that and give you an MSA and you can withdraw the money at the end of the year. A former employer may say, we have another bargain.

He goes out and looks to see what he can get for that, whatever it is, $5,000, $6,000 or $7,000 he has taken out of Medicare and he looks to see what is the best deal he can get from all of those alternatives.

Chairman THOMAS. I have to walk through a couple of models as we move forward on this.

Dr. Orient, on your first page, I am trying to remember the exact language, I will paraphrase it, but you are not a fan of HMOs.

Dr. ORIENT. No, sir.

Chairman THOMAS. In fact, they are undermining, I think was the word. If we are urging, especially with MSAs, if we are urging a free market of choice in this structure, should we, based upon your belief in terms of HMOs, allow those as a choice for people to select? Should they continue to exist?

Dr. ORIENT. I have no objection to them being a choice, but I think that any of the advantages that were given to them, such as subsidies on startup or requirements that employers must offer an HMO if they offer any other kind of insurance, that those should be eliminated and we should truly have a level playingfield.

Chairman THOMAS. Good, that helps in terms of the direction you are going on the HMO. I have no problem with eliminating subsidies that create advantages for one particular model over another, including examining current antitrust laws which were built for the 19th century production of things and not necessarily the delivery of services, where perhaps communication would produce a better product rather than lack of communication among professionals.

So, I am interested in a broad-based removal of subsidies to any kind of a structure. I am sure I will run into my political realities in pursuing that one as well.

I want to thank the panel very much. Obviously, some folks have thought very much about integrating this kind of a concept into our health care system, including the seniors, which, on first blush, frankly, a lot of people are taken aback when you talk about a medical savings account for seniors, given the profile the gentleman from Louisiana discussed, which might be slightly higher for seniors, that you are arguing is not necessarily so.

Mr. Erhart, I want to thank you for giving us an example of a real world opportunity. I noticed in your testimony a number of other companies are inquiring about your structure. Do you have an organization or an association of companies that are sharing information about medical savings accounts or is this so new you are just finding each other now?

Mr. ERHART. It has been very informal up to this point.

Chairman THOMAS. My assumption is, since there is an association for every possible existing relationship, that by next year we will have a medical savings account employers association.

I am looking forward to the experiences, especially on a geographic basis, on a regional basis, since we have found a lot of differences in terms of health care practices across the country. It will be interesting to see how this integrates either in terms of a preferred provider structure or other operations in other parts of the country.

It is an idea I think that is exciting. It is something new. It does do what I think most of us believe is the real answer, and that is get the consumer directly involved in the decisionmaking process in health care. They are ultimately the solution.

I want to thank you folks for your presentation today.

Any questions from the other members on the panel? Thank you very much and the Subcommittee stands adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Potential Role for Employers, Associations,
and Medical Savings Accounts in the Medicare Program Hearing

Written Testimony for the Record
Submitted by the
American Academy of Actuaries'
Medicare Work Group

June 8, 1995

The American Academy of Actuaries provides technical actuarial expertise to public policy makers and maintains the actuarial profession's standards of qualification, practice, and conduct. Academy members include actuaries from all practice specialties: health, life, pensions, and property/casualty.

Academy committees and work groups offer expert testimony, provide technical information, comment on proposed legislation, and work closely with federal and state officials on insurance-related issues. The Academy's Department of Public Policy coordinates the work of committees and work groups with the needs of public policy makers.

This testimony is intended to be an objective analysis of issues surrounding Medicare and medical savings accounts. It is not intended to favor one position over another.

GROWTH IN MEDICARE HEALTH CARE COSTS

The financial problems of the Medicare program are, at this point, so large that there will have to be substantial changes made in the program in order to preserve Medicare for future generations of beneficiaries. According to the *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, to place income and expenditures in balance even over the next 25 years will require either an immediate 30 percent reduction in expenditures, an immediate 44 percent increase in the Hospital Insurance (HI) tax rate, or some combination of both.

To achieve such reductions in Medicare costs in the least detrimental way, innovative ways to reduce program costs will need to be put into place. These innovations will need to deal with the two factors which, in combination, are driving up health care costs in the Medicare

program as well as in the private sector: fee-for-service medicine and third-party payments. Increasing Medicare coinsurance and deductibles is an attempt to deal with the third-party payment factor. Introducing capitated services, such as those called for in the Medicare Risk Program, is one method of dealing with the fee-for-service medicine factor. To date, the federal government has done very little to deal with the factor of third-party payments to control health care costs. Its efforts at producing savings through capitated managed care have not been fully successful.

High deductible plans represent a way to deal with the issue of third-party payments. Direct payments by patients for a portion of the cost of their health care services are a proven method of creating behavioral changes among both providers and patients, resulting in substantial reductions in health care costs.

When patients and providers perceive that they are spending other people's money, they do not concern themselves with either the price or the quantity of services provided. Even the relatively modest cost-sharing provisions of the Medicare program have a substantial impact on the utilization of health care services by Medicare beneficiaries. Research conducted by the Health Care Financing Administration's Office of the Actuary on the Medicare Current Beneficiary Survey found that, even when controlled for self-reported health status, Medicare beneficiaries who did not have Medigap plans, and who were thus fully subject to Medicare's cost sharing provisions, have significantly lower overall health expenditures.[1]

Table 1 indicates the differences in health care spending between Medicare beneficiaries without Medigap plans and those with employer-sponsored Medigap plans. Individuals who are fully subject to Medicare cost sharing (i.e., they are not covered by an employer-sponsored Medigap plan) cost the Medicare program substantially less than individuals who are not fully subject to Medicare cost sharing.

Table 1

Medicare Spending Per Beneficiary for Aged 65 and Older Population, based on Self-Reported Health Status and Coverage by an Employer-Sponsored Medigap Plan

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

Source: Health Care Financing Review.

[1]Approximately 80 percent of Medicare beneficiaries have either Medigap plans or Medicaid to cover Medicare coinsurance and deductibles.

Additionally, research shows that not only are health care costs higher because of third-party payments, but health care costs increase faster because of third-party payments. A forthcoming *Health Affairs* article, co-authored by Mark Freeland, Ph.D. and Al Pedron, Ph.D., shows that the acceleration in the rate of growth in health care expenditures in the United States has been highly correlated with the shift toward third-party payments. This research shows roughly that every ten percentage point shift from out-of-pocket payments to third-party payments results in an increase in the annual rate of growth in health care costs of about 2 percentage points, and this accelerated rate of growth persists for about ten years. This is an important finding because it provides the potential key to reducing the rapid growth of health care costs in the United States.

POTENTIAL ROLE FOR MEDICAL SAVINGS ACCOUNTS

Medical savings accounts (MSAs) could play an important role in facilitating the introduction of high-deductible plans into the Medicare program and reducing Medicare outlays substantially.

Illustrative Example

A plan could be developed that would require Supplementary Medical Insurance (SMI) enrollees who volunteered to switch to a high-deductible plan (with a $1,200 deductible) and who volunteered to forego the purchase of Medigap policies, to pay a $4.00 monthly SMI premium, compared with the current monthly payment of $46.10. They would be allowed to deposit their $505.20 annual premium savings in an MSA tax free. Money withdrawn from the MSA for expenditures other than health expenditures would be taxed as Social Security income. If all SMI enrollees joined this plan, ensuring no favorable selection, the savings to the government in the SMI program could be $5 billion in the first year alone, according to estimates by HCFA's Office of the Actuary. All of these savings would arise from behavioral changes alone, rather than merely shifting costs to beneficiaries or reducing payments to providers.

Potential Impact of Risk Segmentation

Risk segmentation is an important factor that would need to be considered if an MSA with a high-deductible "true" catastrophic plan (including Medicare HI benefits) were offered as an optional Medicare benefit plan. Risk segmentation can be generally defined as a situation where beneficiaries of differing health status systematically choose to enroll in different plan options. It is very important to give careful actuarial attention to plan design and to the administration of enrollment and disenrollment in the options in order to

minimize the impact of risk segmentation. Ignoring risk segmentation could lead to higher overall federal government costs—not substantial cost savings.

Individuals' Ability to Meet High-Deductible Requirements

In deciding whether to introduce high-deductible plans for Medicare beneficiaries, an important policy consideration is whether beneficiaries choosing the high-deductible plan would make provisions to ensure that they have adequate financial resources to meet the deductible requirement. Some policy makers might want to require beneficiaries wanting to enroll in the high-deductible plan to prove that they have adequate financial resources to meet the deductible. Other policy makers might feel that this would be unwarranted interference with beneficiaries' freedom of choice.

CONCLUSION

If the above factors are thoughtfully considered, and MSAs are carefully implemented, they may provide powerful incentives for potentially containing costs in the Medicare program. Members of the Academy's Medicare Work Group are available to discuss these and related issues.

WRITTEN STATEMENT OF
AMERICAN SOCIETY OF ASSOCIATION EXECUTIVES
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ASAE is pleased to have this opportunity to present testimony before the Subcommittee on Health of the House Ways and Means Committee regarding the importance of association plans in health care reform.

ASAE is a professional society of over 22,000 association executives representing more than 10,700 national, state, and local associations. Most of our members work for associations with less than 10 employees. ASAE's members represent tax exempt organizations, mostly under Internal Revenue Code Sections 501(c)(6) and 501(c)(3).

I. INTRODUCTION

The future of association sponsored health plans is in serious doubt, as our nation debates health care reform. Many proposals for a single payor system, or a managed care system with exclusive health purchasing alliances or cooperatives may deny a role for plans which associations now offer or operate for their members.

Associations have for many years sponsored employer group health plans as viable mechanisms for pooling risks along functional and industry lines. Associations have also increased the market leverage and buying power of small employers as consumers of health care services.

The association plans were generated by, and composed of, employers which participate directly in the decision-making process and management of their association health plans.

For more than fifty-five years, association-sponsored health plans have been providing millions of people with an effective way to protect themselves and their families against financial catastrophe. Association plans have enabled these millions of citizens to have access to quality, affordable health care, which was often denied to them through the available market. Today, thousands of U.S. trade and professional employer associations provide health coverage benefit programs to industry groups representing millions of employees and their dependents.

In an October 1992 survey of *Nation's Business* readers, 13% of the respondents polled reported they purchase their health plans through industry associations (90% of the respondents were employers with less than 100 employees).

According to a national survey of trade and professional associations conducted by ASAE and William F. Morneau & Associates, 779 of 6,300 associations reported health premiums paid in 1991 of $6.2 billion. This amount is larger than the total annual health care premium income

reported by Prudential, the largest health insurance carrier in the U.S. In addition, of the 779 associations surveyed, more than 1.9 million lives were covered.

Extrapolated against all associations in ASAE, this data suggests that ASAE member associations may be directly involved in the collection of approximately $21 billion in annual health care premiums – more than the ten largest insurance companies collectively generate in premiums. When examining lives covered, the extrapolation would mean that at least 10 million lives are covered by association plans.

Under the current U.S. health care system, association plans provide significant health care coverage to a substantial number of small employers throughout the nation and in a large cross-section of U.S. industries. Many of these small employers are located in rural areas which are underserved by managed care providers. These employers have sought and received the buying power and protection of qualified association plans which provide access to quality, affordable health care. The ASAE survey uncovered three significant facets of association-sponsored plans:

- Of those associations offering plans, the average penetration of membership (percentage of members participating in the association health plan) is a significant 27%. This is a clearly important member service at these associations.

- 49% of associations with plans have a trust agreement in place. This is a strong indication of the sophistication level of such plans and the degree of effort that is being made to closely manage the programs.

- The vast majority of plans (86%) are funded on a fully-insured basis. This runs counter to the common stereotype of the underfunded MEWA about to go bankrupt and leave thousands of policyholders with unpaid claims.

The importance of the widespread geographic coverage of association health plans can be seen from a study supported by a grant from the Federal Agency for Health Care Policy and Research, which concluded that "reform of the U.S. health care system through expansion of governmental managed competition is feasible in large metropolitan areas. But, smaller metropolitan areas and rural areas would require alternative forms of organization and regulations..." "A substantial number of people live in areas that fall outside" the realm of managed competition, said Richard Krfonic, an assistant professor of Community and Family Medicine at the University of California at San Diego.

In 19 states, the majority of the population lives in areas of less than 180,000 persons, where hospital services must be extensively shared. In 42 states, 20% or more of the population lives in such areas. And, while 23 states and the District of Columbia have at least one metropolitan area large enough to support three HMOs, the study found, in only 10 states do the majority of people live in such areas. Association plans are active in all of these areas currently, which demonstrates their viability and market orientation.

Association plans also have extensive experience in:

- designing special plans to meet the financial needs of their members.
- pooling health risks within organized industry groups.
- gathering employee data.
- collecting and disseminating information on health care quality, cost and resource allocation.
- communicating with members and employees.
- administering of benefit programs.

All Americans should have equal access to high quality, cost-effective health care through health plans offered under a competitive market system. Employers within the U.S. employment-based system should have the flexibility and freedom to select the most effective organizational mechanisms available for delivering health services. Association plans have proven for years to be such a vehicle.

Let's consider association plans in light of the various "reform" proposals. Associations are uniquely structured to be a part of a new or revised health care delivery system. That is because they are already structured to represent their members in other areas. They possess the infrastructure, administrative mechanisms and experience to unify employers and employees into effective consumers of health services.

Employers who join purchasing groups or cooperatives organized by associations can offer employees access to high quality private health coverage at lower costs, and with an expanded number of options.

Associations already offer a wide variety of approved health plans and managed care arrangements (insured arrangements, Blue Cross/Blue Shields, HMOs, self-insured) to employers and employees. Associations can also distribute information, provide price data, and offer qualitative comparisons between health plans.

Associations also develop common statistical databases by major industry and professional groupings. This assists such plans in administering for claims, premium contributions and utilization of health care services.

In summary, qualified and functioning industry-based associations have been successfully providing comprehensive health benefit programs, as well as many other services, to their members for more than fifty years. The administrative systems, expertise in negotiation, data collection and communication are all in place and operational today, not in some theoretical planning scenario.

II. CONSUMER ACCOUNTABILITY & ASSOCIATION HEALTH PLANS

A primary reason why health care spending is out of control is that most of the time, when we enter the medical marketplace as patients, we are spending someone else's money. Economic studies – and common sense – confirm that we are less likely to be prudent, careful shoppers if someone else is paying the bill. Association plans have been dealing with these concerns since health care costs started spiraling in the 1970's. Plan design, member education and provider

involvement have been put to work to hold down health care costs. Most importantly, both employers and their employees have been able to choose between different options.

Member identity with their association, and member control of programs help educate the participants as to the costs and choices in health care, much more so than in traditional insurance coverages.

Association plans are not a "third-party" phenomenon. Members realize that association plans are, in reality, their own money and that "wellness" activities, as well as careful health care purchasing save them money directly.

III. STUDY TRACES HISTORY AND EXTENT OF ASSOCIATION INSURANCE PLANS

Some association executives mistakenly believe that association sponsorship of insurance programs is a new phenomenon. In actuality, many such programs have been in existence for over 55 years. The most successful association-sponsored programs are those that have continually undergone change to adapt to evolving insurance and association management trends.

The health insurance industry has been in a "hard" market for many years. Member difficulty in obtaining appropriate health insurance coverages has led many associations to adopt sponsored health insurance programs.

More than 90% of the respondents indicated "member service" as the primary reason they initiated programs.

Life and health programs appear to be generally attractive to associations with large individual memberships and/or memberships comprising a large number of companies or firms, each of which has only a few employees. The increasingly difficult health insurance marketplace has made the sponsorship of health insurance coverages particularly attractive in recent years.

Those associations reporting life or health programs offered the following coverages:

•medical insurance,	81.7%
•vision care,	8.0%
•prescription plans,	8.6%
•dental care,	30.8%
•accidental death/disab.	25.7%
•basic life,	61.7%
•short-term disability,	29.7%
•long-term disability,	32.1%
•supplemental life,	8.0%
•supplemental AD&D,	7.4%

In looking at the variety of benefit plans associations offer, it is apparent that, if empowered and encouraged by federal legislation, even more expanded programs could be offered.

Approximately 85% of those associations sponsoring insurance programs for their memberships have formal, written agreements with insurance carriers, agents, or brokers.

These agreements can guarantee the association's right to continuing and complete information on the program, including loss statistics, premium income, insurer profit and expenses, and member participation, from participating insurers.

Much of this specific information, needed to design benefit plans and respond to members' needs, would not be available to employers from a governmentally operated health purchasing alliance or cooperative. Currently, association plans use this information to assist their members.

ASAE and the Aon Specialty Group's Risk Management Services consulting unit, Washington D.C. are producing the ***1993 Association Insurance Program Guide and Survey Report.*** This publication contains how-to instructions for implementing and managing a successful program, as well as statistics from our broad survey (conducted in fall 1992) of ASAE members.

IV. EXAMPLES OF ASSOCIATION SPONSORED PLANS, AND HOW THEY BENEFIT EMPLOYEES.

A. Taft-Hartley and Multi-Employer Plans.

There are thousands of Taft-Hartley multi-employer health plans covering more than eight million workers and dependents in industries as diverse as building and construction, clothing, textiles, transportation, services, retail, maritime, food, hotel and restaurant, mining, entertainment, and light manufacturing. Anywhere from two to 2,000 or more separate employers may contribute to a single plan.

These plans provide continuous health benefits coverage to workers as they change employment from one contributing employer to another. This portability or "seamless" coverage is essential for workers in mobile, seasonal industries like building and construction, entertainment, longshoremen and agriculture. Without a central plan covering all of his or her work for multiple employers, such a worker would not have health benefits coverage.

These multi-employer plans enjoy economies of scale in administration, and combined purchasing power, not available to individual or small employers. Participating employers are required to do little other than submit their periodic contributions to the plan with verifying information. All of the plan design and administrative functions are generally performed by the plan trustees with professional assistance. This eliminates any need for a participating employer to maintain its own plan administration work force.

Over the decades of their existence, these multiple employer plans have developed eligibility rules, benefit packages, and financing and collection methods tailored to meet the employment patterns, needs and practices of their particular industries.

These plans have developed industry-specific systems for maximizing coverage, given the employment patterns of the industry and the financing needs of the plan.

Many of these plans cover employers in different states. State-by-state regulation, with its threat of multiple, inconsistent rules, would adversely affect their efficient and economical operation. ERISA's preemption provisions are intended to protect these plans from such conflicting requirements.

These plans, operated by elected officers from industries and unions, are politically and directly accountable for how the plan is operating and how much it costs.

For the associations and unions which sponsor these multiple employer health and welfare plans, these plans are a proud achievement which provide health and income security benefits that would otherwise be unavailable to their members. The contributing employers function as a single employer through these plans for purposes of furnishing benefits and negotiating with health care providers. They are as concerned about the covered workers and as innovative as any single employer, if not more so, since there is more worker involvement in the design, operation and financing of these plans than in any single employer plan.

If any of the health care reform proposals finally adopted allow large employers to opt out of the purchasing system, these plans should be given the same opportunity under the same conditions.

B. Coca-Cola Bottlers' Association

Founded in 1914, the Coca-Cola Bottlers' Association has operated a voluntary group health insurance program since 1937. Smaller bottlers are pooled in a group, and larger participating employers are experience rated and participate in some of the risk of medical claims.

The program now covers approximately 13,000 employees and 26,000 dependents. Approximately 93 cents of every premium dollar goes to the payment of claims. This efficiency is well above that of most insurance company or health maintenance organization plans. The association's plan includes life insurance benefits which help keep costs of medical coverage down.

The average cost per employee for the benefit plans is $2,600, well below the national average of almost $4,000 per employee per year for conventionally insured plans, or even most self-funded plans.

The association also offers an Ergonomics Program which allows employees to be assessed for their physical ability to perform necessary work-related physical tasks, and helping to avoid on-the-job injuries.

The association also provides access to HMO's, PPO's, utilization review, pharmaceutical review, individual care management, and a wellness program to improve health of their members' employees. Additionally, the association is able to negotiate performance guarantees in areas such as claims turn around time, accuracy of claims payments, and customer service.

C. Eastern Material Dealers Association

From its humble beginnings in 1949, the Eastern Group Trust has developed the reputation for consistently good service, fair dealing, and funding stability within the scope of medical care plans.

Primarily organized to respond to the short-term disability income responsibilities under New Jersey statutes, the Group Insurance Trust has expanded its variety of coverages to include group term life, accidental death and dismemberment, weekly disability income, long-term disability income, six medical plans and a dental plan.

The major objectives of the Group Insurance Trust have been to use plan designs that are easily understood by participating employees and to provide as much stability in funding as can be obtained in a rapidly inflating market place of medical care. The program is run as an "experience rated contract" with State Mutual, with surplus funding available for reallocation to reduce future premiums paid by employers and employees.

Directed by a seven-member Board of Trustees, elected by plan participants pursuant to the requirements of Section 501(c)(9) of the Internal Revenue Code, the Group Insurance Trust is managed by staff employees. This staff is responsible for sales, installation, certificate and identification card issuance, billing and collection of premiums, payment of claims and providing Trustee and insurance carrier reports.

Approximately 230 employers participate in providing innovative plans which provide $11 million per year in benefits to the industry's employees.

D. Western Agriculture

Agriculture in the Western U.S., particularly California and Arizona, is highly seasonal, with fruit, grape and vegetable production supplying over half of the entire U.S. consumers' needs, as well as providing major exports which assist the nation's international balance of trade.

Traditional insurance carriers, and all current HMO organizations, declined in the past to provide medical coverage for the 350,000 employees of this vital industry, due to their seasonal employment, wage levels, and predominantly Spanish-speaking language needs.

Four major farm organizations provide virtually all of the health benefits for these seasonal employees, using association designed and operated programs. Self funding is a critical component of these benefit plans, due to the reluctance of the usual insurance market to offer coverages.

The largest of these programs, Western Growers Association, provides benefits to 18,000 employees, offering free choice of medical provider as well as managed care plans.

Grouping the buying power of its 2,000 participating members, Western Growers has been able to negotiate discounts from hospitals which saved 46% on billed charges on 1992, and saving over $4 million dollars for farm employers and their employees. The association's plans average 20% discounts in contracting doctor's fees and elimination of "usual and customary" problems

for patients using contracting physicians. WGA has contracted for 9% below-wholesale drug costs for its medical plans.

The association also operates a licensed and admitted workers' compensation company in Arizona and California, and has integrated on-the-job and off-the-job medical benefits for over 10 years, preventing "double-dipping" and making the coordination of benefits easy.

The association offers flexible benefit plans, which have been very well received by seasonal farm workers. It also offers services by medical providers in Mexico for those workers near the U.S. border, and for those workers with families in Mexico.

These are but a few examples of the thousands of association-sponsored medical plans offered by nonprofit member associations of ASAE.

V. ASAE POSITION

Congress and the Administration has recognized the need for employers and individuals to join together in pooling their buying power. Association plans have been doing just that for over 55 years, and can provide a major service to our nation by being allowed to continue.

Association health plans would welcome many of the insurance reforms currently proposed such as portability, open enrollments, and limitations on preexisting conditions.

ASAE supports the basic goals of health care reform, which would provide quality, affordable, accessible health care for all Americans. ASAE further believes that association health care plans possess many years of proven experience in the delivery of benefits through purchasing coalitions. As such, association health care plans can lead the way to the reform goals of providing the efficient delivery of quality health care to more citizens.

May 23, 1995

Sir:

It has come to my attention that Congress will be debating the issue of medical savings accounts. I'm writing to make known my belief in and support of medical savings accounts -- provided that they are voluntary and tax-free.

I believe such accounts would be a step towards restoring a free market in health care. As with all other commodities the free market works to bring prices down while at the same time improving the overall quality of products and services. This is what the American people need.

Sincerely,

Craig K. Barber
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(415) 587-9083

MICHAEL J. BLAIR

22216 Victory Boulevard #C-303 Woodland Hills, CA 91367-1807

VIA FEDERAL EXPRESS

Wednesday, May 24, 1995

Philip Moseley
Majority Chief of Staff
House Committee on Ways and Means
1102 Longworth Office Building
Independence and New Jersey Avenues SE
Washington, DC 20515

Dear Mr. Moseley:

I wish to enter a written statement into the printed record of the upcoming hearings on Medical Savings Accounts. My statement takes the form of this letter and the pamphlet *Health Care is Not a Right.* Six copies of each are enclosed. Please acknowledge in writing.

Your committee's hearings will no doubt deal with the practical and legal aspects of Medical Savings Accounts. My plea is that you openly discuss the moral aspects, too. Where does morality fit in? The pamphlet will explain.

In brief, when proponents speak of the "right" to health care, there is no escaping the conclusion that some citizens must therefore provide that health care to others. For when someone has a right to a service, someone else must provide it, correct? Otherwise, the "right" is being violated. "Must" in this context means "without choice." Thus, the claimant controls the services of the provider because the provider must give those services on demand.

There is even an American precedent for such a relationship. At one time, a person (A) was entitled to any and all services provided by another person (B). The law was so specific that in fact, A owned B. The institution was slavery. Shakespeare wrote, "A rose by any other name, would smell as sweet." Similarly, slavery by any other name, would be as wrong.

My guiding principle is that **there is no dichotomy between the moral and the practical.** Giving citizens personal control of their own health care spending—and giving doctors personal control of their own lives—is not only what is more efficient; it is also what is right.

Very truly yours,

Michael J. Blair

/mjb
Enclosures

HEALTH CARE IS NOT A RIGHT

by

LEONARD PEIKOFF

This talk was delivered under the auspices of
Americans for Free Choice in Medicine
at a Town Hall Meeting on Health Care
Red Lion Hotel, Costa Mesa, California
December 11, 1993

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LEONARD PEIKOFF is a philosopher and the foremost interpreter of the philosophy of Ayn Rand. He has taught philosophy at Hunter College, Long Island University, and New York University. He is the author of *Objectivism: The Philosophy of Ayn Rand,* the definitive statement of Ayn Rand's philosophic system. Dr. Peikoff's speech, "The Forgotten Man of Socialized Medicine: The Doctor," was presented to the Congress of Neurological Surgeons in 1988 and to other physicians' groups throughout the United States and Canada. A transcript of the talk was published in *Clinical Neurosurgery,* Vol. 36.

Good morning, ladies and gentlemen:

Most people who oppose socialized medicine do so on the grounds that it is moral and well-intentioned, but impractical; i.e., it is a noble idea—which just somehow does not work. I do not agree that socialized medicine is moral and well-intentioned, but impractical. Of course, it *is* impractical—it does *not* work—but I hold that it is impractical *because* it is immoral. This is not a case of noble in theory but a failure in practice; it is a case of vicious in theory and *therefore* a disaster in practice. So I'm going to leave it to other speakers to concentrate on the practical flaws in the Clinton health plan. I want to focus on the moral issue at stake. So long as people believe that socialized medicine is a noble plan, there is no way to fight it. You cannot stop a noble plan—not if it really is noble. The only way you can defeat it is to unmask it—to show that it is the very opposite of noble. Then, at least, you have a fighting chance.

What is morality in this context? The American concept of it is officially stated in the Declaration of Independence. It upholds man's unalienable, individual *rights*. The term "rights," note, is a moral (not just a political) term; it tells us that a certain course of behavior is right, sanctioned, proper, a prerogative to be respected by others, not interfered with—and that anyone who violates a man's rights is: wrong, morally wrong, unsanctioned, evil.

Now, our only rights, the American viewpoint continues, are the rights to life, liberty, property, and the pursuit of happiness. That's all. According to the Founding Fathers, we are not born with the right to a trip to Disneyland, or a meal at McDonald's, or a kidney dialysis (nor with the 18th-century equivalent of these things). We have certain specific rights—and only these.

Why *only* these? Observe that all legitimate rights have one thing in common: they are rights to action, not to rewards from other people. The American rights impose no obligations on other people, merely the negative obligation to leave you alone. The system guarantees you the chance to work for what you want—not to be given it without effort by somebody else.

The right to life, e.g., does not mean that your neighbors have to feed and clothe you; it means you have the right to earn your food and clothes yourself, if necessary by a hard struggle, and that no one can forcibly stop your struggle for these things or steal them from you if and when you have achieved them. In other words: you have the right to act, and to keep the results of your actions, the products you make, to keep them or trade them with others, if you wish. But you have no right to the actions or products of others, except on terms to which they voluntarily agree.

To take one more example: the right to the pursuit of happiness is precisely that: the right to the *pursuit*—to a certain type of action on your part and its result—not to any guarantee that other people will make you happy—or even try to do so. Otherwise, there would be no liberty in the country: if your mere desire for something, anything, imposes a duty on other people to satisfy you, then they have no choice in their lives, no say in what they do, they have no liberty, they cannot pursue *their* happiness. Your "right" to happiness at their expense means that they become rightless serfs, i.e., your slaves. Your right to *anything* at others' expense means that they become rightless.

That is why the U.S. system defines rights as it does, strictly as the rights to action. This was the approach that made the U.S. the first truly free country in all world history—and, soon afterwards, as a result, the greatest country in history, the richest and the most powerful. It became the most powerful because its view of rights made it the most moral. It was the country of individualism and personal independence.

Today, however, we are seeing the rise of principled *immorality* in this country. We are seeing a total abandonment by the intellectuals and the politicians of the moral principles on which the U.S. was founded. We are seeing the complete destruction of the concept of rights. The original American idea has been virtually wiped out, ignored as if it had never existed. The rule now is for politicians to ignore and violate men's actual rights, while arguing about a whole list of rights never dreamed of in this country's founding documents—rights which require no earning, no effort, no action at all on the part of the recipient.

You are entitled to something, the politicians say, simply because it exists and you want or need it—period. You are entitled to be given it by the government. Where does the government get it from? What does the government have to do to private citizens—to their individual rights—to their *real* rights—in order to carry out the promise of showering free services on the people?

The answers are obvious. The newfangled rights wipe out real rights—and turn the people who actually create the goods and services involved into servants of the state. The Russians tried this exact system for many decades. Unfortunately, we have not learned from their experience. Yet the meaning of socialism (this is the right name for Clinton's medical plan) is clearly evident in any field at all—you don't need to think of health care as a special case; it is just as apparent if the government were to proclaim a universal right to food, or to a vacation, or to a haircut. I mean: a right in the new sense: not that you are free to earn these things by your own effort and trade, but that you have a moral claim to be given these things free of charge, with no action on your part, simply as handouts from a benevolent government.

How would these alleged new rights be fulfilled? Take the simplest case: you are born with a moral right to hair care, let us say, provided by a loving government free of charge to all who want or need it. What would happen under such a moral theory?

Haircuts are free, like the air we breathe, so some people show up every day for an expensive new styling, the government pays out more and more, barbers revel in their huge new incomes, and the profession starts to grow ravenously, bald men start to come in droves for free hair implantations, a school of fancy, specialized eyebrow pluckers develops—it's all free, the government pays. The dishonest barbers are having a field day, of course—but so are the honest ones; they are working and spending like mad, trying to give every customer his heart's desire, which is a millionaire's worth of special hair care and services—the government starts to scream, the budget is out of control. Suddenly directives erupt: we must limit the number of barbers, we must limit the time spent

on haircuts, we must limit the permissible type of hair styles; bureaucrats begin to split hairs about how many hairs a barber should be allowed to split. A new computerized office of records filled with inspectors and red tape shoots up; some barbers, it seems, are still getting too rich, they must be getting more than their fair share of the national hair, so barbers have to start applying for Certificates of Need in order to buy razors, while peer review boards are established to assess every stylist's work, both the dishonest and the overly honest alike, to make sure no one is too bad or too good or too busy or too unbusy. Etc. In the end, there are lines of wretched customers waiting for their chance to be routinely scalped by bored, hogtied haircutters some of whom remember dreamily the old days when somehow everything was so much better.

Do you think the situation would be improved by having haircare cooperatives organized by the government?—having them engage in managed competition, managed by the government, in order to buy haircut insurance from companies controlled by the government?

If this is what would happen under government-managed hair care, what else can possibly happen—it is already starting to happen—under the idea of *health* care as a right? Health care in the modern world is a complex, scientific, technological service. How can anybody be born with a right to such a thing?

Under the American system you have a right to health care if you can pay for it, i.e., if you can earn it by your own action and effort. But nobody has the right to the services of any professional individual or group simply because he wants them and desperately needs them. The very fact that he needs these services so desperately is the proof that he had better respect the freedom, the integrity, and the rights of the people who provide them.

You have a right to work, not to rob others of the fruits of their work, not to turn others into sacrificial, rightless animals laboring to fulfill your needs.

Some of you may ask here: But can people afford health care on their own? Even leaving aside the present government-inflated medical prices,

the answer is: Certainly people can afford it. Where do you think the money is coming from *right now* to pay for it all—where does the government gets its fabled unlimited money? Government is not a productive organization; it has no source of wealth other than confiscation of the citizens' wealth, through taxation, deficit financing or the like.

But, you may say, isn't it the "rich" who are really paying the costs of medical care now—the rich, not the broad bulk of the people? As has been proved time and again, there are not enough rich anywhere to make a dent in the government's costs; it is the vast middle class in the U.S. that is the only source of the kind of money that national programs like government health care require. A simple example of this is the fact that the Clinton Administration's new program rests squarely on the backs not of Big Business, but of small businessmen who are struggling in today's economy merely to stay alive and in existence. Under any socialized program, it is the "little people" who do most of the paying for it—under the senseless pretext that "the people" can't afford such and such, so the government must take over. If the people of a country *truly* couldn't afford a certain service—as e.g., in Somalia—neither, for that very reason, could any government in that country afford it, either.

Some people can't afford medical care in the U. S. But they are necessarily a small minority in a free or even semi-free country. If they were the majority, the country would be an utter bankrupt and could not even think of a national medical program. As to this small minority, in a free country they have to rely solely on private, voluntary charity. Yes, charity, the kindness of the doctors or of the better off—charity, not right, i.e., not their right to the lives or work of others. And such charity, I may say, was always forthcoming in the past in America. The advocates of Medicaid and Medicare under LBJ did not claim that the poor or the old in the '60's got bad care; they claimed that it was an affront for anyone to have to depend on charity.

But the fact is: You don't abolish charity by calling it something else. If a person is getting health care *for nothing*, simply because he is breathing, he is still getting charity, whether or not President Clinton calls it a

"right." To call it a right when the recipient did not earn it is merely to compound the evil. It is charity still—though now extorted by criminal tactics of force, while hiding under a dishonest name.

As with any good or service that is provided by some specific group of men, if you try to make its possession by all a right, you thereby enslave the providers of the service, wreck the service, and end up depriving the very consumers you are supposed to be helping. To call "medical care" a right will merely enslave the doctors and thus destroy the quality of medical care in this country, as socialized medicine has done around the world, wherever it has been tried, including Canada (I was born in Canada and I know a bit about that system first hand).

I would like to clarify the point about socialized medicine enslaving the doctors. Let me quote here from an article I wrote a few years ago: "Medicine: The Death of a Profession." [*The Voice of Reason: Essays in Objectivist Thought*, NAL Books, © 1988 by the Estate of Ayn Rand and Leonard Peikoff.]

"In medicine, above all, the mind must be left free. Medical treatment involves countless variables and options that must be taken into account, weighed, and summed up by the doctor's mind and subconscious. Your life depends on the private, inner essence of the doctor's function: it depends on the input that enters his brain, and on the processing such input receives from him. What is being thrust now into the equation? It is not only objective medical facts any longer. Today, in one form or another, the following also has to enter that brain: 'The DRG administrator [in effect, the hospital or HMO man trying to control costs] will raise hell if I operate, but the malpractice attorney will have a field day if I don't—and my rival down the street, who heads the local PRO [Peer Review Organization], favors a CAT scan in these cases, I can't afford to antagonize him, but the CON boys disagree and they won't authorize a CAT scanner for our hospital—and besides the FDA prohibits the drug I should be prescribing, even though it is widely used in Europe, and the IRS might not allow the patient a tax deduction for it, anyhow, and I can't get a specialist's advice because the latest Medicare rules

prohibit a consultation with this diagnosis, and maybe I shouldn't even take this patient, he's so sick—after all, some doctors are manipulating their slate of patients, they accept only the healthiest ones, so their average costs are coming in lower than mine, and it looks bad for my staff privileges.' Would you like your case to be treated this way—by a doctor who takes into account your objective medical needs *and* the contradictory, unintelligible demands of some ninety different state and Federal government agencies? If you were a doctor could you comply with all of it? Could you plan or work around or deal with the unknowable? But how could you not? Those agencies are real and they are rapidly gaining total power over you and your mind and your patients. In this kind of nightmare world, if and when it takes hold fully, thought is helpless; no one can decide by rational means what to do. A doctor either obeys the loudest authority—*or* he tries to sneak by unnoticed, bootlegging some good health care occasionally *or*, as so many are doing now, he simply gives up and quits the field."

The Clinton plan will finish off quality medicine in this country—because it will finish off the medical profession. It will deliver the doctors bound hands and feet to the mercies of the bureaucracy.

The only hope—for the doctors, for their patients, for all of us—is for the doctors to assert a *moral* principle. I mean: to assert their own personal individual rights—their real rights in this issue—their right to their lives, their liberty, their property, *their* pursuit of happiness. The Declaration of Independence applies to the medical profession too. We must reject the idea that doctors are slaves destined to serve others at the behest of the state.

I'd like to conclude with a sentence from Ayn Rand. Doctors, she wrote, are not servants of their patients. They are "traders, like everyone else in a free society, and they should bear that title proudly, considering the crucial importance of the services they offer."

The battle against the Clinton plan, in my opinion, depends on the doctors speaking out against the plan—but not only on practical grounds—rather, first of all, on *moral* grounds. The doctors must defend them-

selves and their own interests as a matter of solemn justice, upholding a moral principle, the first moral principle: self-preservation. If they can do it, all of us will still have a chance. I hope it is not already too late. Thank you.

Chuck Braman
76 Carmine St., #3-D
New York, NY 10014-4346

May 23, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Building, (LHOB)
Washington, DC 20515

Dear Mr. Moseley:

I would like to let all of my representatives in Washington know that I strongly favor the idea of tax-free medical savings accounts, like IRAs; voluntary, tax-free, no compromises! For a summary of the reasons why I favor a fully free market in medical care, please see the enclosed 7 page summary of "The Real Right to Medical Care vs. Socialized Medicine."

Sincerely

Chuck Braman

THE REAL RIGHT TO MEDICAL CARE VS. SOCIALIZED MEDICINE
(Summary of George Reisman article by Chuck Braman)

The Medical Crisis and the Need for Radical Procapitalist Reform

For decades the cost of health care, unlike the cost of other economic goods, has risen relative to prices in general and to people's incomes. The cost of health care is now so high that a radical reform is necessary. The current type of reform being advanced by the Clinton administration, however, is an anachronism. It is, to be exact, the enactment of a full system of socialized medicine, a system based on the mistaken and discredited tenets of Marxism, which will aim to reduce the cost of our partially socialized medical system by means of its full socialization accompanied by price controls and rationing. In contrast, the real reform necessary to reduce the cost of health care would be one based on opposite premises, i.e. one based on the tenets of capitalism, tenets which in this century have reached their fullest development in the political philosophy of Ayn Rand, and in the economic theory of Ludwig von Mises. The radical reform necessary is based on the movement *away* from government interference and *toward* individual freedom.

The Right to Medical Care and the Causes of the Medical Crisis

The root cause of the runaway cost of medical care is philosophical. The cause is the current perversion of the concept of rights, a perversion which underlies the laws which have been passed, the consequences of which are responsible for the current crisis.

The correct concept of rights is based on the individual's right to life, which right includes the right to take the actions necessary for sustaining one's life. Rather than being a claim to goods to be provided by others, it is an injunction against the whole rest of society to leave one free so that one may produce the values which one's life requires. Such a right can only be violated by the initiation of physical force, so that under such a concept of rights the initiation of physical force is abolished, and cooperation among people is achieved through voluntary trade rather than the forced transfer of wealth from one person to another. On a social and economic level, in a division-of-labor society, this right, the right to life, is exercised by selling one's goods or labor (what one produces) for money to buy another's goods and labor (what another produces). Applied to medical care, this means that the right to medical care is the right to all the medical care one can buy from willing providers. Such a right is exactly what is currently violated by medical licensing legislation and all regulations and legislations that artificially raise the cost of medicine, because all represent different forms of the government initiating, or threatening to initiate, physical force against producers and traders who themselves have not initiated physical force, and thus physically restricting their right to produce and trade.

In contrast to the concept of rights described above, which Dr. Reisman refers to as "the rational concept of rights," is the concept of rights put forward

by the Clinton administration, which Dr. Reisman calls "the need-based concept of rights." It is, in simplest essence, based the premise that wealth is something that appears more or less causelessly—as opposed to being produced by the effort of individual people who by that fact retain a right to such property—and that the fact of any one person possessing a need for such wealth gives him a right to it.

There were three cornerstones in the history of medical care in the United States which have lead to the application of this premise in order to pass laws which produced the runaway medical costs we face today. They were (1) the government imposition of medical licensing laws starting in the nineteenth century, (2) the government imposition of wage and price controls during World War II, and (3) the government imposition of the Medicare and Medicaid programs during the 1960's.

Medical licensing increases the costs of medical care by lowering the supply of medical providers. Historically, it has been supported by doctors because it is a means of increasing their wages by virtue of creating a monopoly. As to the extent that is has actually raised the standards by which medicine is practiced (which is limited, since the qualifications imposed by licensing are largely arbitrary), it is through the means of reducing the number of options available to consumers. This is because instead of the market offering a full range of skilled practitioners offering various services at various prices, it essentially must now offer only a higher range of skilled practitioners offering this same range of services at a higher range of prices to fewer people. As a result, it primarily victimizes the poor, thereby playing into the hands of those who advocate socialized medicine.

The second step towards socialized medicine in the U.S. resulted from a string of events following the government imposition of wage and price controls during World War II. It occurred because the government made a single exception to its prohibition of wage increases during this period by allowing employers to pay for tax-free medical insurance for their employees. Because this was the only possible means of increasing wages (and therefore the only possible means of competing for employees), and because the individual employee's alternative to this insurance was taxed by the government, the scope of coverage offered by this form of insurance, as opposed to the traditional private insurance offered up to that point, was artificially encouraged to be made comprehensive rather than to being limited to providing only for emergencies. (In current dollars this form of comprehensive insurance costs the equivalent of $5000/year per family, whereas in current dollars the cost of coverage limited to medical emergencies costs about $2000/year per family.) Following World War II, coercive labor unions made such insurance a standard part of their contracts. The effects resulting from such employer-provided comprehensive insurance are (1) a psychological mindset among employees, akin to that which exists in socialist countries, that medical care is a right of employees that can be provided essentially for free, and (2) an economic situation, akin to that which exists under socialism, whereby all costs are borne collectively by a group rather than by individual people.

Most significantly, the collectivization of costs resulting from such a system is the leading cause of the continuous rise in medical costs since

W.W.II. This is because if one's expenses for any commodity are covered by a huge anonymous group rather than by that individual, the individual has no incentive to contain his spending. When all the individuals within such a group are mutually relieved of responsibility, the result is a form of mutual plunder. Every individual within the group ends up spending more than he would have as an individual because he is able to pass along almost all of his costs to the others, while all the other individuals in the group similarly increase their spending because they are able to do the same. Thus, the amount of spending by each individual within the group increases much more so than it would if each individual was directly responsible for his own costs. In addition to this absolute increase in individual spending, it is the combined increased demand on a limited supply that leads to radically rising prices.

This increase in the prices of medical services resulting from the collectivization of costs following W.W.II led to the third major step towards socialized medicine in the U.S., the imposition of the Medicare and Medicaid programs in the 1960s. These programs were instituted to make the increasingly expensive medical care more affordable to the poor and the elderly. However, since such programs represent an even further collectivization of costs than collectivized insurance, drawing their funding as they do from the entire body of taxpayers rather than from a smaller body of insurance holders, they have lead to the pricing of medical care beyond the reach of the uninsured middle class. As a result, their implementation has lead to the current call for complete socialized medicine.

Ironically, of course, the problems that socialized medicine is supposed to solve are all problems stemming from the previous steps the government has taken towards socializing medicine. Specifically, there have been several consequences following from the concept of a need-based right to medical care and the collectivization of costs to finance it which have acted to raise the price of medical care.

First, of course, is the increase in prices which necessarily follows when one is able to bid on a limited supply of goods and then pass the expense off to an anonymous group. Such bidding on government-supplied goods leads inevitably to government-imposed price controls and rationing as the only possible means of controlling costs, followed thereafter by the government's further refusal to allow anyone to bid the price up any further even using their own money.

Second is an increased demand for medical care, in the form of increased visits and increased services.

Third is the recent phenomenon of irrational standards for malpractice and radically increased malpractice awards. This follows from the notion that if medical care is a right, then a right to medical care as such means a right to the best medical care available. As a result, providing a patient with anything less than the best, most expensive medical care comes to constitute malpractice, whether or not the doctor is being compensated to provide such care. Fear of malpractice lawsuits has lead to the new phenomenon of doctors practicing "defensive medicine," i.e. conducting medically unnecessary tests to provide a record for their defense in the event of a lawsuit. Defensive

medicine is estimated to account for more than one-third of the total cost of health care in the U.S. today.

Fourth is an intense demand created for prohibitively expensive new technology. Traditionally in medicine, as well as in any other field, new technology does not raise costs; initial buyers, who must pay out of their own pocket, are few, allowing the item to slowly develop a market as experience is gained in producing it, during which time its cost falls while its quality improves. Since costs for medical technology are collectivized, however, new, prohibitively expensive technology, which individuals would not be able to afford if they had to pay out of their own pockets, is demanded universally as a matter of right.

Fifth, prices are collectively bid up on patented drugs which need not fear competition, while at the same time prohibitions against price discrimination prevent lower-priced versions of the same drugs from serving the market of the uninsured. (In addition, of course, FDA regulations greatly increase the development time of drugs and further inflate their prices.)

Sixth, lack of profit and loss incentives causes wasteful spending on expensive equipment. The government responds to such wastefulness by such means as requiring a "certificate of need" before it will authorize such expenditures. As a result, expenditures often end up being restricted on necessary as well as unnecessary equipment.

Seventh, government-imposed cost-controls on public patients leads to cost-shifting to private patients, which becomes necessary in order for physicians and hospitals to make up their losses. (Such cost controls include categorizing treatments into "diagnostic related groups," (DRGs)—categories for which the government pays a flat fee, no matter what the actual cost of the treatment, which could be more or less than the fee according to the individual circumstances.)

Eighth, the bureaucratic controls imposed by the government in order to contain the costs increase costs by increasing paperwork and administrative costs.

Finally, government safety, environmental, and labor regulations increase the cost of medical care, probably even more so than in other fields, because of the separation of the buyer from the seller, which buyer is therefore less likely to be aware of and to protest such interference.

Most ironically, and above all, the need-based right to health care and the collectivization of costs required to pay for it eliminates the real, rational right to care in the instances where those who would be able to afford to buy medical care now cannot do so.

The Clinton Plan

The original, rational right to medical care, the right to buy the medical care one needs from willing providers, has become almost impossible to exercise now. Under the Clinton plan it would be made completely illegal. The "Health Security Preliminary Plan Summary" imposes criminal penalties "for the payment of bribes or gratuities to influence the delivery of health services and coverage." Under the Clinton plan dependence on the government would be made absolute, as everyone would be compelled to join a government-approved insurance plan.

Clinton's plan envisions a "National Health Board" that would decide what kind of care would be provided by what methods. Regional alliances would tax away the employee-financed health insurance premiums from medical payroll taxes imposed on small companies to pay HMO-styled insurance companies. (Large corporations of 5000 employees or more would be allowed to constitute themselves as "corporate alliances" and pay these insurance companies directly.) The managed competition referred to by Clinton, which is essentially a form of government-controlled monopoly, refers to the choice, to be made by the regional alliances, of which insurance companies are to be allowed to compete in which markets. Consumers would then choose among these remaining companies. All these insurance companies would offer uniform benefits and operate under the guidance of the NHB.

As the 37 million new, presently uninsured individuals are brought under socialized medicine, demand for health care would increase correspondingly, and yet at the same time Clinton plans to cut current medical spending by $200 billion or more. The only possible outcome of this situation would be shortages and rationing. More expensive procedures would be performed less, fee-for-service practitioners would be controlled and monitored, and the patient's choice of doctors would essentially be lost because the demand for their time will so greatly exceed their supply. The physician's new protection against malpractice lawsuits, irrespective of the outcome on the patient, will be his adherence to "Practice Guidelines," bureaucratic rule books provided by the government detailing minimum standards of treatment.

Areas of medical care likely to suffer would include medical technology (which bureaucrats would not be likely to encourage), and new drugs, whose profitability Clinton is already fighting to restrict. In addition, if the practice of other countries which have instituted socialized medicine is any indication, cutbacks for the aged would be likely, because they demand extensive care and have few years left as voters.

The reduction in administration costs promised by Clinton would essentially represent a reduction in service, and would itself be offset by the new administration costs for the 37 million new individuals who would be joining the system.

Under such a system, the profit motive would be turned against itself because the source of profit under a flat fee system derives from the withholding of care. When combined with the fact that the patient is prohibited from offering his own money to pay for his own care, the result is that the doctor's self-interest becomes set against the patient's self-interest. As under Communism, security is lost because the right to buy what one needs is lost. In place of the individual's calculations of self-interest are the government's considerations of such things as the level of its spending for medical care in relation to its gross national product.

The Free Market Solution

The free market solution to the crisis of rising medical costs is the restoration of the rational right to medical care: the complete removal of government interference between the buyers and sellers of medical care and

the complete removal of all government interference which makes medical care more expensive than it otherwise would be.

Under the free market, the cost of medical care would be determined by the prevailing supply of talent, the state of capital accumulation, the state of technology, the profit motive and the freedom to compete for patients, and the ability to practice price discrimination.

The elimination of licensing would result in the greatest possible supply of talent, while at the same time broadening the range of services offered. The lower end of the market could be served to a large degree by nurses, pharmacists or paramedics providing the particular services in which they are qualified but currently prohibited from performing. To the extent certification is desired, it would be provided by professional degrees, and by certificates which could be provided by private organizations.

In a free market, medical insurance limited to providing for catastrophic illnesses would out-compete collectivized insurance because it would be so much less expensive. Such limited insurance would include an annual deductible in excess of all routine medical expenses, thereby leaving the individual incentives to control cost. Always, the operative standard in a private system would be the benefits to the individual patient's life, as judged by the patient himself by considering potential medical treatments in relation to his other needs.

Toward a Free Market in Medical Care

Of course, the simplest solution to establish a free market in medicine would be to abolish all government intervention in medicine in one stroke. Since such a solution is unlikely to be enacted, however, a gradual solution is the best alternative, provided that it uses as its standard the eventual goal of the complete abolition of government intervention from medicine.

The focus of such a solution would be on the plight of the uninsured, and would approach cost reduction from two mutually reinforcing sides: the elimination of the artificial increase in demand for medical care, achieved by income tax reform and Medicare reform, and the elimination of the artificial increase in costs of medical care, achieved by the liberalization of licensing laws and the reduction of hospital costs.

As an income tax reform, employees should be given a choice between employer-financed medical insurance (which is currently not taxed), and an equivalent tax-free increase to their annual income, which, matching the current cost of employer-financed medical insurance, would average around $5000 per family. Such a choice would create a strong incentive for individuals to purchase less expensive insurance with a high deductible, which would be limited to covering catastrophic illnesses, and which at current market prices would cost about $2000 annually per family. The difference in the costs of these two kinds of insurance could be used to pay the deductible in the event such a need arises.

As a second reform, wealthy Medicare patients could be made to pay a substantial deductible before their coverage would begin and a copayment of costs beyond some maximum limit. Such a measure would not be unreasonable, as the amount of money those eligible for Medicare have paid

into the program since it was inaugurated is substantially less than is typically drawn out.

Alternately, those over 65 should be given a choice of signing away their rights to Medicare and social security in exchange for exemption from all taxes (excluding sales taxes) such as personal, interest and dividend, and estate and gift taxes. Besides increasing personal freedom and personal revenues, such a measure would result in increases in government revenues, since government spending would be reduced, while people who otherwise would have been encouraged to retire would be encouraged to work and save (as well as pay sales taxes), which saving would act to increase capital accumulation and ultimately production.

As a measure to eliminate artificial increases in costs, licensing laws could be liberalized by the method of allowing those holding higher medical licenses to extend the benefit of their licenses to those holding lesser medical licenses, whom they could also train if they deemed such training necessary. As a secondary benefit, such a measure would also act to increase the incomes of all those involved by virtue of opening up a market previously not served.

As a second measure to eliminate artificial increases in costs, hospitals and the uninsured should be exempted from all government regulations and interference from such agencies as the DHHS, SSA, NLRB, EPA, OSHA, etc., and by granting them the right to agree to mutually binding standards of malpractice. Further savings could be realized by allowing physicians to open new hospitals serving such patients, by allowing existing hospitals to practice price discrimination toward such patients, and finally, by creating a Deregulation Agency, whose purpose and powers would be limited to repealing existing regulations.

The above represent strategies which should be used to oppose the Clinton plan. If, however, the Clinton plan is enacted into law, a different, two tiered strategy should be applied. First, there should be a call for legislation introducing the unrestricted right to practice medicine outside of the government's control for those who value that right. Then, after this is achieved, there should begin a fight to end all remaining socialized medicine on behalf of those who do not wish to be forced involuntarily to pay for the health care of others.

Such a fight on behalf of freedom in health care is what is needed immediately as part of the larger fight on behalf of freedom, individualism, and capitalism.

May 22, 1995

Phillip Moseley
Majority Chief of Staff
House Committee Way and Means
1102 Longworth House Office Bldg (LHOB)
Washington DC 20515

Please have this read into today's Congressional Record.

I (and many people who are not writing) favor **Medical Savings** Accounts. Like IRAs, these MSAs would be a fair way to solve the health crisis in a way that is fair to everybody -- gradually phasing out medicare. Contrary to popular belief, health care is not a right.

These MSAs should be voluntary, and tax-free.

Thank you.

Sincerely,
Ann Ciccolella

3710-A Meredith St.
Austin TX 78703

Coalition of Mental Health Professionals and Consumers, Inc.
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Testimony
Karen Shore, Ph.D., Executive Director
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A) Introduction:

I am submitting testimony on behalf of the Coalition's approximately 1250 members. The Coalition is a national, grass-roots organization, made up of clinicians from all mental health disciplines and consumers of mental health care, their family members, and their advocates. The Coalition is working with approximately 24 regional "affiliated groups" that have no legal tie to the Coalition, though some have taken out memberships. Thus, I am not officially testifying for these groups, but do want the Subcommittee to know that several of these groups are state or regional Coalitions (MA, NY, NJ, PA, DE, MD, NC, GA, TN, IL, OH, CO, CA, WA, MO) that have been inspired by our Coalition or that formed prior to our forming (November, 1992), have similar goals, and are attempting to work together. Each of these groups may have dozens, hundreds, or thousands of members.

I am testifying because of plans to increase the number of Medicare beneficiaries to be enrolled in HMO's and other forms of managed care. The Coalition formed specifically because of the decline in quality of mental health treatment brought by managed care organizations (MCO's). MCO's also have a strong impact on the ability of professionals to deliver proper care. The problems of managed care have the most impact on beneficiaries who need treatment, as opposed to those who are generally healthy. Thus, a larger percentage of the Medicare population covered by MCO's than of the general MCO population will experience these problems, as our elderly generally require more treatment than does the general population.

In this testimony, I will outline the problems we have seen in delivery of services under MCO's in the private sector and will offer recommendations. We cannot assume that Medicare beneficiaries will receive better care under MCO's than those in the private sector.

B) Problems with Managed Mental Health Care for Consumers and Providers:

1. Citizens lose the right to freely choose clinicians and treatment facilities.

a) MCO's increasingly limit their provider list to providers who demonstrate a willingness to perform short-term treatment, whether or not it is truly appropriate, and on their willingness to do so without complaint. Thus, the pool of providers available to the consumer may exclude those who would perform or advocate for quality care.

b) Primary care providers often must act as gatekeepers and may limit access to psychiatrists and to psychotherapists. Often, there are financial penalties if primary care providers make "too many" referrals. Corporate profits are often more important than the consumer and treatment. Primary care physicians are asked to do "counseling," but do not have the training to do real psychotherapy.

c) MCO panel limitations often cause the consumer to travel a great distance for their care, which could be especially burdensome for the elderly, and may prevent needed care.

d) Consumers may have to change clinicians often as plans drop providers and merge with other MCO's, or as the consumer changes health plan. Continuity of care and the building of trust in the clinician are impeded. Continuity of care and trust may be particularly important for the elderly, who often are more in need of ongoing treatment than the general population.

e) Clinicians are impeded in their ability to make the best referral possible due to panel restrictions preventing them from referring "out-of-network."

f) Generally, psychiatrists and other doctoral-level clinicians, and even master's level clinicians, may be prevented from performing psychotherapy by MCO's, as MCO's often search for the "cheapest" clinicians. One MCO reportedly has begun using bachelor's level counselors rather than professionally trained master's and doctoral level professionals. When beneficiaries cannot receive reimbursement for treatment by clinicians with advanced training, quality of care is compromised.

g) Patients hospitalized in a non-network hospital in an emergency may be forcibly transferred to a network hospital before they are well, impeding recovery and possibly increasing symptoms.

h) Even if the MCO offers out-of-network benefits (Point-of-Service Option), consumers with limited incomes may be unable to access out-of-network providers, as they are financially penalized for doing so. This may affect the elderly in large proportions due to the large percentage on limited incomes.

2. Patients lose the right to make their own treatment decisions.

a) The MCO may pre-determine that all or most patients are to receive brief hospitalizations and brief, crisis-focused psychotherapy, regardless of patients need. This is based on decisions about money, not treatment and consumer need.

b) The MCO often requires reports from the treating clinician and then takes over treatment decisions. The patient and his/her clinician may be powerless to decide the course of treatment. The sense of powerlessness and the prevention of access to proper treatment may increase a patient's symptoms, especially depression and anxiety. Hospitalization or intensive psychotherapy for a particular patient may be declared "not medically necessary," even though the standards of practice in the professions would clearly show the need for treatment.

c) What is "medically necessary" varies from one MCO to another, as it generally has more to do with costs than with care.

d) Many MCO's will only authorize three or four psychotherapy sessions at a time, leaving the beneficiary and provider unable to know how long their work will be able to continue. Anxiety often rises before each "approval" and session time is often spent on discussing the MCO, rather than on the problem for which the patient sought treatment.

e) Some MCO's deny funds for psychotherapy if the patient refuses medication. This is because medication may produce a fast relief of symptoms, even though it may actually fail to correct the actual problem. This then allows the MCO to discharge the patient without investing much money. In general, there is concern that too many of our elderly are already over-medicated. Often, they are considered too old to make changes and not good candidates for psychotherapy, which is not necessarily true. This puts the elderly at increased risk of over-medication. Further, there is a bias among some physicians and scientists toward medication and away from "talk therapies," but this may reflect little more than an honest bias and the difficulty of forcing "talk therapy" into the molds of empirical science. Patients may have a strong need to talk out their problems, yet their voices do not count under managed care.

3. Consumers lose the right to privacy under managed care.

Because reports must be submitted to the MCO by the provider in order for the MCO to determine whether or not continuing care is "necessary," information that should not leave the treatment room must be given to the MCO, which may store it in their data banks. Psychotherapy patients often require privacy over information involving personal problems. Many consumers are not at all comfortable allowing such information to be divulged, but may have to sacrifice reimbursement if they withhold this information. Under Medicare, psychotherapy providers are not permitted to treat beneficiaries outside the plan. Thus, those requiring privacy or those with paranoid conditions may be forced to forego needed treatment due to inappropriate cost-containment techniques that may be suited to "industry," but not to human services.

4. MCO's may be grossly under-treating consumers of mental health care due to cost-containment. Because it is illegal for psychotherapists to provide treatment for Medicare beneficiaries outside of Medicare, those consumers who need treatment beyond what the MCO dictates may be prevented from legally obtaining needed services.

a) Many MCO's provide a grossly inadequate model of "short-term therapy," "solution-oriented therapy," "crisis intervention," or "stabilization," or they may state that they only treat the "acute phase" of a problem, refusing to pay for proper treatment for "chronic" or "ongoing" problems. This is a standard that would never be tolerated in medical care, and should not be tolerated in mental health care. Examples of MCO literature stating these limits can be provided to the reader.

b) Many patients need time to build trust in the clinician and to tell their story. Patience and understanding from the clinician are as necessary as advice. The clinician needs to spend enough time with the patient in order to know if the problem goes deeper than the surface "presenting problem." These things are too often impossible under managed care.

c) MCO's are misusing research data by not speaking to the limits of the research in order to support their bias toward short-term treatment.

d) Even though the literature in many MCO plans may state that beneficiaries may have "up to 20 sessions" in a year, often times the companies' reviewers are told never to allow more than a few sessions (see vignettes), or providers are warned that if they average more than a few sessions per patient, they will be ejected from the panel or refused further referrals. Thus, the provider may be too afraid to give the consumer the treatment that is needed.

e) A recent Harvard study (James Hegarty, MD, at McLean Hospital, Boston, as reported in *Newsday*, "Study: Managed-Care Squeezes Hospital Stay," 5/24/95) showed that there has been a dramatic increase in re-hospitalizations of psychiatric patients under managed care due to premature discharges. The average length of stay (LOS) at McLean in 1989 was 45 days. By 1994, due to managed care, the average LOS was 15 days. There was a concomitant increase in the number of people readmitted within a month, from 0% in 1989 to 21% in 1994, and an increase in patients who were minimally improved or worse at discharge than at admission, from 4% to 18%.

f) The industry is ignoring 100 years of development in the field of psychotherapy and is creating standards for treatment that are *substandard*.

5. Many managed care provider contracts contain "non-disparagement clauses," prohibiting the provider from saying anything negative about the managed care company to the patient or anyone else, often preventing providers from making the consumer aware that he/she is not receiving proper care.

Consumers are prevented from accessing professionals who follow their ethics and refuse to sign such agreements, as these providers will not be included on the MCO's panel. Also, this can mean that if a panel provider believes that the MCO's recommendations would be harmful to the patient, the provider may not tell this to the beneficiary. The consumer should have the right to know his/her provider's opinions of treatment decisions made by the MCO, especially if the provider believes that the MCO's decision is not in the patient's best interests. Also, these clauses prevent managed care abuses from reaching the press and legislators.

6. Patients may find that they must fight for benefits when they are ill, when their energy should be spent on getting well.

Patients never know whether or not their treatment will be covered until they become ill. Since providers may be at risk if they advocate for the consumer, this leaves consumers often having to spend their energy on advocating for themselves when needed treatment is being denied. Patients who do not have the ability, self-confidence, or energy to advocate for themselves may be seriously under-treated. Often, mental health patients are too derpressed, anxious, or too humiliated by their problems to advocate for themselves. With providers being at risk for unemployment if they advocate for their patients, there may be no one left to advocate for the elderly patient, especially if family is uninvolved or lives far away.

7. Under managed care, many providers fear doing what is right for the patient, putting the consumer at risk.

Since the MCO's now decide which providers will be able to continue working, many have been frightened into silence. Many feel too powerless to protest poor treatment of consumers to the MCO, the press, or to their legislators. When New York State's Assembly held hearings on managed care in January, 1994, several providers told me they were too afraid of being identified by the MCO's to testify. Their fear was that they would be ejected from the networks, refused referrals, or that their patients would be refused future sessions. These very real threats put the consumer at risk, especially in mental health, where patients usually do not advocate for themselves, and especially with the elderly patient, who may not be able to advocate for him/herself.

8. Quality and quantity of care will always be a problem under managed care and any form of capitation, as *there is an inherent conflict of interest when an entity that is supposed to offer care, be it an MCO or an individual provider, keeps whatever money is not spent on treatment.* This is especially destructive when mental health is under-capitalized.

a) MCO's keep money that is not spent on treatment. Corporate profits are soaring while beneficiaries are prohibited from receiving care for chronic and ongoing problems and are being discharged from hospitals prematurely.

b) Even capitated contracts that are made between employers and providers directly, bypassing MCO's, are problematic. One California therapist told me that she was called by a capitated plan and told that she would receive approximately $235 for each patient they send her. Obviously, if she performs one session only, she does very well. She still does well if she performs only two. Obviously, if the patient requires 10 sessions, she is receiving poor wages (with no benefits) for someone with a doctorate or even a master's degree. If the patient requires 40, 50, or more sessions, it becomes ludicrous. Thus, there is a strong incentive to under-treat, and clinicians may simply not be able to afford to

treat patients properly due to under-capitation. It is the bias of the corporations that people should only require 1-3 sessions. This is not reality.

c) It is true that under the fee-for-service system, there was some incentive to over-treat the patient. However, not all providers over-treated, as wise clinicians knew that they would receive future referrals from patients whom they treated appropriately. Also, under a fee-for-service system, if a consumer feels that he/she is not being treated properly, he/she can easily leave that clinician and find another. Further, a system of appropriate co-payments, when used by the insurers, encouraged consumers to be cost- and utilization-conscious.

9. Despite claims that managed care and managed competition comprise a "free market solution," there is no free market for the patient, the actual consumer of health care.

a) Managed competition is really about the elimination of competition. As consolidation continues, only a few large insurers will remain.

b) In several areas, the industry already controls 90% of the market. Where managed care squeezes out fee-for-service plans, *there is no competition for managed care itself.* A lack of competition always bodes poorly for quality.

c) A free market for the patient would mean that the patient is the one who would determine what care is needed, determine the value of that care, and choose freely from all who are qualified to provide that care. Managed care does not allow the patient these liberties. As managed care becomes an arrangement between employers or governments and the insurer, and the "consumer" becomes the employer or government, for they pay the premiums, the "free market" exists between the MCO and the payor. Under managed care, the MCO determines who will receive what kind of treatment, for how long, and who can deliver it. The true consumers of care, the patients, as well as the body of professionals who could administer care, are kept out of the "marketplace."

d) The managed care industry controls both supply and demand in regard to health care services. MCO's have declared that there is an over-supply of mental health professionals. This is predicated, however, on the industry's assumption that only brief forms of crisis-oriented therapy are needed, and that few people need treatment. This is not based upon true demand, which would be based upon the citizens' requests for care. Although fee-for-service is a "subsidized" market, it is still based on a more true supply and demand than under managed care. Under a fee-for-service system which had, in recent years, seen extremely high co-payments for psychotherapy, the demand for services was far greater than what is allowed under managed care. There will soon be a drastic shortage of mental health professionals and other providers, for the number will be based on what the managed care industry "needs," not upon what our citizens need. This will affect our entire society.

C) Recommendations:

1. Allow Medicare beneficiaries to choose among a variety of health plans, including fee-for-service plans, Medical Savings Accounts, MCO's, and any other type of health plan that currently exists or is yet to be devised.

a) Medical Savings Accounts (MSA) are attempts to return the rights of the "free market" to the actual consumers of health care. Incentives are provided that make the consumer cost- and utilization-conscious. Up to the catastrophic limit of the MSA, the consumer retains the right to choice of provider, the right to privacy, and the right to make his/her own treatment decisions.

b) There are some problems with MSA's, however:

i) Beyond the catastrophic limit, the consumer retains freedom of choice, but loses privacy and the right to make his/her own treatment decisions, as treatment may be subject to utilization review. However, because there are no panels, and MCO's can't threaten the providers with unemployment, providers are free to advocate for patients.

ii) The standard MSA contract written by the Golden Rule Insurance Company, has a limit on mental health services of $10,000 per year per individual. This is generally adequate for a patient requiring only psychotherapy, but not for one requiring a day treatment program or hospitalization.

iii) There is some concern that MSA's will not be appropriate for those who are unable to be responsible for their funds. This may affect some of the elderly. It may be necessary to arrange for a relative to make MSA decisions or, when there is no such relative close by, for a consumer case manager (not a case manager contracted by the insurer) to do so.

c) Some MSA plans are combined with MCO's. Again, this penalizes consumers for using out-of-network clinicians, which limits their choice of providers, especially for those with a limited income.

2. Return control over health care to the citizen:

a) Phase out employer involvement in health care. It no longer works. For employees, premium money actually belongs to the employee, for it is taken from his/her wages. Return this money to the employee so that employed citizens can purchase, own, and control their own health care plans. Under Medicare, and for citizens with limited incomes, beneficiaries should be expected to pay a portion of their premiums, based on their incomes, with government paying the balance.

b) Return the three basic rights consumers have lost under managed care (choice, privacy, and decision-making). Employees lost these rights because we now expect employers to pay for insurance, and because employers needed to cut costs once the patient became separated from the consequences of their decisions under the fee-for-service system. Citizens have been separated from the fact that it is their money to begin with, and the greater the separation, the less care they take with that money.

c) In order to protect their freedom, citizens must be financially responsible for their care to whatever extent they can afford to be so.

i) Medicare beneficiaries with adequate incomes would buy their own plans, or at least pay for a portion of their premiums. Government would pay that portion of the premium which is unaffordable for the Medicare beneficiary or other citizens.

ii) Benefit design must create incentives for patients to be cost- and utilization-conscious, without restricting access to care and other freedoms.

d) Individual mandates might be considered. Car insurance is required of all who drive, not just of all who have accidents. Why can't health insurance be required of all who live, not just those who get sick? While we might wish to protect the freedom of the citizen NOT to be insured, all citizens must then pay for emergency care and follow-up treatment when an uninsured individual requires treatment he/she cannot afford out-of-pocket.

3. Protect quality care and consumer freedoms by encouraging citizens to buy and own their own insurance plans. Allow a 100% tax deduction for all citizens buying their own health care plans.

All citizens deserve the tax break now given to employers, especially those who are self-employed or unemployed, which may include a large number of Medicare beneficiaries. Also, it is important for a government to encourage people to take care of themselves, so they will be less dependent upon the government for services. The more health insurance coverage one owns, the less dependent one will be on the government for care.

4. Guarantee portability of health care plans.

5. Prohibit "pre-existing condition" barriers to treatment.

6. Guarantee all citizens in MCO's access to "Point-of-Service" options:

Unfettered access to specialists is crucial for those who are ill.

7. Guarantee the right of all citizens, including Medicare beneficiaries, to "contract privately" with providers of their choice.

In the case that a health plan denies reimbursement for a particular service, the citizen must still be allowed to purchase health care he/she believes is necessary. The MCO might be making incorrect decisions. Medicare beneficiaries cannot currently purchase psychotherapy except from Medicare providers. If Medicare comes under managed care, beneficiaries will also frequently be denied more than a handful of psychotherapy sessions, as is already happening to the general population. Most MCO's are only allowing "crisis" care, and are prohibiting true forms of psychotherapy. We cannot make it *illegal* for Medicare beneficiaries, or anyone else, to obtain genuine psychotherapy.

8. Allow the States to regulate the managed care industry.

a) With a true "free market" system, in which the citizen has the ability to make his/her own health care decisions while being given incentives to be cost-conscious, there will be less need for regulation than there is under managed care.

b) Managed care plans frequently short-change the patient, and often prevent providers from advocating for patients and from delivering the best care they know how to

provide. It is imperative that the federal government allow the States to regulate this industry. ERISA laws were not intended for health care. They were intended for pension plans. If employer involvement were phased out, employers would not object to state regulation of health insurance plans.

9. Allow states the flexibility to experiment with a variety of health care plans.
   a) Encourage the States and regions to develop insurance plans that involve "freedom with responsibility." MSA's attempt to do this.
   b) There are many ideas yet to be devised and written down (e.g., see "Managed Cooperation," item F, below). Please do not lock Americans into any particular form of system, as this will prevent better ideas from being formulated and implemented.

D) Summary:

There are many problems that have already occurred in the private sector under managed care. These problems generally involve the loss of consumer freedoms to make their own treatment decisions, in private, with their chosen clinician. In mental health, the industry has changed the "standards of care" to substandard care.

In general, we urge Congress to institute some insurance reform and to allow the States to regulate the managed care industry. We urge Congress to increase choice of plan for Medicare beneficiaries and others, and to pass legislation that enables the development and implementation of programs that offer alternatives to managed care and managed competition, especially those that re-institute a true free market for the actual consumers of care. We support plans which retain consumer freedom while containing costs by providing incentives for consumers to be cost- and utilization-conscious, thus expecting some financial responsibility from the consumer, according to the financial means of the consumer.

E) **Vignettes from Managed Mental Health Care** - see pages 7 & 8.

F) **"Managed Cooperation:" A Medical/Mental Health Care Plan** - see pages 9 & 10.

These pages contain ideas ("Managed Cooperation") designed by the Coalition. Many of these ideas could be helpful in designing systems of cost-containment that put the consumer of care back in charge of his/her own treatment.

Original Vignettes (#1)
Managed Mental Health Care
(Revised 12/18/93)

The following vignettes are summaries of managed care (MC) cases. Decisions about who can be in treatment, how long treatment can continue, what type of treatment patients can have, and who can provide it, are being made by the MC companies. While they state they are basing decisions on "medical necessity," the companies cannot be free of a need to themselves be profitable. Unfortunately, the cases below are not atypical.

1. Ten year-old "Susie" was involved in a tragic and frightening accident. She and one parent escaped, but the other parent and her sibling died. "Susie" became mute, and began drawing pictures of a little girl with a noose around her neck. The surviving parent brought "Susie" to their HMO. "Susie" began therapy, but her pictures became increasingly darker (a symbolic indication of deepening depression and increasing suicidal risk). After the ninth session, the parent found "Susie" about to make a suicide attempt. This was reported to the therapist (who had not yet earned a master's degree) at the 10th session. This HMO therapist concluded treatment with the 10th session, stating that "Susie" "should be" finished. "Susie" was still mute and suicidal. Fortunately, the parent had some money available to pay for therapy without insurance coverage. The parent asked a friend for a referral outside the HMO and found a psychiatrist who offered a reduced fee. "Susie" was seen three times/week for 18 months. It took 12 months before "Susie" began to speak again.

2. "Mary," a depressed woman with several physical problems related to her emotional disorder, was denied therapy after 8 visits, even though her policy allowed up to 20 visits. The therapist (licensed) strongly recommended further treatment, but the reviewer (not licensed) refused authorization, saying that he had been instructed not to approve any outpatient treatment beyond 8 sessions regardless of the diagnosis or provider recommendation. "Mary" was too depressed to appeal. Within a month, she was hospitalized for severe gastric distress and required surgery. The therapist believes this was caused by inadequately treated depression.

3. "Jane," a depressed and suicidal woman, had finally left her physically abusive husband. She called her MC company for permission to begin therapy and for a referral. The request was refused. The reason given was that "domestic violence is a social problem, not a psychological problem."

4. "Sean," an adolescent boy, asked to be in therapy. His mother called the MC company for permission for him to begin therapy and for a referral. "Sean" stated he would not be comfortable seeing a male therapist. No list of network therapists is published, so the mother could not find an appropriate referral herself. The company agent refused to offer the name of a female therapist, though there were many in the network in that area. Despite many protests by the mother, the agent gave only names of male therapists, stating: "Listen, if you're sick, it doesn't matter who you see. And if you don't take the names I gave you, I can't help you anymore."

5. "Rosa," a young mother with 3 young children, cuts her wrists. Her HMO approved only 8 sessions. The therapist believes her symptom is due to feelings of anger at the responsibilities of motherhood. As the oldest of 9 children herself, "Rosa" had been over-burdened with responsibility as a child, for her own mother was unable to care for the children. Without appropriate treatment, "Rosa" will not likely understand the reasons for her distress. She will likely continue to cut her wrists, possibly escalating to serious cuts. The potential for child abuse is also present should "Rosa" begin directing her anger outward instead of toward herself.

6. "Henry," a middle-aged man with a childhood history of being severely humiliated, requested treatment due to interpersonal problems, including difficulty trusting others. "Henry" refused to return to treatment when the therapist was required to submit a detailed report about him and his therapy. The therapist finally convinced him to return and they spent much time discussing what the therapist should write. The report was written and more sessions were authorized, but "Henry" never returned for treatment. When the therapist called him, "Henry" said that the experience of having to divulge information to the company was too humiliating for him.

7. "Steven" experienced increasing depression, panic attacks, and phobic anxiety that prevented him from working. His psychiatrist provided psychotherapy and medication. There was a brief admission to a local hospital for a suicide attempt. After a year of treatment, "Steven's" insurance was changed to a MC company. The psychiatrist joined the network to be able to continue the treatment. The treatment resistant depression and severe anxiety showed some improvement, but the MC company said "Steven" was a "chronic" patient who wasn't showing enough improvement. The psychiatrist had to plead for more sessions. "Steven" did show more improvement. Later, a new anti-depressant helped lift "Steven's" mood and eliminated almost all panic attacks. However, "Steven" then began manifesting increasing manic symptomatology, including spending sprees. Restarting Lithium, which had been helpful in the past, now led to an organic brain syndrome. To be hospitalized under his MC plan, "Steven" would have had to enter the MC company's "anchor" hospital, which was not in his community, and would have been required to change psychiatrists. "Steven" refused to change psychiatrists and thus refused the hospitalization, though he would have agreed to a local hospitalization with his own psychiatrist. The organic symptoms decreased, but the manic symptoms remained. However, the psychiatrist did not feel "Steven" qualified for an involuntary hospitalization. "Steven" endured a full month of manic symptoms, infuding spending sprees. The cost to "Steven" was great in terms of financial, interpersonal and emotional effects before the manic symptoms remitted with outpatient treatment.

8. "Barbara" was in individual and group therapy before a MC company took over her insurance. She had been sexually abused by her grandfather in many horrifying ways between the ages of 5 and 12. She was also abused by a neighbor at age 12. Marital sex was accompanied by terrifying flashbacks of the abuse. The therapist was told by a reviewer to "hurry it along." Unfortunately, the symptoms had worsened because "Barbara" was given a new assignment at work which required her to work with men about the same age as her grandfather. Also, she had recently undergone her first gynecological exam, which left her psychologically disorganized for several weeks. The reviewer, a psychiatrist, asked if "Barbara" was suicidal. When the therapist said she was not, the reviewer disallowed further group treatment, stating she was just "following company policy." Group treatment, in addition to individual treatment, is often extremely important for sexual abuse survivors.

9. "Linda" was in treatment for about 1 1/2 years before a MC company took over. "Linda" was unable to tolerate anti-anxiety medication, but did respond to psychotherapy. Toward the end of the second year, "Linda" witnessed her 22 year-old daughter being hit by a car, leaving her a quadriplegic. "Linda's" symptoms increased dramatically. She was likely manifesting signs of Post Traumatic Stress Disorder. The therapist called the reviewer for permission to continue treatment. The therapist was told: "Well, doctor, let me tell you something. We are going to cut you off - be prepared - its coming down the pike soon!"

10. "Allison" had been sexually abused by two of her brothers for several years during childhood. She was raped as an adolescent, and battered throughout her first marriage. She was in group and individual therapy. Group therapy was later denied by the MC company. When the therapist, a recognized expert in treatment of sexual abuse, told the reviewer that the literature speaks to the importance of individual and group therapy for optimal treatment, the reviewer said: "Listen, we are not interested in providing optimal treatment. We are interested only in providing that which is absolutely medically necessary."

11. "Bill" is usually in control of his anger, but when he loses his temper, he threatens his pregnant wife with a loaded gun. His therapist was encouraged to complete the work in 8-12 sessions. Although the reviewer agreed this was a "long-term" case, he stated that it is not the company's policy to provide long-term treatment.

12. "Jennifer," in her late 30's, noticed pain in one breast, though she found no lump on self-examination. Her HMO doctor also found no lump. "Jennifer," suspecting a problem, asked for mammography. The doctor, who also acted as "gatekeeper," stated that the HMO does not pay for mammography for women under 50 unless there is a physical finding upon examination. With this refusal, "Jennifer" had a mammogram outside her HMO at her own expense. The test showed breast cancer. She decided to sue the HMO. Distressed by the cancer and the refusal of the HMO to provide the services she deemed necessary, "Jennifer" requested psychotherapy to deal with the stress. The HMO refused to authorize psychotherapy for her.

MANAGED COOPERATION

A Medical/Mental Health Care Plan

An Idea for the future

(revised 2/14/95)

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1. The success of a health care plan will depend on the value system upon which it is based. Cooperation seeks solutions that enhance and are fair to all parties involved.

2. Managed Cooperation optimally balances patient choice and freedom with responsiblility, instills provider responsibility to the patient, and engenders cost- and utilization-consciousness in patients and providers.

3. Managed Cooperation can be written in both single and multiple payer versions.

4. Benefit design would encourage patients and providers to be conscious of costs. When little or no co-payment is expected at the time of service, patients may not be motivated to question a provider's fees or suggested procedures. External controls (gatekeepers, case managers, and utilization reviewers) may then be called upon to do this, reducing patient control over their care. It is important, therefore, for patients to be financially responsible for their care at the time of service to the extent that out-of-pocket expenses are significant enough to the patient that the patient questions providers about fees and recommendations, but not to the point where out-of-pocket costs are burdensome and present a barrier to treatment for those with limited incomes. Sliding scales for premiums, fees and co-payments, deductibles, and catastrophic limits are all possibilities under Managed Cooperation.

5. We suggest a gradual phase-out of employer involvement in health care. When employers buy coverage, they may, understandably, seek to control the care given, limiting the freedom of citizens to make their own treatment decisions, in privacy, with their chosen clinicians. Since the money used by employers to buy insurance really comes out of the employees' income, we encourage a return of this money to employees in the form of income so that they may buy and own their own policies. This returns control over health care choices and decisions to the individual citizen. The possibility of an individual mandate might be considered.

6. Managed Cooperation relies upon regional cooperation. Cost-containment procedures as described below would be carried out by Regional Boards made up of consumer advocates, professionals, government representatives, and insurers (if a multiple payer plan is used).

7. Annually or every other year, Regional Boards would recommend fee ranges and insurance reimbursement levels for each procedure and send this information to consumers, clinicians, and insurers (the government if single payer systems are used or to insurance companies if a multiple payer system is used). Insurers would set dollar amounts for each procedure's reimbursement. Providers would set fees, preferably on a sliding scale, starting with a fee minimally above the reimbursement, up to a reasonable "full fee." The co-payment would be the difference between the reimbursement and the fee for the patient's income level, and could be legally waived if necessary. Clinicians would provide current and prospective patients with their fee schedule

upon request. The intention is to provide true discounts for those with limited incomes. The Board's recommended fee ranges would protect wealthier patients from being over-charged. High-priced clinicians would have to be able to justify their fees to patients. Caps on fees and the mandatory use of sliding scale fees could be instituted if a voluntary sliding scale did not adequately control fees. Sliding scales might be able to be used for hospital expenses if the percentage share for costs was graduated according to income (e.g., citizens earning $30,000 might only pay 5% of hospital bills up to a catastrophic limit appropriate for their income, while those earning $300,000 might pay 50% of all bills up to an affordable catastrophic limit.

Under this system: a) the insurer's liability is limited by the fixed reimbursement, b) patients and providers, due to a co-payment scaled to the patient's income, become cost- and utilization-conscious, c) patients could "comparison shop" and have freedom of choice, and d) practitioners would be guaranteed at least a minimum payment for each procedure (the fixed reimbursement), yet would retain some independence to compete in a truly free market based upon training, talent, reputation in the community, and fees.

8. Regional Boards could regulate purchases of expensive machinery; perform outcome studies; focus on fraud and incompetence, rather than micromanagement; and settle disputes between patients, providers, and insurers.

9. Government support for building hospital-based and free-standing primary care centers would reduce emergency room visits and encourage primary care use.

10. Outpatient psychotherapy would cover individual, group, and marital/couple/family treatment, as allowing children, adults, or families to remain in distress is harmful and costly to our country. Coverage for 40-50 sessions/year is recommended, as: a) 85% of patients use less than 26 sessions, even with liberal benefits and no UR (utilization review), b) liberal outpatient benefits reduce inpatient costs and, thus, overall mental health costs, and c) preventing the 15% of patients who need long-term psychotherapy from receiving it may increase society's costs and harm patients and their families. UR can be used to provide additional sessions beyond the annual limit for those who demonstrate strong psychological and/or medical need AND financial need. UR would not intrude on session content or personal information. Inpatient treatment would require UR, but at reasonable intervals. Medication management would be given the same status as any medical visit. Partial hospitalization, half-way houses, and group homes would be supported to reduce inpatient costs and the costs to society of inadequately treated mental health needs. There would be no limit to inpatient care for the seriously mentally ill (schizophrenia, bipolar disorder, major depression, severe borderline personality disorder, etc.), but appropriate UR would be utilized. Patient education would be developed to explain mental health problems, different forms of treatment and psychotherapy, and the educational requirements of different types of clinicians.

11. UR, or at least denials of benefits, would be done by licensed, practicing professionals who are independent of the insurer, and who have training comparable to that of the treating clinician. UR would focus only on those procedures known to be over-utilized.

12. Incentives in the form of partial premium rebates could be used to encourage patients to refrain from submitting smaller claims.

13. Claims procedures would be simplified and standardized, and claims could be submitted either by patients or providers.

May 22, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Mr. Moseley,

I am strongly in favor of passing a bill to institute MEDICAL SAVINGS ACCOUNTS. It is the only way to take responsibility for myself and provide for my medical future. It's voluntary, tax free and it gives me the right to choose what kind of health care I want and when.

Remember---- HEALTH CARE IS NOT A RIGHT!!!

Sincerely,

Kathleen Conn

Kathleen Conn
1548 Middle Rd.
E. Greenwich, RI 02818

TESTIMONY OF CONSORTIUM FOR CITIZENS WITH DISABILITIES

The Consortium for Citizens with Disabilities (CCD) is a working coalition of over a 100 national consumer, service provider, and professional organizations, which advocate on behalf of persons with disabilities and their families. Since 1973, CCD has advocated for federal legislation, regulations, and funding to benefit people with disabilities. Fifty of the these organizations comprise the CCD Health Task Force, which works to enact comprehensive health care legislation that will meet the needs of persons with disabilities and chronic illnesses, and their families. This testimony is presented on behalf of the Task Force.

People with disabilities include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses, which impair their ability to function. Lack of adequate and affordable health care coverage is a critical issue for many persons with disabilities and chronic illnesses, who have experienced first hand the myriad problems with the current system of private insurance. In particular, they are subjected to the many discriminatory practices of the health insurance industry, which either refuses to insure them outright, or will only issue a policy with a pre-existing condition exclusion.

The Importance of Medicare for People with Disabilities & Chronic Illnesses

Millions of people of all ages with disabilities and chronic illnesses depend on Medicare for health care coverage. The Consortium for Citizens with Disabilities (CCD) Health Task Force has major concerns that the deep spending cuts to the Medicare program being considered by Congress will have a significant negative impact on beneficiaries, particularly people with disabilities. We are also concerned that encouraging Medicare beneficiaries to join managed care programs will limit their choice of providers, and will not achieve the proposed savings since many of these managed care entities will seek primarily to enroll lower risk beneficiaries. Additionally, we believe that the use of vouchers by Medicare recipients would lead to adverse selection and would undermine the social insurance basis of the Medicare program.

Who is Covered?

In 1994, approximately 4.2 million adults under age 65 with disabilities were enrolled in Medicare.

People with disabilities under age 65 who meet the eligibility criteria for the Social Security Disability Income (SSDI) Program can qualify for Medicare health care coverage after a two year waiting period. SSDI is a social insurance program paid for by Social Security taxes of workers and their employers. Eligibility for disability benefits is based on the number of years worked, and the amount of the benefit is based on a person's earnings.

Examples of individuals who are eligible for Medicare through the SSDI program include:

- A 30 year old man who sustained a spinal cord injury in a car accident;
- a 45 year old woman with multiple sclerosis; and
- a 52 year old man with Alzheimers Disease.

People with severe disabilities who have limited work histories, but who were disabled prior to age 22, may also be eligible for SSDI on the basis of their parents' work history. For example, a 35 year old man with severe mental retardation who has never held a job and who is dependent on his parents, can receive SSDI benefits both while his parents are alive and after they are deceased.

People who are eligible for SSDI may return to work. If they are covered under a large group health plan (i.e., for 100 employees or more), Medicare is the secondary payer for health care expenses. A large group health plan cannot treat any individual it covers differently simply because they have a disability and have Medicare coverage. If the person with a disability is not covered by his or her employer's plan, Medicare is the primary payer and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

What is Covered?

Medicare is the largest single purchaser of hospital care, physician services, and rehabilitation services. While people with disabilities require access to the full range of health services, rehabilitation services are of particular importance. The range of inpatient and outpatient rehabilitation services covered by Medicare includes physical therapy, occupational therapy, speech therapy, recreational therapy, durable medical equipment, and orthotics and prosthetics.

These services may be provided in a number of locations, including:

- rehabilitation hospitals or units in general hospitals;
- skilled nursing facilities;
- comprehensive outpatient rehabilitation facilities;
- rehabilitation agencies;
- private offices; and
- patient's homes through the services of a home care agency.

Medicare is the single largest payer of medical rehabilitation services in the United States, accounting for an average of 40% of revenues in rehabilitation hospitals and more than 50% in rehabilitation units in hospitals.

Issues and Concerns

Potential Reductions in Medicare Services

The House and Senate Budget Resolutions propose between $256 and $282 billion in Medicare cuts over the next 7 years. Currently, Medicare does not cover important services such as outpatient prescription drugs and most preventive and screening services. As a result, many Medicare beneficiaries -- even those with Medigap policies -- have high out-of-pocket expenses. For those without Medigap policies, including many individuals on SSDI, out-of-pocket expenses are even higher. Further budget cuts in Medicare will result in benefit cuts and increases in out-of-pocket payments.

Low Reimbursement Rates and Cost-Shifting to Private Payers

According to the Physician Payment Review Commission, Medicare pays physicians approximately 70% of their charges. Health care providers and hospitals have traditionally shifted the shortfall in Medicare payments onto private health insurance payers. Deep cuts in Medicare funding will further exacerbate this problem. The Medicare program has already been cut significantly -- nearly $200 billion since 1980, and most recently, by $56 billion in 1993. Singling out Medicare for additional spending reductions will likely result in continued cost-shifting to businesses and privately insured individuals as hospitals and physicians try to recoup lost revenues.

Difficulty in Finding Physicians who will Accept Medicare Patients

As managed care plans have increased their share of the health insurance marketplace, they have been able to negotiate lower rates from health care providers who are less able to shift costs to private payers. Further reductions in Medicare reimbursement rates would put additional financial pressure on providers. As a result, fewer doctors and other health care practitioners may be willing to provide care to Medicare beneficiaries.

The magnitude of these recent cuts has already had a negative affect on many Medicare beneficiaries, who are having difficulties finding physicians willing to treat them. People with disabilities and chronic illnesses develop long-term relationships with particular providers to help maintain their optimal health status. Medicare funding cuts which force providers to discontinue providing services to these vulnerable individuals may have serious effects on the quality of their health care and their health status.

Recommendations

Given the pending insolvency of the Medicare Part A Trust Fund, and the escalating costs of the Part B program, the CCD Health Task Force recognizes that the financing problems in the Medicare program must be resolved. However, any action taken by Congress to address these problems must not jeopardize the Medicare program's guarantee of affordable health insurance protection for people over 65 and adults with disabilities. In particular, we are concerned that spending cuts not reduce necessary health services or lead to increased deductibles and copayments for Medicare beneficiaries.

We believe it is inadvisable to cut Medicare further or to restructure the program without simultaneously addressing the larger systemic problems in the U.S. health care system. Medicare's problems are symptomatic of the general failure of the U.S. to guarantee affordable health insurance protection for all individuals. Attempting to fix Medicare's problems alone could lead to unintended negative consequences, not only for Medicare beneficiaries, but for the health system generally.

MEDICAL SAVINGS ACCOUNTS

Many Members of Congress believe that Medical Savings Accounts (MSAs) have the potential to reduce health care costs and increase the number of Americans with insurance. There have been suggestions that MSAs be implemented not only in the private sector but in the Medicare program as well.

The Consortium for Citizens with Disabilities Health Task Force has major concerns with the emphasis presently being placed on Medical Savings Accounts as a solution to our health system's problems of access and affordability. The use of MSAs is not only untested, but also has the very strong potential for making comprehensive health insurance less affordable for persons with disabilities and serious chronic illnesses. *Because of our many concerns, which are discussed below, and in the absence of other reforms, the CCD Health Task Force does not support the establishment of MSAs as either an incremental reform or as a solution to the health care problems facing millions of uninsured and underinsured individuals in the U.S.*

Supporters of MSAs state that:

- MSAs will allow the marketplace, not the government to address the cost and access issue. By giving responsibility for paying for health care to consumers, it is assumed that MSAs will reduce unnecessary health care expenditures because individuals who are spending their own money will be more prudent purchasers. It is also assumed that the lower cost of catastrophic health insurance will lead more employers to offer health insurance.

- MSAs will lead to lower administrative costs because insurance companies will only be involved with claims higher than the deductible amount.

However, MSAs are untested, and it is not clear that they will either lower costs or improve access to services.

What are MSAs and How do they Work?

Medical Savings Accounts are tax-exempt savings accounts modeled on Individual Retirement Accounts that employed individuals can use to pay for health-related expenditures. State MSA laws generally create incentives for people to set up these accounts by exempting from state taxes the money contributed to these accounts. MSAs work like this:

- Employers can purchase a standard health insurance plan with a low deductible ($250 - $500 annually per person) or a catastrophic health insurance plan with a high deductible ($3000-$5000 annually per person). Because most people will not have health care costs higher than several thousand dollars, the premiums for high deductible catastrophic health insurance plans are much lower than for plans with low deductibles.

- An employer sets up a MSA for employees who want to participate in this type of plan and deposits, in pre-tax dollars, an amount equal to the difference between the cost of a standard low deductible plan and a catastrophic high deductible plan. The self-employed can also set up a MSA.

- Employees can use the money in their individual account for health care expenses. When the high deductible is met, the insurance company then pays the bills. If money is left in the account at the end of the year, it can be withdrawn and used for other purposes or carried over with accrued interest into the next year.

The CCD has several major concerns about MSAs:

- The catastrophic health plans that are purchased in conjunction with MSAs can impose pre-existing condition limitations and can refuse to cover persons with certain health conditions or disabilities.

- Catastrophic health plans with high deductibles often do not provide the comprehensive coverage needed by persons with serious illnesses or conditions. Some of these plans have lifetime or per condition limits of only $100,000.

- The American Academy of Actuaries has estimated that persons with high health expenses will experience major increases in out-of-pocket costs with MSAs. MSAs may also increase out-of-pocket costs if the amount employers contribute to the MSA is not sufficient to cover the annual catastrophic deductible. Additionally, the combined cost to the employer of an MSA contribution and the catastrophic heath plan premium may not be less than the cost of a standard health plan.

- If large numbers of individuals choose MSAs plus catastrophic health plans, the health insurance market will be further segmented, reducing the size of the population pool needed to spread risk adequately.

- MSAs will likely lead to adverse selection because they will be utilized primarily by younger, healthier people who do not anticipate a need for health care. Persons who anticipate health care expenditures, those who need comprehensive coverage, and those who are older and at higher risk for needing health care are likely to remain in standard low deductible health insurance plans. Individuals with MSAs could also change to a low-deductible plan when they become sick or anticipate medical bills (e.g., childbirth expenses), thus exacerbating the problem of adverse selection.

- Adverse selection will lead to higher premiums for persons in standard, low deductible health insurance plans. It has been estimated that if MSAs are widely adopted, the cost of a standard, low deductible health insurance policy would rise by as much as 26%. Increases of this magnitude will make comprehensive, low deductible insurance unaffordable both for employers and individuals who want to purchase these policies.

- There is no evidence that MSAs will make consumers more cost conscious when they are seriously ill. Physicians -- not consumers -- determine what treatment is needed. If surgery is recommended, consumers don't look for the cheapest surgeon, they look for the best surgeon.

- Some individuals may forgo preventive and early intervention services if they are allowed to use money left in their MSAs at the end of the year for personal expenses other than health care. This concern also raises the question of whether it is appropriate to allow pre-tax dollars to be used for non-health expenses.

- It is likely that catastrophic health plans will restrict the type of health care expenditures that will count towards the deductible. For example, if an individual spends $3000 on mental health services, there is no guarantee that all of these expenses will be counted towards the deductible, particularly if the insurance has limited coverage for these services.

- A majority of Americans are enrolled in some form of managed health care plan. It is unclear whether MSAs can be coordinated with these plans. Those opposed to managed care view MSAs as a means to maintain the market for indemnity insurance and fee-for-service health care delivery.

- Experience with MSAs is very limited. It is not clear whether they will result in savings. Some analysts predict that any potential system cost savings will be eliminated by the additional costs required to administer MSAs.

Most importantly, the CCD Health Task Force believes that allowing employers and the self-employed the option of establishing tax deductible MSAs in conjunction with high deductible catastrophic insurance coverage is not the solution to our nation's health system problems because:

- MSAs do not address the need for insurance by millions of working Americans whose employers will not contribute to the cost of health insurance; and

- MSAs do not address the need for insurance by millions of low-income individuals who are self-employed or unemployed and who cannot afford to buy health insurance.

Should you require additional information regarding this document or the CCD Health Task Force position, please contact one of the three CCD Co-Chairs listed below.

Janet O'Keeffe
American Psychological Association
202-336-5934

Peter Thomas
Amputee Coalition of America
202-466-6550

Kathy McGinley
The Arc (Association for Retarded Citizens)
202-785-3388

To: Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Bldg (LHOB)
Washington, DC 20515

May 22nd, 1995

From: Thomas Fahrner
1174 Fremont St
Santa Clara, CA 95050-4816

Re: Medical Savings Account

Mr. Moseley,

I strongly support the idea of voluntary tax free medical savings accounts. I urge you to support the passage of such medical savings account legislation. I think it is a step in the right direction. It moves us closer to a system in which each person is responsible for their own medical care.

Sincerely,

Thomas Fahrner

Thomas Fahrner
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w (408) 946-2304

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May 23, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Building, (LHOB)
Washington, DC 20515

RE: Medical Savings Accounts

Dear Mr. Moseley:

It is my understanding that the debate on the question of medical savings accounts (MSA's) is going to happen soon. I would like my statement of support for MSA's read into the *Congressional Record* for consideration by the Congress. I will call you at (202) 225.3625 on May 25 to follow up.

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Health care costs are a major concern of Americans today. No one, whether he is for, against, or undecided on the moral-political issue of individual rights or one's "right" to health care, considers health care costs a debatable issue; everyone acknowledges that costs are going up almost exponentially. Furthermore, the driving force behind health care costs is acknowledged almost universally: costs are related directly to the supply and demand of goods and services. The reason that health care costs are so high today is because there is a constant high demand for all types of health care that must be filled by relatively few, highly skilled, highly regulated (by government) providers, and paid for directly or indirectly by the government. The net result: costs that are ever increasing.

In recent years, there have been attempts to curtail the rising costs of health care, principally through managed care vehicles in the private sector, supported by the implicit and explicit threats of even *more* government regulation. With the Republican Contract with America and its aftermath, there has been a movement by the Congress to apply similar managed care methods to Medicare and Medicaid. This alone is not a rational solution to the problem. One cannot advocate, in good conscience, the use of government force to make people pay into a system all their lives and then suddenly invoke managed care tactics to make it difficult, if not impossible for them to obtain medical care, presumably that they have already paid for. Thus, medical savings accounts should be available to all
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Americans in order to bridge the transition from Medicare/Medicaid systems to a system financed by individuals without using the government as a third party payer. The MSA is a mechanism to phase out government interference into the medical markets.

The MSA is a financial vehicle that is ethically sound, in contrast to Medicare, Medicaid and the government's regulatory control of the private insurance industry. The MSA restores the political and economic power of an individual to retain property he has already earned: his money. An MSA, like an IRA, allows a person to accumulate, tax free, a certain annual amount of money for the purpose of paying for his health care as well as saving for his future. It offers him the incentive of using accrued money to pay for his medical bills out of pocket or, in the case of a medical crisis, it sets the economic stage favorable for the development of a market for individual, high deductible, catastrophic medical insurance.

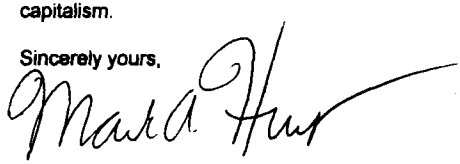
For those older individuals who have already paid into the Medicare/Medicaid system for many years, they could receive whatever benefits of the system as it exists but, in addition, could also begin sequestering their future earnings into an MSA for any future medical needs.

An MSA gives younger individuals an opportunity to take charge of their own health care before their money is removed and funneled into a third party payer system such as Medicare. Over the course of such an individual's life, he would be able to accumulate far more than any Medicare/Medicaid system could ever offer him -- *without the bureaucracy.* More fundamentally, he could save his money under a system of political freedom and voluntary action, rather than the current system of involuntary monetary expropriation via taxation by the government.

Mr. Moseley, I implore you and the Congress to consider seriously the moral and medical implications of MSA's for the future all Americans. It is morally right that a person in this country be able to retain that which he has earned. Happily, what is moral is also practical. When people spend their own money in seeking goods or services, they have a powerful personal incentive to search for the best services available at the lowest price, which ultimately will decrease the overall cost of providing health care to patients.

Health care that is "purchased" at the price of individual rights and political freedom is slavery. In reforming our health care system, we must reclaim America's philosophical foundation, which is individual liberty and its corresponding political-economic system: capitalism.

Sincerely yours,



Mark A. Hurt, MD

P. Michael Hutchins
911 North Road
Carlisle, MA 01741

22MAY95

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Building, (LHOB)
Washington, DC 20515

Mr. Moseley:

The institution of medical savings accounts would be an important step towards giving back some control over their future to the people who are the heart and engine of this country (those who produce the wealth that they need to live).

No medical system can work, long term, that is built upon a foundational structure that puts primary emphasis on entities other than the beneficiary paying for medical care. Before our wonderful, unequalled medical system is destroyed, please work to establish at least this tiny island of sanity.

Sincerely,

P Michael Hutchins

P. Michael Hutchins

May 22, 1995

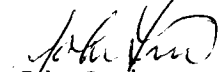
Mr. Phillip Moseley
Majority Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Mr. Moseley,

I am strongly in favor of passing a bill to institute MEDICAL SAVINGS ACCOUNTS. It is the only way to take responsibility for myself and provide for my medical future. It's voluntary, tax free and it gives me the right to choose what kind of health care I want and when.

Remember---- HEALTH CARE IS NOT A RIGHT!!!

Sincerely,



John Lewis
1548 Middle Rd.
E. Greenwich, RI 02818

May 21, 1995

Larry Salzman
7500 Parkway Dr. #304
La Mesa, CA 91942

Mr. Phillip Mosley
Majority Chief of Staff
House Ways & Means Commitee
1102 LHOB
Washington, DC 20515

Dear Mr. Mosley,

As an American I have a strong interest in the future of freedom for our nation. As such, the recent debate concerning the adoption of socialized medicine is of grave concern to me. Fortunately, reason has temporarily prevailed on this issue. The real problems with our medical system which gave rise to President Clinton's ill-conceived solution, however, still exist. Costs have skyrocketed, many Americans do not have access to medical care and worse, doctors have come increasingly under control of onerous regulation - replacing the sanctity of their scientific judgment with the edicts of beauracrats and hospital administrators.

The above looms ominous in my desire for reliable, affordable, innovative medical care for me, my family and others I care for. I believe that freedom breeds prosperity and that prosperity is the prerequisite of innovation, affordability and reliability - in medicine as in all other human endeavors. The solution to our medical woes, therefore, must begin with the extension of freedom to this vital human need. Tax-Free Savings Accounts for individuals wishing to provide for their own medical expenses is a healthy first step toward extending freedom for medical consumers and providers. Please seriously consider the adoption of this modest first step into a free medical marketplace as you deliberate over how to solve the real problems with the medical system in the United States.

Sincerely,

Larry Salzman

Henry L. Solomon
77 Seventh Avenue – Apt 16V
New York, New York 10011
212-243-3364

May 23, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Buildings (LHOB)
Washington, DC 20515

Dear Mr. Moseley,

I would like to express my full support for Tax Free Voluntary Medical Savings Accounts as an important step forward in getting ~~the~~ government out of the business of making potentially life and death medical decisions on behalf of free citizens who should be left free to use their own independent judgement to lead their own lives, and seek their own happiness as befits a free people

Sincerely,
Henry C. Solomon

○

H.R. 1818, THE FAMILY MEDICAL SAVINGS AND INVESTMENT ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JUNE 27, 1995

Serial 104–80

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104TH CONGRESS
1ST SESSION

H. R. 1818

To amend the Internal Revenue Code of 1986 to allow a deduction for contributions to a medical savings account by any individual who is covered under a catastrophic coverage health plan.

IN THE HOUSE OF REPRESENTATIVES

JUNE 13, 1995

Mr. ARCHER (for himself, Mr. JACOBS, Mr. THOMAS, Mr. DELAY, Mr. CRANE, Mr. SHAW, Mr. BUNNING of Kentucky, Mr. HOUGHTON, Mr. HERGER, Mr. MCCRERY, Mr. HANCOCK, Mr. CAMP, Mr. RAMSTAD, Mr. ZIMMER, Mr. NUSSLE, Mr. SAM JOHNSON of Texas, Ms. DUNN of Washington, Mr. COLLINS of Georgia, Mr. PORTMAN, Mr. ENGLISH of Pennsylvania, Mr. ENSIGN, Mr. CHRISTENSEN, Mr. SOLOMON, Mr. YOUNG of Alaska, Mr. MYERS of Indiana, Mr. DORNAN, Mr. SMITH of Texas, Mr. ROHRABACHER, Mr. FROST, Mr. HALL of Texas, Mr. BURTON of Indiana, Mr. LIPINSKI, Mr. TORRICELLI, Mrs. VUCANOVICH, Mr. SAXTON, Mr. CALLAHAN, Mr. GALLEGLY, Mr. PICKETT, Mr. UPTON, Mr. POSHARD, Mr. STEARNS, Mr. BARTLETT of Maryland, Mr. BREWSTER, Mr. CRAPO, Mr. HILLEARY, Mr. INGLIS of South Carolina, Mr. KNOLLENBERG, Mr. MANZULLO, Mr. ROYCE, Mr. TALENT, Mr. CHAMBLISS, Mr. CHRYSLER, Mr. GANSKE, Mr. JONES, Mr. LARGENT, Mr. THORNBERRY, Mr. WATTS of Oklahoma, Mr. WELLER, Mr. WHITE, Mr. WICKER, Mr. HOKE, and Mrs. JOHNSON of Connecticut) introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend the Internal Revenue Code of 1986 to allow a deduction for contributions to a medical savings account by any individual who is covered under a catastrophic coverage health plan.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Family Medical Savings and Investment Act of 1995".

SEC. 2. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

"(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the lesser of—

"(A) $2,500, or

"(B) the deductible under the catastrophic health plan covering such individual.

If the catastrophic health plan covering such individual provides coverage for any other eligible individual who is the spouse or any dependent (as defined in section 152) of the taxpayer, subparagraph (A) shall be applied by substituting '$5,000' for '$2,500'.

"(2) PRORATION OF LIMITATION.—

"(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

"(i) such individual is not an eligible individual for all months of the taxable year,

"(ii) the deductible under the catastrophic health plan covering such individual is not the same throughout such taxable year, or

"(iii) such limitation is determined using the last sentence of paragraph (1) for some but not all months during such taxable year.

"(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount equal to 1/12 of the limitation which would (but for this paragraph and paragraph (3)) be determined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a catastrophic health plan were true for the entire taxable year.

"(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS, INCLUDING TRANSFERS FROM FLEXIBLE SPENDING ARRANGEMENTS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

"(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

"(B) in a case described in paragraph (4)(B), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

"(4) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

"(A) IN GENERAL.—This subsection shall be applied separately for each married individual and without regard to any community property laws.

"(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same catastrophic health plan, then the amounts applicable under subparagraphs (A) and (B) of paragraph (1) shall be divided equally between them unless they agree on a different division.

"(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(c) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to any month, any individual—

"(A) who is covered under a catastrophic health plan at any time during such month, and

"(B) who is not, while covered under a catastrophic health plan, covered under any health plan—

"(i) which is not a catastrophic health plan, and

"(ii) which provides coverage (other than permitted coverage) for any services which are covered under the catastrophic health plan.

"(2) CATASTROPHIC HEALTH PLAN.—The term 'catastrophic health plan' means any health plan which provides no compensation for an individual's expenses covered by the plan (other than for permitted coverage) for any calendar year to the extent such expenses for such calendar year do not exceed $1,800 ($3,600 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

"(3) PERMITTED COVERAGE.—The term 'permitted coverage' means—

"(A) coverage only for accidents, dental care, vision care, disability income, or long-term care insurance,

"(B) Medicare supplemental health insurance,

"(C) coverage issued as a supplement to liability insurance,

"(D) liability insurance, including general liability insurance and automobile liability insurance,

"(E) worker's compensation or similar insurance,

"(F) automobile medical-payment insurance,

"(G) coverage for a specified disease or illness, and

"(H) a hospital or fixed indemnity policy.

"(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution described in subsection (f)(3), no contribution will be accepted unless it is in cash.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder—

"(i) for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any depend-

ent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise, or

"(ii) for long-term care insurance for such individual, spouse, or dependent.

"(B) HEALTH PLAN COVERAGE MAY NOT BE PURCHASED FROM ACCOUNT.—

"(i) IN GENERAL.—Such term shall not include any amount paid for coverage under a health plan unless such plan is a catastrophic health plan.

"(ii) EXCEPTION.—Clause (i) shall not apply to any amount paid for long-term care insurance.

"(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

"(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

"(A) Section 219(d)(2) (relating to no deduction for rollovers).

"(B) Section 219(f)(3) (relating to time when contributions deemed made).

"(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

"(D) Section 408(h) (relating to custodial accounts).

"(e) TAX TREATMENT OF ACCOUNTS.—

"(1) ACCOUNT TAXED AS GRANTOR TRUST.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the account holder of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

"(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this

subparagraph, all medical savings accounts of the account holder shall be treated as 1 account.

"(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

"(f) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder shall be included in the gross income of such holder to the extent such amount does not exceed the excess of—

"(i) the aggregate contributions to such account which were allowed as a deduction under this section or which were excluded under section 106(b), over

"(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account holder shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 10 percent of the amount of such payment or distribution

which is includible in gross income under paragraph (1).

"(B) DISABILITY OR DEATH CASES.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

"(3) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the account holder if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such holder not later than the 60th day after the day on which he received the payment or distribution.

"(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

"(g) COST-OF-LIVING ADJUSTMENT.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1996, each dollar amount in subsection (b)(1) or in subsection (c)(2) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1995.

"(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and

in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations."

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

"(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220."

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 of such Code (relating to contributions by employer to accident and health plans) is amended to read as follows:

"(a) GENERAL RULE.—Gross income of an employee does not include employer-provided coverage under an accident or health plan.

"(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

"(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee. For purposes of the preceding sentence, the

terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.

"(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

"(3) TRANSFERS FROM FLEXIBLE SPENDING ARRANGEMENTS.—

"(A) IN GENERAL.—A flexible spending arrangement for health shall not cease to be treated as such an arrangement, and no amount shall be includible in the gross income of the employee, solely because amounts not paid out as reimbursements under such arrangement are contributed to a medical savings account of such employee.

"(B) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this paragraph, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(i) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(ii) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

"(4) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year."

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 of such Code is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after

paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting "; or", and by inserting after paragraph (18) the following new paragraph:

"(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include

any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able

to exclude such payment from income under section 106(b)."

(d) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to tax on prohibited transactions) is amended—

(1) by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.", and

(2) by inserting "or a medical savings account described in section 220(d)" in subsection (e)(1) after "described in section 408(a)".

(e) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended—

(1) by inserting "**OR ON MEDICAL SAVINGS ACCOUNTS**" after "**ANNUITIES**" in the heading of such section, and

(2) by adding at the end of subsection (a) the following: "The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure to so file unless it is shown that such failure is due to reasonable cause."

(f) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 220. Medical savings accounts.
"Sec. 221. Cross reference."

(2) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

○

H.R. 1818, THE FAMILY MEDICAL SAVINGS AND INVESTMENT ACT

TUESDAY, JUNE 27, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 11 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 15, 1995
No. HL-12

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Thomas Announces Hearing On H.R. 1818, The "Family Medical Savings And Investment Act Of 1995"

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on H.R. 1818, the Family Medical Savings and Investment Act. **The hearing will take place on Tuesday, June 27, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 11:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses. Any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The fact that Americans with conventional health insurance have few incentives to buy medical services carefully or benefit from staying well are major factors affecting health care cost growth. One approach to providing incentives for Americans to be more cost conscious purchasers of medical services is to make available alternatives to conventional insurance such as medical savings accounts (MSAs). Medical savings accounts are used to pay for out-of-pocket medical expenses up to a catastrophic limit after which costs would be covered by insurance. MSAs would give people more control over their health care dollars and the opportunity to save the MSA funds not spent that year for future health care needs.

H.R. 1818, the Family Medical Savings and Investment Act of 1995, allows individuals who are covered by a catastrophic health plan to maintain a medical savings account to assist in saving for expenses not covered by the health plan. Within limits, contributions would be excludable from gross income if made by the employer and deductible if made by the individual. In general, the amount of the individual or employer contributions that could be deducted or excluded for a taxable year would be the lesser of (1) the deductible under the catastrophic health plan, or (2) $2,500 if the MSA covers only the individual or $5,000 if the MSA covers the individual and the spouse or a dependent of the individual. Withdrawals from an MSA would be excludable from income if used for medical expenses for the individual and his or her spouse or dependents.

In announcing the hearing, Chairman Thomas stated: "The American people know that health care spending must be reduced -- it takes an ever increasing bite out of the average family paycheck. What we are trying to do with this bill is provide people with a tool to help them take control of their own health care spending."

FOCUS OF THE HEARING:

The hearing will examine the issues involved in expanding health care coverage options available to individuals and families under H.R. 1818. The Subcommittee is particularly interested in technical issues involved in implementation of the MSAs established in H.R. 1818.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, July 18, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. The Health Subcommittee will come to order, please.

Today, the Health Subcommittee will receive testimony on H.R. 1818, the Family Medical Savings and Investment Act of 1995. I am pleased to be an original cosponsor of what I believe to be an important health reform and tax legislation bill. It has been developed by the Chairman of the Ways and Means Committee, Congressman Bill Archer, and our distinguished colleague from the Committee, Congressman Andy Jacobs.

H.R. 1818 amends the Tax Code to allow Americans who are covered by a catastrophic health insurance plan to maintain a medical savings account, which we normally call MSAs, to assist in paying for medical expenses not covered by their health plan.

Providing Americans with MSAs combined with catastrophic health coverage is an alternative to congressional health insurance. The MSA concept has, frankly, caught the imagination of the general public as well as many of the Representatives here in Congress.

It is an attractive alternative to conventional health insurance, I believe, because it would contribute to two of the most important goals of health reform. First, it would assist in expanding affordable health coverage for Americans, and second, MSAs would promote personal responsibility in cost conscience purchasing of medical services.

The old-fashioned fee-for-service form of health insurance leaves physicians and their patients with little knowledge and, therefore, little concern about the costs of particular treatments or procedures. Historically, health insurance has been there to pay, so often neither the physician nor their patients have spent medical care dollars carefully.

In addition, as the old style indemnity insurance has grown in cost, it has fueled medical inflation. The old style insurance has itself become a factor in the decline in coverage as employers and individuals have found it more difficult to bear the burden of such costly health insurance.

Coverage by coordinated care arrangements, such as health maintenance organizations, have proved defective in curbing health care costs. But in our pluralistic society, many employers and individuals see choice of additional strategies to health care coverage as a plus in working the affordability game. MSAs are one such alternative.

This approach will enhance coverage by keeping it affordable. And unlike most employer plans, MSAs are truly portable, following an employee when he or she leaves a job, changes jobs, or retires.

MSAs also empower the individual in regard to medical care purchasing, I believe, and an individual with an MSA will benefit from taking responsibility for staying well and avoiding health costs or buying carefully when medical services are necessary.

These new incentives for individual consumers of health care should keep costs down, since those with MSAs are personally responsible for how much they spend on a significant portion of their health care needs.

H.R. 1818 provides Americans with more choices. Combined with the freedom to make their own medical care decisions, these choices can make health care more affordable for those with MSAs while increasing the awareness of health care costs.

I look forward to the testimony not only from our distinguished colleagues but from the other panels today to shed more light on MSAs and how they work.

Ordinarily Chairman Archer, the sponsor of the bill, would lead off the testimony. He is unavoidably delayed until a little bit later in the hearing, and, therefore, before hearing from our colleague, the principal cosponsor of the bill, Andy Jacobs of Indiana, I would recognize the Ranking Member, Mr. Stark.

Mr. STARK. Well, Mr. Chairman, since it is raining this week, I will include a little rain on the parade.

I appreciate your having these hearings, but I think medical savings accounts are a scam. They would transfer money from people who are sick or are liable to become sick or pregnant to those who have the good fortune to be healthy.

They are especially skewed to benefit healthy people in high tax brackets at the expense of taxpayers in general. And, worse, if they caught on, they would undermine the entire health care system by making insurance less affordable for anyone who has a high probability of having high medical expenses.

MSAs are a brilliant scheme to skim healthy people out of the insurance pool, leaving those who are sick or who are planning a baby at increasingly expensive traditional plans. And the MSAs would force traditional plans to increase their premiums to make up for the money that MSAs take out of the pool.

MSAs allow people to pay for otherwise uninsured's medical expenses out of tax free income. Insurance companies that would benefit financially from these plans have been quick to tout the advantage of this approach. In fact, one of the major proponents is a company already notorious for its efforts to exclude sick people from its insurance pool. But more objective analysts, including the American Academy of Actuaries, have pointed out that while MSAs may be great for people who are both healthy and in a high tax bracket, those who are sick and taxpayers in general will be paying for the windfalls that go to those rich folks. And while the healthy and wealthy few save money, resources available for health care in general will shrink, and most families will risk paying much more in health care costs out of their own pockets.

The proponents of MSAs rest their arguments on a large fallacy, and the fallacy is that overall health care expenditures will be reduced if tax preferred medical savings accounts are made available. There is no evidence to this effect, and certainly no evidence that the public in general has any concept of how to purchase health care or what it costs.

Health care decisions are made in large part by health care providers, not the patients. In fact, there is a potential for health care costs to actually rise for the individuals that move out of highly managed HMOs or move out of plans with significant provider discounts and into MSA plans with very loose utilization and fee controls.

Putting off a tetanus shot or a flu shot may save a buck today, but it may very well end up costing a whole lot more tomorrow. For the healthy, there may be a reduction in the premium for their health care coverage, but for those remaining in the standard policies, they will see a premium jump. Again, overall, there is no proof that health care expenditures will be reduced as a result of the availability of MSAs.

Thank you, Mr. Chairman.

Chairman THOMAS. And for the rest of the story, the gentleman from Indiana, Mr. Jacobs.

STATEMENT OF HON. ANDREW JACOBS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. JACOBS. Thank you, Mr. Chairman.

Obviously, Mr. Stark's and my view of this is slightly different. I am not in the habit of perpetrating scams, but it is in the eyes of the beholder, I suppose.

The explosion in medical inflation occurred in the United States, I believe the record will show, around 1965–1966, in the late sixties. Coincident with that explosion was the advent of Medicare, a very deep pocket. It was begun on an unfortunate model; namely, that of the Pentagon—the infamous "cost plus contract," which meant that whatever your costs are would determine your profit; the higher the cost, the higher the profit. It was an invitation to excess and to waste.

By 1983, the Reagan administration—I had the honor of being one of your predecessors, Mr. Chairman—the Reagan administration proposed the diagnostically related groups and the prospective payment to cease that kind of nonsense and inject a little bit of market incentive into the Medicare systems. If we had not passed that law in 1983, God knows what would be left of Medicare now more than a decade later.

The literature is rife with articles about third party payers. My colleague, Mr. Christensen, has a very bad cold now. If he goes to see a doctor, he will get over it—with all due respect to my friend from Nevada, if he goes to see a doctor—we are not talking about broken legislation now—he will get over it in 6 days. And if he does not go to see a doctor, he will get over it in 6 days.

Now, if you are paying his bill and the doctor tells great jokes, then maybe John would be tempted to go on over anyway. Or if I have a hangnail and my doctor tells good jokes I might go anyway. The point being that there is a difference between using money that does not seem like yours and money that is yours. That is what the medical savings account is all about.

My friend Pete says, well, there is no proof that that will save money. To me, that is like saying there is no proof that if you do push-ups you will be in better shape. It has been proved at the Forbes organization, for example.

I listened to a woman in a meeting explain that with her medical savings account she went to see a doctor who said she needed an operation that cost $8,000. Well, she had the medical savings. That is her money. So, she goes to a second one and says, you are crazy, that guy is ripping you off, I can do it for $4,000. But she even went to a third doctor and he said, you're really crazy, you do not

need an operation at all. Now, Pete, there is $8,000. Chalk that up. And that can be multiplied by millions of people.

I hear it said that it will shrink the pool of insurance money to pay medical bills. Of course it will. That is exactly what we are trying to do. If you shrink the prices, the proportion of the U.S. economy that puts money into medical care will shrink. You will not need as much insurance at that point.

And finally, Mr. Chairman—by the way, when I chaired this Committee I always allowed each witness two "finallies" and one "in conclusion." I will see if I can make it on the finally.

In the old days, if you had a fender-bender you went to the insurance company and the first question the guy with the clipboard would ask is, is this an insurance job, and you knew what the price was going to be if it was, and you knew what the price was going to be if it was not.

Cha-cha and off.

Chairman THOMAS. And, in conclusion, I thank the gentleman from Indiana.

The gentleman from Nebraska, Member of the Subcommittee, Mr. Christensen.

STATEMENT OF HON. JON CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. CHRISTENSEN. Thank you, Mr. Chairman, and as Mr. Jacobs has already stated, I am experiencing a summer cold, so if I start to hack and cough I will apologize profusely to the Committee.

Thank you for your leadership in this area and for having these hearings today. Medical savings accounts, or MSAs, are a revolutionary idea whose time has come. Although there are countless variations, MSAs generally allow individuals to save money in a tax exempt account, much like an IRA. Instead of purchasing an expensive first-dollar type of insurance policy, the individual would purchase a less costly, high-deductible catastrophic health insurance policy to cover major medical expenditures. The individual can use the money in the MSA to cover routine medical expenses with the catastrophic policy covering major medical expenses.

MSAs have many benefits. First, MSAs create strong incentives for cost and quality conscious health care decisionmaking. Most health care experts will tell you that the main reason health care costs have skyrocketed in recent years is because there is little or no price sensitivity in health care purchases. Under the third party payer payment model that currently dominates our health care system, transactions between health care providers and individuals are paid by a third party such as an insurance company or the government.

Current estimates reveal that 95 percent of hospital bills and over 80 percent of physician fees are paid by some third party. This system perpetuates the misconception that someone else is picking up the health care tab and, thus, the individual does not have to worry about the cost or the need for care. This has created increased health care consumption, which in turn has caused inflationary pressure on health care costs.

MSAs alleviate this problem by giving people control over their own health care dollars. When they know and understand it is

their own money they are spending, individuals are much more careful and selective about the medical services they use. The increased price sensitivity results in more efficient use of health care resources, and, thus, lower health care costs.

The Rand Corp. has confirmed this. In a study conducted in the early eighties, researchers studied the health care decisions of over 2,000 families. What they discovered was that the lower the health insurance deductible, the greater the utilization with no discernible difference in health outcomes. When these findings are extrapolated, the Rand study shows when people are spending their own money on health care, they spend 30 percent less with no adverse effect on health.

Second, MSAs encourage savings by individuals. Our country is facing a savings crisis. We have the lowest savings rate in the industrialized world. As a matter of public policy, we must do everything we can to encourage people to save money. MSAs provide a vehicle for employees to save their hard-earned dollars. Unlike flexible spending accounts where the funds in the account remain the property of the employer and any unused funds traditionally revert to the employer, all money in an MSA belongs to the individual. This money can be saved by the individual to cover future health care expenses.

Third, MSAs are completely portable. One of the greatest concerns that I hear from Nebraskans and others about is "job lock," the situation which individuals are scared to leave their current job because they might lose their health insurance. MSAs, unlike traditional employer-provided health insurance, follow the individual. They allow individuals to save money that can cover health care expenditures and insurance during temporary loss of employment.

And, finally, MSAs are a proven tool in cutting health care costs with no adverse effect on the individual's health. We have heard numerous examples from Dominion Resources to Quaker Oats to Golden Rule to even my colleague on my right and his company where they testified last month before our Committee.

In conclusion, I want to touch just briefly on the issue that we have been working on, that we will be working on later this year, and that is the Medicare problem. I believe that MSAs also hold a solution facing us with that problem.

Last month, we heard an individual from the National Center for Policy Analysis, Peter Ferrara, testify and highlight a proposal from Dr. John Goodman about how MSAs can help in reducing the consumption with Medicare. I truly believe that using the MSAs with the Medicare dilemma we are faced with to help create an advantageous system for seniors, allow more opportunity, more cost consciousness and place for emphasis on the individual.

I truly believe that MSAs are part of the answer to every phase whether it is private, Medicare, or the entire health care system. It is truly a revolutionary idea that has come.

I thank the Chairman for holding these hearings and thank you. I will be glad to answer any questions and would ask that my full testimony be entered into the record.

Chairman THOMAS. Without objection, all the written testimony of the Members will be made a part of the record.

[The prepared statement follows:]

Testimony of Representative Jon Christensen
Before the Health Subcommittee
of the
Committee of Ways and Means
June 27, 1995

Mr. Chairman, I want to thank you and the other members of the Subcommittee for this opportunity to testify today regarding a health care reform measure that represents a significant step in solving the problems facing our health care system. What I'm referring to, of course, is the Medical Savings Account.

Medical Savings Accounts, or MSAs, are a revolutionary idea whose time has come. Although there are countless variations, MSAs generally allow individuals to save money in a tax-exempt account, much like an IRA. Instead of purchasing an expensive "first-dollar" type of insurance policy, the individual would purchase a less costly, high-deductible catastrophic health insurance policy to cover major medical expenditures. The individual can use the money in the MSA to cover routine medical expenses with the catastrophic policy covering major medical expenses.

MSAs have many benefits. First, MSAs create strong incentives for cost- and quality-conscious health care decision making. Most health care experts will tell you that the main reason health care costs have skyrocketed in recent years is because there is little or no price-sensitivity in health care purchases. Under the third-party payment model that currently dominates our health care system, transactions between health care providers and individuals are paid by a third party such as an insurance company or the government. Current estimates reveal that 95 percent of hospital bills and over 80 percent of physician fees are paid by some third party. This system perpetuates the misconception that someone else is picking up the health care tab and, thus, the individual doesn't have to worry about the cost or need for care. This has created increased health care consumption, which in turn has caused inflationary pressure on health care costs.

MSAs alleviate this problem by giving people control over their own health care dollars. When they know and understand that it's their own money they are spending, individuals are much more careful and selective about the medical services they use. This increased price sensitivity results in more efficient use of health care resources and, thus, lower health care costs.

The Rand Corporation has confirmed this. In a study conducted in the early 1980s, researchers studied the health care decisions of over 2,000 families. What they discovered was that the lower the health insurance deductible, the greater the utilization with no discernible difference in health outcomes. When these findings are extrapolated, the Rand study shows that when people are spending their own money on health care they spend 30 percent less with no adverse effect on health.

Second, MSAs encourage savings by individuals. Our country is facing a savings crisis; we have the lowest savings rate in the industrialized world. As a matter of public policy we must do everything we can to encourage people to save money. MSAs provide a vehicle for employees to save their hard-earned dollars. Unlike Flexible Spending Accounts (FSAs), where the funds in the account remain the property of the employer and any unused funds traditionally revert to the employer, all money in an MSA belongs to the individual. This money can be saved by the individual to cover future health care expenses.

Third, MSAs are completely portable. One of the greatest concerns that I hear from Nebraskans and others about is "job-lock" -- the situation in which individuals are scared to leave their current job because they might lose their health insurance. MSAs, unlike traditional employer-provided health insurance, follow the individual. They allow individuals to save money that can cover health care expenditures and insurance during temporary lapses in employment.

Finally, MSAs are a <u>proven</u> tool in cutting health care costs with no adverse affect on the individual's health. We've all heard how *Forbes* magazine, Dominion Resources,

Quaker Oats, Golden Rule Insurance Company and others have successfully implemented MSA-type accounts to the benefit of both employer and employee.

For example, last month Tom Erhart, Vice-President for Human Resources for RCI, a Michigan-based automotive specialty company, testified before this Subcommittee on MSAs. Mr. Erhart told the Subcommittee that since implementing its MSA program, the company was able to: (1) increase the level of benefits to its employees while reducing its health insurance costs by nearly 15 percent; (2) return, on the average, over $1,000 to nearly 75 percent of its employees; and (3) significantly reduce employer and employee paperwork. As Mr. Erhart put it, it's a "win-win situation for employer and employee."

It is for these reasons that I am a proud original cosponsor of H.R. 1818, Chairman Archer's Family Medical Savings and Investment Act of 1995. This historic piece of legislation provides that individuals covered by a catastrophic health plan, *i.e.*, a plan that has a deductible amount of at least $1,800 per individual or $3,600 for more than one person -- will be eligible for tax relief for maintaining and using an MSA for medical expenses not covered by the health plan. Where contributions are made by an employer, contributions would be excluded from the employee's gross income. Where contributions are made by an individual, contributions would be tax deductible. In both instances withdrawals from an MSA would be excluded from income if used for medical expenses for an individual and their family. I'm confident that this important measure will be passed in the 104th Congress as yet another plank in the incremental health care reform platform Republicans have proposed in order to "zero-in" on specific problems with our health care system.

Before I close, I want to briefly touch on the tremendous potential MSAs hold in helping us save Medicare from financial ruin while at the same time giving our nation's seniors improved health care benefits and quality.

By now hopefully we all understand that Medicare is going broke. The Trustees of the Medicare Trust Fund, including four of President's Clinton's own appointees, recently

announced that, beginning next year, Medicare will spend more than it takes in. By 2002, it will be completely bankrupt. If this happens, no one in America will have Medicare--*No one*. Something must be done to protect, preserve and improve this vital program. It must be done in a manner that gives our nation's seniors more choices in health care; that gives them better, higher quality health care; and, most importantly, ensures that Medicare will be there for them and for generations to come.

I'm hopeful that MSAs will play a vital role in achieving these goals. During last month's hearings on the potential role that MSAs might have in the Medicare program, I was especially impressed with testimony of Peter Ferrara, a Senior Fellow with the National Center for Policy Analysis out of Dallas, Texas. Mr. Ferrara highlighted a proposal that he and Dr. John Goodman, the father of MSAs, drafted. Under that proposal, seniors would be free to withdraw their share of Medicare spending each year and use it to purchase private coverage of their choice, including an MSA option. Under the MSA option, the senior would use part of the funds to purchase a high-deductible health insurance policy. The remaining funds would be placed in an MSA and used to pay for medical expenses below the deductible. The senior citizen would be able to withdraw any remaining MSA funds at the end of the year and use them for any purpose. Like MSAs in the non-Medicare setting, MSAs for Medicare recipients would create effective incentives for recipients to be cost- and quality-conscious in their health care decisions while at the same time providing seniors with greater choice of health care providers and services.

In closing, I want to again thank you Mr. Chairman and my colleagues on the Subcommittee for the opportunity to testify before you today. When I began my campaign for the United States Congress nearly two years ago, this nation was facing one greatest public policy challenges it has ever faced. Health care reform was the hot topic and everyone was looking for ways to halt skyrocketing costs and address such problems as portability and pre-existing conditions. The current occupants of the White House were advocating the government takeover of one-seventh of our nation's economy as the solution to these problems. I took a different route. I campaigned on a little-known reform called the Medical Savings Account because it was the free-market alternative to the government-knows-best type of reform that was being proposed. Health care decisions are best made by individuals, not governments. It made sense two years ago. It makes sense today.

Thank you.

Chairman THOMAS. Now we will hear from our friend, the Chairman of the House Agriculture Committee, the gentleman from Kansas, Mr. Roberts.

STATEMENT OF HON. PAT ROBERTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. ROBERTS. I thank the Chairman not only for his leadership but for his strong support of the MSA concept, the medical savings account concept, and would only opine, in regard to Mr. Stark's observation that he is raining somewhat on the MSA parade, that you do not necessarily have to be that Al Capp character in regard to Li'l Abner, which really dates me, Joe Boozlefoop, or whatever his name was—Mr. Jacobs has the name, you know, I can't remember that—but, at any rate, this is not really doom and gloom. It is just not a program to get the wealthy and the healthy to take away or skim and scam or film and flam in regards to your regular policyholders.

My remarks come, obviously, because of my association with the House Agriculture Committee. One quarter of the U.S. population, about 65 million persons, do reside in the rural areas. We have very special characteristics and special needs that pose challenges to providing our rural health care services. We are more likely than the urban residents to be simply uninsured. We are often out of the mainstream of employment-based health insurance coverage because we are self-insured farmers and ranchers or small business people or seasonally employed workers such as a custom cutter.

Many rural residents are employed by small businesses that do not provide health insurance benefits or are unemployed altogether. As a result, a higher proportion of our residents must purchase individual health insurance policies on their own. These policies are generally more costly than the group coverage and make the coverage less affordable in the rural area.

But we in rural America are used to developing our own solutions to our health care problems. Rural consumers are not looking for more Federal handouts or any more regulatory schemes. Rural Americans are looking for the proper tools to make their own decisions and to help themselves. The medical savings accounts are such a tool that will help our farmers and ranchers and our small business people certainly meet their health care needs.

The farmers and small business folks really prefer an approach to health insurance coverage that puts them in charge of their own health care dollars. The family savings account does just that. This approach will allow the individual to control their spending through the use of a high-deductible and catastrophic plan combined with the MSA trust to pay for the smaller medical bills. These plans encourage savings and responsible spending decisions. They help ensure that individuals and families have the adequate health insurance in times of economic hardship or unemployment. Since they are portable, they also really start to eliminate the fear of losing health benefits due to a job loss or a change. And finally, the individuals have the option to choose the plan that works best for them.

I know we are moving into a new managed care world. The MSA, the medical savings account will become an even more important

tool in rural areas. This is partly because there are not many doctors or hospitals to manage in a rural area.

I have often asked the question, how do you manage care that is not there? While I support efforts to really try to integrate the health services and strongly encourage the networking of facilities and providers, managed care is simply not readily available in much of our rural areas. Many rural health care consumers are a little nervous about the possibility of someone or some corporation simply coming into their community and telling them where they will have to go for care. If individuals are in control of their own health spending through a medical savings account, they are also in control of choosing their own doctor and their health care facility. Until the managed care becomes, and I would say if and when it becomes, more established in the underpopulated rural areas, the MSAs will protect and preserve the right of the patients to choose his or her own family doctor.

Mr. Chairman, we had hearings in the sometimes powerful House Agriculture Committee with the former Chairman Kika de la Garza, and we heard from all sorts of rural health care providers, and the support was across the board, the Farm Bureau, the Wheat Growers, other commodity groups; all farm organizations endorsed the MSA.

I want to thank you for your leadership in this regard. I want to thank you for restoring the tax deduction for the self-employed up to 25 percent; it will be 30 next year. That is part of the answer. The MSA is part of the answer. I urge swift and favorable passage of this act and I thank you, sir, for the opportunity.

[The prepared statement follows:]

TESTIMONY OF REP. PAT ROBERTS
FAMILY MEDICAL SAVINGS ACCOUNTS
HEARING BEFORE THE
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
JUNE 27, 1995

Mr. Chairman, thank you for the opportunity to discuss health insurance reform with you today, particularly Medical Savings Accounts (MSAs) and their impact on the health of rural Americans. I am pleased that this committee has introduced legislation which will greatly improve the health care insurance options for all Americans, rural and urban alike.

One-quarter of the U.S. population--about 65 million persons--reside in rural areas. Rural communities have unique characteristics and special needs that pose challenges to providing rural health care services. Rural residents are more likely than urban residents to be uninsured. They are often out of the mainstream of employment-based health insurance coverage because they are self-insured farmers and ranchers or seasonally employed workers such as custom harvesters. Many rural residents are employed by small businesses that do not provide health insurance benefits or are unemployed altogether. As a result, a higher proportion of rural residents must purchase individual health insurance policies on their own. These policies are generally more costly than group coverage and make health insurance coverage less affordable in rural areas.

However, compromise is a way of life for rural residents and we in rural America are used to developing our own solutions to health care problems. Rural consumers are not looking for more federal handouts or regulatory schemes. Rural Americans are looking for the proper tools to make their own decisions and help themselves. Medical Savings Accounts (MSAs) are one such tool that will help farmers and ranchers meet their health care needs.

Farmers and small business proprietors prefer an approach to health insurance coverage that puts them in charge of their own health care dollars. The Family Medical Savings and Investment Act does just that. This approach will allow individuals to control their spending through the use of a high deductible catastrophic plan combined with the MSA trust to pay for smaller medical bills. These plans encourage savings and responsible spending decisions. MSAs help ensure that individuals and families have adequate health insurance in times of economic hardship or unemployment. Since MSAs are portable, they also eliminate the fear of losing health benefits due to a job loss or change. Furthermore, individuals have the option to choose the plan that works best for them.

As we move into a new "managed care world", MSAs will become an even more important tool in rural areas. This is partly because there are not many doctors or hospitals to manage in rural areas. I've often asked the question, "How do you manage care that is not there"? While I support efforts to integrate health services and strongly encourage the networking of facilities and providers, managed care is simply not readily available in much of rural America. Many rural health care consumers are a little nervous about the possibility of someone or some corporation coming into their community and telling them where they will have to go for care. If individuals are in control of their own health spending through an MSA, they are also in control of choosing their own doctor and health care facility. Until managed care becomes more established in underpopulated rural areas, MSAs will protect and preserve the right of the patient to choose his or her own family doctor.

The House Agriculture Committee held a hearing on rural health care last March where I heard from a variety of rural health providers and consumers from across the country. The theme of "freedom of choice" and "individual responsibility" came through loud and clear. Several witnesses strongly recommended that Congress create MSAs or Medi-Save accounts in order to encourage this responsibility and preserve choice. A soybean farmer from Georgia told me that "farmers can be part of the solution by designing and managing their own coverage". While MSAs may not be a panacea for health insurance, I believe they are a part of the solution.

Thanks to the work of your committee, we are making progress in our efforts to improve health care options for those in rural areas. By restoring the tax deduction for the self-employed to 25 percent earlier this year, your committee has taken the first step to bring tax fairness to rural residents. I am still hopeful we can increase this deduction to 100 percent in the near future. The Family Medical Savings and Investment Act is another step to increase insurance options and improve the health care of rural Americans.

Again, thank you for this opportunity to share my thoughts with you this morning. As always, it has been a pleasure meeting with this committee. I applaud you in your efforts to establish Medical Savings Accounts and look forward to working with you.

Chairman THOMAS. I thank the gentleman.
The gentleman from Michigan, Mr. Chrysler, welcome back.

STATEMENT OF HON. DICK CHRYSLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CHRYSLER. Thank you, Mr. Chairman, and Members of the Committee. Thank you for inviting me here today to relate to you and the American people the positive experience my company enjoys with medical savings accounts.

At my company, RCI, we use medical savings accounts as our answer for health insurance and we are proof positive that they work. Michigan had the wisdom and the vision to enact medical savings accounts in 1993. After our first year of implementation, we can already say that the program has been an enormous success. While our medical savings account plan carries substantially higher benefits than our former insurance plan, our annual health care expenditures per employee was actually reduced by $600 from $4,800 to $4,200. That is a savings of 14.3 percent in just 1 year.

At RCI, an employee with dependents received $3,000 in a medical savings account. Single employees receive $1,500 in their accounts. With this MSA, the employee can purchase any kind of health service they want, medical, dental, prescription drugs, anything they need, as long as it is medical. Any money left in the MSA at the end of the year is the employee's money to keep. Seventy-five percent of the employees at RCI received money back, usually over $1,000, at the end of our first year.

I will say that the average American will spend about $1,000 per year on health care. Coupled with the employee's medical savings accounts is a $1,500 insurance policy put into place in the event the account is exhausted. Any additional medical expenses above the MSA are paid by this policy. It is similar to car insurance, where you have a high-deductible.

For the employees, this health care plan is beneficial in two ways: First, by being in control of their health care dollars they can receive a return at the end of the year; second, it creates an incentive to take better care of themselves through preventive measures, to avoid costlier medical procedures later.

When it is the employee's own money, they will spend it wisely, asking how much it will cost, and shopping around for the best price. That is the best way to control cost. Free enterprise, alive and well.

With an average healthy life, an individual who puts money away each year from his or her medical savings accounts, compounding it over a lifetime of work, will have a substantial nest egg of well in excess of $100,000 at retirement. And that is exactly when it is needed, because about 80 percent of our health care dollars are used in the last 6 months of life.

Currently, no tax advantages exist to rollover remaining MSA accounts to the following years, leaving most employees to take the cash option at the end of the year. If Congress authorizes MSAs and grants them tax deductible status, these programs will have an unlimited appeal to both employees and employers, providing a win-win situation for everyone involved.

I truly believe we would see a dramatic reduction in health care costs nationwide with the expanded use of MSAs. In addition, if a person is unemployed for a period of time, he or she could use his or her medical savings account to continue their health insurance until they find a new job. In addition, a huge pool of money would be created by MSAs which would be a great resource capital for entrepreneurs.

Medical savings accounts could also help very costly government programs, such as Medicare and Medicaid, work better. For Medicaid, the government would give an individual on welfare an MSA voucher which could be taken to an insurance company of the individual's choice to get an MSA insurance policy. If that individual has money coming back to them at the end of the year, it should be held until they find a job, giving them another financial incentive to find work.

With MSAs in place over a period of years, the need for Medicare would be diminished greatly. If a person had accumulated approximately $100,000 in their medical savings account by age 65, that individual could purchase a super MSA from an insurance company with $100,000 deductible for the remainder of his or her life.

We need to create these types of programs to solve our long-range crisis in Medicare and Medicaid. Based upon my firsthand experience with medical savings accounts at RCI, I can honestly tell you the theory behind them works in real world application.

In my opinion, medical savings accounts provide the best health care program when it comes to the high level—when it comes to high-level benefits, employee satisfaction, freedom of choice, efficiency, and cost effectiveness. The Archer-Jacobs bill is a tremendous step toward expanding the use of this innovative approach to health care in our country and has my full support. The only scam is that the MSAs were never allowed to be reported out of a Committee in the past to be voted on by the full floor of the House.

Medical savings accounts can play a positive role in reducing health care costs and improving the health care delivery system nationally. Congress should take action now to expand MSAs as the preeminent choice in providing a free market solution for health care for all of our citizens.

Thank you.

Chairman THOMAS. I thank the gentleman.

Arriving with us on the panel is the Chairman of the Full Committee, but I would request of the Chairman—I would prefer he bat cleanup, if he does not mind, because he is going to be speaking directly to H.R. 1818 and some Members are speaking in general on the MSA. And we do want to focus as the subject of this hearing on H.R. 1818. Therefore, I will turn to the gentleman from Arizona, Mr. Salmon.

STATEMENT OF HON. MATT SALMON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SALMON. Thank you very much, Mr. Chairman. I appreciate the opportunity to testify before your Subcommittee.

I would like to congratulate Chairman Bill Archer and Representative Andy Jacobs for introducing their bill, H.R. 1818. I believe it is a fantastic step in the right direction.

I am also proud to be a cosponsor of the same bill. I would like to make a comment because I have been involved in this debate for a few years, having sponsored a medical savings account bill in the Arizona State legislature, and having successfully shepherded that through. I have heard all the arguments from A to Z as to why this is not going to work, and it predominately comes from those insurance companies that I think are paralyzed with fear they will lose market shares, and I think that is really what this gets down to.

I have heard the arguments that people will skimp when it comes to taking care of their preventive medicine, that they will not make intelligent decisions in purchasing their health care. I think that is balderdash. In fact, I do not think people are as dumb, as government believes they are. I think that individuals make better decisions than bureaucrats do and I believe that that is the same for government bureaucrats and insurance bureaucrats.

I think individuals have more of a vested interest in the successful outcomes and the health of their families than bureaucrats could ever hope to. I think the best attributes of a medical savings account are, number one, it empowers people; it allows them to shop for the best deals and it gives them incentives to control costs.

Second, it cuts dramatically administrative costs. During the course of my campaign, I spent a lot of time in hospitals, health care centers, doctors' offices, and I found that across the board, doctors are spending about 35 to 40 percent of their time on administration, on red tape and bureaucracy, and on sending paperwork to either Medicare or to insurance companies.

Let me illustrate how we can save if you are dealing on a cash basis with your health care provider.

About 7 years ago my last child was born, Matthew. The cost, through my third party payer, as with many people, was $3,500. Seven years ago, for a healthy delivery.

My sister-in-law had a baby 2 months later, same hospital, same doctor, only they didn't have insurance so they paid cash, $1,500. You cannot tell me that we are not going to see a cut, a reduction in our costs, by cutting out needless bureaucracy and paperwork.

Let's talk about the need, though, for a Federal tax incentive. I was successful in getting a State law passed in Arizona. I believe we are one of seven States now that provide State tax benefits for medical savings accounts, but it is not even close to the whole enchilada.

I think we understand that in order to really give people the incentives toward medical savings accounts, we have to have a level playingfield with other kinds of medical insurance and give the same types of tax preference to medical savings accounts we do to other kinds of coverage.

Several companies have found when they went onto MSAs they have cut their costs without the Federal tax deduction, and the Archer bill will expand this greatly. Almost 90 percent of Americans spend less than $3,000 a year on their health care expenses.

I also feel, personally, that medical savings accounts would be a great step in helping us to resolve the crisis with our Medicare system. I think that Federal employees should be able to put their government contribution toward a catastrophic plan with an MSA.

And I would love to come back and talk about that at some other time.

I do believe that individuals can make these decisions. They will make good decisions for their families if we simply level the playingfield and give the same kind of preference as we do to other types of care.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Written Statement of Rep. Matt Salmon before the Health Subcommittee of the Ways and Means Committee

June 27, 1995

As a proud cosponsor of Chairman Archer's Family Medical Savings and Investment Act of 1995, H.R. 1818, I appreciate the opportunity to testify before this subcommittee. The Ways and Means Committee, and this Health Subcommittee, should be commended for investigating Medical Savings Accounts (MSA's), and Chairman Archer and his staff deserve our thanks for their persistence in advocating Medical Savings Accounts.

Last year I stood beside Arizona Governor Fife Symington as he signed our state's Medical Savings Account Act into law. I had introduced the bill in the State Senate because my examination of MSA's led me to conclude that they could improve considerably our health care delivery and insurance systems for millions of people in Arizona and across America. But I also recognized at that time that no state or states, and no employer or employers, could unleash the full promise of MSA's without changes in federal law. Thus, I promised I would take my fight for MSA's to Congress; and, needless to say, I have been extremely encouraged to find that many others have been fighting, and continue to fight, for the same goals.

What we are fighting for is to put MSA's on a level playing field with other forms of insurance, be they HMO's or fee-for-service plans. We are not attempting to mandate MSA's on anyone, but rather to offer Americans an additional option.

As you will hear throughout today's hearing, a high-deductible catastrophic insurance plan, combined with a Medical Savings Account, can empower patients to reduce their own health care expenditures. Health care costs will fall as the persons receiving medical care are put in charge of shopping for fairer rates and negotiating their own expenses. This will particularly be true in the case of MSA's because participants who are successful will be able to keep their savings.

The federal tax deduction envisioned in the Archer bill will make MSA's attractive. Currently, some employers provide MSA's for their employees, even though MSA's do not enjoy the federal tax deduction that traditional employer-provided health insurance receives. Once the playing field is leveled, as with the Archer bill, the cost-cutting potential of MSA's will fully flourish, and the empowerment it provides to employees will quickly make MSA's a popular choice for many Americans.

By giving MSA's the tax incentives that other types of health insurance currently receive, we will reverse the upward spirals in health care costs. In fact, I believe MSA's are part of the answer to how we can preserve and protect our Medicare system; and I would love to see MSA's made available to federal workers, as a first step towards providing this option to all Americans. I intend to push these ideas through legislation currently being drafted, and I hope you would invite me back to talk about them at a later date.

Thank you again for holding this hearing, and I urge you to support Chairman Archer's fine MSA bill. Our constituents will benefit from its prompt passage. Thank you very much.

Chairman THOMAS. Thank you very much.
And our friend from Iowa, Hon. Dr. Ganske.

STATEMENT OF HON. GREG GANSKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. GANSKE. Thank you, Mr. Chairman. And I want to applaud the Chairman of the Full Committee, Chairman Archer, and Mr. Jacobs for their leadership in this area. I have had the opportunity to discuss MSAs with Chairman Archer on several occasions and his insights have proven very valuable to me and I am sure will help guide this Congress.

I want to look at MSAs from a little different angle. I may be the only Congressman who has actually practiced medicine under a free market.

Prior to becoming a Congressman last November, I was a plastic surgeon and I know from personal experience that when the consumer pays the bill, medical costs are controlled. While about 90 percent of my practice was reconstructive, some of my practice was cosmetic surgery. I can assure you that when the patient spends his own money, the free market can work to hold down medical costs.

Before most patients ever crossed my doorway, they had phoned every other plastic surgeon within a 50-mile radius to find out what the total cost of their package would be. Consequently, medical inflation in this field has been virtually zero for the last decade.

All of my patients had questions about options, outcomes, and risks, but unlike my reconstructive patients, those who came to me for cosmetic procedures were also concerned about price because nobody else, the government or insurance company, was paying for their treatment. So they were very much aware of the financial aspects. There lies the basic reason that health care costs have risen far above regular inflation.

There is a fundamental disconnect in our country between the payor and the patient. When somebody else is perceived as the payor, the goods and services are perceived as being free and demand explodes and the patient does not care what it costs. The recognition of the "it is free syndrome" is why even managed care is moving to higher deductible policies.

The problem with higher deductible policies is that preventive care may be avoided leading to more serious and expensive health care costs later on. That is why a mechanism is needed that provides an individual with the ability to pay the deductible for preventive and necessary care and, at the same time, provides them with a carrot not to overutilize the services. That is why I am very hopeful that Congress will enact legislation to allow for the tax free funding of medical savings accounts, because it is MSAs that provide the mechanism to cover that high deductible while, at the same time, making the patient cost conscious.

Critics of savings accounts will claim that health care has become so complex that patients just are not capable of making quality or cost-conscious decisions about their treatment. I would say it is the current system of third party payment and not the complexity of medicine that has created these incentives.

In my medical practice, patients who spent their own dollars on sometimes very complex procedures were quite knowledgeable about the quality issues in addition to the cost.

My own sister has a child with Down's syndrome. She has taken over the health care of that child. She is very knowledgeable about Down's syndrome and works very closely with her pediatrician. Where there is an interest, there will be knowledge.

Health care consumers can, and do, make wise decisions. By setting up MSAs as an option for Americans, this Committee will take a giant step toward eliminating overutilization of health care services. I look forward to working with this Committee on this problem.

Thank you.

[The prepared statement follows:]

STATEMENT OF HON. GREG GANSKE,
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. Chairman, thank you for holding this important hearing and for allowing me to testify.

I first want to applaud the Chairman of the Full Committee, Mr. Archer, for his leadership in this area. I have had the opportunity to discuss Medical Savings Accounts with him on several occasions. His insights have proven valuable to me and I am sure will help guide this Congress.

As a plastic surgeon prior to becoming a Congressman last November, I know from personal experience that when consumers pay the bill, medical costs are controlled. While most of my practice was reconstructive and paid for by third party payers, I also did some cosmetic surgery. I can assure you that when patients spend their own money, the free market can work to hold down medical costs. Before most patients ever walked into my office, they had probably called every other plastic surgeon within fifty miles of Des Moines. They shopped for the best package price which included all their expenses and also considered the quality of each doctor they called.

All of my patients had many questions about options, outcomes, and risks. But unlike my reconstructive patients, those who came to me for cosmetic procedures were also very concerned about price. Because no one else (the government or an insurance company) was paying for their treatment, financial aspects of one treatment option versus another were of much greater concern to them.

And that is the basic reason that health care costs have risen far faster than inflation. There is a fundamental disconnect between the payor and the patient. When somebody else is perceived as the payor, the goods and services are perceived as being free and demand explodes and the patient doesn't care what it costs.

Recognition of the "it's free syndrome" is why even managed care is moving to higher deductible policies. The problem with high deductible policies is that preventive care may be avoided leading to more serious, and expensive, health care needs later on. Therefore, a mechanism is needed that provides an individual with the ability to pay the deductible for preventative or necessary care and at the same time provides him with a carrot not to over-utilize services.

Accordingly, Congress must enact legislation to allow for funding of Medical Savings Accounts (MSAs) with pre-tax dollars by employers or employees, or both. People should be able to select an insurance policy with a high deductible and lower premiums, placing the savings in an MSA for routine medical expenses. Individuals holding down their health care costs are rewarded by keeping unspent balances in the MSA. Those funds can continue to grow, eventually funding long-term care insurance or a Medicare MSA for retirees.

Critics of MSAs will claim that health care has become so complex that consumers aren't capable of making quality and cost-conscious decisions about their treatment. It is the current system of third-party payment, and not the complexity of medicine, which has created disincentives for consumers to become knowledgeable. In my medical practice, patients spending their own dollars were very responsible in learning about the costs and benefits of each procedure. My sister has taken charge of the care of my nephew with Down's Syndrome, developing a keen understanding of the treatments which are worth the cost, and those that are not. These anecdotal findings are confirmed in scientific studies such as the one performed by the RAND Corporation. They found that individuals with higher deductibles were as healthy as those with lower deductibles, but were smarter consumers and avoided unnecessary services.

Health care consumers can, and do, make wise decisions when they have a financial incentive to do so. By setting up MSAs as an option for more Americans, this Committee will take a giant step in the effort to eliminate over-utilization of health care services.

Other critics of MSAs contend that MSAs will be chosen by the healthy and that this adverse selection would drive up the cost of other types of insurance. One could make exactly the same argument about managed care, or for that matter, the marketing and pricing strategies of "traditional" insurance. In practice, the potential of adverse selection for MSAs does not seem to be a problem for those companies already using non-tax deferred accounts.

It is clear that if this country is going to reduce its health care inflationary spiral, someone is going to control the spending. Government bureaucrats have been racheting the tourniquet for the past decade, and managed care gatekeepers are increasingly making those decisions in the private sector. The question is not whether choices are going to be made. The simple fact is that they will and nothing that this Congress does can change that. But we can address the question as to who makes those choices. Congress should enact Medical Savings Account legislation for individuals and retirees, encouraging health care consumers to be just as knowledgeable and cost-conscious as my patients were. . . and to make those choices for themselves.

Thank you again, Mr. Chairman, for the opportunity to submit these remarks. I look forward to working with you and the Members of the Committee to see that the goal of Medical Savings Accounts becomes a reality.

Chairman THOMAS. And now it is our privilege to hear from the Chairman of the Ways and Means Committee, the gentleman from Texas, the sponsor of H.R. 1818, Chairman Archer.

STATEMENT OF HON. BILL ARCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman ARCHER. Thank you, Mr. Chairman. It is rare that the Chairman of the Full Committee testifies before a Subcommittee, but this is, in my opinion, a very rare proposal, an extremely important proposal.

As we move into the Byzantine halls of health policy and seek reform to strike at the flaws in the system, we should recognize the great strengths of the system, too. And I applaud the Members and the Chairman of the Subcommittee for their work in trying to improve on a very good system by world standards.

We know that people want more personal choice and control over their health care spending, and the bill before you today, H.R. 1818, the Family Medical Savings and Investment Act, does just that. And I am pleased that my colleague and my longtime friend, Andy Jacobs, has joined me in developing this proposal. We have been working on this for at least 3 years now, having introduced it some time back, and I believe we have continued to improve it as we have gone along.

It will work for Texans and Hoosiers, for Californians, and Virginians because it increases personal choice and personal responsibility for their health care spending. It provides American families with an opportunity not only to determine what health services they need, but also to do their part to put a lid on health care costs, costs that have continued to skyrocket due to overutilization and lack of accountability.

H.R. 1818 allows individuals who are covered by catastrophic health plans to maintain a personal medical savings account to assist in paying out-of-pocket expenses. And within limits, the contributions are excludable from gross income if made by the employer and deductible if made by the individual.

It allows families to have freedom to go to any doctor, hospital, or drug store they prefer. Families have control of how their health care dollars are spent. If they find themselves facing health care costs when they are unemployed or during retirement, the reserves accumulated in their medical savings account balances can be used to meet those needs.

And it is truly portable. You can take your medical savings account with you if you change jobs or retire. Paperwork is reduced. Expenses are simply paid out of the MSA. Premium increases in the catastrophic plan are lower because the premium base, with the high-deductible policy, is lower.

Americans with conventional health insurance have few incentives to buy services carefully. I believe this bill puts consumers in the loop and provides the American family with a valuable tool to use to help make the family paycheck stretch further; Freedom, choice, personal responsibility, and savings. Those are the hallmarks of the Family Medical Savings and Investment Act, H.R. 1818.

And I thank you for these hearings, Mr. Chairman. I look forward to working with you in developing what I believe will be a very constructive approach to health policy.

[The prepared statement follows:]

BILL ARCHER
7TH DISTRICT, TEXAS

CHAIRMAN
WAYS AND MEANS
COMMITTEE

JOINT COMMITTEE
ON TAXATION

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June 27, 1995

Statement of the Honorable Bill Archer
Committee on Ways and Means
Subcommittee on Health
Hearing on H.R. 1818

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to be here today to discuss an issue that is important to all of us.

Less than a year ago, the American people dismissed a plan to create a new government run health care system.

The people spoke and we listened.

Today as we begin to undertake health care reform that is carefully targeted towards identified problems, we recognize that people want more personal choice and control over their health care spending. The bill before you today (H.R. 1818), the Family Medical Savings and Investment Act, does just that. I'm pleased that my colleague and friend -- Andy Jacobs -- joined me in developing this proposal -- one that we believe will work. It will work for Texans and Hoosiers -- for Californians and Virginians. It increases personal choice and personal responsibility for their health care spending.

This bill provides American families with an opportunity not only to determine what health services they need, but also to do their part to help put a lid on health care costs -- costs that have continued to sky-rocket due to over-utilization and lack of accountability.

H.R. 1818 allows individuals who are covered by a catastrophic health plan to maintain a medical savings account to assist in paying for out-of-pocket expenses.

Within limits, contributions would be excludable from gross income if made by the employer -- and deductible if made by the individual.

In general, the amount of the individual or employer contributions that could be deducted or excluded for a taxable year would be the lesser of the deductible under the catastrophic plan or the $2,500 if the MSA covers only the individual. The deduction would be $5,000 if the MSA covers the individual and the spouse or a dependent of the

individual. Withdrawal from an MSA would be excludable from income if used for medical expenses for the individual and his or her spouse or dependents.

The bill allows families to have the freedom to go to any doctor, hospital or drugstore they would like. Families have control of how their health care dollars are spent. If they find themselves facing health care costs when they are unemployed or during retirement, the reserves accumulated in their medical savings account balances can be used to meet those needs.

It is truly portable. You can take your medical savings account with you if you change jobs or retire. Paperwork is reduced -- expenses are simply paid out of the MSA. Premium increases on the catastrophic plan are lower because the premium base with a high deductible policy is lower.

Americans with conventional health insurance have few incentives to buy medical services carefully.

I believe that this bill puts consumers in the loop and provides the American family with a valuable tool to use to help make the family paycheck stretch further.

Thank you again for this opportunity to appear before your Subcommittee. I'll be glad to respond to any questions the Members may have.

Chairman THOMAS. I thank the Chairman for his testimony.

I thank all the Members for their testimony.

Are there any Members who wish to inquire of the Members? The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

One of the points that was brought out by you, Mr. Salmon, was the administrative costs. I do not think that that can be downplayed at all, because every hearing we have on health care somebody brings up administrative costs and the bureaucracies that are set up in the private sector as well as the public sector. Because one of the criticisms that we always hear people that criticize Medicare and Medicaid and the whole Federal bureaucracy is that they respond by saying that we have this huge bureaucracy in the private sector. I think that is one place that medical savings accounts will help address, is the huge costs that we have in both the public and the private sector.

Chairman Archer, could you please address—how potentially this could be applied after somebody has been in the system for years, when they get older? Because one of the problems we have now is in long-term care for the elderly. How could this be applied if somebody has been in it for 20 years and now they have a medical savings account built up versus the system we have now?

Chairman ARCHER. Well, each individual that was able to accumulate any savings, and, obviously, not every individual could do so, but I think most would, will then have access to that later on in life, which would be very helpful to offset some of the additional expenses that come later in life.

We also are in the process of trying to develop, in fact we will develop, a medical savings account for retired persons, for senior citizens. It will have to be somewhat different than this, but I think it should be an option for Medicare enrollees also, should they elect to use it.

Mr. ENSIGN. Thank you.

Dr. Ganske, you mentioned that you were one of the only doctors, well, maybe a different profession, but certainly I experienced the same things in veterinary medicine that you experienced with your elective plastic surgery.

Can you address, because this was something I experienced, the communication between the doctor and the patient, when you are having to educate them on the cost as well as everything else in that elective part of your practice. One of the things you hear about, is that we have lost the doctor-patient relationship that used to exist.

Mr. GANSKE. Well, I think that a question concerning the patient's ability to be a wise consumer is going to relate to the kind of access they have to information that would allow them to comparison shop. And there are mechanisms and agencies we will develop that will allow a person not just to phone other surgeons or physicians in the medical area, but to get a comparisons.

Insurance companies have already developed a lot of data on comparison costs in the medical area. We already have RBRVS data and it would be very simple for a practitioner to simply calculate a conversion factor, for instance, on relative value standards for data that we already have on specific types of services that you

could give. That would then give a consumer a reasonable way of shopping in an informed way.

Mr. ENSIGN. Thank you, Dr. Ganske.

Mr. Salmon, what was your experience after this bill was passed in Arizona? Obviously, there is not as much incentive on the State level as there is from the Federal level, but, still, what was the experience from some of the companies?

Mr. SALMON. Their experience was a lot of the insurance providers, the traditional insurance providers of days of yore, actually went to medical savings accounts coupled with catastrophic care policies and it opened up a whole new market.

As far as companies that have offered medical savings accounts—I have heard it said there is no proof that they are going to work—virtually every case study of every company that has offered medical savings accounts has shown that health care inflation has been far less, with those companies than it has with traditional companies offering PPO and HMO coverage.

Mr. ENSIGN. Thank you.

And I would like to thank the Chairman also for holding these Committee hearings. I think that medical savings accounts are not going to be a panacea for our health care concerns, but they are certainly one of the answers to reforming our health care system. Thank you.

Chairman THOMAS. I thank the gentleman for his questions. The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me thank all of our colleagues for their contributions to our work here in this Committee. I very much appreciate your testimony and your interest in health care issues.

I come to this issue from a similar perspective to you. The current Tax Code discriminates against medical savings accounts. An employer under our current Tax Code can set up a self-insured plan—which may be the most inefficient plan imaginable yet the Tax Code gives full tax preference to that type of plan. But, that employer cannot set up a medical savings account and get the same type of tax advantage. So I think we must, at least initially, remove that discriminatory practice which is currently in our Tax Code.

I worked with my friend Mr. Jacobs last year and Mr. Thomas to include the MSA provisions in the bill that we moved through this Committee last year, in the context of comprehensive health care reform. While we are not going to get comprehensive health care reform, that is clear, I think we need to work on a bill that will remove the discriminatory provisions and allow employers to have this option available to their employees with the same tax incentives as traditional insurance, and I look forward to working with my colleagues.

I do think, though, that we should look at the issue of risk selection; we should look at the administrative savings that we would like to be able to achieve; we should look at providing proper information to the consumer to make an intelligent choice and encourage preventive health care. These are issues that have been brought up that I hope that in our deliberations, as we move forward on legislation, that we listen to the concerns that have been

raised and, hopefully, develop an MSA bill that will be the best for all parties involved. I look forward to working with my colleagues in that regard, and I thank you for your testimony.

Chairman THOMAS. Thank the gentleman from Maryland. The gentleman from Texas.

Mr. JOHNSON. Thank you, Mr. Chairman.

Chairman Archer, I wonder if you could explain, maybe for the record, why we want a penalty tax included on withdrawals one and two. Is there any ultimate limit on what a savings plan can accrue?

Chairman ARCHER. We felt that if this savings account was going to be protected to be used for medical needs, that simply being able to withdraw at will was not a desirable thing to have.

We believe that it is very important that people should be encouraged to save and be able to accept personal responsibility to the greatest degree possible, and, therefore, we feel that it is appropriate to have a penalty for withdrawal for unauthorized purposes.

There is no limit to how much can be accumulated in the medical savings account.

Mr. JOHNSON. So over a 10-year period, it could go as high as $20,000 to $30,000 if they wanted to?

Chairman ARCHER. If you were fortunate to do a lot of good preventive maintenance and keep yourself in good shape, eat right and take care of yourself.

Mr. JOHNSON. Or found a good doctor like Ganske. Thank you, sir. I appreciate it. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from California, Mr. Stark.

Mr. STARK. Well, as I say, I want to thank the panel. I think that there is evidence for a great deal of belief in free enterprise and thrift and shopping for medical care, and I only wish that that were sufficient to deal with the problem of the uninsured and the rising cost of medical care.

Unfortunately, the Joint Committee, in analyzing this, says it is assumed that this proposal would have a limited effect on the self-employed who currently do not have insurance; for individuals without insurance it would have a limited effect; for the low-income insured it would increase the tax benefits available to those individuals, but they are assumed to be insufficient to induce low-income individuals to purchase health care coverage. It does say, however, the bill for high-income uninsureds could provide an incentive to some high-income individuals who were perhaps voluntarily uninsured.

So, it does sound like it is a good bill for the rich who can use the tax deduction but will not do much, if anything, for 40 odd million Americans without health care coverage or for those who are attempting to have insurance in their own business. For the small business person who cannot get insurance, and for the low-income individuals in our country, it does not do much. For the high-income folks, it does let them buildup a tax exempt savings account with which they may have happier retirement years.

I look forward to the rest of the witnesses and appreciate our colleagues' contributions today. Thank you, Mr. Chairman.

Chairman THOMAS. Gentlewoman from Connecticut.

Mrs. JOHNSON OF CONNECTICUT. Chairman Archer, to clarify on the record, what kinds of expenses would be deductible under a medical savings account approach?

Chairman ARCHER. The normal medical expenses, which I believe that we have already clarified under the current law.

Mrs. JOHNSON OF CONNECTICUT. It is impressive that the medical savings account allows deductions for a lot more medical expenses than most insurance policies allow. You can deduct the cost of glasses, for example. The definition is in the Code. It defines the medical expenses that you can deduct over and above 7.5 percent of income.

But it will allow families to deduct prescription medications. It will not depend on whether you have a policy that covers prescriptions. It will allow you to deduct prescription medications, and I think dental visits, and vision care. So, it allows a far more comprehensive approach in support of health care benefits than any individual insurance plan, and I want to make that really clear on the record, because it provides an option that nothing else in the market provides.

I do want to commend my colleague, Mr. Roberts, because there are areas of the country in which managed care is not going to be the right answer. There are areas of the country where fee-for-service medicine is going to be the right answer. And as Mr. Ganske pointed out, fee-for-service medicine is perfectly capable of controlling costs if the incentives are right. This is the only legislative proposal out there that is going to assure that America will have the kind of high quality health care system that is appropriate in each area.

I do think this will mean that modernization of fee-for-service medicine will take place and it will survive in those areas where it ought to, and a family will have far more choices under this option than they have under any offer in the market now.

That is why it is such an important proposal, and I appreciate your work on it. I appreciate the depth of experience of this panel. We have never had a panel before us on this issue where there has been such depth of experience. This is a mature proposal in a way that it was not a few years ago, and I look forward to working with you to pass it and provide for the American people the same kind of choice that this week we are going to provide for seniors in America through Medicare Select.

Chairman THOMAS. I thank the gentlelady. If there are no other questions, I will thank the panel very much——

Mr. JACOBS. Mr. Chairman, could I make one observation for the record, take 30 seconds?

Chairman THOMAS. The gentleman from Indiana.

Mr. JACOBS. The old saying is that a rising tide lifts all boats. And the question has been raised about how in the world would this proposal help people who do not have insurance, people who are on Medicare, people who are not employed, self or otherwise?

And the answer is that a falling tide lowers all prices, if you think about it. If you have millions of people in this country employed, exercising discretion and prudence in shopping, the prices do not simply fall for them, they fall for the entire economy and

thereby inure to the benefit of the Medicare Program and the Medicaid Program and the unemployed generally.

Chairman THOMAS. If you will hang on for just a moment, I believe the spirit has moved the gentleman from Washington.

Mr. MCDERMOTT. Mr. Chairman, thank you. I just wanted to ask a question. Many of the people on the panel are advocates of changing the tax structure to some kind of flat tax or something. Can you tell me how this would work in relationship to a flat tax system?

Chairman ARCHER. With a flat tax, you would still have—you would still have, I assume, although I do not know what flat tax proposal you are looking at, it is one thing to talk about a flat tax, it is another thing to analyze all of the details of it, but it is very possible that it could still have the same tax deductibility consequences under a flat tax, depending on how it is arranged.

If you go to taxing goods and services, which I would like to do, then you do not have to worry about tax deductions for anything because you are not taxing income in any way, shape, or form. So, there is no need to be concerned about how the income tax law will apply to these sorts of programs.

Mr. MCDERMOTT. So, you are really saying that you think that under a flat tax you would still have tax deductibility of health insurance.

Chairman ARCHER. Depending on—I am not the advocate of the flat tax in this Congress, but depending on the actual formulation of the flat tax, it is very possible that you could.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Once again, I want to thank the panel.

The Chair would request that the next panel consisting of Mr. Hustead, Mr. Hendee, and Mr. Goodman please come forward. The Chair would inform each of the members if you have a written statement it will be made a part of the record without objection and you may proceed to inform the Subcommittee in any way you see fit in the time afforded to you.

Mr. Hustead.

STATEMENT OF EDWIN C. HUSTEAD, SENIOR VICE PRESIDENT, HAY/HUGGINS, ON BEHALF OF AMERICAN ACADEMY OF ACTUARIES MEDICAL SAVINGS ACCOUNT WORK GROUP

Mr. HUSTEAD. Thank you, Mr. Chairman.

My name is Edwin Hustead. I am the chair of the American Academy of Actuaries' work group on medical savings accounts and also a senior vice president with the Hay/Huggins actuarial consulting firm.

We have prepared a general report on medical savings accounts, which was delivered in May and hopefully has been of some use, and are now proceeding to a report and a study specifically on H.R. 1818 and other proposals.

I think it is helpful, when you think in terms of a medical savings account and a high-deductible deductible plan and their effect, to think of three steps in the process: First, there would be the enabling legislation, such as H.R. 1818; second, employers and insur-

ers would then redesign their programs and their benefits packages to take advantage of the option that would be offered by a high-deductible plan and an MSA; and, third, this offering would then be provided to the employees and the employees would choose the plan they want.

To just talk briefly on those three steps, and our written testimony is there for the record, the legislation, to the extent that I have had a chance to look at it, seems well-designed to deal with the setting up and enabling legislation for a high-deductible MSA option for employers and insurers. It deals successfully with the problems we have pointed out, such as the interaction of two policies for two family members.

One technical issue that I would raise, at least in my reading of the bill, suggests that a family would have to meet a $3,600 deductible in order to be able to set up an MSA, whereas an individual would only have to meet an $1,800 deductible. If I am reading that correctly, that means an individual in a family would have to meet more of an increase in deductible than an individual in their own policy. You may want to look at that provision.

Most of what would go on in a high-deductible/MSA introduction would deal with the employer response. Now, the assumption of the work group is that the employers would want to keep their health care costs constant, so the employers will then want to redesign their health plan to accommodate high-deductible MSA options, and in our report we show what would happen if an employer were to introduce a high-deductible plan.

For example, if an employer were to go from a $200 deductible plan to a $2,000 deductible plan, they could save an average of $828 per person. That would be the amount they could put in a medical savings account and keep their costs constant.

But there are two cautions, in reference to the employer design. First, if an employer were to keep other options in their program, then it is likely that the healthiest individuals would go to a high-deductible plan and the savings would be less than the figures we show in our report. Second, if the employee who had a medical savings account were to consider that MSA as just another form of insurance, then the cost savings could be lower than had been predicted in our report. So, we would suggest to employers they view those two aspects.

Another thing that employers will have to consider as they redesign their plans will be how to deal with current management approaches, the health maintenance organizations, the point-of-service plans, and so forth. Employers have been very successful and done quite a bit with managed care organizations to control cost in recent years. Presumably, they will want to add to those savings that they have already achieved through introduction of a high-deductible plan.

And finally, an employer or insurer is going to have quite a communication process, as they relate these plans to the individuals. Employers are used to having successful communication programs and we think that they can achieve that to tell employees what they really have and how these new plans work.

As far as the result on the individuals, we show in the report, and I show in the testimony that, on average, individuals will gain

from this new system. There will be 25 percent of employees and individuals who do not meet the current deductible. If an employer gave them $700 or $800, that would be a net gain. There would be, as has been pointed out so far already, the employees and individuals with very high medical expenses with a net loss. In the example we give, the loss could be $1,200 per person per year with high medical expenses. We figure that about 8 percent of the employees would be in that category.

As far as overall savings, if you take an average group and move them from a current fee-for-service nonmanaged plan to a high-deductible plan, administrative savings would be substantial. We figure about 20 percent of the administrative costs would be saved, claims costs would be saved. There would be savings up to 10 percent of the total cost, again depending on how the individual viewed their MSA.

Thank you very much.

[The prepared statement and attachment follow.]

[Medical Savings Accounts Cost Implications and Design Issues attachment is being held in the Subcommittee's files.]

STATEMENT OF EDWIN C. HUSTEAD, HAY/HUGGINS, ON BEHALF OF AMERICAN ACADEMY OF ACTUARIES MEDICAL SAVINGS ACCOUNT WORK GROUP

INTRODUCTION

Thank you for the opportunity to address the subcommittee today on the subject of medical savings accounts (MSAs) and, specifically, on H.R. 1818, the "Family Medical Savings and Investment Act of 1995." I am Edwin Hustead, the chairperson of the American Academy of Actuaries' Medical Savings Accounts Work Group and a Senior Vice President with the Hay/Huggins division of the Hay Group. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries.

Briefly, H.R. 1818 would enable employers and their individual employees to establish MSAs. The bill stipulates that the only insurance coverage required would be a catastrophic health insurance plan with a deductible of at least $1,800 a year. The employer or individual could contribute a given amount, on a tax-deferred basis, to the MSA. This amount could be no greater than the lesser of the deductible or $2,500 a year.

MEDICAL SAVINGS ACCOUNTS

An MSA is an individual medical account that employees can draw from to pay for their ongoing medical expenses. It is set up by an employer for an employee who is eligible for health insurance coverage, and funded by employer and/or employee contributions. The concept of MSAs has generated tremendous interest this year, largely because some believe that, if MSAs were to become popular, they would provide sufficiently powerful incentives to covered individuals to motivate them to play a more active role in making responsible decisions on how their medical care dollars are spent. However, others are concerned that MSAs might neutralize the utilization controls already in place in managed care plans, and place an increased financial burden on the very individuals who are most in need of health care services.

The Academy Medical Savings Accounts Work Group's May 1995 report, "Medical Savings Accounts: Cost Implications and Design Issues," presents actuarial analysis and commentary on the MSA concept.

Employer Contributions for Health Care

Table 1 shows the work group's estimates of the approximate cost of insurance plans with various deductible and maximum out-of-pocket limits. If, for example, an employer were to replace a $200 deductible plan with a $2,000 deductible plan, the premium for the average employee would decrease by $828. This illustration assumes that the $200 deductible plan would have a $1,000 maximum limit on out-of-pocket expenses and that the $2,000 plan would have a $3,000 limit. It also assumes that the plan would cover a typical work force and that all employees would participate in the plan.

Table 1
Cost of Different Copayment Designs- Individual Plan

Deductible/ Maximum Out-of-Pocket	Premium	Reduction from Baseline Premium
Baseline		
$200/$1,000	$2,699	-0-
$1,000/$2,000	2,176	523
$1,500/$2,500	1,996	703
$2,000/$3,000	**1,871**	**828**
$3,000/$4,000	1,666	1,033
$4,000/$5,000	1,501	1,198
$5,000/$6,000	1,369	1,330

Source: American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*. Public Policy Monograph No. 1, May 1995.

Note: Relative cost of plans after consideration of induction, before consideration of the MSA.

What causes this reduction in premium? Raising the deductibles and out-of-pocket limits reduces the portion of the bill paid for by insurance, inducing employees—now responsible for paying a larger share of their health care costs—to use less health care services. This effect, termed "induction" by the work group, may work so as to bring the consumer into the health care arena as an active payer.

The work group assumes that employers will probably try to hold their health expenditures constant with the introduction of the MSA and high-deductible plan. The employer could keep the total health care expense at $2,699 per person by putting the $828 in premium savings into an MSA (Table 1). The total employer cost, $1,871 for the high-deductible plan and the $828 to the MSA, would equal the cost of the low-deductible plan costing $2,699.

Factors Affecting Premium Savings

There are at least two aspects of MSAs that could reduce the premium savings employers would otherwise enjoy by purchasing a less expensive high-deductible plan, and therefore, the amount that an employer would be willing to contribute to an MSA. First, if employees consider their MSA balance as little more than another form of insurance, then much of the savings from induction would be lost. Consider, for example, a $500 health care expense. The current low-deductible plan would pay $240 of the current cost, with the individual responsible for the remaining $260 of the $500 expense (Figure 1). The MSA/high-deductible, in contrast, would pay none of the cost (Figure 1).

Figure 1
$500 Health Care Bill

Low-Deductible Plan	MSA/High-Deductible Plan
Plan Pays $240	Plan Pays $0
Calculations	
$500 cost	
- $200 deductible	
= $300	
$300	
x 80% coinsurance	
= Plan payment of $240	

Possibly, the $260 out-of-pocket expense of the employee enrolled in the low-deductible plan could encourage him/her to use less health care services. On the other hand, the employee with an MSA balance of at least $500, which he/she views simply as another form of insurance—not part of personal savings—may actually be encouraged to use more health care, because he/she would assume that their out-of-pocket expenditures had actually decreased by $260.

Second, if an employer offers the MSA/high-deductible plan within a benefit program that includes other options for health insurance coverage, the healthiest people would tend to select the high-deductible plan; the less healthy people would most likely continue using the low-deductible plan. Since health care costs for the employees who opt for the high-deductible plan would be lower than average, the premium savings from moving to a high-deductible plan would also be lower than is shown in the Table 1.

Another factor that could affect how much money is actually saved is the interaction between the MSA/high-deductible plan and managed care. If H.R. 1818 were enacted, employers would need to review their health benefits programs to determine how to integrate the MSA option with their current benefit plans. One concern employers have mentioned is the interaction between an MSA/high-deductible plan and current managed care plans, such as health maintenance organizations. Employers have expended a great deal of effort in applying strict management to their health insurance programs to maximize savings, with recent trends in health premiums suggesting that much of this effort has been successful. Some of these savings could be lost if the MSA/high-deductible plan were to attract significant numbers of enrollees.

Impact on Employees

The work group's analysis shows that, on average, employees would benefit financially from

enrollment in an MSA/high-deductible plan. However, employees with a large medical expense, such as $25,000, who are enrolled in an MSA/ high-deductible plan would pay $2,000 more out-of-pocket for covered health expenses than the individuals covered under a low-deductible plan. The net loss to these employees, after application of the $828 MSA contribution, would be $1,172 (Figure 2). The work group's analysis showed that approximately 8% of the insured population would face the full $1,172 increase in out-of-pocket expenses.

Figure 2
$25,000 Health Care Bill

Low-Deductible Plan	MSA/High-Deductible Plan	Difference Between Plans
Enrollee pays $1,000	Enrollee pays $2,172	$1,172
	Calculations	
$1,000 maximum-out-of-pocket limit	$3,000 maximum-out-of pocket limit - $828 MSA contribution = $2,172	$2,172 - $1,000 = $1,172

It is important to determine which health care expenses will be covered by the high-deductible plan and those that can be paid from the MSA. Employees could be permitted to spend their MSA funds on items not generally covered under the health plan. For example, an employee might spend $2,000 for permitted MSA expenses that include $500 of services not allowable under the MSA/high-deductible plan. Having spent $2,000, an employee who had to be admitted to a hospital might presume that he was only responsible for 20% of remaining charges up to the $3,000 maximum out-of-pocket limit. However, the insurer would review the $2,000 in expenditures and determine that the employee would, in fact, have to pay the first $500 of the hospital bill before the insurance protection begins.

Effect of Health Care Costs

The work group's analysis found that the replacement of a low-deductible fee-for-service plan with an MSA/high-deductible plan would result in lower health care expenditures for a typical group of employees. In addition, administrative expenses would decrease by approximately 20%. Health care costs for this typical group of employees would decrease by up to 10%, depending on the extent to which the employees considered the funds in the MSA to be personal savings, rather than insurance.

CONCLUSION

The concerns noted above about the effects of H.R. 1818 emphasize that employers will need to give some thought to redesigning their overall health benefits programs to incorporate an MSA/high-deductible plan. This new kind of plan could be a valuable new option for employees. However, to integrate the new MSA/high-deductible plan successfully, employers will need to design them carefully and get accurate estimates of their probable cost. In addition, employers will need to communicate effectively with their employees about how the new plan works.

The work group has not yet completed its analysis of H.R. 1818. One important point to note at this time, however, is that the $3,600 lower limit on the deductible for a family plan may be overly burdensome. Most employer plans currently provide a deductible per individual family member—often with a maximum on the total deductibles for a family. The individual deductible is usually the same as the deductible for a single-person plan. If the family plan requirement of $3,600 is read as a minimum expenditure that the family must meet, then the increase in out-of-pocket expenses will be much greater for a family than for an individual.

The Academy work group is available to answer additional questions.

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ISSUE BRIEF
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Medical Savings Accounts

The efficacy of medical savings accounts will be determined, in large part, by their plan design. However, young and healthy employees could be big winners with an MSA. Depending upon plan design, approximately two-thirds of current workers would gain financially if employers combined MSAs with high-deductible plans.

In an American Academy of Actuaries study, the 17 percent of employees who have no medical expenses reimbursed by their current health plan would have the highest gain—possibly more than $600 under an illustrative plan examined by the Academy. The 8 percent of employees who have high medical expenses would have the greatest loss—as much as $900 under the same plan. Administrative costs, which now account for approximately 15 percent of claims payments, also would be considerably lower under MSAs.

This brief is based on the full report, "Medical Savings Accounts: Cost Implications and Design Issues," which is available from the American Academy of Actuaries.

1. Introduction: What Is an MSA?

A medical savings account (MSA), as envisioned in most current proposals, is an individual medical account that employees can draw from to pay medical expenses. It is set up by an employer for an employee who is eligible for health insurance coverage and is funded by employer and/or employee contributions.

Funds in the MSA would be designated as the employee's own money. Any portion of the fund that is not used to pay for current medical expenses can simply accumulate in the MSA. There it is allowed to earn interest and will be available for any future medical expenses.

Funds in an MSA usually would not be sufficient to cover the cost of major illness. So MSAs will almost always be combined with a health insurance plan that covers medical expenses above a fairly high deductible.

Deductibles that have been discussed range from $1,000 to as high as $3,000. Above the deductible, the catastrophic insurance plan might also have some co-insurance, say 20% of all medical expenses up to $5,000. Amounts in the MSA could be used to pay expenses up to the deductible and copayments above the deductible, provided the MSA had sufficient funds.

As a general rule, MSA funds would come from annual tax-free contributions made by the employer to each employee's account. Initially, the employer would probably contribute an amount equal to the difference between the per-employee cost of the high-deductible insurance and the per-employee cost of the employer's lower-deductible plan. If the combined MSA/high-deductible plan generated further future savings, the employer might or might not choose to pass the savings on to workers through higher MSA contributions.

Because MSAs cannot be established under current law, there are many theories about how MSAs might

The American Academy of Actuaries is the public policy voice of the actuarial profession, providing the actuarial profession's expertise to policy makers. This issue brief is taken from a monograph on medical savings accounts produced by the Academy's Medical Savings Account Work Group, Edwin Hustead, chairperson. Other members of the group are Peter Hendee, Roland E. (Guy) King, Mark Litow, Gerald R. Shea, Harry L. Sutton Jr., and George B. Wagoner Jr.

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affect the U.S. health care system. Employers, employees, health care providers, and the IRS all would be affected. Determining their preferences is critical to predicting how MSAs would affect U.S. health care.

2. Effect of the High Deductible

The high-deductible component of the MSA/high-deductible coverage will have one very important feature. It will include copayments from the patient (such as deductibles or co-insurance) substantially higher than those typical in today's health insurance market. This could exert a potent effect on how MSA owners decide to spend their MSA funds.

Available research indicates that the demand for traditional health care depends to a considerable extent on how much of a provider's bill must be paid out of one's own pocket. In 1978, when Newhouse et al. investigated the two extremes, total coverage and no coverage, individuals with full coverage of medical expenses made twice as many physician visits as those without coverage.

Copayments exert two significant effects. Higher copayments cause a decrease in insured health care expenses because less of each medical bill is paid by the insurer. Also, having to pay more out of one's own pocket discourages people from using health care services.

How will employees think about their MSAs? If they think of them as little more than another type of insurance, then utilization might be much the same as with a typical low-deductible plan. In some cases, utilization might actually be greater. By contrast, if employees consider their MSAs to be personal savings accounts, utilization might be depressed to almost the same level as a high-deductible policy without an MSA.

If workers look upon their MSA as savings, potentially countervailing motivations would arise. Having control of how health care dollars are spent, through an MSA, could make individuals smarter shoppers for medical care.

On the other hand, insurers generally place limits on what they will reimburse. Without these limits, MSA funds will be available for more services than plans currently cover. In many proposals, all the services recognized by the IRS as legal for income-tax-deduction purposes are considered appropriate for MSA expenditures. Services for routine physicals, eyeglasses, psychological consultations, and cosmetic services are often excluded or limited.

Other plan design elements can also modify the cost-deterring impact of a high deductible. These include limitations on cost-sharing like out-of-pocket maximums. Also, provisions stipulating whether deductibles include or exclude certain kinds of services can alter the effect of the deductible.

Further, the amount of new savings possible from adding a high deductible depends greatly on how much cost savings has already been achieved by the plan that preceded the new high-deductible plan. Perhaps the old plan, through tightly managed control, such as in an HMO, has already eliminated most of the excess utilization. Then, the high deductible will likely not yield very much in further savings. Hospital costs, in particular, may not be susceptible to further savings. Data show that utilization has already dropped by 25% in the last 10 years. There will, however, be more room for savings in other areas such as drugs, outpatient care, and professional services.

Conclusion. The extent to which MSAs will generate savings is far from certain. When consumers are offered only catastrophic coverage through high-deductible plans, health care spending falls. However, when MSAs which work so as to offset the high deductible are introduced, health care spending may or may not fall, depending on a number of factors. Spending could decrease if the law governing MSAs is well-conceived, if employers design their MSA options carefully, and if workers eventually view their MSAs as their own personal savings.

3. Tax Treatment of MSAs

It will be critical, in promoting the widespread introduction of MSAs and ensuring that they are financially sound, to establish a well-thought-out roster of tax regulations to foster these objectives.

Under most MSA proposals, both contributions to MSAs and payments for health expenses from MSAs would come from before-tax monies. However, employees would have to pay taxes if they used their MSA funds for nonmedical purchases, in addition to a penalty if the money was taken out before some specified age.

Right now, health care expenses paid by employers are fully tax deductible. Current proposals stipulate that all contributions to MSAs would be tax deductible as well. However, some specify that an employer's total tax deduction for the new MSA/high-deductible plan would be limited to what

the employer pays in insurance premiums for the current health care plan.

There are substantial differences among proposals concerning the tax treatment of the investment income that would accumulate on unspent MSA funds. Some proposals would tax the interest earnings on MSA account dollars. Others would allow investment earnings to accumulate tax free.

Proposals also differ in regard to how much money could accumulate in an MSA. And there are differences in what is specified as appropriate nonmedical circumstances for making withdrawals from the MSAs.

Conclusion. If either contributions to or medical withdrawals from MSAs were taxed, there would be no particular advantage to having one. Few employees would want an MSA, and few employers would establish them. On the other hand, if there are no limits on pre-tax contributions and the tax-free buildup of funds, MSAs would lead to greater government subsidization of health care and lost tax revenues. MSAs could then become a tax shelter for the well-to-do and a tax-free vehicle for special-purpose savings (e.g., down payments on first homes). The tax treatment of MSAs must be skillfully crafted to encourage their adoption, while discouraging their use as mere tax-planning devices.

4. Administrative Expenses

Currently, administrative expenses for all the insured plans in the United States average 15% of claims payments. MSAs could reduce some of this expense. Employees would have direct access to the funds in their MSA account, so they would not need to file any claims.

However, the administrative costs of the high-deductible component must be considered, too. With a standard (low) deductible plan, there are many low-cost claims. For these, administrative expenses represent a high percentage of the claim payments. The low-cost claims are avoided with a high-deductible plan. But insurers will absorb considerable expense in managing the complex cases under the high-deductible plan. For example, a $2,100 claim with a $2,000 deductible in place will be expensive to administer. The insured amount is only $100, but the entire $2,100 of expenses must be verified as covered expenses.

For the MSAs themselves, however, administrative costs will probably be much lower than with a standard low-deductible plan. In fact, if MSAs are not subject to expenses like premium taxes, sales commissions, or extensive reporting for tax purposes, administrative expenses could be as low as 2%.

Conclusion. Administrative expenses, which now account for approximately 15% of claims payments, would be about the same for high-deductible replacement plans. There would be overall administrative cost savings, however, because there would be fewer claims to process. The administrative expenses for MSAs would be lower than the expenses for other types of health insurance. Thus, for a combined MSA/high-deductible plan, administrative costs will be less than the current 15%.

5. Health Plan Options

Adverse selection is one possible consequence of employers offering MSAs as one of a range of health coverage options for their employees.

Roughly defined, adverse selection results when individuals attempt to figure out, and then opt for, the insurance coverage that provides them with the greatest financial benefit. Presented with a range of health plans, the healthier people would tend to pick the high-deductible, low-cost plan. The less healthy would usually choose a low-copayment plan. The effects of this selection process are increased premiums for the low-copayment plans and corresponding decreases in premiums for the high-deductible plans.

But even more problematic is the case in which the MSA is offered alongside other plans whose fundamental philosophy and design differ dramatically from that of the MSA—managed care plans.

The current environment is built around a system of management controls and discounts. The extreme approach, traditional HMOs, combines both of these. Integrating the MSA concept into this environment presents significant problems. The goal of the government and employer should be to preserve the savings achieved by the current environment while offering the employee more influence in the purchase of health care.

The simplest solution for employers would be to offer the managed care plan as a totally separate option. It would be possible, but difficult, to integrate managed care into the framework of the MSA itself. The latter approach would require a major restructuring of the copayment and reimbursement structure of the traditional HMO. State and federal law would have to be modified to permit HMOs to compete within this changed environment.

Conclusion. Employers, insurers, and providers have built a complex web of management controls and discounts that have already squeezed much of the savings out of the health care industry. Most of these programs offer several ways for the employee to opt out of the highly managed care but with control mechanisms that overcome the effect of adverse selection. The major problem for employers and insurers will be to expand and restructure their programs to fold in an MSA/high deductible option without losing the savings already achieved by the current program.

6. Effects on Health Care Costs

To estimate what savings (or losses) might be anticipated from the new MSA/high-deductible plans, three actuarial assumptions are needed. These are (1) the distribution of health care expenditures under current plans; (2) the change in utilization and cost that would ensue from the higher copayments of the high-deductible components; and (3) the extent to which the availability of an MSA fund would offset the savings from high deductibles.

The work group compiled the best available data on how health dollars are spent today. The group selected a range of factors used in predicting how much utilization and cost might decline when copayments increase. This information was employed to determine the consequences of substituting a new MSA/high-deductible plan for a fee-for-service plan that has little or no management of care.

The new MSA's effect could range, on average, from almost full offset of the expected dampening impact of a higher copayment to little impact at all. The key is the employees' perception of their MSAs. Do they think of their MSAs as their own personal savings which must be conserved for medical emergencies? Or do they view their MSA as merely additional insurance money to spend as they like on health care? It is this spectrum of differences in how employees would view their MSAs that requires the use of ranges in the estimates below.

Bearing this in mind, we can anticipate the impact of increasing a deductible for an individual from $200 to $1,500. Co-insurance above the deductible is 20%. Then, total expenditures for health care costs would decrease from $3,041 per employee to a range of $2,695 to $2,976.

Also, the premium for the health plan would drop by a range of $585 to $690. Assuming that the employer holds constant how much it spends for its employees' health care, this is the amount that the employer would pay into each employee's MSA.

The *average worker's* out-of-pocket expenditures would fall from $882 to a range of $536 to $817. However, the range of out-of-pocket charges for *individual workers* would be much greater.

The largest average savings for the 17% of employees who have no medical expenses reimbursed by their current health plan would be $574 to $676. This money would actually accrue for those workers, personally, in their MSA accounts.

At the other end of the spectrum, the largest cost increase would be experienced by the 8% of employees who have high medical expenses. They could see an average increase in their cost ranging from $827 to $926. And an individual worker could have a much higher increase than the average. These are their incurred out-of-pocket expenses that would be added to the out-of-pocket expenses under their old plan, less the employer MSA contribution.

These numbers are predicated on two assumptions. First, all employees are covered by the MSA, so there is no adverse selection. Second, managed care in the current plan is minimal. Under this scenario, roughly two-thirds of all employees would stand to gain financially by the introduction of MSAs. The other one-third would lose, because less of their high medical costs would be covered.

Conclusion. It is reasonable to expect some savings in health care expenses from the introduction of MSAs. However, that expectation is predicated on a favorable outcome with a long list of factors. Some of these factors will be within the control of the individual company (plan design features). But others (notably, tax treatment) are external to the company.

Therefore, achieving the greatest possible savings via MSAs will require well-designed legislation. It will also rest upon careful planning on the part of those employers that decide to establish health care plans with MSAs. Finally, the savings will depend on the extent to which individuals believe they have some stake in spending their MSA dollars wisely, along with their ability to become more sophisticated, cost-conscious health care shoppers.

Mr. CHRISTENSEN [presiding]. Mr. Hendee.

STATEMENT OF PETER G. HENDEE, CONSULTING ACTUARY, ODELL & ASSOCIATES, INC., WINSTON-SALEM, NORTH CAROLINA

Mr. HENDEE. Mr. Chairman, thank you for this opportunity to testify regarding the Family Medical Savings and Investment Act of 1995.

My name is Peter Hendee. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I am here as a consulting actuary who practices in the health care financing market.

This bill will encourage the use of a promising health care financing mechanism. It will eliminate the handicap imposed in the current tax law on health care savings by giving savings the same tax treatment now reserved for health care spending. This will make it practical for employers to provide medical savings accounts for their employees.

Not only will medical savings accounts be put on a level playingfield with other mechanisms for employee health care, the bill also counters the current tax law's bias against the self-employed and individuals who purchase their own health insurance. These people will continue to be at a tax disadvantage for the catastrophic portion of their health care financing, but their medical savings accounts will be treated on a consistent basis with employer-provided health care.

I would like to address a couple of provisions of the bill. The distribution rules are reasonable and they are not too onerous. The taxes on distributions that are not used for health care are significant enough to encourage responsible behavior. But very importantly, they are not excessive; the accountholder will feel that money is available for a nonhealth care need if it arises, and this is necessary for the accountholder to have an incentive to be a careful purchaser of health care.

The bill also includes an automatic inflation adjustment for the minimum catastrophic deductible, and that will make sure that this critical plan feature receives the periodic attention it needs. It needs attention because over time the rising cost of medical care can make current deductibles less significant and that will weaken the individual's incentive to control health care spending.

One concern I have with the bill is that mandated insurance benefits, such as first dollar coverage for certain preventive services, are required by some States. As a result, in those States it may not be legal to issue health insurance coverage that meets the proposed definition of a catastrophic health plan. So, under this bill, citizens of those States could not buy a catastrophic policy and set up a medical savings account.

I do have two possible solutions for your consideration. The first is to preempt the mandated benefit requirements, at least for catastrophic products to be used with medical savings accounts. And an alternative is to expand the definition of "permitted coverage" in this bill to include those mandated benefits.

Many States have enacted medical savings account legislation, many others are considering it, but the unfavorable Federal income

tax treatment is a forceful impediment to the widespread use of this popular free market health care reform.

I am pleased to be here today to support the same tax treatment for health care savings as for health care spending, and I will be happy to take your questions.

[The prepared statement follows:]

Testimony of

Peter Hendee
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on H.R. 1818
The Family Medical Savings and Investment Act of 1995

before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives

June 27, 1995

Mr. Chairman, thank you for this opportunity to testify regarding the Family Medical Savings and Investment Act of 1995 (H.R. 1818).

My name is Peter Hendee and I am a Member of the American Academy of Actuaries, a Fellow of the Society of Actuaries and a Fellow of the Conference of Consulting Actuaries. I am here as a consulting actuary who practices in the health care financing market.

Enacting this bill into law will encourage the use of a promising health care financing mechanism. It will eliminate the handicap imposed by current tax law on health care saving by giving saving the same tax treatment now reserved for health care spending. This will make it practical for employers to provide these accounts for their employees.

These accounts enable individuals to make their own health care purchasing decisions and to accumulate the funds that they do not spend. This makes the patient a buyer as well as a user of health care and provides an incentive to seek cost effective quality health care. It will restore free market characteristics to the provision of health care.

Authority over health care spending is given to the patient instead of imposing third party controls on the patient. This reduces third party intrusion into the provider-patient relationship.

Not only will medical savings accounts be put on a level playing field with other mechanisms for providing employee health care, the bill also counters the current tax law's bias against the self-employed and individuals who purchase their own health insurance. Although these people will continue to be at a tax disadvantage for the catastrophic insurance portion of their health care financing, their medical savings accounts will be treated on a consistent basis with employer provided health care. They will not have to fund these accounts with after tax dollars.

Distributions

The proposed distribution rules are responsible but are not onerous. Taxes on distributions not used for health care are significant enough to encourage responsible behavior. Very importantly, they are not excessive; the account holder will feel the money is available for an important need. This is necessary for the account holder to have an incentive to be a careful purchaser of health care.

Inflation

This bill includes an automatic inflation adjustment for the minimum catastrophic deductible. This provision will make sure that this critical plan feature receives the periodic attention it

needs.

As the cost of medical care rises, deductible levels that are catastrophic today will, over time, be reached by an increasing portion of individuals and families. Periodic updating of the deductible is necessary for the long term success of these plans. The catastrophic deductible must not be allowed to become irrelevant, such as a $50 deductible is today. If it becomes immaterial, then the individual's incentive to control health care spending is weakened.

Administrative Expenses

Filing and processing claims has a cost for patients, for health care providers, and for insurance companies. Small expenses, particularly for routine services, are better handled by the patient paying for them directly.

The majority of people will not exceed their catastrophic deductible amount in a year. These people can pay for all of their health care directly. This eliminates the need to process detailed information on their health care spending.

State Laws

Mandated insurance benefits, such as first dollar coverage for certain preventive services, are required by some states. For example, Florida Insurance Law Section 627.6579 specifies a schedule of physician services for children that must be covered, exempt from any deductible, under all group insurance policies that provide expense-incurred family coverage. As a result of these laws, in some states it may not be legal to issue health insurance coverage that meets the proposed definition of a "catastrophic health plan."

One possible solution is to preempt state mandated benefits, at least for catastrophic products to be used in conjunction with medical savings accounts. Another possible solution is to expand the definition of "permitted coverage" in H.R. 1818 to include mandated benefits.

Conclusion

Many states have enacted medical savings account legislation and many other states are considering such action. Unfavorable federal tax treatment, however, is a forceful impediment to widespread use of this increasingly popular free market health care reform.

I am pleased to be here today to support the same tax treatment for health care saving and health care spending. I will be happy to take your questions.

Mr. CHRISTENSEN. Thank you, Mr. Hendee.

Dr. Goodman, the Committee would be pleased to hear your testimony.

STATEMENT OF JOHN C. GOODMAN, PH.D., PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. GOODMAN. Thank you, Mr. Chairman.

My name is John Goodman. I am president of the National Center for Policy Analysis.

Mr. Chairman, I would like to begin by saying that I believe the traditional fee-for-service health insurance policies that we have, most of us have grown up with, cannot survive in the marketplace. A policy that allows you to see any doctor you want to see, select any test you want to have, while sending the bill to someone else, I think simply cannot, will not, be affordable for most Americans. Therefore, what is happening in the marketplace right now is that people are exercising one of two options. Either they are going into managed care programs where their choice of physician is restricted and where there are limits on the kinds of tests they can have access to, or, if they want to make many of those decisions for themselves, then they have to agree to manage some of their own health care dollars.

Of course, one of the ways to allow them to manage their own health care dollars is through medical savings accounts. We presented this option to our own employees and the answer was unanimous, they opted for the medical savings account. This chart to my right shows how we designed it for the employees with families who work for the NCPA.

We have a deductible for the families of $2,000, and we make a deposit to the medical savings account of $1,500. So, when our employee is going to the medical marketplace, the first $1,500 they spend from their medical savings account. The next $500 they spend out-of-pocket, and when they reach the $2,000 deductible the plan covers all expenses above that.

Now, if we can look at the next chart I think I can answer Mr. Stark's question, at least for employees who work for us. In the left-hand column you see our previous year's policy.

Mr. CARDIN. Excuse me, is this in our written material because I personally cannot see those numbers. Maybe I need new prescriptions. Can that be moved forward?

Mr. GOODMAN. It is in the material. It is in my testimony, yes.

Mr. CARDIN. Thank you.

Mr. GOODMAN. Last year, suppose we have an employee with a child who had cancer, and that family knows they will hit the maximum on their deductible and copayment.

Well, the deductible last year was $500 and we had a 20-percent copayment for another $1,000. With this sick child, that family would have spent $1,500 in out-of-pocket expenses. This year, for no extra cost to us, by the way, we moved to the medical savings account plan, and now as you can see, the most this family will pay out-of-pocket is $500. So, for the family with the sick child, it is as though the switch of plans resulted in a $1,000 raise for that family. We have reduced by $1,000 the cost to them of medical care for that child.

Now, not all employers may choose to design their plan the way that we have, but of the plans I have looked at in the marketplace, most of them have this type of design. In other words, if you look carefully at choices people are exercising, you will find that in most cases sick people gain by choosing the medical savings account alternative.

I would also like to address one other criticism that has been made this morning, and that is the idea that medical savings accounts interfere with managed care. The fact of the matter is they really do not. At the NCPA, we have to decide when our employees have actually met the $2,000 deductible before the plan starts paying for all medical expenses. As it turns out, we count all of their expenses as long as they stay in a network that has been selected for us by the insurer. If the employees go outside the network, which they can, then we only pay 75 percent of the usual and customary fees.

What we have is essentially a network, a point-of-service plan that is very common in managed care plans around the country, but we also have a medical savings account. What we have done is we have integrated the medical savings account with managed care. We think, in this way, we get the advantages of both.

The problem, Mr. Chairman, that several others have pointed out this morning, is the tax law. The tax law discriminates against this kind of plan. It subsidizes other kinds of plans. What we ask for is a level playingfield. Let us let the market decide what the right kind of plan is. Let us not do so legislatively.

Thank you.

[The prepared statement follows:]

Medical Savings Accounts and the Future of Health Care

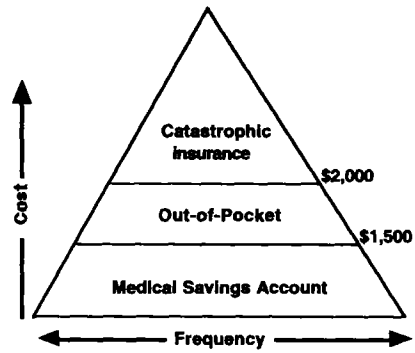
John C. Goodman, Ph.D.
President, National Center for Policy Analysis

The traditional, fee-for-service health insurance policy — that lets people choose their own doctor or select any diagnostic test and send the bill to someone else — is being priced out of the market. Most people can no longer afford it. As a result, most people will have to settle for one of two options: (1) either they will enroll in a health maintenance organization (HMO) that restricts their choice of physicians and limits their access to medical services; or (2) if they want to make these choices for themselves they will have to manage their own health care dollars through Medical Savings Accounts (MSAs).

Currently, the Internal Revenue Service taxes MSA deposits, although employer payments for third-party insurance are tax free. The Archer-Jacobs "Family Medical Savings and Investment Act" (HR 1818) would end this discriminatory treatment.

How Medical Savings Accounts Work. Medical Savings Accounts give people the opportunity to move from a conventional, low-deductible health insurance plan to one with a high deductible (say $2,000 to $3,000) and to put the premium savings in a personal savings account. These accounts are used to pay for routine and preventive medical care, and are combined with a high-deductible health insurance policy that pays for major expenses. Employees and their families pay all medical bills up to the deductible from their MSAs and out-of-pocket funds. Catastrophic insurance pays all expenses above the deductible.

FIGURE I



Employers and their employees are turning to MSAs for the same reason others are turning to managed care: to control rising health care costs. Since employees get to keep any MSA money they do not spend, they have a financial incentive to shop prudently in the medical marketplace. In general, they won't spend a dollar on health care unless they get a dollar's worth of value. Employer experiences with MSA plans show that the incentives work: employees curtail health care spending significantly.

The NCPA's Employee Health Plan. In 1994 the employees of the National Center for Policy Analysis had a conventional fee-for-service health plan with a $500 deductible and a 20 percent copayment. Under this policy, an employee was at risk for up to $1,500 out of pocket. If three members of the same family all became seriously ill, the family was at risk for $4,500 in medical bills.

This year the NCPA adopted an MSA plan that limits the exposure of the employees and at the same time gives them more control over their health care dollars. *At no extra cost to the employer*, the plan creates a $1,500 deductible and deposits $1,125 to an MSA for individual employees. For family coverage, the deductible is $2,000 and the MSA deposit

is $1,500. [See Figure I]. The total out-of-pocket exposure is $375 per individual and $500 per family. [See Figure II.]

FIGURE II

Options for NCPA Employees

	Family	
	Conventional Policy[1]	Medical Savings Account Policy
Deductible	$500	$2,000
Maximum copayment	$1,000[2]	- 0 -
MSA deposit	- 0 -	$1,500
Total out-of-pocket exposure	$1,500	$500

[1] The figures in this column are per family member up to a maximum of three people.

[2] 20 percent of the first $5,000 of expenses above the deductible.

NCPA employees may use their MSA funds to see any doctor, enter any hospital or pay any medical bill. However, spending counts toward satisfying the deductible only if the service or procedure is covered under the health plan. For example, employees can pay for dental care or eye glasses with their MSAs, but those expenses do not apply toward the deductible. Furthermore, all spending counts toward the deductible only if employees see doctors within a network. If they go outside the network, only 75 percent of "usual and customary" fees are counted.

In the future, the buildup of MSA funds will give the employees important options with respect to expensive medical procedures. For example, the health plan will pay the full costs above the deductible only if the procedure is done by a network doctor in a network hospital. But employees will be able to use their MSA funds to go outside the network and pay that portion of the bill not covered by insurance.

Benefits of Medical Savings Accounts. Widespread use of MSAs would create the following benefits.

- People would have first-dollar coverage for primary or preventive care, using their MSA funds; this would be particularly beneficial for lower-income workers who may be short on funds and may be tempted to avoid basic care.
- MSAs would restore the doctor/patient relationship, making doctors agents of patients, rather than agents of a third-party payer bureaucracies.
- MSAs would allow patients rather than third-party payers to make the sometimes tough choices between health care and other uses of money.
- Paperwork and administrative costs would be greatly reduced; since patients would be paying most bills directly out of their MSA, primary care physicians would rarely be burdened by insurance forms.
- Those who live healthy lives and avoid risky behavior would benefit financially from those choices.

- MSAs would put the consumer, rather than an insurance company or the government, in charge of the health care system.

Answering the Critics of Medical Savings Accounts. The existence of plans like the NCPA's refutes most of the major criticisms against MSAs. It is ridiculous to argue, as some have, that the plan isn't actuarially feasible since the very existence of the NCPA employee benefit plan and 1,000 similar private plans prove the opposite. The argument that MSAs benefit the healthy, but not the sick is also easily refuted. A person with high expected health care costs benefits by choosing the new NCPA plan because his total financial exposure is $375, rather than $1,500 under the NCPA's old plan. For families, the exposure is $500 rather that $1,500.

Finally, the criticism that MSAs are incompatible with managed care is clearly untrue, since the NCPA's MSA plan has a managed care component. Although MSAs probably are inconsistent with the traditional philosophy of HMOs, efforts to make medicine cost-effective are natural allies of Medical Savings Accounts.

Under the NCPA plan, for example, the insurance company has established a preferred provider network (PPO) and has negotiated discounted rates with hospitals and other providers. But the employee is free to use that MSA money for the purchase of any type of medical care. Patients who go outside the network can pay for the full cost of the service from their MSAs.

Tax Fairness. If MSAs have all of these benefits, why haven't they become more widespread? The reason is the tax system. When an employer spends a dollar on health insurance, the employee escapes federal and state income taxes. But if the employer puts that dollar in an MSA to pay medical bills directly, it is taxed as income.

Because of this distortion, seven states have passed MSA legislation under their state income tax systems to create a level playing field between self-insurance and third-party insurance. Those states are letting people avoid the state income tax on money they set aside in a Medical Savings Account.

However, states have no control over federal tax law, which is why America needs the tax changes proposed in the Archer-Jacobs bill.

Health Care in the Information Age. The traditional philosophy of HMOs was summed up by an HMO manager several years ago: "Patients do what their doctors tell them to do; therefore, if you can tell doctors how to practice medicine, you can cut costs." This approach assumes that patients are compliant because they do not know what services they are not receiving.

A model based on patient ignorance, however, is unlikely to survive in the new Information Age. Increasingly, patients will use the Internet and other computer services to tap into various medical libraries and databases, discuss ailments with other network users and follow diagnosis decision trees. Thus, the best model for the future is one that assumes that patients will know as much as their doctors — not about how to practice medicine but about what medical practice offers.

One such model is Medical Savings Accounts. Using their accounts, patients will seek doctors who are financial advisors as well as health advisors. Physicians will be aided by sophisticated computer programs. No large bureaucracy will be required. When all patients have ready access to information, doctors acting as their agents will probably outperform most bureaucracies.

In order to take full advantage of the information age, however, Congress needs to give patients, health care providers and insurers the freedom to experiment with the most efficient and cost effective ways of providing quality health care.

Mr. CHRISTENSEN. Thank you, Dr. Goodman.

Since the NCPA, National Center for Policy Analysis, has its own medical savings plan, how difficult was it for you to convert from the health care plan a year or two ago to its current MSA type of plan?

Mr. GOODMAN. It was not difficult at all. Now, we are a small business. We only have 28 employees and, therefore, we cannot afford to give choices to our employees a larger organization could. We consulted with all of them, and whatever we did, it had to be the same plan for everyone.

Mr. CHRISTENSEN. Did you find that the MSAs have been deficient in providing health care coverage with respect to any particular type of health care; for example, hospital stays of specific types of medical procedures? Are there any deficiencies thus far in the plan; and what has been the overall general reaction of the employees?

Mr. GOODMAN. We have been in the plan since January 1, so we have not had a tremendous amount of experience with it. But it is comparable to other plans that other employers have had for a longer period of time.

The basic plan covers basic medical care, but there are certain things that we do not cover, and people can use their medical savings accounts, for example, to buy eyeglasses and certain other kinds of care that are not covered by the plan. Our employees have flexibility, and, of course, what they do not spend at the end of the year they get to take home and keep.

Mr. CHRISTENSEN. How much do you anticipate the MSAs saving your company in administrative costs?

Mr. GOODMAN. Our goal in making this transition was that I did not want the cost to the employer to increase. In the two columns that you are looking at, from two different insurance companies, the cost to us remained the same. My instructions were, let us put as much as we can in the medical savings account with no increased cost to the employer.

Now, what this means is that the savings we get under this plan, the employees get to keep it. That is true of most medical savings account plans. It is wrong to think of them primarily as designed to save money for the employer. They do not. Primarily, the people who economize and save money in their account get to keep it. That is a good feature of this kind of incentive system. It is designed so that those who economize get the benefits of their economizing.

Mr. CHRISTENSEN. Some States have already enacted legislation that would allow favorable tax treatment for MSAs. I know Michigan was one of them. We heard Congressman Chrysler testify earlier. How significant of an impact do you see H.R. 1818 having on the States and what specific legislation do you see would have to be enacted to accomplish that goal?

Mr. GOODMAN. At the State level?

Mr. CHRISTENSEN. Yes.

Mr. GOODMAN. Really, none. There are about 14 States now that have adopted medical savings accounts under their State income tax laws. But what most States do is they piggyback on the Federal Tax Code. So, if medical savings accounts were created under Fed-

eral tax law, it would automatically be created under most State income tax systems.

Mr. CHRISTENSEN. My final question would be how could we improve H.R. 1818? Any suggestions for improvement?

Mr. GOODMAN. Well, I would allow the money to grow tax free. I cannot tell you now what the revenue loss as a result of that decision would be. But, I think it ought to function like a normal IRA. That money should grow tax free. Certainly if when you pull it out you are going to pay taxes plus a penalty, you should get the benefits of tax free growth. But I support the act as now written.

Mr. CHRISTENSEN. Thank you very much.

Mr. Crane, any questions?

Mr. CRANE. Thank you, Mr. Chairman.

Mr. Hustead, if I read your testimony correctly, on balance, your group thinks that medical savings accounts will be able to deliver quality health care at a reduced rate; is that a correct reading?

Mr. HUSTEAD. I think we say that if we are looking at a traditional fee-for-service plan and raising the deductible, that should be able to deliver the same health care as now at a reduced rate, yes.

Mr. CRANE. Have you ever designed an MSA plan for a client?

Mr. HUSTEAD. No, I have not.

Mr. CRANE. Have any of you had any experience in that realm?

Mr. HENDEE. I have designed one medical savings account program and am currently designing another. Designing a program generally involves raising the deductible and determining how much money would be saved as a result of raising the deductible, and then the employer makes a decision as to the appropriate level of contribution to the account.

Mr. CRANE. I have heard that with a $200 deductible in contrast to a $1,500 deductible policy, the differential in premium cost is almost four to one. Does that sound reasonable? In other words, you would be paying four times as much for a $200 deductible than for a $1,500 deductible.

Mr. HENDEE. It would depend a lot on the program of benefits that you provided. The report of the Committee that Mr. Hustead chairs indicates that for a change comparable to the one you described, the savings would be on the order of $600 to $800. That is my recollection, for that change in deductible. And depending on what the total program of benefits was, that amount of money could be a different percentage of the original premium.

Mr. CRANE. Thank you very much. Dr. Goodman.

Mr. GOODMAN. Well, if you look at market prices for insurance around the country, you will see that the amount you save in premiums by choosing a high deductible over a low deductible varies. The most significant variable is how high are the health care costs in the region generally. So, if you are in a high cost city, like New York or Los Angeles, you will save much more by going to a higher deductible than you will if you are in a low cost area or even an average cost city like Dallas.

Mr. CRANE. I see. Thank you very much.

Mr. CHRISTENSEN. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Mr. Hustead, you have produced, I suppose, the most comprehensive report of this MSA concept. Did the insurance companies that

do a lot of high-deductible assist or enter your review? Or were they contacted at all?

Mr. HUSTEAD. We did get information from a lot of insurance companies who sell individual products and the report does reconcile our numbers with those individual products. We did go to those employers who have said that they have MSA accounts that are saving substantial money and in several cases we got information, but it was fairly scarce. In other cases, we were not provided any information. We did provide in the report the information that was provided by several of these organizations.

Mr. STARK. Is that usual, that they will not give you policy information?

Mr. HUSTEAD. Well, the insurance policy information we got, because that is public information. The information on how employers are managing their own plans, now, that often is not available because so many confusing things are happening within the organization. They would have had to do a fairly good analysis process.

But I think we threw out our net and with our members were able to get all the information that does exist on these plans.

Mr. STARK. Mr. Goodman, you are referred to as the father of MSAs. Who is the mother? It seems to me that the chief contributors to the National Center for Policy Analysis are Golden Rule Insurance. And Pat Rooney, he is the director; isn't he?

Mr. GOODMAN. The premise is not correct. The chief contributors to the NCPA—or should I say the chief contributor is not Golden Rule Insurance Co. Golden Rule makes an annual contribution of about $60,000 to our organization.

Mr. STARK. And Mr. Rooney is the director?

Mr. GOODMAN. No. He is the chairman of the Golden Rule. Our annual budget is $3 million, and so that is a small part of our——

Mr. STARK. How much of the $3 million comes from insurance companies?

Mr. GOODMAN. Pardon me?

Mr. STARK. How much of the $3 million comes from insurance companies?

Mr. GOODMAN. Probably less than $100,000.

Mr. STARK. Golden Rule is the big one, then.

Mr. GOODMAN. Yes.

Mr. STARK. OK. We asked if you would send us more detail on your plan. I presume you are going to send that on to us.

Mr. GOODMAN. Yes, I am. I received your note and I looked at my plan and learned something I didn't realize, and might not have realized had you not requested it. Our plan does not include a reference to medical savings accounts.

In other words, our contract with the insurance company is just a high-deductible policy and the plan pays for all expenses over $2,000. We have a separate arrangement with a third party administrator to manage our medical savings accounts. But, I will be happy to send you the contract.

Mr. STARK. Yes. As I say, I would be interested because just as Mr. Hustead said, some of these are a little hard to focus on just what the terms are, and if one was writing legislation to enact them, it would be helpful to know what the state of the art is.

[The following was subsequently received:]

Golden Rule®

THE MEDICAL SAVINGS ACCOUNT PLAN PARTICIPATING EMPLOYER APPLICATION

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439

Trustee: National City Bank, Indianapolis, Indiana

Section 1 EMPLOYER INFORMATION

Company's Legal Name: National Center for Policy Analysis

Business Address: 12655 N. Central Expwy. Ste. 720 (Street) Dallas (City) Tx. (State) 75243 (Zip) Dallas (County)

Contact Person: Rena Brand Phone: (214) 386-6272

Nature of Business: Thinktank on policy issues How Long in Business _____ years

Section 2 OTHER INSURANCE INFORMATION

Has an insurance carrier terminated your coverage within the last five years? If yes, provide name of carrier: no

Please check the number of insurance carriers you have had in the last 3 years: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than five

Is this insurance being applied for to replace other group health insurance coverage? Yes ✓ No ____ If yes, please submit a copy of current or prior carrier's coverage and last bill with employees' names.

Effective Date: 11/1/91 Company Name: Pacific Mutual

Policy or Group No.: 13095

WE SUGGEST THAT YOU NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE THE CERTIFICATES OF COVERAGE FROM GOLDEN RULE.

Section 3 EMPLOYEE AND DEPENDENT INFORMATION

A. Total Number of Employees (Part-time and full-time) 18

B. Total Number of Full-Time Employees (A full-time employee is one who works at least 30 hours per week and 48 weeks per year.) 18

C. Total Number of Qualified Employees (Full-time employees not declining this medical coverage due to other group health insurance coverage.) 14

D. Total Number of Qualified Employees Requesting Medical Coverage 14
Note: Groups with 51 or more employees: the number in response D must be at least 75% of all qualified employees (response "C") and at least 60% of all full-time employees (response "B"). Groups with 3-50 qualified employees: the number in response D must be at least 90% of all qualified employees.

	Yes	No
E. Is any employee/dependent currently on a continuation of benefits under COBRA or State Continuation Law?	☐	☑
F. Has any employee/dependent qualified for a continuation of benefits under COBRA or State Continuation Law and not yet elected to continue coverage?	☐	☑
G. Has any employee or their dependents had claims in excess of $7,500 in the last two years? If yes, please list the employee's name(s). _____	☐	☑
H. Do you contribute at least 50% of the premium cost of coverage for your employees?	☑	☐

I. Please list any employee who is not actively at work.

Name	Reason
n/a	

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GROUP NEW BUSINESS

Please list any employee or dependent who has had coverage rejected by a previous carrier.

Name	Reason
n/a	

Section 4 COVERAGE INFORMATION FOR NEW EMPLOYEES

A. Waiting period for new employees. You must choose one ___ 0 Days* ___ 30 Days* X 90 Days
*Not available to groups with 3-50 employees.

B. Life Insurance and Accidental Death and Dismemberment Insurance (AD&D).

Employee Classification	Amount of Life Insurance	Amount of Weekly Disability Income Insurance (optional)
All	$15,000	

C. Deductible Option (Single employee deductible/family deductible
You must choose one
☑ Plan I $1,500 Single/$2,000 Family
☐ Plan II $2,000 Single/$3,000 Family

D. Coinsurance Option PPO
You must choose one
☑ 100% coverage after the deductible
☐ 80/20 coinsurance to $5,000 per covered person

E. Optional Coverage
☑ Maternity (same as any illness)
☐ Weekly Disability Income
☐ Dependent Life - Option A
☐ Dependent Life - Option B

Section 5 EMPLOYER AGREEMENT AND REPRESENTATIONS

The Employer represents that the Producer of Record has (a) provided employer and employee brochures; and (b) discussed group eligibility, contribution requirements, participation requirements, precertification requirements, provisions for preexisting conditions, and that the Employer fully understands these requirements and provisions.

The Employer understands and agrees:

(a) to make timely payments of the required premiums billed by Golden Rule;
(b) that Golden Rule has the right to change premium by class as necessary (Premium factors include age, gender, claims experience, employee participation, geographic area, and the length of the Employer's participation in the plan);
(c) that the Underwriting Department may call the Employer and employees at the Employer's place of business to develop information to enable Golden Rule to make a prompt underwriting decision;
(d) that the Producer of Record: (1) is an independent contractor assisting the Employer; (2) not an agent of Golden Rule; and (3) cannot bind coverage or change or modify conditions of coverage; and
(e) to comply with Golden Rule requirements regarding the insurance plan, as set forth in the policy or communication in writing by Golden Rule.
Specifically, the Employer warrants and represents that:
(1) Employer has provided Golden Rule with the names of all full-time employees, even if they do not intend to be insured by Golden Rule;
(2) Employer will provide Golden Rule with the names of all new employees and new dependents, even if they do not intend to be insureds; and
(3) all information on this form is true and correct.

Section 6 JOINDER AGREEMENT

The undersigned Employer, desiring to obtain the benefits of group insurance for its employees, hereby agrees to join one of the Golden Rule Trusts as a Participating or Enrolled Employer. If approved by Golden Rule, the Employer accepts and agrees to be bound by the provisions of: (a) the Agreement and Declaration of Trust dated July 30, 1977, as amended, which created the Trust; and (b) the Master Insurance Policy issued to the Trustee by Golden Rule. The Employer understands that the documents referred to in items (a) and (b) are subject to future amendments.

Signed at Dallas, Tx on 12, 7, 94 (Month, Day, Year)
Employer Signature Rena K. Brand Rena K. Brand
Employer Name National Center for Policy Analysis Title Dir. of Administratio

MET-AF-12 42

PRODUCER'S STATEMENTS

I hereby certify that all of the information herein is complete and correct, that the firm is a bona fide business establishment, and that I know nothing unlavorable about the group. I certify that each employee has completed the employee application with his or her own hand. I further certify that I have complied with all of Golden Rule's rules and requirements; (2) I have explained to and the Employer fully understands the provisions for preexisting conditions and precertification; and (3) I have explained to the Employer the requirements for contribution and participation and these requirements are being met. I have instructed the Employer to not cancel current group coverage before certificates of insurance have been issued by Golden Rule Insurance Company and delivered by me.

Signed at Dallas, Tx on 12, 7, 94 (Month, Day, Year)
Producer Signature
Producer Name James Waldron CLU Producer Number 258-40-7361 Phone Number 214-231-9531

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Mr. STARK. Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Thank you, Mr. Stark.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Gentlemen, thank you for coming today. I am sorry I missed part of your testimony but I am familiar with the concept, having been a promotor—not the father—but a promotor of this concept for some time. I appreciate the work Dr. Goodman has done on this.

Dr. Goodman, just to clear up one thing, you said that the savings under this type of plan go to the individuals involved and not to the employer. But isn't it true that as an employer you anticipate savings in the future in terms of future increases in your premium costs to cover your employees?

Mr. GOODMAN. Well, that's correct. What we did in moving from 1994 to 1995 was we held our plan costs constant, and for the future we anticipate that as employees save money for themselves they will also save money for the organization.

Mr. MCCRERY. I just wanted to clear that up.

At the end of your testimony, Dr. Goodman, you state that Congress should give patients and health care providers the freedom to experiment with ways to provide quality health care more efficiently and effectively.

Can you give us some examples of that?

Mr. GOODMAN. Well, what we have now is an income tax structure which encourages third party payers to pay every medical bill because the payment of third party premiums is excluded from the taxable income of the employees.

What we recommend and what this bill does is make self-insurance through medical savings accounts just as attractive under the Income Tax Code as todays third party premiums are. And if you create a level playingfield, what you will do is allow insurers, employers and employees to be more flexible and come up with options that none of us have considered here this morning. We should not have people making these decisions based on tax advantages. We should allow them to make these decisions based upon health care needs and the economics of the health care marketplace.

Mr. MCCRERY. Well, for example, someone might use some of his MSA money for a physical exam that might not have been covered under a traditional insurance policy; is that correct?

Mr. GOODMAN. That is correct.

Mr. MCCRERY. OK.

Mr. Hustead and Mr. Hendee, you know, we have a very limited experience so far with MSAs though hope to get more in the future. Can you comment on what you think the stability of the premium for a high-deductible policy might be over time?

Mr. HUSTEAD. Well, while there may be little experience with MSAs, there is a good deal of experience on ranges of options like in the Federal employees health benefits program. And generally you find that once the employees sort them out into the various plans, low-deductible, high-deductible, HMOs, and so forth, that the cost of each of the plans tend to rise at about the same rate. So, they are fairly stable once you go over the initial sorting out of people.

Mr. MCCRERY. Mr. Hendee, do you have any comment on that?

Mr. HENDEE. I would agree that the increase would tend to be similar under both programs.

Mr. MCCRERY. You do not see a danger if a great segment of the market were to go toward high-deductible policies? You do not see a danger that that kind of instrument would—the premiums for that kind of instrument would grow more than we have experienced under the current system?

Mr. HUSTEAD. No. There would be the initial reaction in the simple case of just having the low- and high-deductible plan that the cost of the low-deductible plan would go up as the healthier people move to the high-deductible plan. But then the premiums, once that initial change happened, would rise at about the same rate.

Mr. HENDEE. I believe that actually the rate of increase of all policies would decrease. This is in the academy's report, HCFA research has shown that as the percentage of health care costs that are paid by third parties increases, so does health care inflation. So, moving to catastrophic policies will decrease the percentage paid by third parties and, hopefully, would decrease the health care inflation.

Mr. MCCRERY. OK. Thank you very much.

Mr. CHRISTENSEN. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I am having a difficult time reconciling the testimony from Mr. Hustead and Dr. Goodman. Let me see if I can try to set this up and get a response from both of you.

Mr. Hustead, you indicated that if you move from a $200 deductible to a $2,000 deductible, that an employer would start $828 in premium savings, on average, if I am reading your chart correctly.

Mr. HUSTEAD. That is correct.

Mr. CARDIN. Yet, Dr. Goodman has indicated that his firm moved from a $500 deductible to a $2,000 deductible, and the $500 deductible policy had copayments up to $1,000 and that the savings to his company were $1,500, that he was able to put into the medical savings accounts. If I understand, it was at no additional cost to the employer to put the $1,500 in the medical savings account.

Dr. Goodman also indicates that he comes from an average cost community. So, it did not seem like it was high cost. How do we reconcile what appear to be significant differences in the potential savings from what Mr. Hustead has come up with and what Dr. Goodman is experiencing? Any explanation?

Mr. HUSTEAD. Well, the very reason for the organization of our work group last year, is that as actuaries would testify before Congress and give their evidence, there seemed to be this great difference in the actuarial community. We got together people from we think, all ranges of view on this topic and sat down and said, when we put our models together and look at experience based on millions and millions of lives over many years, what are the actual facts, what is really happening here.

We also, as indicated earlier, went out to the insurance companies and to people who had MSAs and said, what are your findings? Let us make sure we get this all stated together. And the range of opinion among the actuaries, based on this body of data was fairly narrow. Some of us, depending on the situation, might

say, well, you could reduce the premium by $800, some $600, but, generally, we found our models to be quite consistent.

Of course, if you have any individual cases, as I understand Dr. Goodman has, and, of course, as he says, it has just started so really we do not know what the situation will be, but if you just have 20 or 30 people, you could easily have cost savings of $1,500 or $2,000 if you have cost increases.

Mr. CARDIN. I will give Dr. Goodman a chance, if I might. Using your figures, the $828 savings, that gets eroded if it is a small amount that the employer puts in, if I understand your testimony, unless the employee buys in, this is not really my savings for health care, the savings are not as much. And if there are other options allowed under the employer's plans, only the healthier people will likely opt into the medical savings account. Is that right?

Mr. HUSTEAD. It is a caution we make that those type of things could happen. We think, or at least I think, that a large employer with a number of options in their plan, can control that situation. But if you take a group where you do allow current options to continue and where you do set up the MSAs; if you compare the savings to what would occur if you moved everybody to a high-deductible plan, you generate less savings if you allow selection to occur.

Mr. CARDIN. Dr. Goodman, if I understand your plan, you only have that one plan so your employees are in the high-deductible plan.

Mr. GOODMAN. That is correct.

Mr. CARDIN. So, you do not run that risk.

Also, you are putting a significant amount of money into their savings accounts so they really do have an interest in trying to save some money.

Mr. GOODMAN. That is correct.

Mr. CARDIN. Have you experienced this type of savings, the $1,500, and is that net of the tax advantages? You are not getting a tax advantage right now.

Mr. GOODMAN. No, we are not. We have to pay taxes on all the money deposited, which is a feature the Archer bill, of course, would change. But we do pay taxes on it, even if the money is spent on medical care. We have to pay taxes on the deposits to the medical savings account.

Mr. CARDIN. You believe that you will be able to realize a $1,500 per employee savings that you are giving back to the employees through the medical savings accounts.

Mr. GOODMAN. We have already done it.

What we did was we held the employer's total cost constant and saved enough to put $1,500 in the medical savings account. Now, employees will spend part of that money. In fact, we anticipate half the money will be spent by employees on medical care.

Mr. CARDIN. Trying to look at this from the employer's point of view right now. From the employer's point of view, it came out no additional cost.

Mr. GOODMAN. That's right.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Goodman, in your testimony you noted that the NCPA and an insurance company established a preferred provider network. Can you tell the Subcommittee a bit about how this PPO agreement was achieved?

Mr. GOODMAN. No, I really can't, except it appears on the surface to me to be a very normal preferred provider arrangement in Dallas. It includes a large number of doctors and our employees do not feel constrained by operating within the PPO network, although some may choose to go outside it.

Mr. ENSIGN. Since the NCPA was able to establish a PPO, don't you think this factor is a very strong indication that MSAs can be integrated into the existing health care system?

Mr. GOODMAN. Oh, yes. In fact, we have done it. And in fact most private plans that have medical savings accounts are integrated with some sort of managed care.

Mr. ENSIGN. Thank you. And thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I recall Premier Gorbachev being here and he gave us a warning once talking about how you get along with Americans. He said you can always agree sort of on the general principles but the devil is usually found in the details. And I sort of have the feeling that we are talking a little bit about the details here today.

Mr. Christensen was kind enough to pass out a card for one of these medical savings accounts and I just absentmindedly started reading the back side of it and since you guys are actuaries, and you have these plans out there, I wonder if your card said something like this on the back. It says: "Medical precertification is required at least 7 days prior to admission, surgery, or home health care. For emergencies call in 24 hours. If not certified, benefits may be reduced." Then it says this sentence, which I wondered if you would have on your card, "Certification is not a guarantee of payment."

Now, if the doctor tells me I need to go in and have my gallbladder taken care of, and I call up 7 days in advance and say I am going to the hospital, my doctor has ordered me in to have my gallbladder removed, and they say, well, yeah, we will certify that, what does that line mean, "Certification is not a guarantee of payment"? Does that mean after I'm out of the hospital I will have to argue with them?

Mr. HUSTEAD. It could well be. I do not think this is language that is limited to MSA. This is typical language for health plans.

I think the warning they are getting at is that—while the insurer will precertify your need to be in the hospital, if you, say, go on for 4 or 5 days, when the health plan says you should only be limited to 3 or 4 days, the plan will not pay the extra days.

Mr. MCDERMOTT. What they are certifying is 3 days in the hospital to have your gallbladder out. They do not tell the patient that, they just say, yes, you can go have it done, but hidden in the drawer is the chart that says, after 3 days out, you go, ready or not, or you will pay it yourself. Is that what you are suggesting?

Mr. HUSTEAD. I think what happens is, that the doctor and the insurer and the hospital work together on the issue with the pa-

tient's knowledge. But it is more of a legal statement that says just because you get in does not mean we will pay the whole bill.

Mr. MCDERMOTT. So, people should read this card very carefully if they decide they want to get involved in it.

Mr. HUSTEAD. That is correct.

Mr. MCDERMOTT. Let me ask a question about the plan. Dr. Goodman, could you tell me, the people who are in your plan, what is the age range? What is the oldest person and the youngest person in your plan?

Mr. GOODMAN. Oh, my gosh. Probably 65, 64; 65 would be the oldest and 19 or 20 would be the youngest.

Mr. MCDERMOTT. What is the average?

Mr. GOODMAN. Approximately 35.

Mr. MCDERMOTT. Thirty-five. So basically healthy young people?

Mr. GOODMAN. Yes. Reasonably healthy.

Mr. MCDERMOTT. Reasonably healthy.

Mr. GOODMAN. We have some employees with health problems.

Mr. MCDERMOTT. And when they pay money for their health care, they reach into their medical savings account to pay for something, does that money get counted against their deductible under the health plan; or is it only on certain procedures that are covered in the health plan that to be counted toward the deductible?

Mr. GOODMAN. As long as it is a covered expense, it is counted against the deductible. If they stay within the network, all they spend counts against the deductible.

Mr. MCDERMOTT. But if they have—so if the medical savings plan is very narrow—for instance, does it include mental health benefits?

Mr. GOODMAN. Some mental health benefits, but I cannot tell you the extent of them.

Mr. MCDERMOTT. So, if they go beyond this narrow little mental health benefit, then anything they spend beyond that would not be counted against the deductible?

Mr. GOODMAN. I did not say it was narrow or little. There is some mental health benefit, but I cannot tell you the extent of it. But once they go outside the plan, which they are free to do and they have the money that allows them to do that, that does not count toward the deductible.

Mr. MCDERMOTT. I see. So, they could really spend their whole account outside of the plan on medical benefits, since the definition of medical benefits for which the medical savings account could be used is a fairly broad one. But the plan might be narrow, and, therefore, would never count against the deductible. Then, if they had a big problem, they would have a big deductible all of a sudden.

Is that a fair assessment of a potential problem?

Mr. GOODMAN. That is fair, but that same statement could be made about the conventional plan that we had last year. In other words, the movement to the medical savings account did not really change the range of benefits employees were entitled to. What it does is it allows them to manage more of their own health care dollars.

Mr. MCDERMOTT. So, you are saying that the Continental and the medical savings account up there on that chart, the benefit packages are exactly the same?

Mr. GOODMAN. Roughly the same.

Mr. MCDERMOTT. Roughly the same.

Mr. GOODMAN. Yes.

Mr. MCDERMOTT. What is the difference?

Mr. GOODMAN. Well, I cannot tell you that every comma and period is the same, but, roughly, they are the same benefit structure.

Mr. MCDERMOTT. But there is a $500 deductible on one and $2,000 on the other. That is where I am having my trouble figuring out——

Mr. GOODMAN. That has to do with the part to be paid by the patient. But the services covered by the two plans are virtually the same. How much mental health is covered by the two plans is the same in both cases.

Mr. MCDERMOTT. Is there alcohol rehabilitation in the plan?

Mr. GOODMAN. I'm sorry?

Mr. MCDERMOTT. Is there an alcohol rehabilitation benefit in the plan?

Mr. GOODMAN. I cannot tell you. I do not know.

Mr. MCDERMOTT. I see.

Thank you, Mr. Chairman. I would like to have—I also would like to see a copy of your actual plan that people have, so we can actually look at what this card guarantees them to or does not guarantee them to.

Mr. GOODMAN. That is not our card.

Mr. MCDERMOTT. I understand that. We will get the plan from this one, too, but I would like to see yours, because I think people will get caught in the details. What sounds like a good idea, you can manage your own health care money, presumes you know what is going to happen to you. None of us know and people are going to get squeezed by this thing.

Mr. GOODMAN. Mr. Chairman, may I respond to that?

Mr. CHRISTENSEN. Yes.

Mr. GOODMAN. The restrictions that are there on that card have nothing whatever to do with medical savings accounts. Those are the kinds restrictions that are being imposed on people by managed care plans all over the country. And what medical savings accounts do is, it gives people a little bit of freedom, and a little bit of control over their own health care dollars so that every decision is not made by the managed care bureaucracy.

Mr. MCDERMOTT. I would just, in answer, it is on a medical savings account. It is the RCI medical savings account, so it is the same as HMOs. Whatever you think you are getting away from in an HMO, you will meet it coming around the corner in this.

Mr. CHRISTENSEN. The gentleman's time has expired. The card the gentleman is holding up is the MPO, Michigan Provider Organization. It is a managed care network and it is an example of RCI. So, it is part of managed care.

I will recognize the gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman, and, Mr. McDermott, you might want to check your insurance policy. I have checked mine. I get it through the Federal employees health benefits pro-

gram, and on the back it says "Precertification is required for all hospital admissions and is ultimately your responsibility." I think you will find that it is the same——

Mr. MCDERMOTT. I have the same card. My point was this is not giving people any——

Mr. MCCRERY. If the gentleman would like me to yield.

Mr. MCDERMOTT. Yes. You brought it up. This medical savings account does not give you anything, because you are in the same box. The insurance companies have got you in the vice.

Mr. MCCRERY. Well, except for the first $2,000, you have pretty much total freedom. You are not dependent upon the insurance company, you are dependent on yourself. So, there is a great difference between the two.

Reclaiming my time. I just want to say to the gentleman that everybody needs to read the back of their card, in fact, their whole policy.

If I can shift the focus for just a second to HMOs, HMO type managed care plans, I want to address this to Mr. Hustead and Mr. Hendee. Are there risk selection problems associated with HMOs in the marketplace?

Mr. HUSTEAD. Any option has risk considerations with it.

Mr. MCCRERY. But are there risk selection problems, particularly associated with HMOs in today's climate?

Mr. HUSTEAD. I am not——

Mr. MCCRERY. In other words, is there a fear or do we know that healthier people tend to gravitate toward HMOs? Is there a risk selection problem in today's marketplace with HMOs?

Mr. HUSTEAD. I think, in general, the studies have shown healthier people, younger people have selected HMOs over the years, yes.

Mr. MCCRERY. Mr. Hendee?

Mr. HENDEE. Yes, the common expectation is healthier people do move toward HMOs.

Mr. MCCRERY. And what about MSAs, are there risk selection problems associated with MSAs; and, if so, are they roughly comparable to those associated with HMOs, or are they greater? Less than?

Mr. HUSTEAD. It depends on the group. I think the same general forces are there, in that the people—I guess if we are saying who will stay with the traditional fee-for-service, low-deductible plan and not go to an HMO or a high-deductible plan, people that need the most health care tend to stay there because it provides the greatest benefit. With a large employer, who will now look at the MSA and high-deductible option, these are the types of selection questions they have dealt with for years, and I think they can successfully monitor and deal with selection to make the effects what they want them to be.

So, I do not think the introduction of high-deductible plans introduces any large new selection problems compared to what has gone on in the past.

Mr. MCCRERY. Mr. Hendee.

Mr. HENDEE. The selection may actually go in the other direction, to some degree, because people who do have some medical problems and want to preserve their choice and not be restricted

by case management may prefer to go with a medical savings account and the high-deductible plan, whereas under the current situation they would stay with the low-deductible plan to preserve their choice.

Mr. MCCRERY. So, are you saying that there is——

Mr. HENDEE. You are not necessarily just going to get the low cost people moving to the MSA.

Mr. MCCRERY. Is it your opinion that the risk selection problems associated with MSAs is no greater than that associated with HMOs.

Mr. HENDEE. I agree that an MSA option produces selection concerns comparable to those produced by an HMO option. Depending on the specific situation those concerns may be greater or less.

Mr. MCCRERY. OK. Thank you.

Mr. CHRISTENSEN. I thank the panel for their testimony.

I would now call up the next panel, Hon. Bret Schundler, Jean Samuelson, and Charles Rateliff.

Chairman THOMAS [presiding]. I want to welcome the panel and tell you that if you have a statement we will make it a part of the record without objection, and you can address the Subcommittee in any way you see fit in the time available to you. And we will go first with the mayor of Jersey City, New Jersey, Hon. Bret Schundler.

STATEMENT OF HON. BRET SCHUNDLER, MAYOR, JERSEY CITY, NEW JERSEY

Mr. SCHUNDLER. Thank you for allowing me to join you today. I want to express my strong support for H.R. 1818, the Family Medical Savings and Investment Act of 1995, which grants contributions to medical savings accounts with the same sort of tax deductibility now permitted only for the payment of health insurance premiums. I think this is the most constructive and important piece of health care reform legislation that this Congress will face.

Last year, Jersey City, New Jersey, was one of the first public entities in the United States to provide MSAs to its employees. Previously, all of our employees were in the medical—what is called the State health benefits plan, which provides three options for our employees. One is a standard, low-deductible indemnity policy; the second is an HMO; and the third is a preferred provider option plan.

What we have done is added a fourth option which is a catastrophic policy with a medical savings account. And I might add the catastrophic policy mirrors the State low-deductible policy. So, the benefits that are covered are 100 percent the same, but what you have is a higher deductible with the MSA option.

Right off the bat, 56 percent of our eligible employees chose the MSA option over their previous coverage. And we expect that percentage to rise to over 90 next year. Moreover, for every employee who has chosen the MSA option, the city has achieved immediate budgetary savings of $500, and we expect even greater savings to be realized in the future.

Now, how has the MSA been able to please both our employees and reduce our health care costs? The answer is relatively simple. In the past, Jersey City covered its management employees

through the New Jersey State health benefits plan, as I mentioned. Most chose the fee-for-service option where employees had to pay a $200 front end deductible and a 20 percent copayment on the first $2,000 of expenses for each covered family member.

That means if you had a family of four you could have potential out-of-pocket expenses of up to $1,800 in medical expenses. That would be 20 percent of $2,000 times four people, plus another $200 up front deductible. So, that comes to $1,800.

Under the MSA plan, the city purchases that catastrophic insurance policy that covers 100 percent of the family's medical costs above $2,000. Then we put $1,800 into the medical savings account. This gives the family the opportunity to draw on that medical savings account to cover the first $1,800. They cover out-of-pocket the next $200. And above that $2,000 limit, the insurance covers 100 percent of their expenses.

If at the end of the year there is money left in the medical savings account, they will get a check for the unused portion of the account. It is not hard to see why the MSA plan is more attractive. If family health care costs are high, family out-of-pocket expenses will be less under the MSA than under the previous low-deductible policy most of our employees chose.

To be precise, for a family of four, the out-of-pocket exposure goes down from $1,800 to $200. Now, if the health care costs are low, the family will actually have money rebated to it, representing whatever is remaining in the MSA. Obviously, the prior low-deductible policy never rebated money to you if you had low health care costs.

The reason we expect to see over 90 percent next year is when those rebate checks go out I suspect those who chose not to look at the MSA plans just may reevaluate their medical health plan needs.

Now, the cost to the city again is down by $500. Last year, it was $6,800 for everybody who chose the standard plan. Now it is $6,300 and costs us $4,500 for the catastrophic insurance policy and $1,800 for the cash contribution. So, that is a savings of $500 per family.

We also expect to save even more money in the future as, again, employees begin to look for value in the way they spend their money. Forbes, Inc. has been able to reduce its health care premiums by approximately 25 percent in the 3 years they have had their plan in effect.

I know that the critics of MSA argue that many families, lured by the prospect of a check at the end of the year, may not get necessary care. I have to say from personal experience that is not the way MSAs work. I recently went in for foot surgery to treat a recurring ailment and at the end the doctor offered to give me a padded shoe, for instance. I simply said, I do not need that, I already have one at home. I might not have even brought up the subject had there not been a financial incentive to actually reduce my medical cost.

The bottom line is that the American people are not afraid to make informed judgments about their own health care needs. What they are afraid of, however, is losing the opportunity to make their own judgments because of third party rationing. If we can control

health care costs by maintaining choice and incentivizing citizens to get what is good for them, and what actually makes fiscal sense for all of us, that is a great power and that is a great positive.

I would like to conclude by simply saying I think Congress should immediately offer medical savings accounts to federal employees. It would represent a far greater savings to the American taxpayer if you make this available as an option. You do not have to replace anything you offer your employees today. You should simply give them an additional option.

I might add, if you did the same with Medicare and Medicaid you would dramatically reduce health care costs in America. If you have that combined effect with Jersey City and Medicaid/Medicare and Federal employees all having an MSA option, I think you will take the wind out of health care inflation.

In short, I would like the Ways and Means Committee to move quickly to pass the Family Medical Savings and Investment Act of 1995. Thank you very much.

[The prepared statement follows:]

STATEMENT OF HON. BRET SCHUNDLER, MAYOR, JERSEY CITY, NEW JERSEY

Chairman Thomas and Members of the Subcommittee on Health:

I would like to express my strong support for HR 1818, "The Family Medical Savings and Investment Act of 1995," which grants contributions to Medical Savings Accounts (MSAs) with the same sort of tax deductibility now permitted only for the payment of health insurance premiums. This is the most constructive and important piece of health care reform legislation that Congress will entertain this year.

Last year Jersey City, New Jersey was one of the first public entities to provide MSAs to its employees. The results have been extremely positive. Right off the bat, 56% of our eligible employees chose the MSA option over their previous coverage -- and we expect that percentage to rise to over 90% next year. Moreover, for every employee who has chosen the MSA option, the City has achieved immediate budgetary savings, and we expect even greater savings to be realized in the future.

How has it been possible for us to both please our employees and reduce our health care costs? The answer is relatively simple.

In the past, Jersey City covered its management employees through the New Jersey State Health Benefits Plan. Most chose a fee-for- service option, where employees had to pay a $200 front-end deductible and a 20% co-payment on the first $2,000 in expenses for each covered family member. That means a family of four had potential out-of-pocket expenses of up to $1,800 in medical expenses annually.

Under the MSA plan, the city purchases a catastrophic insurance policy that covers 100% of a family's medical costs above a $2,000 deductible. The city then places an additional $1,800 in a medical savings account that the employee can draw down upon for payment of most of that deductible. Putting these elements together means that a family of four would, at most, have to pay $200 in out-of-pocket deductible expenses. Moreover, if a family's total health care costs fall below $1,800 in a given year, the money remaining in the MSA account will be refunded to the employee at year's end.

It's not hard to see why the MSA plan is more attractive. If family health care costs are high, family out-of-pocket expenses will be less under the MSA than under the standard policy most employees had previously chosen. If family health care costs are low, the family will actually get the money left over in the MSA rebated back to them, which doesn't happen under most insurance plans.

The cost to the City for family coverage under the State Health Benefits Plan was $6,800 per year and rising (premiums had doubled in just the last five years). The cost to the City to offer the MSA option is only $6,300 -- $4,500 for the catastrophic insurance policy, and $1,800 for the cash contribution to the Medical Savings Account.

What a deal! We've been able to obtain better coverage for our employees, which lowers their out-of-pocket expenses and maintains their ability to choose their own doctor while lowering total health care costs for the City!

Because of the MSA's rebate potential, we expect even larger savings in the future, as our employees are incentivized to avoid gratuitous expenses, and the reduced claims experience that results translates into lower premiums. For example, Forbes, Inc. has been able to reduce its health insurance premiums by approximately 25% by offering MSAs to its employees, while most other employers with traditional fee-for-service insurance plans have seen their health insurance premiums increase.

The critics of MSAs argue that many families, lured by the prospect of a check at the end of the year, will be tempted to forgo the medical care they need. But that's not how MSAs work. I can share a personal experience about how MSAs eliminate wasteful medical spending. Last week, I had minor foot surgery to treat a recurring ailment. After the procedure, my doctor offered me a padded shoe, but I refused because I already

had one at home from an earlier procedure. Because I was enrolled in an MSA, I had an economic incentive to refuse something I just did not need. In contrast, if an insurance company were going to be picking up the entire tab, what incentive would I have had to say anything?

The bottom line is this: the American people aren't afraid to make informed judgements about their own health care needs. As consumers, we make thousands of purchasing decisions each and every year. What we do fear is losing the right to make choices for ourselves through third-party rationing. We don't think government, or our employer, should have the power to determine what health care we are eligible to receive. We want to retain that power unto ourselves. And that's why MSAs are so popular -- they keep the power to choose in our hands as patients, instead of putting it into the hands of government, employers, insurance companies, or health care providers.

"The Family Medical Savings and Investment Act of 1995" will make MSAs even more attractive and will accelerate their usage. It will stop the foolish practice of treating funds that an employer deposits into an MSA as taxable income. Under HR 1818, only the unspent funds that an employee is rebated at year's end would be taxable. Individuals would also be given the option of starting a "medical IRA," whereby unspent funds accumulated from their MSAs could be saved, tax-free, for future medical expenses. This too is a great idea, which will expand the affordability, and portability, of health insurance.

Unlike most tax expense legislation, HR 1818 will not put a dent in the federal treasury. Right now, employers deduct 100% of their employees' health insurance premiums as a business expense. This practice will continue with MSA contributions treated the same way as premium payments, but because total health care costs to the employer will decrease with MSAs, the cost to the Treasury of this tax exclusion will also decrease. Further, when employees are rebated any extra funds remaining in their MSAs at year end, this additional personal income will be taxable.

I would recommend that Congress take this proposal one step further and offer MSAs as a voluntary option to federal employees, as well as to Medicare and Medicaid recipients. It would improve the coverage provided by these programs, reduce their cost, and slow down their future cost growth -- again, not by third-party rationing, but by giving individuals an incentive to take an active interest in the quality and cost of the medical care they receive.

MSAs are the solution to maintaining health care choice while restraining health care inflation. But there is an additional benefit from MSAs that you cannot put a price tag on. By providing a financial incentive for Americans to take an active interest in their health care needs, MSAs will also help to increase American health consciousness, and will encourage Americans to practice even greater preventative care. Let's hope that the House Ways and Means Committee moves quickly to pass the "Family Medical Savings and Investment Act of 1995."

Chairman THOMAS. Thank you, mayor.
Miss Samuelson.

STATEMENT OF JEAN A. SAMUELSON, DIRECTOR OF BENEFIT SERVICES, CORNELL UNIVERSITY, ITHACA, NY

Ms. SAMUELSON. Mr. Chairman and Members of the Committee, I would like to thank you for providing me the opportunity to testify on the Family Medical Savings and Investment Act of 1995.

Chairman THOMAS. Ms. Samuelson, I want to tell you these microphones are very unidirectional so you will have to get it down close to you so we can hear you. Thank you.

Ms. SAMUELSON. At Cornell and through various employee benefits organizations in which I take an active role, we are always looking for the most innovative ways to provide benefit choices to our employees and their families. I began investigating the medical savings accounts for Cornell's employees and will certainly continue to follow this legislation because we want to provide a responsible level of protection in a manner flexible enough to accommodate the needs in today's increasingly diverse work force.

Therefore, we were especially pleased at the approach taken in this legislation. By resisting the temptation to define exactly the benefits available in a medical savings account, you provide the broad freedom of choice that will be most responsive to the largest numbers of employers and their employees.

As the representative of an employer who sponsors a section 125 cafeteria plan, and as a participant in that plan, I believe that this legislation helps employers and employees obtain many of the same goals as flexible health care benefits; Greater individual control and choice in designing plans that meet each individual employee's needs.

Mr. Chairman, we applaud your statement that this bill is a framework awaiting improvement. Already in meetings with staff we have found a willingness to work to resolve problems that arise for particular constituencies. In the end, as these diverse interests bring their creativities to the task, you and the Committee will fashion an even stronger bill. Thus, we support the Family Medical and Savings and Investment Act and also the process you have started to further perfect the bill.

We believe the legislation should go forward and that it will allow cafeteria plans and flexible spending accounts to coexist and augment medical savings accounts. There need be no inherent conflict between medical savings accounts and plans covered under section 125 of the Internal Revenue Code.

I am a board member of the Employers Council on Flexible Compensation, which, coincidentally, has just conducted research into working Americans' attitudes on medical savings accounts. Since 1992, the council has cosponsored Workplace Pulse, the only periodic survey of full-time employed workers.

This most recent Workplace Pulse, which was conducted in early June and released today, found that 85 percent of American workers believe the government does not provide adequate incentives through tax advantages for the average working person to save for future and current health care needs.

Asked specifically whether Congress should create medical savings accounts, a majority of workers support such legislation. By a margin of 56 to 32 percent, working Americans want MSAs. Moreover, participating workers said that if their contributions are tax exempt, they would be willing to contribute as much as $99 monthly to an MSA or $72 if their interest or investment gain were not taxed. Two out of three, 66 percent, said they would participate in medical savings accounts if they were not taxed on the principal or interest accruing in their accounts.

Mr. Chairman, we believe that many of the health care reform proposals put forth last Congress failed to account for the diversity of today's work force and the desire of working Americans to make their own decisions about their health care needs. We believe that the public rejects the "big brother knows best" attitude that has characterized much Federal policymaking in this area and we are encouraged this Congress may pursue creative solutions such as medical savings accounts, solutions that respond to employers' and employees' desires to control their own health care destinies.

[The prepared statement and attachment follow:]

Statement of Jean A. Samuelson
Director of Benefit Services
Cornell University
Before the
Committee on Ways and Means
House of Representatives
June 27, 1995

Mr. Chairman and members of the Committee, I would like to thank you for providing me the opportunity to testify on the Family Medical Savings and Investment Act of 1995, HR 1818. My name is Jean Samuelson, Director of Benefit Services, Cornell University, Ithaca, New York. At Cornell and through various employee benefits organizations in which I take an active role, we are always looking for the most innovative ways to provide benefits choices to our employees. We have investigated the appropriateness of medical savings accounts for our employees and will continue our analysis because we want to provide what is best for our workforce.

Therefore, we were especially pleased at the approach taken in this legislation. By resisting the temptation to define exactly the benefits available in a medical savings account, you provide for the broad freedom of choice that will be most responsive to the largest number of employers and their employees.

As an employer who sponsors a Section 125 cafeteria plan, we believe that this legislation helps employers and employees attain many of the same goals as flexible healthcare benefits--greater individual control and choice in designing plans that meet each individual employee's needs.

We are aware that some believe that HR 1818 will diminish the effectiveness of cafeteria plans. We are also aware that insurers and others who design and administer benefit plans feel threatened by certain provisions of this bill, but we are encouraged that members and staff have exhibited a willingness to work to resolve reasonable issues.

Mr. Chairman, we applaud your statement that this bill is a framework awaiting improvement. Already, in meetings with staff, we have found willingness to work to resolve problems that arise for particular constituencies. In the end, as these diverse interests bring their creativity to the task, you and the Committee will fashion an even stronger bill. Thus, we support the Family Medical Savings and Investment Act and also the process you have started to further perfect the bill.

We believe that the legislation should go forward and will allow cafeteria plans and flexible spending accounts to co-exist and augment medical savings accounts. There need be no inherent conflict between medical savings accounts and plans covered under Section 125 of the Internal Revenue Code.

Several of the organizations that I work with are also investigating medical spending accounts and their appropriateness. I am active in the Tompkins County Health Care Coalition in western New York state. Several of us, employers of various sizes, will be receptive to this legislation.

I am a board member of the Employers Council on Flexible Compensation which, coincidentally, has just conducted research into working Americans' attitudes on medical savings accounts. Since 1992, the Council has co-sponsored Workplace Pulse, the only periodic survey of full-time employed workers.

This most recent Workplace Pulse, which was conducted during the first week of June and released earlier today, found that 85% of American workers believe that the Government does not provide adequate incentives through tax advantages for the average working person to save for their current and future healthcare needs.

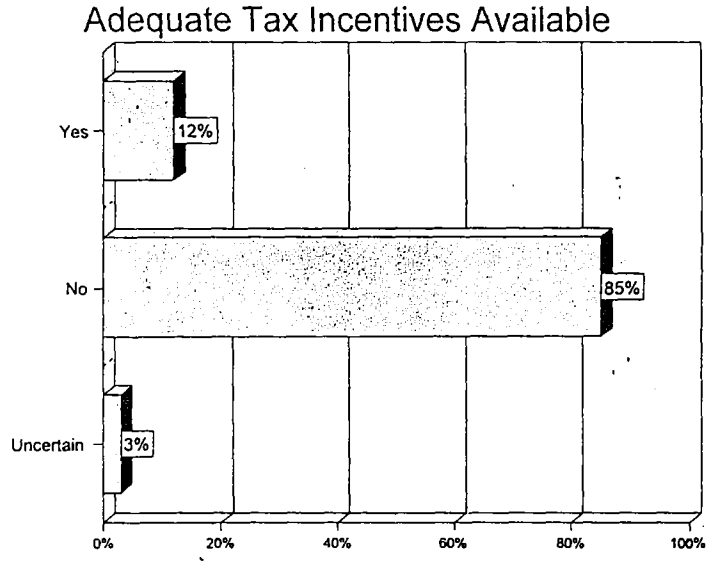
Asked specifically whether Congress should create medical savings accounts, a majority of workers support such legislation. By a margin of 56 to 32 percent, working Americans want MSAs. Moreover, participating workers said that if their contributions are tax exempt, they would be willing to contribute as much as $99.00 monthly to an MSA--or $72.00 if their interest or investment gain were not taxed. Two out of three, 66 percent, said that they would participate in medical savings accounts if they were not taxed on the principal or interest accruing in their accounts.

Mr. Chairman, we believe that many of the healthcare reform proposals put forth last Congress failed to account for the diversity of today's workforce and the desire of working Americans to make their own decisions about their healthcare needs. We believe that the public rejects the "big brother knows best" attitude that has characterized so much federal policy-making in this area. Rather, we are encouraged that this Congress may pursue creative solutions such as medical savings accounts--solutions that respond to employers' and employees' desires to control their own healthcare destinies.

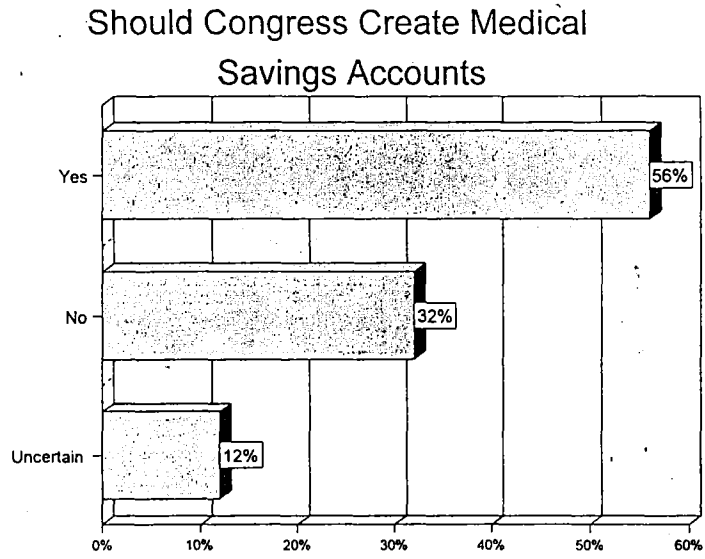
Thank you.

Medical Savings Accounts

As the leading source of employee opinion on workplace benefits issues, Workplace Pulse examined employee opinion on Medical Savings Accounts. Initially, the survey looked at tax advantage incentives to encourage workers to save for health care needs. One question asked: "Do you think the government provides adequate incentives through tax advantages for the average working person to save for their current and future health related needs, yes or no?"



On the subject of Medical Savings Accounts, Workplace Pulse asked: "Congress is considering a new Medical Savings Account that would allow you to have money put aside for current or future medical expenses. This would be somewhat similar to the current Individual Retirement Account, except the money would be set aside to meet medical expenses now and after you retire. Do you think Congress should or should not create this new Medical Savings Account?"



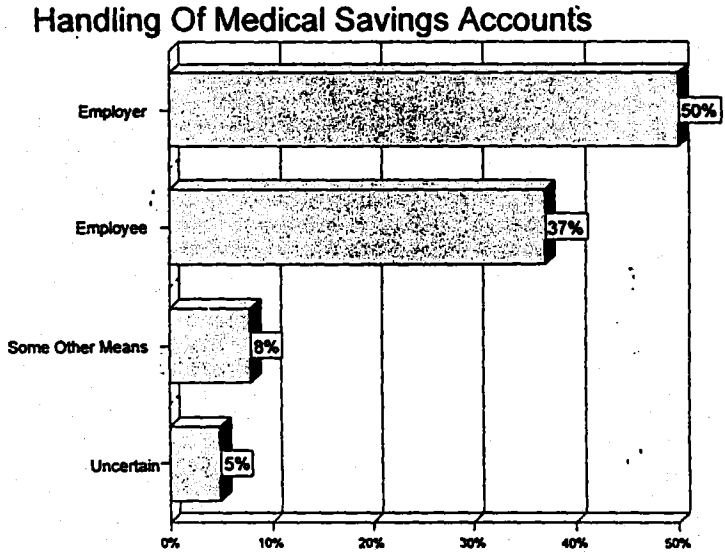
How do working Americans feel about tax advantages which could be associated with Medical Savings Accounts? Workplace Pulse asked: "Congress has not yet decided on the tax advantages associated with Medical Savings Accounts. How much money, if any, would you want your employer to withhold from your salary each month and put in a Medical Savings Account for you under the following conditions? If none, just say so."

- If the money you put in a Medical Savings Account is taxed like your regular earnings, but you do not have to pay taxes on any interest or gain from investments in this account.

- If the money put into a Medical Savings Account is tax deductible just like an Individual Retirement Account where you pay no taxes on the money invested in the account or the earnings from the account.

Employee Participation In Medical Savings Accounts		
	No Taxes On Interest Or Gain	*No Taxes On Money Invested On Interest Or Gain*
Employees Participating	44%	66%
Employees Not Participating	47	26
Undecided Employee	9	8
Average Monthly Investment - All Employees	$35.17	$71.42
Average Monthly Investment - Participating Employees	$72.09	$99.09

A final Medical Savings Account question looked at how these accounts should be handled. Workplace Pulse asked: "Do you think Medical Savings Accounts should be handled through your place of employment where money is automatically deducted each month and your employer handles the paperwork, or would you prefer that Medical Savings Accounts be handled by individuals who can open an account at a local bank or investment firm?"



Chairman THOMAS. Thank you very much, Miss Samuelson.

Next we will hear from Mr. Rateliff, from Wal-Mart, and I understand he is accompanied by an employee or should I say an associate?

Mr. RATELIFF. Associate, yes, sir.

Chairman THOMAS. Associate, Miss Cindy Pierce.

Mr. RATELIFF. I appreciate that.

STATEMENT OF CHARLES R. RATELIFF, SENIOR VICE PRESIDENT, BENEFITS ADMINISTRATION & RISK MANAGEMENT, WAL-MART STORES, INC., BENTONVILLE, AK; ACCOMPANIED BY CINDY PIERCE, ASSOCIATE

Mr. RATELIFF. Thank you for giving us this opportunity to speak to you today. My name is Charles Rateliff and I am senior vice president for benefits administration and risk management at Wal-Mart Stores, Inc., and as you mentioned, with me today is Cindy Pierce. Cindy is an associate from Missouri and I will refer again to Cindy later in my testimony.

Wal-Mart Stores, Inc. is a member of the International Mass Retail Association, a trade association representing the Nation's $282 billion mass retail industry and which collectively employs over a million people.

Our message is very simple and short. We at Wal-Mart have looked at medical savings accounts, or Medisave, carefully and think it is simply an excellent idea. Patient control is at the heart of Medisave. It is our belief that health care consumers will make better health care spending decisions through the freedom Medisave would provide. They will be able to work with their doctors to tailor care to their needs if more of their spending is free of rules and procedures which are necessarily part of health insurance.

Critics of Medisave feel doctors and patients will not be able to make sound health care decisions without the help of institutional managed care. We believe that notion greatly underestimates the American public. For example, Wal-Mart pharmacies answers tens of thousands of inquiries a week from customers who personally pay for their own prescriptions and who are shopping for the best prices.

In the short-term Medisave will give people, that is health care consumers, more control of their health care dollars; give people more insurance options; give people an affordable way to choose higher deductible, lower cost insurance; give people a financial incentive to shop prudently in the medical marketplace, and lead to more affordability in health coverage.

Additionally, in the long run, Medisave will improve doctor-patient relationships by removing insurance-managed care from many health care services, lower health insurance costs, provide a way to pay for long-term care, promote personal savings, and most importantly, lead to a healthier America, which is what we all want.

We have been able to speak to a number of other employers about the Medisave concept. The way we see it, medical savings accounts would be offered as voluntary options to employees funded

by either employer contributions, voluntary employee contributions, or a combination of both.

Medisave is an idea that working men and women of America want and will understand. We have received a number of calls and letters from Wal-Mart associates around the country asking for the kind of help that Medisave could provide. For example, one of our hourly associates, Joi Easterling, had a good idea. Wal-Mart offers four health plans currently with deductibles ranging from $250 to $1,000. Joi switched from the $250 plan to the $1,000 plan and put her biweekly payroll deduction savings in a special savings account. She estimated that her family would soon have enough savings to cover the higher deductible and then some. However, not all people can do what Joi did because of the tax disincentives involved. Joi will have to put aftertax dollars into her savings account. Medisave would level the playingfield and encourage many others to save.

As I introduced Cindy earlier, Cindy has worked in several areas of our company. Cindy is an hourly associate and a young mother who we are happy to report is going to have her second baby soon. Cindy lives in Missouri and gave us this idea in 1994 as an expense savings idea through a program we have, and if I could, I would read it briefly.

She asked us to consider a payroll deduction for the health insurance deductible to be put in a reserve and credited to that associate. Then as each associate incurs claims that will go to the deductible, the amount can be taken from the account and reimbursed to the associate, either by separate check or through their payroll check.

And it is her supervisor, Rose Cooksey, who wrote on here, excellent idea; this would help associates to save money for unexpected bills that would go to the deductible.

Please give Wal-Mart families such as Cindy's the Medisave option. Thank you.

[The prepared statement follows:]

STATEMENT OF CHARLES R. RATELIFF, SENIOR VICE PRESIDENT, BENEFITS ADMINISTRATION AND RISK MANAGEMENT, WAL-MART STORES, INC.

Thank you for giving us an opportunity to speak to you today.

Wal-Mart, Stores, Inc. is a member of the International Mass Retail Association, a trade association representing the nation's $282 billion mass retail industry, and which collectively employs over a million people.

Our message is very simple. We at Wal-Mart have looked at Medical Savings Accounts or medisave, carefully and believe it is simply an excellent idea.

Patient control is at the heart of medisave. It is our belief that health care consumers will make better health care spending decisions through the freedom medisave would provide. They will be able to work with their doctors to tailor care to their needs if more of their spending is free of the rules and procedures which are necessarily part of health insurance.

Critics of medisave feel that patients and doctors won't be able to make sound health care decisions without the help of institutional managed care. We believe that notion greatly underestimates the American public. For example, Wal-Mart pharmacies answer tens of thousands of inquiries a week from customers who personally pay for their own prescriptions and who are shopping for the best prices.

In the short-term medisave will:

- Give people -- health care consumers -- more control of their health care dollars,
- Give people more insurance options,
- Give people an affordable way to choose higher deductible, lower cost insurance, and
- Lead to more portability in health coverage.

Additionally, in the long run medisave will:

- Improve doctor-patient relationships by removing insurance "managed care" from many health care services,
- Lower health insurance costs,
- Provide a way to pay for long term care,
- Promote personal savings, and most importantly,
- Lead to a healthier America, which is what we all want.

We have been able to speak with a number of other employers about the medisave concept. The way we see it, medical savings accounts would be offered as voluntary options to employees, funded by either employer contributions, voluntary employee contributions, or a combination of both.

Medisave is an idea the working men and women of America want and will understand. We have received a number of calls and letters from Wal-Mart associates around the country asking for the kind of help medisave would provide.

One of our hourly associates, Joi Easterling, had a good idea. Wal-Mart offers four health plans with deductibles ranging from $250 to $1000. Joi switched from the 250 plan to the 1000 plan and put her bi-weekly payroll deduction savings in a special savings account. She figured out that she and her family would soon have enough savings to cover the higher deductible and then some. However, not all

people can do what Joi did because of the tax disincentives involved. Joi will have to put after-tax dollars into her savings account. Medisave would level the playing field and encourage many others to save.

Another associate with a good idea is Cindy Pierce, who is with me today. Cindy is an hourly Wal-Mart associate and a young mother who we're happy to report is going to have her second baby soon. Cindy, who lives in Missouri, gave us this in 1994 as an expense savings idea. Let me read it:

> Consider a payroll deduction for the health insurance deductible to be put in a reserve and credited to that associate. Then as each associate incurs claims that will go to the deductible, the amount can be taken from the account and reimbursed to the associate, either by separate check or though their payroll check.

Her supervisor wrote:

> Excellent idea! This would help associates to save money for unexpected bills that would go to deductible.

Please give Wal-Mart families such as Cindy's a medisave option.

Thank you.

Chairman THOMAS. I thank the panel very much, and the gentleman from Louisiana wishes to inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Rateliff, you offer four different kinds of health insurance packages?

Mr. RATELIFF. Yes, sir.

Mr. MCCRERY. Approximately how many of your employees are covered by the high-deductible choice?

Mr. RATELIFF. The highest deductible? We have a—let me briefly explain—$250, $500, $750, and $1,000. There is about 8 percent in the thousand dollar coverage.

Mr. MCCRERY. And is that what you—is the thousand dollar deductible what you would describe as your MSA account?

Mr. RATELIFF. No, sir. We have not designed an MSA account, per se. That example was one of our associates that chose that route. She didn't know what to call it but she chose that as a way to save premiums, set the money aside and use it as she needed it.

Mr. MCCRERY. So, do you see more employees moving to higher deductible policies; is that a trend in your company?

Mr. RATELIFF. Yes, sir, we offered these—we just began offering these about 3 years ago. We had lower deductibles. We began offering multiple options and this is exactly what we have seen, associates like Joi that have moved up to higher deductible levels and reduced their premium costs and saved the difference.

Mr. MCCRERY. And what has been the experience with your company in terms of your overall health care costs?

Mr. RATELIFF. This last year we had—we are a self-insured plan, which the company pays about two-thirds of the cost, and our plan was flat. We had no premium rate increase this year.

Mr. MCCRERY. Is that unusual?

Mr. RATELIFF. Very unusual.

Mr. MCCRERY. Ms. Samuelson, if MSAs are made tax deductible, put on the same basis as any other health insurance vehicle, do you think that insurance companies will go out of business or will they adapt to the change, and create new insurance products? What is your opinion on that?

Ms. SAMUELSON. I do not think they will go out of business. I think they will start marketing more catastrophic health insurance policies. Cornell is a self-insured employer, so I am not sure I am adequately representing the view of insurers, but New York State insurers have an advantage already.

Mr. MCCRERY. Well, I happen to agree with you. I think the insurance industry will adapt rather readily to the concept of MSAs and begin to offer a variety of vehicles to employers who are not self-insured and to the marketplace in general.

Mr. Chairman, those are all the questions I have of this panel.

Chairman THOMAS. I thank the gentleman. The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

Mayor, a couple of questions. First of all, if we apply this to the Federal employees, do you think that we will have similar numbers of people signing up? And a lot of people have talked about the risk

selection. With the large amount that we get to potentially sign up, do you think we would have problems with risk?

Mr. SCHUNDLER. I think you would get large amounts to sign up. I think your experiences would be similar to my own. You would achieve immediate savings. You would find some people, just by virtue of not paying attention, would keep whatever they are choosing now. And those who are paying attention would probably switch immediately. The next year, after you sent the checks out, you would see most of your people switch.

I do not think you would see adverse selection. As was testified by someone earlier, I think, if anything, those who are concerned because they know they have health problems and they know they are going to be seeing a doctor, they may well have already been—Because if they have seen a lot of doctors, they may already know who they trust and those who they do not, so they are the most averse toward going into an HMO. They want to go to a doctor because they know they have a real problem.

So, if anything, you will see a lot of people going into it who, in fact, are more unhealthy, but that still gives them an incentive to try to get the best deal. Again, it reduces their out-of-pocket expense when they go into the MSA versus staying in the current policy. It also gives them the ability to stay with the doctor they want. But, if per chance it should be a good year, they are going to be directly getting money back, and that is a good thing. They are going to want to get their health care costs under control.

Mr. ENSIGN. Could you address any potential conflicts? Are there any with 1818 and the current State law that you know of?

Mr. SCHUNDLER. No, not at all, not at least in New Jersey.

I want to point out the provider we have offering the MSA to us is actually Blue Cross/Blue Shield of New Jersey, who manages the State plan. So, we directly went to the provider who is already providing the three options we had. We asked them to create a fourth for us. The State gave us explicit permission to go and to pilot it for the State's benefit, to offer a fourth option, and most employees are extremely happy and the insurance company was able to adapt very quickly.

Mr. ENSIGN. Thank you.

Ms. Samuelson, right now 1818 single taxpayer can deduct up to $2,500 annually. Do you think the bill would be more effective if the individual was allowed to deduct, say, $2,000 initially and then increase to $3,000, say over like a 7-year period? Do you think that would make the bill any better?

Ms. SAMUELSON. I do not know. I do not see what effect that would have on it. At least this way it is consistent with the dependent care accounts.

Mr. ENSIGN. OK. Mr. Rateliff?

Mr. RATELIFF. Rateliff.

Mr. ENSIGN. OK. Mr. Rateliff, based on Wal-Mart's experience with MSAs and your employees, long-term do you see this being an effective alternative? Do you think over the long term—we get some of these switches, like maybe up to 90 percent in the first couple of years. Do you think long-term employees will stay with it?

Mr. RATELIFF. We have no experience with it yet. We are just studying it. And yes, we do believe long term that they will make that conversion. We are getting too many cards and letters and phone calls from associates that are asking to have those sorts of options. They may not know—they do not call it Medisave or medical savings accounts.

Mr. ENSIGN. What do you think long-term it will do to your administrative costs?

Mr. RATELIFF. That is a good question, too. Our costs currently run about 3 percent. We felt like if we could cut those in half, I think that is hard to estimate at this time, it would save us about $7 to $8 million corporately. Since we are self-assured, we would pass that back to lower premiums in the plan.

If I might address the previous question to Ms. Samuelson, we believe a higher deductible option later on, having seen the patterns we have seen so far of folks wanting higher deductibles, would be something they would want. They would like to accumulate the money and move into a high-deductible, be able to continue to reduce their premiums long term. We would like to see that.

Mr. ENSIGN. Very good. Thank you, panel, and thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman. Let me thank all our witnesses for their testimony. It is very helpful to us.

Mayor Schundler, I am impressed by the results you have been able to accomplish in Jersey City. It is very impressive the type of savings you have been able to achieve for your taxpayers as well as providing additional incentives for your employees.

When was that plan put into effect?

Mr. SCHUNDLER. This January.

Mr. CARDIN. So, you have just 6 months of experience?

Mr. SCHUNDLER. Right.

Mr. CARDIN. At the present time. If I understand it, you offer your employees a choice. They can get the identical benefit structure, the only difference being the deductible and copay.

Mr. SCHUNDLER. That's right.

Mr. CARDIN. And they can choose to go into the medical savings account plan or go into the traditional plan.

Mr. SCHUNDLER. Lower deductible plan.

Mr. CARDIN. Right. What has been the experience? What is the percentage difference?

Mr. SCHUNDLER. Fifty-six percent have chosen the MSA in the first year. Again, I am convinced after the checks go out in December, we will see more switch into it.

Mr. CARDIN. Have you noticed any trend as far as the age of the employee or the health history of the employee as to which ones are choosing which plans?

Mr. SCHUNDLER. No, I honestly have not studied that, so I cannot answer it.

I think, again, one of the things we were able to do for our employees that was charted out for them, what the impact would be on them if they had high costs or low costs. They benefit under either scenario with the MSA.

There is only one place where you actually are a little worse off, and that is if you have costs which are right about the deductible level. If your costs are, for instance, $2,000, because your MSA contribution is taxable income to you, it actually is marginally less attractive. But that is a very narrow band, between about $1,800 and $2,200 of expenses where you lose out. And you lose out only slightly.

If you pass this, that will even—that band will be eliminated, and it will be more attractive for the employee. And it is much more attractive when your costs are much higher or much lower.

Mr. CARDIN. You are estimating a $500 per family savings for the taxpayers.

Mr. SCHUNDLER. That is in pocket now.

Mr. CARDIN. Pardon?

Mr. SCHUNDLER. That is in pocket now. Because our premiums immediately went from $6,800——

Mr. CARDIN. That is the question I wanted to ask. You have achieved that through your——

Mr. SCHUNDLER. That is already achieved. We think the—the premium already went from $6,800 to $4,500 because the deductible went up. But as the claims experience goes down, then we think you will see further premium reductions in the next couple of years. And, ultimately, when it begins to go up farther into the future because of inflation and so forth, it will go up more slowly. And the experience we have had, actually the premiums for the standard plan doubled in just the last 5 years.

Mr. CARDIN. If the Federal legislation prohibited the annual withdrawal of the funds for the employee but required that they be accumulated for health reasons or to reach the age of retirement or the age of when it is permitted under IRAs to withdraw funds, would that have, in your view, a negative impact on your plan?

Mr. SCHUNDLER. I think so. I think it would have—monies tomorrow are less attractive than moneys today. So, I think that takes away some of the incentive that we want to create for people to shop around for quality and cost.

Mr. CARDIN. Well, thank you very much, and I would appreciate it if you would keep us informed if you find out some of the demographics as to who chooses which plans. They may be useful to us.

I know the underlining insurer is doing that and if we could get that information it would be certainly useful to us in our analysis.

[The following was subsequently received:]

City of Jersey City - MSA Pilot Program

MSA Participant Profile

Average age: **42.2yrs.**

72% are **male**
28% are **female**

61% are **married**
36% are **single**
4% are **divorced**

37% have **coverage 10**(Employee Only)
22% have **coverage 40**(Employee and Spouse)
36% have **coverage 50**(Employee and Family)
5% have **coverage 80**(Employee/Child/Children)

City of Jersey City
Bret Schundler, Mayor

MEDICAL SAVINGS ACCOUNT (MSA) PILOT PROGRAM

Employee Census (3/1/97)

	MSA
Employee Only:	49
Employee/Spouse:	25
Employee/Family:	43
Employee/Children:	7
Total:	124 (56%)

	Traditional
Employee Only:	24
Employee/Spouse:	24
Employee/Family:	13
Employee/Children:	2
Total:	63(29%)

	Blue Choice (POS)
Employee Only:	6
Employee/Spouse:	3
Employee/Family:	15
Employee/Children:	3
Total:	27(12%)

	HMO Blue
Employee Only:	2
Employee/Spouse:	1
Employee/Family:	3
Employee/Children:	1
Total:	7(3%)
GRAND TOTAL:	221

Note: Page 108:(Lines 2473 - 2476)
Page 113:(Lines 2565 - 2567)

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. I just wanted to ask Mrs. Pierce, as an associate of Wal-Mart, what have you felt to be the general feeling of the associates? Have they been very satisfied thus far? What has been your general experience personally as well as your representation of the other associates at Wal-Mart?

Ms. PIERCE. On this plan?

Mr. CHRISTENSEN. Yes.

Ms. PIERCE. We have not really even——

Mr. RATELIFF. Again, we have not instituted an MSA. We have no experience.

Mr. CHRISTENSEN. Do you feel that there will be a general acceptance by a lot of the associates for that?

Ms. PIERCE. Oh, definitely. Yes, I do.

Mr. CHRISTENSEN. I wanted to ask Mayor Schundler, why do you favor an MSA over managed care? And maybe you could delineate a little more specifically why you think an MSA may be a better alternative to go than a managed care system?

Mr. SCHUNDLER. I think what managed care does ultimately is third party rationing. It is not as good to say that if you do something bad to yourself, we will make it all well again, than if you can say to someone, we will give you an incentive not to do something bad to yourself.

So, you naturally have inflation when people are in managed care systems because people are still going out and not doing preventive care. They have no incentive necessarily financially. So, what ends up happening is, the way you begin to control costs in a managed care system is by reducing benefits or by increasing employee copay. That is the only way you will really begin to reduce costs in the long term.

I think it is far better to focus on preventive care, responsible action, and on consumer shopping around. And that is the way to really control health care costs without having to take away benefits.

Mr. CHRISTENSEN. I Really appreciate your leadership in these areas as well as all the other areas you have been leading in. I think we look forward to maybe taking it one step farther and adding a little bit of a Federal slice to this MSA with an amendment. So, thank you so much for your leadership.

Mr. SCHUNDLER. Congressman, if I could add one point?

Mr. CHRISTENSEN. Yes.

Mr. SCHUNDLER. I think you would also see the Treasury benefit immediately. Because, again, since health care costs are an exclusion and our total exclusion now goes from $6,800 to—again, we are not taxable to begin with. But say we were a corporation, our costs would go from $6,800 to $6,300. That is $500 more per family member you would be able to tax.

I might add that the rebate under the Archer plan is taxable income also. So, you would be able to tax that also. You would have an immediate positive impact not only if you extended it to your employees, but for everybody else who uses it. There would be more money for government to tax unless there is an exclusion.

Mr. CARDIN. If whoever has the time would yield?

Chairman THOMAS. The gentleman would be happy to yield.

Mr. CARDIN. If I could ask one more question, mayor, if I might. The premiums for those individuals who are not in the MSA option, has that premium changed at all?

Mr. SCHUNDLER. No. Well, no, it has not changed with the exception of it went up with the regular State plan. There has been no adverse effect, in short.

Mr. CARDIN. You were paying $6,300.

Mr. SCHUNDLER. $6,800 on that plan.

Mr. CARDIN. And that is still at $6,800. You have not achieved savings in the plan like you have in the MSA option?

Mr. SCHUNDLER. That is correct.

Chairman THOMAS. But it has not gone up, either.

Let me underscore the gentleman from Maryland's request about information, mayor. You have only been in the program, I understand, 6 months, so, obviously, we would be very interested.

As you may have heard from other panelists, some of the criticism is there is an adverse selection process. And it just seems to me that if you have any data on the initial selection—I assume you did some advertising and across the board in materials of the city employees.

Mr. SCHUNDLER. Right.

Chairman THOMAS. Have you done any analysis at all as to who jumped at the opportunity to utilize the MSA?

Mr. SCHUNDLER. Again, I apologize I cannot give you good information. Anything I would bring to you today would be conjecture. My employees——

Chairman THOMAS. We would be very anxious if you would analyze the profile. It is of great concern to us and we would appreciate having some empirical data.

[The information was not available at time of printing:]

Chairman THOMAS. What about the other cities in New Jersey? As you move around to various city organization, have you gotten some inquiries? How large is Jersey City?

Mr. SCHUNDLER. Two hundred thirty thousand people. We have about 2,500 employees.

Now, we were the first—we were the first to do this. There have been a lot of cities leaving the State plan because of the dramatically rising premium costs to being in the State plan. As you might imagine, there has been a lot of union opposition, because typically what the cities have done as they leave the State plan they may actually try to get copayments or what have you from their employees. So, it creates a lot of fractiousness.

Instead of leaving the State plan, we went to the State and said, give us permission to add an alternative that will allow us to achieve the savings we are interested in and it will make our employees very happy and feel secure.

Chairman THOMAS. Thank you.

And, obviously, Mr. Rateliff, Wal-Mart has a significant number of employees. What percentage of the employees of Wal-Mart are hourly associates?

Mr. RATELIFF. About 85 percent.

Chairman THOMAS. About 85 percent. That would translate into how many numbers, roughly? Ballpark.

Mr. RATELIFF. Well, we have 600,000 on the payroll totally.

Chairman THOMAS. The two examples you gave us of folks who were prescient enough to ask for this without knowing the name of it were in fact both hourly associates?

Mr. RATELIFF. Yes, sir.

Chairman THOMAS. If you do initiate any program like this, once again we would appreciate having any data that you have in materials of age or income groups or other discernible categories who see this perhaps as an option more than other categories. We think it will be a definite plus as an additive. Some folks see it as a panacea. I believe a number of folks testified today that as an additive it certainly is an attractive option.

Mr. RATELIFF. That is correct.

Chairman THOMAS. I have been urged by several of my colleagues to go ahead and move the bill today. This is a hearing, not a markup, but I can assure you that sentiment expressed on both sides of the aisle is largely in support of this concept. I just hope we can quit talking and move the product.

I want to thank you very much for your testimony, once again, indicating to Congress that things are going on in the private sector, Mrs. Samuelson, among State institutions, among cities, and among the private sector, and it is time that Congress caught up to the ideas that are out there. Thank you very much.

This hearing is adjourned.

[Whereupon, at 1:25 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION FOR THE RECORD ON MEDICAL SAVINGS ACCOUNTS AND THE "FAMILY MEDICAL SAVINGS AND INVESTMENT ACT OF 1995, H.R. 1818"

The American Dental Association (ADA) is very pleased to have an opportunity to submit this statement for the record on the issue of Medical Savings Accounts (MSAs). The Association is the largest dental organization in the United States, representing more than 140,000 dentists.

The ADA enthusiastically supports H.R. 1818, the "Family Medical Savings and Investment Act of 1995", introduced by Chairman Archer (R-TX) and Representative Jacobs (D-IN), which offers consumers the option of managing their own insurance program through medical savings accounts.

MSAs are a market-friendly means of controlling medical health care costs by reducing demand for unnecessary medical services. The advantages of MSAs are clear: they empower and motivate individuals to seek only necessary, cost-effective care because consumers will be using their own money. At the same time, freedom of choice of providers is guaranteed; and the insurance is portable because it belongs to the individual, thus addressing the "job lock" issue that has been one of the major concerns of health care reformers. MSAs can even increase coverage because they can be used to cover services which may be important to the individual, but which are not usually covered under more traditional insurance.

Further, like millions of Americans, many dentists are self-employed and may take only a 25 percent (30 percent beginning in 1996) deduction for premium payments for their health coverage. This is a long-standing inequity ameliorated with MSAs.

The ADA commends the Chairman for his leadership in developing an alternative insurance proposal as part of health system reform that emphasizes equity, efficiency and individual responsibility.

H.R. 1818 permits an "eligible" individual to deduct annual contributions to a Medical Savings Account (MSA) totaling the lesser of $2,500 or the deductible under a catastrophic health plan. The contribution ceiling is raised to $5,000 if the catastrophic plan also covers a spouse or dependent. To become "eligible" for an MSA, an individual is limited to catastrophic health plan coverage, except for certain "permitted coverage" including dental care only plans.

The bill defines catastrophic health plans as any health plan that provides no compensation for expenses covered by the plan until the expenses exceed $1,800 for an individual or $3,600 if the plan covers more than one person. However, exceptions to this deductible provision are allowed for "permitted coverage," including plans furnishing coverage only for dental care. Withdrawals from an MSA are excluded from income if they are used for "qualified medical expenses" for medical care as defined in

section 213(d) of the Internal Revenue Code, which includes dental care. Long-term care insurance and catastrophic health plan coverage may also be purchased with MSA funds.

Employer-provided coverage under an accident and health plan may continue without such contributions being taxed as gross income to employees. Employers will also be able to continue to exclude such contributions from employment taxes.

Dental Benefits and MSAs

The ADA supports the use of MSA funds for dental service expenditures not covered by dental benefit plans. Oral health is an essential part of total health care. Many medical conditions are self-limiting, but dental diseases are chronic, progressive and destructive, becoming more severe over time. Dental disease, however, is almost entirely preventable with regular examinations. The ADA believes that MSAs are an excellent opportunity for those with no or inadequate dental coverage to better access the dental delivery system.

It is essential, however, that MSAs remain an option and not a substitute for employer-provided free-standing dental insurance that is tax deductible for the employer and excluded from employees' income. Twelve million Americans had dental coverage in 1970, by 1992 that number expanded to 110 million. From 1980 to 1992 the percentage of school children free of tooth decay increased from 37 to 50 percent. This success is attributable, in part, to the increased access to care afforded through the availability of dental plans. Most dental benefit plans fully cover services that prevent disease. Significantly, the National Institute of Dental Research estimates that Americans saved nearly $100 billion in dental care bills during the 1980s because of dentistry's emphasis on preventive oral health measures. The Association believes that it would be contrary to sound public policy to undermine the current cost-effective dental benefit system by taxing those benefits.

The Association notes that some MSA proposals restrict individuals who elect the MSA option to high-deductible medical benefit plans. The ADA understands the rationale for such a restriction as it applies to medicine, but believes it is unnecessary and inappropriate to apply such linkage to dental benefit plans.

Standard dental benefit plans have historically required significant beneficiary cost-sharing through copayments, deductibles and limits on the type and frequency of care, and they invariably use annual maximums. As a result, the dental patient with dental coverage is already sensitized to the cost of dental treatment. Indeed, currently about 50 percent of all

dental expenditures are out-of-pocket, while only about 20 percent of medical costs are directly borne by the patient.

The CATO Institute, long a proponent of medical savings accounts, in its March 14 policy analysis, implicitly supports the Association's proposition that dental benefit plans already strike a proper balance between patient and third-party responsibility. According to the analysis, cost increases have risen less rapidly for services characterized by lower third-party payments. For example, from 1965 to 1990 inflation-adjusted increases for hospitalization costs rose 350 percent and physician costs increased by 250 percent, but dental costs rose only 200 percent. In addition, "From 1960 to 1990 out-of-pocket health spending relative to personal income did not increase at all. Yet total health care spending relative to income tripled during that period."

Further, linkage of dental coverage to a catastrophic plan is also inappropriate. Medical benefit plans are inherently different from dental plans. All medical benefit plans are, first and foremost, intended to provide insurance against catastrophic events that could bankrupt the average family. Consequently, even high-deductible medical coverage serves the primary purpose of medical coverage and, when linked with an MSA, provides many individuals with appropriate incentives to cut costs.

On the other hand, dental expenses are not catastrophic in nature. In fact, the standard dental benefit plan is really not an insurance plan at all, but a prepayment plan. First dollar coverage in dental plans is invariably limited to preventive and diagnostic services. Patients who require more extensive and costly care must bear an increasingly greater share of the cost. At the same time, most dental plans reimburse preventive services at 100 percent of costs because prevention is such a integral, cost-effective component to good oral health.

A high-deductible dental benefit plan, which would not reimburse until a threshold amount is reached, would preclude payment of preventive services for most people. Even on the surface, this appears "penny wise and pound foolish" as a cost-control mechanism in dentistry because it merely defers treatment, and, therefore, will increase the eventual cost of dental care. Individuals who choose to avail themselves of the MSA program must not be required to settle for a dental coverage plan that fails to cover preventive services at 100 percent. To require otherwise would be a clear step backward for the approximately 110 million Americans with dental coverage and would support the contention of MSA opponents that medical savings accounts undermine preventive care efforts.

The Association believes its reading of H.R. 1818, which permits individuals (or employers on behalf of employees) to continue to purchase dental only coverage with pre-tax dollars while participating in the MSA option, indicates that this bill supports the ADA's position that the integrity of free-standing dental plans must not be threatened.

In closing, Mr. Chairman, the Association is very pleased to be given an opportunity to comment on H.R. 1818. The ADA believes it is an outstanding bill that takes the proper approach toward health care cost containment -- the establishment of a system with market-based incentives to empower individuals to make wise health care purchasing decisions.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

RE: Medical Savings Accounts and the "Family Medical Savings and Investment Act of 1995, H.R. 1818"

June 27, 1995

Mr. Chairman and Members of the Committee:

The American Medical Association (AMA) appreciates the opportunity to submit this statement for the record regarding the "Family Medical Savings and Investment Act of 1995," and to express our overwhelming support for the passage of medical savings accounts (MSA) legislation by this Congress.

We commend Chairman Bill Archer and Representative Andrew Jacobs for their leadership in introducing this legislation. MSAs, combined with catastrophic insurance coverage, represent a refreshing and rational reform of our health delivery system. Empowering individuals with the ability to choose the type of health care they will purchase and from whom has continued to remain at the center of the health reform debate: Should we favor more government control over our health care dollars or more freedom for all of us as consumers of health care to make our own decisions? The answer from the American people is clear, and the Archer-Jacobs MSA legislation will help to provide health care consumers with that freedom.

For almost a decade, the AMA has been on record as supporting the adoption of MSAs as an option in our health care system. In fact, a longtime AMA health policy economist, Jesse Hixson, PhD, is credited by the National Center for Policy Analysis (NCPA) with the original concept of medical savings accounts. We believe MSAs not only represent a cost effective approach to providing health care, but also strengthen the market for medical care by assuring patients more freedom of choice.

We understand that the Archer-Jacobs legislation would allow individuals to establish a medical savings accounts in conjunction with a catastrophic health policy. Such catastrophic health plan would be a plan that has a deductible amount of at least $1,800 for an individual or $3,600 if the plan provides coverage for more than one individual.

Within certain limits as described in the Archer-Jacobs legislation, employer contributions would be excludable from gross income if made by the employer and deductible if made by the individual. The amount of individual contributions that could be deducted or employer contributions that could be excluded for a taxable year would be the lesser of either the catastrophic health plan's deductible, or $2,500 per individual or $5000 if the MSA covers a family. Withdrawals from a MSA would be excluded from income if used for qualified medical expenses for the individual or family.

There are many advantages to using MSAs and the AMA would like to touch on several reasons we believe the Archer-Jacobs bill would be beneficial to our health care delivery system.

The Advantages of MSAs

MSAs are cost-effective. A fundamental problem exists today in the way we finance our health care. Because many of us receive our health care insurance from an employer-provided plan, we do not personally feel the need or the desire to pay attention to the cost of a medical procedure. With traditional insurance, consumers are insulated from prices and do not perceive the full cost of consuming health care resources. Numerous studies provide evidence that third party payment for health care shields patients from cost awareness and the responsible consumption of health care dollars. In fact, a Rand Corporation study found that individuals who had access to "free care" consumed at least 30 percent more than those who had to pay a substantial portion of the bills up to a maximum amount out-of-pocket.

One might ask a simple question: Is it more desirable to link the patient to the cost of health care or insulate the patient from the cost? Unfortunately, the lack of this direct linkage has led to systematic overuse by consumers who have had little incentive to limit spending or thoughtfully weigh the cost/benefits of services. Consumers are not exerting as much pressure on providers for economic efficiencies as they would if they were paying the full cost of medical care directly out of their own pockets. The result is that many prices may be higher than they otherwise would be and many providers are less efficient than they could be.

MSAs will spur much needed competition in the health care marketplace. MSAs as contained in the Archer-Jacobs bill represents a market approach, rather than a regulatory approach, to reducing health care costs by encouraging prudent health care buying and saving. Rather than achieving cost containment through global budgeting or price controls, which usually leads to gaming or other distortions in the health care system, the AMA believes the Archer-Jacobs bill would create incentives to wisely use one's own health care dollars, rather than continue the present perverse incentives to freely consume someone else's.

Companies searching for more innovative and cost-effective ways to provide health care benefits for their employees have learned first-hand the benefits of putting employees in control of their health care dollars through the use of MSAs. It has been reported that *Forbes* magazine health costs fell 17 percent in 1992 and 12 percent in 1993. Likewise, in the first year of a MSA plan for its employees, health costs for Golden Rule Insurance Company were 40 percent lower than they would otherwise have been. Dominion Resources and Knox Semiconductors, two northeast companies, have had virtually the same experience with their MSAs -- the cost of the premiums for their employee's health insurance fell significantly.

Further, by allowing unspent balances in MSAs to be carried over to subsequent years as set forth in the Archer-Jacobs bill, consumers will be rewarded for practicing responsible consumption. We believe it is more desirable to reward health care consumers for using the system cost effectively rather than punishing them for not using the system in a cost effective manner. By encouraging appropriate use of our nation's health care dollars, while preserving individuals' access to the physicians and plans of their choices, MSAs as contained in this legislation, represent one of the best approaches to achieving cost savings in a competitive environment.

We believe the Archer-Jacobs bill would have the capacity to increase portability of health care policies, a goal which has broad bipartisan support. The portability aspect of MSAs will enhance job mobility by eliminating "job-lock" that forces many employees, especially those with pre-existing conditions, to stay in jobs in order to continue receiving needed coverage. Indeed, recent public opinion surveys conducted by the Employee Benefit Research Institute in conjunction with The Gallup Organization found that one in five Americans surveyed indicated they or a family member passed up a job opportunity based solely on health benefits.

In addition, MSA funds could provide financial resources for workers who become temporarily unemployed, allowing them to purchase bridge health insurance while they are between jobs. According to the NCPA, a leading advocate of MSA legislation, of the 37 million Americans who are uninsured this month, more than 50% will be insured four months from now. More than 70% will be insured within one year. While the greater availability of MSAs will not completely solve the portability problem, they could result in greater access to our health delivery system.

Improving the Doctor-Patient Relationship

By giving consumers the ability to make their own decisions about the value of the health care they will purchase, we believe the Archer-Jacobs bill has the potential for substantially improving the physician-patient relationship, a relationship which has eroded by the increasing intrusion of third party payors. Unlike some traditional health benefit plans which "manage" care by limiting access through plan restrictions, MSAs would eliminate the need for bureaucratic restraints that interfere with patient choice and the patient-physician relationship. As recognized by the NCPA, patients and doctors would be encouraged to manage the care -- not a third-party payor. Moreover, MSAs would empower patients to make prudent and sensible treatment choices, and reap the reward of their savings. Savings accrued by more cost conscious purchasing of health care would accrue to the patient, not to the HMO or some other third party payor. Most important, MSAs would allow the individual -- not a third party -- to choose the physician, plan, treatment, and range of services that best meet his/her needs.

The Archer-Jacobs legislation would provide a responsible way to pay for future health care expenses including long term care costs. MSAs have unlimited potential in our health care system. From the private sector to Medicare and Medicaid, MSAs are a viable option in the health care marketplace as well as an important savings mechanism for future undetermined medical expenses.

MSAs and Medicare Transformation

The AMA fervently believes that the Medicare program must be transformed. An important component of this transformation should be the availability of MSAs as an option for Medicare beneficiaries to choose as we recognize is envisioned in the Archer-Jacobs legislation. We believe that each Medicare beneficiary should have an expanded set of choices that range from the restructured traditional Medicare program to various health plans to Medical Savings Accounts. A Medicare Medical Savings Account option should be funded by a defined government annual contribution with the requirement that part of these funds be applied toward purchase of a high-deductible, catastrophic insurance policy each year. The AMA would advocate that contributions to the MSA in the amount of the value of the government contribution amount be exempt from federal and state income taxation. Further, we believe distributions from a Medicare MSA should be tax advantaged if used for medical expenses, catastrophic health insurance premiums or long term care premiums as also foreseen in the Archer-Jacobs MSA bill.

The AMA strongly favors Medicare MSAs because of their potential to enhance the operation of the medical care market, to promote competition between health care providers, and to temper the rates of price inflation of medical services. Exercising greater choice may increase the complexity of the beneficiary's decision-making about medical care, but it will undoubtedly provide enhanced opportunities for more prudent use of medical care resources.

There have been several criticisms of MSAs, a few which the AMA would be pleased to address from a physician's viewpoint. It has been argued that MSAs like those proposed in the Archer-Jacobs legislation are likely to reduce incentives to seek preventive medical care. We disagree. The AMA has long advocated the importance of preventive medicine from routine checkups for kids to mammograms and prostrate screenings for adults. We are aware of no long-term studies to support the contention that MSAs are likely to discourage individuals from seeking preventive medical care. In fact, MSAs could be a source of funds for services such as preventive care not always covered by traditional health insurance. Moreover, anecdotal evidence from employers suggests that employees are most interested in seeking preventive care including wellness programs to avoid greater health risks and costs down the road.

It has also been argued that MSAs are not likely to reduce costs because consumers are not in a position to bargain for reductions in costs as are managed care plans and insurance companies. This argument overlooks the fact that a significant number of employee benefit plans are self-insured. While many of these plans contract with insurers as third party administrators, such plans are increasingly recognizing that direct contracting with physician groups can avoid insurance costs. Further, consumers can and will make prudent decisions about their health care just as they decide the type of mortgage to purchase, the kind of car to buy or the amount of life insurance to carry. As Thomas Sowell wrote during the health care reform debate last year,

"No freedom can be more personal than to decide for yourself what should be done to preserve your health and your life."

Recognizing the importance of preserving patient choice in health care, a number of states have recently passed measures authorizing the use of tax-free MSAs for medical expenditures. As a result, there is now an increased availability of MSAs, usually combined with high deductible, catastrophic health plans. To date, at least eleven states have enacted MSA laws including Arizona, Colorado, Idaho, Illinois, Michigan, Mississippi, Missouri, New Mexico, Utah, Virginia and West Virginia.

On the Federal level, the 103rd Congress produced a number of proposals incorporating MSAs, with over 200 bipartisan House and Senate supporters. Legislation introduced so far this year demonstrates the continued enthusiasm on both sides of the aisle for MSA legislation.

As the dog days of summer wear on, the AMA believes it is time for the United States Congress to step up to the plate and hit a home run for patients, physicians and, in short, our health care system by passing sound and sensible MSA legislation such as the Family Medical Savings and Investment Act of 1995.

Mr. Chairman, we are grateful for the opportunity to share our thoughts with you. The AMA looks forward to working with you, Chairman Archer, Representative Jacobs and the Congress as this important legislation moves forward.

Testimony to the House Ways & Means Committee
Health Subcommittee Hearing on Medical Savings Accounts
June 27, 1995

By John Burry, Jr.
Chairman and Chief Executive Officer of Blue Cross & Blue Shield of Ohio
Chairman of Mountain State Blue Cross & Blue Shield

The 104th Congress has committed itself to reforming the way health care is financed in America. The Ways and Means Committee, in particular, is to be commended for taking on the two most fundamental issues relating to health care financing: the continuing struggle to contain health care costs and the inequitable tax treatment of health care expenditures.

If we learned anything in the health care debate which consumed the last Congress, it is that it is a mistake to act too quickly without fully assessing the practical implications of a legislative proposal. The American health care system is extraordinarily complex. Health care is one-seventh of our economy, a $1 trillion industry which employs millions and, most importantly, provides vital services to every one of us and our families. Any piece of legislation which relates to an industry so large and complex is certain to have dramatic ramifications. Congress saw last year just how disruptive even a well-intentioned proposal could be if not fully considered.

Much of what Congress is seeking to do brings welcome common sense to the subject of health care financing. For example, the permanent extension of the deduction for health insurance expenses of self-employed persons which this Congress passed earlier this year is an excellent first step in making needed health insurance coverage affordable for all our citizens.

With respect to certain other proposals, however, I urge you to heed the lessons of 1994 and take a harder look. In particular, I urge you to consider more fully the practical effects of medical savings accounts, particularly as proposed in H.R. 1818, "The Family Medical Savings and Investment Act of 1995", upon our system of insurance and health care financing.

In general, medical savings accounts, including that proposed in H.R. 1818, would permit persons to make tax-preferred contributions to accounts which could be drawn upon to fund the high deductibles associated with catastrophic health insurance policies. At first glance, the medical savings account has a seductive and emotional appeal. Its concept is simple, and there is an aura of self reliance to it that rings of democracy.

Notwithstanding that initial appeal, however, the impartial experts who have thought through the real world consequences of MSAs, including the Congressional Budget Office, the Congressional Research Service, the National Association of Insurance Commissioners, and the American Academy of Actuaries, have separately concluded that the practical effects of MSAs could be devastating.

It is difficult to overstate the harm MSAs would cause to our current system of health care financing. As the CBO bluntly stated, MSAs "could threaten the existence of standard health insurance."

<u>MSAs Would Undermine Standard Insurance Through Adverse Selection</u>

The CBO concluded that medical savings accounts would "exacerbate the problem of adverse selection" in the health insurance marketplace. By inducing healthier persons to gravitate towards high deductible plans, MSAs would undermine the very purpose of insurance: spreading the financial burden of the few who incur high medical expenses among the many who do not.

If healthy people are given an incentive to take their dollars out of the insurance pool, the results could be disastrous for the older and sicker people who would be forced to pay ever-higher premiums in a futile attempt to insure one another.

That's why the National Association of Insurance Commissioners opposes medical savings accounts, saying "[A]s a result, the health insurance pool would contain a higher proportion of 'high-risk' individuals and insurance costs would be higher for those left in the health insurance pool."

The American Academy of Actuaries reached the same conclusion, stating, "Less healthy individuals who need and select low-deductible insurance plans will likely pay more for their coverage, since the most healthy and highest income persons in the group are likely to select MSA programs." Thus, the Academy of Actuaries observed, "The greatest losses will be for the employees with substantial health care expenditures. Those with higher expenditures are primarily older employees and pregnant women."

Even the Heritage Foundation, a principal supporter of MSAs, has conceded that their appeal is limited largely to the so-called "young immortals" and those in higher income brackets.

Medical savings accounts are presented as an incentive for the health care consumer to shop independently for the best care and the best price. The outdated premise for this argument evolved from a single 1979 Rand Institute Health Insurance Study that implied that if people had to pay more out of pocket for medical care, they would consume less. Significantly, the Rand study predated the introduction of managed care, and could not take into account the gathering momentum of the medical revolution.

Blue Cross & Blue Shield of Ohio concluded a major study two years ago to see if MSAs made sense in a much more evolved medical marketplace. Our study of 38,729 families, a huge sample, demonstrated that MSAs would bankrupt our current system of financing health care and significantly add to the cost of medical care.

The families in the study were insured through Blue Cross & Blue Shield of Ohio's small-business insurance coverage. The total health care charges of the families in the study for one year were a shade more than $159 million, a sum which reflected typical utilization patterns. If MSAs such as those now being considered by the Ways and Means Committee had been in effect, there would have been a shortfall of more than $50 million. That's because the sum of all catastrophic premiums plus all the amounts actually withdrawn from MSAs to pay medical expenses, a much smaller amount than that deposited, would have totalled less than $110 million.

The reason for that shortfall is self-evident. As numerous experts have observed, MSAs would violate the basic tenet of underwriting: that the resources of many are pooled to meet the extraordinary needs of a few. In short, the money that normally would be pooled through the payment of premiums would instead be locked up in MSAs. As a consequence, those funds would be retained in the accounts of the relatively healthy, and would be unavailable for payment of the medical expenses of the relatively sick. The bottom line would be that there would be insufficient funds within the system to cover those who most need medical attention.

This would leave an insurer with one of two options. First, an insurer could increase dramatically the cost of its policies, thus boosting the costs which MSAs are meant to contain. Second, health insurers could exclude the 10% or so of families who incurred the majority of health care costs. If insurers chose that option, MSAs effectively would deprive the most frail, infirm, and chronically ill any health care coverage at all.

Where would those families go for their insurance? Would any private insurer be willing to stop in and provide for such a high risk group? If they did step in and provide insurance, would it be prohibitively priced?

The answer is that those families could not obtain affordable insurance. The result would be that either the government would have to assume the cost of their coverage or those families would be added to the growing number of uninsured Americans.

We don't need to speculate about the harmful effects adverse selection has upon insurance markets and--more importantly--upon the lives and health of the persons who seek to buy insurance. Those effects are evident in insurance markets today.

Right now, the business of insurance is to a large extent an exercise in identifying the healthy people to whom to sell policies and excluding those who actually need the insurance. That is particularly true in the individual market, to which MSAs would be primarily directed.

MSAs would make this unwelcome trend much worse: they are tailor-made for identifying healthy persons who may be profitably insured--it makes no sense for a sick person to utilize an MSA.

Medical Savings Accounts Would Not Effectively Contain Health Care Costs

In addition to causing adverse selection, MSAs would not achieve the individual savings which their advocates claim.

If one accepts the argument that MSAs leads health care consumers to shop for bargains because they would have something to gain, that is, the savings they would retain in their accounts, then one must accept the corollary: consumers will make no effort to limit utilization and contain costs once they exceed a catastrophic deductible because they would have nothing to gain. Those expenses would be borne by the insurer.

Significantly, the great majority of health care costs in our country are incurred beyond typical catastrophic deductibles, costs which would be wholly unaffected by MSAs.

CBO estimates that 83% of health care goods and services are consumed by persons whose medical expenses exceed $2,500 a year. Our study yielded similar data: the healthiest 68% of the families studied consumed only 16% of the health care resources, while the remaining 32% of the families with members who suffered from serious illness spent a stunning 84% of the total. Almost all of the latter amount consisted of health care costs which exceeded catastrophic deductibles.

What's more, MSAs would not even effectively contain costs below catastrophic deductibles. Individual consumers aren't in a position to insist on more productive and efficient medical goods and services. MSAs are based on the inaccurate premise that consumers have sufficient information and expertise to make sound medical purchases. MSAs would provide them with neither.

Reform is induced by informed purchasing by employers and other groups, which MSAs would not promote. Instead, MSAs would weaken the bargaining position of large groups by encouraging healthy individuals to seek health care on their own. If a large employer or other group sought to negotiate only on behalf of the relatively unhealthy, who likely would run up substantial medical expenses, providers would have no reason to offer those groups favorable rates.

Discounts would only be realized by those who effectively sought them out. Moreover, experience proves that providers will offset the cost of discounts by either increasing volume or raising prices to others. Effective cost containment comes from both insurance reform and increased productivity in health care delivery systems, which MSAs would do nothing to promote. While MSAs give individuals incentives to seek discounts, isolated discounts are not synonymous with cost containment and increased productivity.

In fact, MSAs such as that proposed in H.R. 1818 would serve to preserve much of the fee-for-service system which has limited productivity gains, for there is no other practical arrangement for individuals to purchase specific medical services. For that reason, CBO has concluded, "[T]he catastrophic-plus-MSA option might attract people out of group- and staff-model health maintenance organizations. Those people would no longer benefit from the efficiencies of HMOs." Because H.R. 1818 expressly limits MSAs to persons covered by catastrophic policies, it would drive consumers away from the low- or no-deductible managed care plans which have proven in the medical marketplace as among the most effective means of containing health care costs.

In addition, MSAs would blunt the financial incentives which would otherwise encourage consumers and providers to restrict themselves to medically necessary and appropriate services. Advocates of MSAs regularly have taken out ads which claim that the accounts are a means of funding health care without government involvement. The opposite is true. H.R. 1818, like all MSA proposals, provides that consumers would not bear full cost of medical expenses funded by MSAs--those expenses would be subsidized through the tax system. Under present law, consumers bear the full cost of deductibles up to 7.5% of adjusted gross income. Thus, MSAs would eliminate certain disincentives to over-utilize health care.

Finally, MSAs such as that proposed by H.R. 1818 would impede effective cost containment because they generally may be drawn upon to be spent tax free on any "medical expenses," a term which includes a great many health care costs which cannot be applied to a catastrophic deductible. Thus, MSAs would provide a tax subsidy to many expenses presently borne fully by the consumer, thus encouraging additional consumption.

MSAs Would Discourage the Use of Primary and Preventive Care

H.R. 1818, like other MSA proposals, would discourage the use of primary and preventive care. Specifically, MSAs seek to reduce demand for care without reducing the need for care through health prevention and promotion efforts.

MSAs would discourage the use of cost-effective primary and preventive care because those expenses likely would not be covered by insurance. On the other hand, the consequences of the failure to obtain such care would be fully covered once the catastrophic threshold was crossed.

MSAs impose a financial penalty upon persons who seek primary and preventive care. Because, as MSA advocates stress, the accounts are personal property, withdrawals from the accounts take money out of the pockets of the patients. The resulting disincentive to seek primary and preventive care would be avoided through the use of a standard low-deductible policy.

This problem may be mitigated in part if a portion of the amounts deposited in MSAs were forfeited unless spent on preventive care, but H.R. 1818 has no such provision.

Medical Savings Accounts Would Constitute Regressive Tax Policy

H.R. 1818, like most MSA proposals, provides that contributions to MSAs would be tax deductible. Because tax deductions are worth more to high income taxpayers who are subject to higher marginal rates, MSAs would be highly regressive.

What's more, MSAs would be utilized disproportionately by high income persons because low to moderate income individuals often lack sufficient liquidity to establish MSAs.

On the other hand, MSAs would hurt the poor and the sick. MSAs, by design, require dramatically increased cost-sharing by consumers. Yet studies show that increased cost-sharing adversely affects health outcomes for persons with unhealthy life styles, a group which is disproportionately poor.

In the end, medical savings accounts would serve only the healthy, and only the wealthy could afford healthy insurance.

How to Contain Health Care Costs

If medical savings accounts are not the answer, how do we contain health care costs?

The debate over the issue of health costs takes many forms and directions, bringing with it an increasingly emotional dialogue that, for the most part, overlooks the fact we are in the midst of a medical revolution as great in magnitude as was the Industrial Revolution. It is important to understand this when we address the issue of health care costs, for it is not like debating another trade agreement, public works project, or entitlement program.

We must deal with the growing expense of medical care, but we must understand that a substantial part of the cost is a dual health care system, one encumbered by the past with a vast network of hospitals no longer needed, but costing more and more to maintain.

This health care system represents Parkinson's Law at work -- over time, the structure of our medical community has expanded without any direct relation to the nature of services or delivery system required to meet efficiently the public's needs.

The second system we are supporting is in the vanguard of the medical revolution: the technologically advanced, research oriented, vertically integrated delivery systems, and more sophisticated concepts of managed care. This system is designed to provide ambulatory outpatient care for more than 80% of those services previously provided on an inpatient basis.

America cannot afford to support two health care systems. In the debate over health care cost containment, too little consideration has been given to this reality. Instead, health care reform proposals have tended to focus on how to pay to maintain what is already in place.

Rather than concentrate on new ways to fund our wasteful dual system, we need to search harder for ways to save money.

One in three hospital beds goes unused in this nation. We need to close more hospitals and work to build a vertically integrated system that brings doctors, hospitals, and insurers together as a team to manage costs. This must be done to combat excess capacity and duplication of high technology that hospitals use to compete with each other.

Cost management will become more critical as the medical revolution gains in momentum and offers medical advances that promise to abate cancer, fight heart disease, and prolong life. The unlocking of genetic codes will change medicine forever. Unless we deal with the realities of today, the medical triumphs of tomorrow will be available only for the privileged.

We recognized the need to address the future in 1987 when we urged passage of an Ohio law that enabled Blue Cross & Blue Shield of Ohio to negotiate for the best hospital rates for its 1.5 million customers.

This action helped Cleveland drop from the fourth most expensive hospital city in the U.S. to the 33rd in nine years. By projecting the "Cleveland Model" nationwide, an annual savings of $20 billion could be achieved, enough to cover nearly 12 million uninsured Americans.

In addition, Blue Cross & Blue Shield of Ohio joined with the Greater Cleveland Growth Association (Cleveland's chamber of commerce) and the Council of Smaller Enterprises to create an alliance which led to the nation's biggest small group purchasing coalition for health care. This prototype has been the subject of study by other groups across the country.

Blue Cross & Blue Shield of Ohio has also taken the lead in containing health care costs by fighting systemic waste and fraud. Experts estimate that 25% of the cost of the U.S. health care system is lost through waste and fraud. That is nearly $230 billion annually. Even a partial list of potential savings shows the significance of the problem:

- $4 billion annually if uniform claim forms and electronic claims processing and billing could be put on line nationally, according to the U.S. Department of Health and Human Services.

- $20 billion through the reduction of unnecessary patient care and other administrative savings through computerized patient records, as estimated by the U.S. General Accounting Office and the Department of Health and Human Services.

- $80 billion by the elimination of health care fraud, estimated at upward of 10 percent of total medical expenditures by the U.S. General Accounting Office. In Cleveland alone, a special fraud squad set up by Blue Cross & Blue Shield of Ohio has saved an average of $2 million a year.

- $42 billion that is attributed by the American Medical Association to the treatment that results from unhealthy habits such as smoking, drinking, obesity, and violence.

- $10 billion that is lost to the insurance system by the 12 million Americans who choose not to take available health insurance and make the rest of us pay more for coverage.

- $6 billion in excessive drugmaker profits and research and development of "me too" drugs that represent no therapeutic gain, according to the U.S. Office of Technology Assessment and the House Energy and Commerce Committee.

- $19 billion of excess costs from the 11% of physician procedures deemed unnecessary or inappropriate, as estimated by the Value Health Sciences, Blue Cross & Blue Shield Association, and U.S. Health Care Financing Administration.

When you consider that these sums far exceed the estimated cost of covering the nations's uninsured, you get some idea of what could be done with these wasted dollars. My point is that there is much we can do to streamline the health care system without adding more money to it.

Conclusion

MSAs proponents ask the right question--how can staggering health care costs be contained? But MSAs are the wrong answer.

In essence, MSAs would require taxpayers to provide a first-dollar subsidy for costs that individuals can bear themselves. Moreover, that subsidy--by design--would be higher for the affluent than for persons of limited means.

In return for that subsidy, taxpayers would get nothing but the bill. Health care costs would not be reduced. To the extent costs would be affected at all, they would be shifted rather than contained. Moreover, MSAs would have no impact on the great majority of health care costs which are incurred beyond catastrophic deductibles.

The worst aspect of MSAs, however, would not be their expense or their failure to contain costs. The greatest flaw of MSAs would be their devastating impact on insurance markets.

By inducing healthier persons to gravitate towards high deductible plans, MSAs would undermine the very purpose of insurance–spreading the financial burden of the few who incur high medical expenses among the many who do not. The CBO got it right--MSAs "could threaten the existence of standard health insurance."

Health care reform is an extremely complex undertaking for which there are no simple answers. If something sounds too good to be true, it usually isn't. And nothing sounds better than the premise of MSAs–that we can contain health care costs by creating a vast new tax break. Unfortunately, it just isn't so.

Health care costs can be contained, but not through the gimmickry of medical savings accounts. I look forward to working with Congress and the Ways and Means Committee to identify and implement the steps necessary to secure a sound financial basis for our nation's health care system.

Statement by Greg Scandlen, Executive Director
Council for Affordable Health Insurance

Mr. Chairman, my name is Greg Scandlen and I am Executive Director of the Council for Affordable Health Insurance. The Council, also known as CAHI, is an association of small to mid-sized insurance companies that was formed in March 1992 to fight for free market solutions to the problems in the health care system. We also represent several hundred individual members including some of the nation's leading actuaries, physicians, insurance agents and Americans interested in free market solutions to the nation's health care problems.

Mr. Chairman, I would like to take this opportunity to thank you for conducting these hearings on H.R. 1818, the Family Medical Savings and Investment Act of 1995. I would also like to thank Chairman Bill Archer and your colleague, the Honorable Andy Jacobs of Indiana for their dedication to the issue of free market health care reform through the enactment of federal medical savings account legislation.

As I am sure you are all aware, Mr. Archer and Mr. Jacobs introduced legislation similar to H.R. 1818 in the 102nd U.S. Congress and in the 103rd U.S. Congress. Those bills, too, attracted a broad spectrum of Democratic and Republican co-sponsors. However, H.R. 1818 has become the definitive medical savings account bill in the 104th U.S. Congress because it accomplishes so much with little or no cost to the federal government.

The MSA concept is a popular one both in this Congress and in the state legislatures. Since the Council was founded in 1992, 13 states have enacted medical savings account laws including Arizona, Colorado, Idaho, Illinois, Indiana, Michigan, Mississippi, Missouri, Montana, New Mexico, Oklahoma, Utah, and West Virginia. Two additional states, Washington and Virginia, have recently enacted MSA laws that rely on further federal action to make them marketable. Medical savings account legislation is also pending in an additional 16 states. While the states have certainly taken the lead in developing innovative insurance reforms in the past, medical savings accounts have taken the lead in the states in 1995.

As the Executive Director of CAHI, I am also an employer with seven employees, and each of us is using a medical savings account system to keep down the cost of our individual health care. By moving from a low deductible policy to a high deductible policy, we have saved enough money to fund our $1,000 deductibles. However, we must pay state and federal taxes on this additional money because under current tax laws, this $1,000 is a taxable benefit. Why should my employees be penalized by the U.S. Tax Code for being prudent purchasers of health care?

H.R. 1818 begins to address the problem of federal tax inequity for individuals and the self-employed who must purchase their own health coverage. It does so by allowing these individuals to deduct their MSA contribution, even though they might not be able to deduct the cost of the catastrophic insurance plan. None the less, the MSA deduction is a substantial step in the right direction.

H.R.1818 also provides a source of funds for preventive care, and gives incentives to begin saving for health care when it is really needed, and really expensive, later in our lives. Many employees with regular deductibles or copayments do not have sufficient out-of-pocket funds to access preventive care services. MSAs provide a source of funds to pay for these services, even for low income workers.

H.R. 1818 also allows long-term care insurance premiums to be considered a qualified medical expense under the U.S. Tax Code, and it allows LTC insurance premiums to be paid directly from the MSA. By promoting the purchase of long-term care insurance, H.R. 1818 will, in the long run, help reduce Medicaid costs.

Medical savings accounts, as designed under H.R. 1818, will also make a major contribution to reducing the numbers of uninsured in this country, and lessening the problem of "job-lock." It will do this by providing employees with a source of funds to pay for COBRA continuation coverage when they are between jobs. As you know, most of the uninsured are without coverage only for a short period of time, usually when they have lost their job. This is the very time when they are least able to afford to pay for health insurance because they are without an income. MSAs directly address this very real problem.

Many have referred to medical savings accounts as a cousin of the Section 125 flexible spending account (FSA). H.R. 1818 brings these two closer together by allowing an employee to make an annual contribution from an FSA into an MSA. By addressing FSAs in their legislation, Chairman Archer and Rep. Jacobs have responded to the concerns raised by employers about the uncertainty that has existed about Section 125. Section 125 remains a popular element of health care reform that many rely on not only for health care, but for other cafeteria-type plans and services. CAHI believes that Section 125 will be enhanced by H.R. 1818, and will not and should not, be jeopardized by Medical Savings Accounts.

During the past three years, several dozen versions of medical savings accounts have been introduced in the U.S. Congress. Until the dawn of the 104th Congress, most of the beltway interest groups did not pay much attention to the concept, but in recent months, my organization has been flooded by requests from hundreds of organizations trying to get up-to-speed on the issue. We have been working overtime to educate these interest groups, but I'm afraid there are still some misconceptions out there.

The biggest concern we hear is that Medical Savings Accounts may lead to adverse selection, meaning that only the young and healthy would want an MSA, leaving the sick and aged behind in HMOs and other managed care settings. This concern must be clearly addressed and understood because it is so misleading, and possibly self-serving.

There are a few things we know about selection. One of them is that high users of health care services avoid managed care whenever they can. Why? Because their one great priority is to preserve their personal network of providers. Many observers attribute all of managed care savings to this very process -- the young and healthy don't mind going into an HMO, because they don't have ties to any particular physician. Therefore the average cost of an HMO is lower. Foster Higgins surveyed nearly 1,000 mid-sized firms and discovered that in dual choice situations, the indemnity plan was $1,000 more expensive per employee than the HMO alternative because, "healthier employees choose the HMO, and the indemnity plan is left with the poorer risks." (*Highlights*, September, 1994) To the extent MSAs help preserve their choice of provider, MSAs will be extremely attractive to high risk individuals.

But that is just half the reason they would opt for an MSA. Under most traditional indemnity plans, including fee-for-service PPOs, the insured is responsible for paying a regular deductible and a substantial copayment, totaling thousands of dollars. In most MSA arrangements we have seen, the high user of services will actually have to pay less out of pocket than they do today, provided of course, that the tax advantages of the Archer/Jacobs bill are available.

Because many state mandated benefits require first dollar coverage of certain services, the catastrophic policy as defined in H.R.1818 would be illegal in those states. There are two ways to address this problem, either of which would be acceptable to my organization:

1. Include a federal preemption of state benefit requirements for these catastrophic insurance plans;

2. Include these state benefit requirements in the definition of "permitted coverage," thereby allowing the catastrophic policy to provide coverage for those state mandates.

Mr. Chairman, you have before your committee today health reform legislation that will accomplish more than any other health reform plan I have seen. At little or no cost to the federal government, H.R. 1818 will return our health care system to individuals by allowing them their choice of physicians, facilities and services; it will allow them to save for their long-term care and to pay for services not covered by their insurance; it will stabilize and reduce the spiraling cost of health insurance by dramatically reducing administrative costs; it will avoid adverse selection; it will strengthen the doctor-patient relationship; but more importantly to the House Committee on Ways & Means, it will save the federal government precious dollars in the long run by reducing health care costs without artificial controls, price caps, or a new and potentially costly bureaucracy.

Our current health care system is not broken, but it has been badly harmed by over-regulation, tax inequities, and incentives to spend money rather than save. H.R. 1818, the Family Medical Savings and Investment Act of 1995, will not solve all our nation's health care problems, but it will certainly go a long way in providing choice and quality of care to all Americans, giving them proper incentives to stay healthy, get preventive care, and save for the future. H.R. 1818 is an American solution to an American problem and should be enacted. Thank you, Mr. Chairman.

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA

This testimony is submitted for the hearing record by the Group Health Association of America (GHAA), the leading national association for health maintenance organizations (HMOs). GHAA's 385 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs. Our member plans started -- and continue to lead -- the nation's move to high quality, organized health care delivery.

The Group Health Association of America (GHAA) appreciates the opportunity to submit this statement for the record to discuss the Chairman's "Family Medical Savings and Investment Act of 1995" as well as other proposals that establish tax-preferred medical savings accounts (MSAs). GHAA supports the need for expanded choice of coverage options in the health care marketplace. However, as Congress works towards this goal, it is important that all options be treated in an equitable manner, both in terms of tax and regulatory treatment.

GHAA applauds Chairman Bill Archer and Representative Andrew Jacobs' interest in providing consumers with an additional option for their health care benefits coverage and in encouraging individuals to become more educated and prudent consumers of health care services. However, we have concerns with certain features of the H.R. 1818, specifically the mandatory linkage with catastrophic coverage, the unlimited accumulation of unused tax-preferred MSA funds, and the ability to use MSA funds for non-health related expenses.

Our concerns with elements of H.R. 1818, as well as with other proposals that link MSAs with catastrophic coverage, are focused on the competitive advantage that these proposals grant to catastrophic coverage over other forms of comprehensive coverage, including HMOs. By restricting access to MSAs, individuals who might otherwise select HMO coverage may be encouraged to purchase catastrophic coverage, losing the benefits of HMO-based care delivery. In many ways, HMOs' philosophy is fundamentally at odds with catastrophic coverage, and thus, with proposals that link MSAs with catastrophic coverage.

HMOs believe that the availability of preventive care and early treatment for health problems promotes better health and is more cost-effective than traditional fee-for-service coverage. In addition, HMOs treat health problems in a comprehensive, coordinated fashion to ensure that patients receive the most appropriate care in the most appropriate setting. The indemnity-based catastrophic coverage that is likely to be available under an MSA/catastrophic coverage option provides a fragmented, uncoordinated approach. This lack of coordination and continuity imposes unnecessary costs and exposes patients to unnecessary risks.

H.R. 1818: "The Family Medical Savings and Investment Act of 1995"

H.R. 1818 would allow eligible individuals to establish a tax-preferred "medical savings account" (MSA) if they have health insurance coverage through a catastrophic plan. Catastrophic coverage is defined as a health plan that provides coverage for health services after the enrollee has met a minimum deductible of $1,800 for individuals or $3,600 for families. Individuals who receive catastrophic coverage from their employer would be able to deduct the amount that either their employer or they had contributed to their MSA during the plan year, up to the lesser of the catastrophic plan's deductible or $2,500 ($5,000 for families). Self-employed individuals and individuals without employer-provided coverage could deduct contributions to their MSA, but could not use money in their MSA to pay for their catastrophic plan premiums (such payments would be treated as they are under current tax law, self-employed individuals could deduct 30 percent of their premiums and individuals could deduct premiums to the extent that they exceed 7.5 percent of their adjusted gross income).

MSA participants could not use their MSA funds to purchase health benefits coverage (including catastrophic coverage), except for long-term care coverage. Withdrawals from an MSA would

be excluded from income if used for qualified medical expenses (as defined under IRC §213*). Withdrawals for non-health related expenses would be permitted, but would be treated as taxable income and assessed a 10 percent penalty.

Concerns with MSA/Catastrophic Coverage Proposals

As stated above, GHAA is concerned with the structure of H.R. 1818's MSA proposal because it links MSA availability to an indemnity-type catastrophic plan and thus, provides more favorable tax treatment to a specific form of coverage than other health care coverage options. We believe that this catastrophic-based structure is likely to have a negative impact on the current health care marketplace as well as on consumers -- those who remain enrolled in a comprehensive coverage arrangement, such as an HMO, who likely will face increasing premiums, and those with MSA/catastrophic coverage option who likely will find themselves "at-risk" for a significant portion of their health care costs.

GHAA believes that MSA/catastrophic coverage designs are problematic for the following reasons:

- ***Interferes with market dynamics***. Under current tax law, all employer-based health benefits coverages (excluding coverage provided to the self-employed) receive the same tax treatment -- whether an employee selects HMO, PPO, FFS or catastrophic coverage. Under H.R. 1818, individuals with employer-provided catastrophic coverage would receive the additional benefit of being able to (or having their employer) set aside tax-preferred dollars an MSA to cover unreimbursed health care expenses. GHAA believes that the favorable tax treatment of employees' out-of-pocket payments for health-related services under MSA/catastrophic coverage gives a financial incentive to select MSA/catastrophic coverage in preference to comprehensive coverage, such as HMOs. Providing a tax advantage to catastrophic coverage could undermine the positive trends that HMOs are creating in the marketplace by serving to lower the growth of health care costs and improve quality of care. By assigning MSA/catastrophic coverage options tax advantages over other coverage options, the federal government is essentially picking "market winners" and encouraging employers and employees to choose MSAs for their tax benefits instead of evaluating their overall quality and cost-effectiveness.

- ***Creates adverse selection against comprehensive coverages***. Experience with flexible spending arrangements and catastrophic products has shown that catastrophic coverage -- which has lower premiums because of the significant deductible -- tends to be most attractive to young, healthy individuals who have no or limited expectations for requiring health services. Conversely, older and less healthy individuals will be unlikely to find catastrophic coverage attractive, given their anticipated need for health care services. As a result, tax-preferred catastrophic coverage likely would result in adverse selection against HMO and more comprehensive coverage options, thereby increasing premium costs for those remaining in the comprehensive coverage arrangements.

  The likelihood for adverse selection was highlighted by the National Association of Insurance Commissioners (NAIC) in the context of last year's reform debate. In a letter to the Senate Leadership, NAIC's Special Committee on Health Care Reform expressed their concern that individuals at low risk for expensive health care treatment would opt for catastrophic coverage, leaving the non-catastrophic health insurance pools with a high proportion of "high risk" individuals and causing insurance costs to be higher for those left in the health insurance pool.

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*Limited deduction allowed for unreimbursed expenses for "medical care," including amounts paid for the "diagnosis, cure, mitigation, treatment, or prevention of disease;" for transportation "primarily for and essential to such medical care;" and for "insurance covering such care." Deductions are not allowed for cosmetic surgery unless it is deemed necessary.

The current health care marketplace has evolved to limit selection bias and to ensure that various coverage options serve similar populations. Contrary to statements that have been made about selection patterns in HMOs, evidence is accumulating that HMOs care for unhealthy and chronically ill populations at approximately the same rate as the fee-for-service (FFS) sector. A study published recently in the peer-reviewed journal *Health Affairs* ("Do HMOs Care For the Chronically Ill?", *Health Affairs,* Spring 1995) noted that there is no consistent pattern to the types of individuals with chronic conditions that are enrolled in HMO or FFS plans. An analysis by the National Research Corporation found similar results, concluding that the self-assessed health status of the HMO and FFS populations is virtually identical.

- ***Leaves individuals with considerable exposure for out-of-pocket costs.*** MSA/catastrophic coverage proposals that rely on employer funding for MSAs with money saved from switching from "comprehensive" coverage plans to catastrophic-type plans could leave individuals with considerable out-of-pocket expenses. According to analyses by the Congressional Research Service (CRS) (using the Hay Group) and Ford Motor Company, annual employer contributions to MSAs are likely to be significantly lower than the catastrophic plan's deductible, requiring individuals to pay for the majority of their care on an out-of-pocket basis. For example, catastrophic coverage with a $2,500 deductible would reduce premiums by only about $600 for individual coverage over a typical comprehensive coverage alternative. Assuming that the employer puts all of the "savings" in the employee's MSA, it would take over four years for the employee to accumulate enough funds to cover the deducible, assuming that the individual does not withdraw any money to pay for medical expenses.

Recommendations for Modifying H.R. 1818

To ensure that MSA proposals do not provide a competitive advantage to catastrophic coverage and to maintain a level playing field among all types of health benefits coverage offered within the employer-based health care system, we recommend that MSA proposals be modified by incorporating the following elements:

- ***Eliminate the catastrophic coverage link.*** Allow an MSA option to be offered to any eligible employee, whether they receive health benefits coverage through a catastrophic coverage or a comprehensive coverage option, such as an HMO. MSAs should be available to all eligible employees regardless of the type of coverage they select in order to promote choice among coverage options based on quality and cost-effectiveness.

- ***Ensure that MSAs do not receive inequitable tax treatment,*** by limiting the amount of funds that could be maintained in an individual's MSA in a given year and by allowing MSA withdrawals only for health-related expenses. Limiting MSA balances (contributions and accumulations) to a set amount would limit MSAs savings potential and therefore, limit the perception of MSAs as a non-health care related savings account. Individuals currently have access to individual retirement accounts (IRAs) which are designed explicitly as a vehicle for long-term savings and will serve the purposes of long-term savings more effectively than MSAs.

  Limiting MSA withdrawals to health-related expenses also would minimize the chance that individuals would use their MSAs for purposes other than health benefits coverage (e.g., savings for future non-health related purchases or as a tax shelter). Allowing MSA participants to use unspent MSA funds on non-health related expenses, even with strict penalties, provides an incentive to avoid obtaining preventive and/or routine health care services in order to build up balances to pay for cars, homes, etc.

- ***Establish strict rules for switching between catastrophic and comprehensive coverage.*** Require employees to indicate their intent to switch from catastrophic to comprehensive coverage at least one year before the start of the new plan year. Requiring MSA participants to wait a year before switching to comprehensive coverage would protect

HMOs and other comprehensive coverage plans from adverse risk selection by limiting employees' abilities to select catastrophic coverage during healthy years and switch to comprehensive coverage when specific health conditions emerge.

- ***Require catastrophic coverage policies to meet the same standards as other health benefit plans.*** Catastrophic coverage should be subject to the same standards that apply to other health plans, to ensure that individuals have the same access to all coverage options. For example, catastrophic coverage would have to be offered on a guaranteed issue basis (i.e., without regard to health status) if federal of state law includes such a requirement for other health plans.

GHAA believes strongly that consumers should have a choice among a wide variety of coverage options in the health care marketplace. However, to build on the advances that health plans have made in recent years to provide high quality, cost effective care to their enrollees, it is crucial that reform proposals -- particularly those proposals that establish tax-preferred MSAs -- treat all plans in an equitable manner. The catastrophic coverage-based MSA provisions described in H.R. 1818 could reverse advances in the current marketplace, by providing a tax advantage to old-style, uncoordinated, and inefficient health care coverage. To this end, the federal government should not provide catastrophic plans more favorable tax treatment than comprehensive coverage options by linking MSA availability with a catastrophic coverage requirement.

As this MSA legislation moves forward, we urge you to consider the serious consequences that could result for the health care marketplace and for consumers if MSA proposals are not designed in a thoughtful manner.

Virginia Bankers Association

BENEFITS CORPORATION

P.O. Box [illegible] • Richmond, Virginia [illegible]

(804) 643-8060

July 5, 1995

Mr. Phillip D. Mosley
Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Re: Statement for the Record for the June 27, 1995 hearing on HR 1818 Family Medical Savings and Investment Act

Dear Mr. Mosley:

I am John Vellines, Chief Administrative Officer of the Virginia Bankers Association Benefits Corporation. I am submitting this testimony not as a banker, but as an administrator of a trade association sponsored multiple employer health insurance trust. The Virginia Bankers Association has been offering health insurance to its members for 49 years, and 78% of the banks participate in our plan.

The Virginia Bankers Association Benefits Corporation wholeheartedly supports the concept of Medical Savings Accounts, and specifically endorses HR 1818. We believe that one of the reasons that medical care costs have consistently risen faster than inflation in general is that the receiver of the medical service is not the direct payer of that service. While not a total solution to that problem, MSA's will assist in bringing the patient into the loop as a better consumer.

We would like to respectively suggest that the committee consider several changes to the bill that we believe will counter some of the objections of the MSA concept and make the bill more effective.

1. To assure that MSA participants do not ignore preventative care, we suggest that the redesignated Section 220 (c)(3) Permitted Coverage be extended to allow a panel of adult preventative care treatments, as well as well baby care and immunizations for infants. The Preventative panel can provide for a schedule of treatments, such as mammograms, pap smears, and PSA tests based on age and sex.

   One efficient way to provide this coverage is to allow the catastrophic policy to pay first dollar coverage for preventative and well baby care subject to a modest co-pay, such as $15. This would encourage adults to get the preventative care they need, and assure that parents will not be disincented to provide for the important medical care needs of their infants.

   This method of covering preventative care would only add about 2% to the price of the $1,800 catastrophic insurance policy.

2. We suggest that retirement be added to the list of permitted tax free withdrawals, subject to existing IRA withdrawal rules. While this recommendation seems to vary from the "pure" intent of MSA's, we believe that encouragement of retirement savings is a very high societal priority, and we should take advantage of this perfect opportunity to blend the two goals. Adding this feature will make MSA's more attractive to a broader segment of the population, and ultimately relieve some of the long term pressure on the Social Security Retirement system.

Your staff will have to determine the budgetary ramifications of this change, but we suspect that the short term effect would be minimal. Society's long term benefit should offset any short term budgetary impact.

3. Much of the debate centers over the inability of MSA's to take advantage of the gains that Managed Care have brought to the table over the last few years. We believe that it may be possible to merge the two concepts. Initially, we would recommend a Preferred Provider Organization (PPO) network overlay. This would at least allow MSA participants to take advantage of existing physician and hospital contracts and discounts. Further extensions into gatekeepers, etc, will evolve over time.

   While it would appear that HR 1818's silence on this issue would allow MSA administrators to proceed with Managed Care initiatives on their own, you may wish to insert language encouraging these efforts.

In summary, let me repeat our strong support for this bill. We believe that this first step will go a long way in solving one of the core problems in America's health care system.

Sincerely,

John B. Vellines
Chief Administrative Officer

JBV/bhc

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SAVING MEDICARE AND BUDGET RECONCILIATION ISSUES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JULY 19, 20, AND 25, 1995

Serial 104–72

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SAVING MEDICARE AND BUDGET RECONCILIATION

WEDNESDAY, JULY 19, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:40 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas, Chairman of the Subcommittee, presiding.

[The advisories announcing the hearings follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 7, 1995
No. HL-13

CONTACT: (202) 225-1721

Thomas Announces Hearing on Saving Medicare and Budget Reconciliation Issues

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on saving medicare and budget reconciliation issues. **The hearing will begin on Wednesday, July 19, 1995, and continue on Thursday, July 20, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.** The hearing may be continued on subsequent dates.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions, which are generally excepted as the most accurate assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require an immediate 44% increase in the current payroll tax rate, and would increase taxes on a person earning $20,000 by $260 and a person earning $30,000 per year by $390. In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance (SMI) trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last five years."

With both the House and Senate agreeing to the conference report on the budget resolution, the Subcommittee will now focus on increasing spending in the Medicare program to an additional $353.9 billion over the next seven years. Medicare today spends $4,800 per beneficiary. Under the budget resolution, $6,700 will be spent per capita by 2002. This will enable the Congress to ensure both the short-term solvency of the Medicare hospital insurance trust fund and preserve the Medicare program.

Several innovative Medicare initiatives have been proposed by national organizations. The Subcommittee will review these proposals and any others offered by interested parties. Since the Subcommittee will be considering Medicare budget reconciliation in September, this hearing will provide an opportunity for interested parties to comment on Medicare payment policy and policy in such areas as: graduate medical education, home health services, skilled nursing facilities, durable medical equipment, clinical laboratories, fraud and abuse, hospital outpatient departments, and prospective payment system (PPS)-exempt hospitals.

In announcing the hearing, Chairman Thomas stated: "As the fiscal problems associated with the Medicare program become more broadly understood, several national organizations have proposed initiatives to increase Medicare spending at a slower rate. In addition, many groups have developed proposals to save the Medicare program by more closely reflecting the innovations in the private market today. The Subcommittee welcomes these proposals and looks forward to working with interested parties in developing policy alternatives."

DETAILS FOR SUBMISSIONS OF REQUESTS TO BE HEARD:

Requests to be heard at the hearing must be made by telephone to Traci Altman or Bradley Schreiber at (202) 225-1721 no later than the close of business, Wednesday, July 12, 1995, for the July 19 date and Thursday, July 13, 1995, for the July 20 date. The telephone request should be followed by a formal written request to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff of the Subcommittee on Health will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff at (202) 225-3943.

In view of the limited time available to hear witnesses, the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to summarize briefly their written statements in no more than five minutes. **THE FIVE-MINUTE RULE WILL BE STRICTLY ENFORCED. The full written statement of each witness will be included in the printed record.**

In order to assure the most productive use of the limited amount of time available to question witnesses, all witnesses scheduled to appear before the Subcommittee are required to submit 300 copies of their prepared statements for review by Members prior to the hearing. **Testimony should arrive at the Subcommittee on Health office, room 1136 Longworth House Office Building, no later than 11:00 a.m. on July 17, 1995.** Failure to do so may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, August 3, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

*****

** NOTICE -- ADDITIONAL DAY SCHEDULED **

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 18, 1995
No. HL-14

CONTACT: (202) 225-3943

Thomas Announces Additional Day for Subcommittee Hearing on Saving Medicare and Budget Reconciliation Issues

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee's hearing on Saving Medicare and Budget Reconciliation Issues will be continued on **Tuesday, July 25, 1995. The hearing will begin at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.** This day has been added to accommodate additional witnesses. Only members of the public who, in accordance with the prior press release, have requested to be heard and have been contacted by the Committee, will be scheduled to testify on July 25. Other interested members of the public are invited to submit written statements for the record of these proceedings.

All other details for the hearing remain the same. (See Subcommittee press release No. HL-13, dated July 7, 1995.)

* * * * *

** NOTICE -- CHANGE IN TIME **

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 19, 1995
No. HL-13-Revised

CONTACT: (202) 225-3943

Time Change for Subcommittee Hearing on Saving Medicare and Budget Reconciliation Issues

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on Saving Medicare and Budget Reconciliation Issues previously scheduled for Thursday, July 20, 1995, at 9:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will begin instead at 10:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-13, dated July 7, 1995.)

* * * * *

Chairman THOMAS. The Health Subcommittee will come to order.

This morning this hearing, which may last for 3 days will focus on the subject matter of what can we find from this diverse series of panels to assist us in ways to preserve and protect our Nation's Medicare Program.

Today's panels consist of providers, think tankers, and representatives of beneficiaries. As we know, the administration's Medicare trustees' reported in April that the Medicare Program will go broke if we do nothing by 2002. It will go broke actually in 1996. It will go bankrupt in 2002, that is by next year more money will be spent than is coming in, and by 2002 we will drop rapidly into a deficit.

So what we want to do is listen to this relatively broad spectrum of witnesses as to what they have to contribute based upon their analysis of steps that should be taken to preserve Medicare. I look forward to listening to the testimony. And since we have a long list of witnesses, I suggest we begin as soon as possible.

With that, I yield to the gentleman from California Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

The Republicans decided months ago to cut Medicare by $270 billion, and it appears that you do not want the American seniors to know how you are going to cut that $270 billion. So we are playing this wonderful shell game of which pot is the pea hidden under.

Now, I think that it may be under all three. The retirees and the disabled are the people who are going to pay this $270 billion. As far as we can tell, you are going to do it by increasing the deductibles, the copayments, and the premiums. The insurance companies and the health care managers are going to make more profits. The $270 billion will go to pay for tax cuts for the richest in America. The insurance companies are not going to suffer or swallow any of that.

If this is not the case, we would be curious to see the plan. It is too important for every American to preserve Medicare to have changes of this magnitude made in backrooms with people whose only concern is finding that $270 billion.

On June 27 Mr. Gibbons and myself, Mr. Dingell and Mr. Waxman wrote to Chairmen Archer and Bliley requesting a legislative process for Medicare which allowed opportunity for public scrutiny and discussion of the specific changes proposed. They have not yet responded to our letter, and we wonder what they are afraid of. Are they afraid that this exercise has nothing to do with saving Medicare at all, but saving the tax cuts in the Contract With America.

If the Republicans are afraid that seniors will figure out that the documents we have seen make clear that they plan to take billions of dollars out of the pockets of the beneficiaries through increased premiums, deductibles and copayments in part B, all of which, by the way, have nothing to do with saving the part A trust fund, I question whether Republicans think seniors are too naive to know the difference between part A and part B and a shell game when they see it.

My sense is that your plan will be pay more and get less for America's seniors. First, there is a 75-percent increase over current law in the part B premium costing seniors over $500 a year by

2002. Second, there is an increased part B deductible and new copays which will cost the average senior another $300 a year.

Third, perhaps the worst of all, there is the fixed cap on Medicare which will rise on an age adjusted basis only 4.6 percent, while private premiums are going up over 7 percent a year. This means that any senior who is enticed into this fixed-dollar voucher scam will have a payment gap of over $1,200 a year by the time the plan is completed, and they will have to come up with that $1,200 a year out of their pockets.

I would like to know how the average senior with an income of $17,000 a year or one of the 11.5 million single women over the age of 65 who live on incomes of less than $8,000 a year are supposed to pay these. I think my colleagues on the other side of the aisle are playing fast and loose with something pretty precious, at least to my mother, and that is her Medicare. And to add insult to injury, you are keeping a secret of what you plan to do until the last possible minute.

The saying goes you can run, but you cannot hide. We all understand that the Republicans need these huge Medicare cuts to pay for tax cuts for the rich, and no amount of wailing over the part A trust fund can hide the fact that we are making 37 million Medicare beneficiaries pay backbreaking increases in out-of-pocket expenses to provide a tax break to the wealthiest 1 million in our society.

So we will hear today from people who mostly will benefit from that plan. I look forward to the hearing.

Thank you.

Chairman THOMAS. I thank the gentleman.

I understand that there are Members who have written statements and, without objection, their written statements will be made a part of the record

We have a statement of Representative Kleczka on the hearing which, without objection, will be made a part of the record.

[The opening statement of Mr. Kleczka follows:]

Statement of Rep. Gerald D. Kleczka
July 19, 1995

Mr. Chairman, I want to thank you for holding these important hearings so that we may finally begin the dialogue that is so critical to the democratic process. Although I would prefer to discuss the specifics of your impending Medicare reform proposal, I welcome the opportunity to at least discuss the general issues, and to perhaps obtain answers to a number of questions I have about the plan you and your Republican colleagues are working on to reform the Medicare system.

Frankly, I am very concerned about some of the rumors that are circulating about this proposal, and it is my hope that these hearings will give us the opportunity to clear up some of the confusion that I and my constituents are experiencing. Because, as we all know, $270 billion is a tremendous amount of money--no matter how you look at it. Whether you call it a cut, or a reduction, or slowing the growth, $270 billion is still $270 billion.

Where does this money come from? Will Medicare beneficiaries have to pay more to continue seeing the doctor of their choice? Will Medicare pay doctors and hospitals less? Do you plan to reduce benefits? How many years do you estimate that your proposal will extend the Medicare Part A Trust Fund?

Yesterday, the Washington Post reported that Republican plan will increase copayments to 25 percent from the current 20 percent, and impose *new* copayments of 20 percent for home health services, clinical lab services and the first 20 days of a skilled nursing home stay. In addition, the plan will purportedly raise the annual $100 deductible and, apparently, increase monthly premiums. I am interested to know if this report is accurate. And if it is, why are these particular provisions included?

These proposals are especially perplexing to me because it has been my understanding that the reason that the Republicans are undertaking such a difficult task of reforming the Medicare program is to protect the Medicare Part A Trust Fund. But the provisions I just listed are cuts in the *Part B* program and will do nothing to resolve the Trust Fund dilemma. So why would you make seniors pay more?

Hopefully some of our witnesses can shed some light on the Republican proposal. I understand that you have been working quite closely with a number of these groups so perhaps we can glean some information from them about what to expect from you in September. The American Medical Association apparently has recommended that Medicare's payments to physicians be *increased* by $14.5 billion. Is this going to be part of the plan?

Mr. Chairman, I am puzzled by these reports. They just don't make sense to me or to millions of seniors who rely on Medicare. I appreciate the opportunity to ask these important questions. After all, when you are talking about $270 billion, the answers could mean the difference between closing a hospital or keeping it open, seniors receiving care from their own doctor or a stranger, living on their own or with their children, and having some health care coverage or none at all.

Chairman THOMAS. I know the gentleman is busy with a number of activities, but perhaps he missed the trustees' report in April, perhaps he missed the President's budget suggestions in June that we are going to have to trim the growth of Medicare. And what we are looking for are suggestions from everyone who participates in Medicare, since I think most rational people believe that something should be done, rather than nothing.

Dr. Bristow, of the American Medical Association, I believe has in fact submitted a suggested revision of the Medicare growth history. I invite you to provide us with any testimony you see fit, with the backdrop that apparently you are part of this cabal that is out there to continue the shell game.

Dr. Bristow.

STATEMENT OF LONNIE R. BRISTOW, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION OF AMERICA, INC.

Dr. BRISTOW. Thank you, Chairman Thomas.

Mr. Chairman and Members of the Subcommittee, my name is Lonnie R. Bristow, M.D., and I am a practicing internist from San Pablo, California. I am also the president of AMA, the American Medical Association.

You have asked the AMA to testify today about the proposal we have developed to transform Medicare. When we came before you last month, we identified a key factor contributing to Medicare's enormous growth. The person consuming health care services, the patient, has been insulated from the costs of these services by third-party payment mechanisms, principally Medigap. We also described how cost controls have further insulated both the patient and the physician from the economic consequences of their health care decisions.

The AMA's proposal to transform Medicare sets out to correct these structural flaws, with the long-range goal being to reduce the dependency of future generations on government subsidized medical care. It presents a fundamental shift away from government control and toward personal responsibility, individual choice, and an invigorated marketplace.

This shift can save billions of dollars for both beneficiaries and the program, thus assuring Medicare's long-term viability. By getting rid of the current distortions, physicians and providers can compete openly for patients based on value. Now, here is how it would work.

Each elderly or disabled beneficiary could choose from several different options for Medicare, individually tailoring the program to fit his or her particular circumstances. Yet, the government would pay exactly the same amount, regardless of the patient's choice. One patient might decide to stay in what we think of as traditional Medicare. AMA's proposal would retool cost sharing, so that once that patients meets the yearly deductible, all further costs for covered services would be paid for by Medicare. Additionally, the patient would get a refund if she did not use all of her deductible amount.

This patient could for the first time comparison shop for value in her Medicare services. She would do this by using physicians' ---blished "conversion factors" and quality information. If her phy-

sician charge is less than Medicare's set amount, she could keep the savings. Similarly, if her physician charges more, she pays the difference. No Medigap and no more stacks of forms.

Now, this patient's husband, on the other hand, might decide against enrolling in traditional Medicare and instead enroll in Medichoice. This option would give him access to a wide array of plans similar to that offered by the FEHBP to Members of Congress and Federal employees. Like his wife, he would have information on rates and plan quality to assist his value shopping. He would pay the difference when the plan costs exceed the government contribution or, conversely, keep the savings when the government contribution exceeds the plan's costs.

Now, this couple's neighbor may decide on another option in lieu of these comprehensive plans. She may decide to establish a medical savings account coupled with a high deductible catastrophic policy. This plan would also be funded by the government's annual contribution amount, and distribution from the account for covered medical expenses or long-term care would be exempt from taxation, and unspent balances would be allowed to accumulate in the account.

Now, it is very important to note that the AMA's proposal provides a safety net for low-income beneficiaries. A patient at or below the Federal poverty level would be exempt from any cost sharing, and those with incomes between the poverty level and 150 percent of that level would face some modest cost sharing adjusted on a sliding income scale.

The AMA proposal does not focus solely on plan design. We also call for establishing a partnership for health care for value. Now, this private sector forum, in coordination with the government, would work to promote standards of quality and rules of fair play in the health care marketplace.

The AMA's proposal also calls for reducing Medicare's contribution to graduate medical education funding and placing a large portion of that with an all-payer GME funding system. In addition, we recommend gradually reducing the number of publicly funded residency slots. Our proposal describes many other recommended changes, such as raising Medicare's eligibility age and income-relating Medicare's benefit subsidy.

Mr. Chairman and Members of the Subcommittee, as you review this plan and have questions, we would be happy to explain our thinking and our actuarial conclusions with you. We believe the time for tinkering is past. A bold vision is required if we are to strike a fair balance between fantastic technological possibilities and clear resource limits. The AMA's proposal for Medicare transformation attempts to achieve that balance, while keeping front and center the very patients that Medicare is intended to assist.

I would welcome your questions and your feedback.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

RE: Saving Medicare and Budget Reconciliation Issues

Presented by: Lonnie R. Bristow, MD

July 19, 1995

Mr. Chairman, my name is Lonnie R. Bristow, MD. I am an internist from San Pablo, California, and President of the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I thank you for the opportunity to present testimony to the Subcommittee today regarding the AMA's proposal to transform Medicare. We are pleased to share our thoughts with you as the Congress considers how to best protect the promise of Medicare in an era of sharply limited resources.

A wide range of experts have independently concluded that, despite Medicare's clear success in improving the health status of our elderly and disabled citizens, the program cannot be sustained without a fundamental restructuring. The AMA has testified before this subcommittee earlier this year regarding those factors precipitating Medicare's current crisis. The time has passed for tinkering and minor modifications. In light of what is known about the program's structural flaws and its looming bankruptcy if basic reforms are not made, the AMA has synthesized almost ten years of policy consideration and research by our association into the proposal we will describe to you today and which has been distributed to every Member of the Congress. It is based on principles that the AMA has repeatedly advocated for reforming Medicare to correct current structural problems and to reduce the dependency of future generations on subsidized government medical care.

The reforms we propose are a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. The AMA's proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and financing mechanism, with the reasonable opportunity to change either if they prove unsatisfactory. An effective health care marketplace is only achievable if we rid ourselves of the current program's distortions that have had the perverse effect of aggravating, rather than easing, the government's burden in keeping Medicare's promise. As long as Medicare insulates patients from the true cost of the services they are consuming, a competitive Medicare marketplace will never flourish and costs will continue to escalate.

AMA'S PROPOSAL FOR MEDICARE TRANSFORMATION

Distilled to two central ideas, AMA's proposal is premised on the belief that:

- **Individual responsibility, changed incentives and reduced administrative costs will produce savings for most patients and lead to the fiscal integrity of the Medicare program; and**

- **Medicare beneficiaries -- our patients -- should have enhanced choice and the ownership and responsibility for their Medicare entitlement, while receiving the highest quality medical care.**

SAVINGS

How can a system premised on choice and individual responsibility offer savings to the Medicare program? When individuals have a financial stake in their medical care, they are more likely to be prudent consumers and seek the highest value for their money. Patients and physicians alike become sensitized to price and, more important, value. When marketplace distortions are eliminated through the removal of government price controls, physicians and other providers will compete in the marketplace. The private sector has demonstrated that competition can yield savings.

These savings are the result of a more prudent use of resources by patients, coupled with increased efficiency by physicians. **Enhanced beneficiary cost-consciousness does not have to mean substantial increased costs for beneficiaries. It is primarily the manner in which beneficiaries pay today -- not the amount -- that defeats any incentive to use the program efficiently.** Our proposal will actually bring an estimated 40% of beneficiaries some level of savings. It will leave about half of beneficiaries no better or worse off than if they had remained under the current system, and it will call on an estimated 10% to pay marginally more. This benefit accrues while simultaneously saving the program billions of dollars. (See attached chart demonstrating overall projected net savings achieved through these changes, as well as the effect on simulated low and heavy users of health care services.)

Nor do these savings have to come from a continuation of past failed policies repeatedly reducing physician payments. Physicians have, year after year, contributed their fair share to the budget deficit effort. Physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. Projected further declines, based on the current flawed payment formula, will actually bring physician payments lower, at the end of the century, than they were at the beginning of the 1990s when RBRVS was first implemented (see attached chart). Our proposal achieves savings while minimizing further reductions that will push many physicians over their own budgetary red line, reducing or eliminating entirely their ability to continue caring for Medicare patients. Competition requires that prices be decontrolled and beneficiaries rewarded for seeking better value in the marketplace. Our proposal for physician price competition builds on the current RBRVS-based system. We call on the Secretary of HHS to design a similar system for DRG-based hospital payments in the HI program, as well.

Some have mistakenly portrayed the AMA's plan as allowing for "balance billing." This is an inaccurate and misleading characterization, as the concept of "balance billing" is a remnant of the government "command and control" system which we are attempting to transform. This old system perversely serves to penalize physicians for setting their prices too low. The AMA's proposal would allow the government to set its price, physicians to set their conversion factor, and patients to compare value among competing caregivers. Given that approximately 93% of physicians who currently treat Medicare patients accept assignment, the hypothesis projected by our critics of steeply escalating prices appears unfounded.

As another element of savings, AMA's proposal greatly reduces waste and unnecessary administrative costs. An undistorted market will wither nonessential costs, while maintaining those elements that truly contribute to greater value in caregiving. In addition, the AMA advocates institutionalizing modernized Medicare administrative practices to include computerization of patient records and claims systems (embracing confidentiality and security measures for individuals' health information), a public-private partnership to explore telemedicine's promise, and changing payment policies to encourage preventive care and care provided in subacute or home settings.

BENEFICIARY CHOICES

The heart of AMA's proposal would provide the elderly and disabled with several different options for Medicare. Each Medicare beneficiary would have an expanded set of choices that range from remaining in the restructured traditional Medicare program, to selecting from various competing health plans (including managed care options), to investing in a Medical Savings Account (MSA) coupled with a catastrophic plan . In general, Medicare patients would have enhanced opportunities to make prudent use of medical care resources and to be personally rewarded for those decisions.

How might people actually take advantage of greater personal responsibility under a transformed Medicare? One patient, for example, upon enrolling in the Medicare program, may decide to stay in "traditional" Medicare. Her spouse, however, may want to take advantage of one of the many managed care plans offered under a new "Medichoice" -- a plan very similar to the Federal Employee Health Benefit Plan (FEHBP) he had enjoyed when he was a postal worker. Their neighbor may decide to take advantage of the MSA option with a high deductible catastrophic policy offered under Medichoice. **Each beneficiary could personally tailor the program to fit his or her individual circumstances** and, in the vast majority of cases, each Medicare beneficiary will save money or spend the same amount as under the current system.

I. A beneficiary electing to remain in the modified **"traditional"** Medicare:

- would only have one form of cost sharing to replace the current multiple deductibles and coinsurance -- once they met a preset yearly deductible, all costs for covered services would be paid by Medicare, and beneficiaries would get a refund if they did not use their deductible amount;

- would have no need to purchase medigap insurance for deductibles and coinsurance of covered services and no need to fill out yet more forms; and

- would be able to **compare value** in choosing a physician using, in part, a published "conversion factor," and either pay the difference when the physician charges exceed the government payment or keep the savings when the government payment exceeds the physician charges.

This modified form of beneficiary cost-sharing will serve to reduce, on average, the individual's out-of-pocket costs, reward individuals for being prudent consumers of routine medical services, and reduce both patient and provider paperwork and other administrative complications of dealing with Medigap supplemental insurers.

II. Patients choosing "**Medichoice**" would have access to a wide range of plans similar to those offered by the Federal Employees Health Benefit Plan (FEHBP). Each person would receive:

- advance notice of the government's contribution (to be actuarially determined) toward the cost of Medichoice plans;
- information and rates on plans in the individual's area to assist "value comparison"; and
- a Medichoice election and enrollment form (available on attaining Medicare eligibility and on an annualized basis).

Patients would either pay the difference when the plan costs exceed the government contribution or keep the savings when the government contribution exceeds the plan costs.

III. Each Medicare-eligible individual would also have the option, in lieu of comprehensive plans (such as traditional Medicare or Medichoice), to establish a "**Medical Savings Account**" coupled with a catastrophic policy. Our MSA/catastrophic plan would:

- be funded by the government's annual contribution amount;
- consist of a fund from which the beneficiary would pay deductible medical expenses and a high deductible catastrophic medical expense insurance;
- allow unspent balances to accumulate in the fund; and
- provide for distribution from the MSA fund (exempt from federal and state income tax) for medical expenses, including health insurance premiums and long-term care expenses.

The MSA option would undoubtedly prove attractive to many beneficiaries because they could provide funds for purchase of items and services formerly not covered by Medicare, such as prescription drugs or extended long-term care. The AMA strongly supports Chairman Archer's MSA legislation, as detailed in our recent separate statement to the Committee.

In the AMA proposal, we specifically take into account those in our society who are most dependent financially on the Medicare program. Those whose incomes are at or below the poverty level would be exempt from any Medicare cost-sharing. Those with incomes between the poverty level and 150% of that level would face some cost sharing, adjusted on a sliding scale based on income.

Medicare must be transformed into a defined contribution program to tighten the program's original open-ended entitlement that has contributed so significantly to Medicare's fiscal instability. To serve beneficiaries optimally under such budgetary constraints, however, the program must provide a wide variety of choices to allow for the full spectrum of needs and financial means within the beneficiary population.

The newly empowered Medicare beneficiary should not be restricted in choice of plans or providers. We must correct the current competitive disadvantage of physician-sponsored health plans. Physicians are positioned to ultimately balance the cost and quality equation better than any others in the marketplace, with the potential to save substantial amounts which today go to the administration and institutional investors of giant corporate plans. A simple program to help stimulate physician plans much as was done for HMOs in the 1970s is a necessary direction to pursue.

QUALITY AND HEALTH PLAN STANDARDS

As Medicare becomes a part of a meaningful way for patients to make choices in the private marketplace, costly and complicated government regulations can be reduced and the private sector can exercise its self-regulatory expertise. We are proposing an unprecedented **"Partnership for Health Care Value"** organization that focuses private sector efforts to promote standards of quality and rules of fair competition that protect the patient-physician relationship. The Partnership will also coordinate and expand current fragmented efforts to find, report and eliminate fraud and abuse. A dramatic, yet simple, way to materially decrease fraud is to share responsibility for its detection with organized medicine. According to the FBI, physicians are the least likely group to engage in fraud, yet the most useful in assisting in its prosecution.

The Partnership would also serve to educate physicians, providers and patients about reducing care of marginal value and increasing preventive care. It would build on current efforts in this arena, such as the soon-to-be-released booklet on health care advanced directives, jointly produced by the AMA, the American Bar Association and the American Association of Retired Persons. The Partnership would expand continuous quality improvement in medical care and quickly communicate clinical advances to every physician.

In addition, to protect our patients, the AMA urges that plans be guided by the following principles which have enjoyed bipartisan support in the past Congress. In general, plans should:

- disclose to patients plan information, rights and responsibilities;
- provide for appropriate professional involvement in plan medical policy matters;
- disclose utilization review plan policies and procedures;
- provide reasonable opportunity for patient choice of plans and physicians; and
- provide reasonable access to physicians and specialists.

GRADUATE MEDICAL EDUCATION

Additional Medicare savings can be achieved by making the funding of our graduate medical education (GME) system more rational. The marketplace in medical education needs a new set of rules. The necessary restructuring of GME financing must be sensitive, however, to the multiple obligations of teaching hospitals, which provide a high level of specialized care, as well as care to the uninsured and the underinsured, and to medical schools, which carry out both educational and research missions.

We propose that Medicare's contribution to GME be reduced over time and that the private sector play a stronger role in both work force planning and funding of GME. All the entities delivering health care today benefit directly or indirectly from the GME system, yet many contribute little to it. It will take time to develop and implement a fair all-payer system for GME. We recommend a gradual reduction in the number of publicly funded residency positions and the transition to a GME funding system supported by all payers, public and private.

The AMA's proposal also calls for the establishment of a cooperative private-public sector physician workforce planning initiative to study physician workforce needs and make recommendations about the future funding of GME. The planning group's considerations would include issues such as suitable specialty mix, geographic distribution and appropriate training.

ADDITIONAL MEDICARE CHANGES

We are also calling for three additional changes: (1) including preventive services in the Medicare benefit when availability of such services can clearly be shown to reduce overall program costs; (2) raising Medicare's eligibility age over time so that it is consistent with that of Social Security; and (3) reducing by a modest amount the Medicare subsidy of high income beneficiaries.

CONCLUSION

Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely on this program in the future, as well as those working Americans who are called upon to help finance it. Continuation of past stop-gap measures, such as chopping away at rates paid to providers in hopes of getting more services for less money, will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care. Simplistic budget-cutting has not resulted in cost-control over recent years; on the contrary, price controls have had the perverse effect of exacerbating Medicare's fiscal crisis and severely threatening the promised access of beneficiaries to medical care.

Americans who depend on the Medicare program for their medical and health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. As the nation attempts to strike a balance between enormous technological possibilities and clear resource limits, it is imperative that patients make the choices with physicians as their trusted advisers. Our proposal for Medicare transformation attempts to achieve the new balance that is required. We look forward to working with the Congress on this vital effort.

# # #

LOW USER

DESCRIPTION: Healthy enrollee with only 2 visits for $300 total

Out-of-Pocket Spending

Current Law		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 300
Part B		Coinsurance:	$ 0
Effective Deductible:	$ 0	Total Medicare Premium:	$1,064
Effective Coinsurance	$ 0	Out-of-Pocket Spending:	$1,364
Premium:	$ 553		
Medigap Premium:	$1,011		
Out-of Pocket Spending:	$1,564		

HEAVY USER

DESCRIPTION: Ailing enrollee, several MD visits, 3-day hospital stay, 7-day hospital stay; expenses total $10,000.

Out-of-Pocket Spending

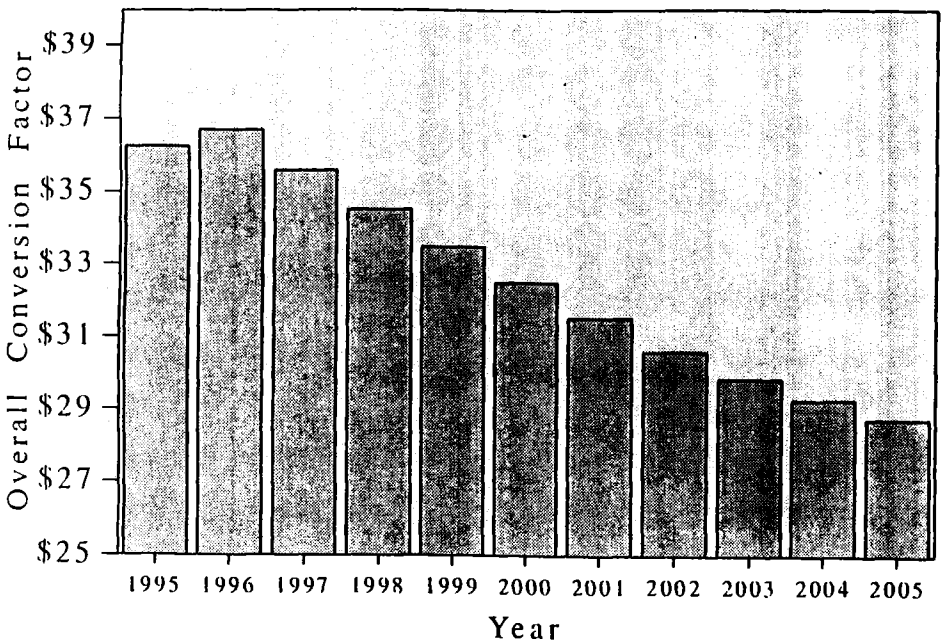
Current Law		AMA Proposal	
Hospital Deductible:	$ 0	Deductible:	$ 500
Part B		Coinsurance:	$ 0
Effective Deductible:	$ 0	Total Medicare Premium:	$1,064
Effective Coinsurance	$ 0	Out-of-Pocket Spending:	$1,564
Premium:	$ 553		
Medigap Premium:	$1,011		
Out-of Pocket Spending:	$1,564		

Summary of Beneficiary Net Savings

Case	Current Law	AMA Proposal	Net Savings
1. Non-User	$1,564	$1,064	$500
2. Low User	$1,564	$1,364	$200
3. Medium User (no Hospital)	$1,564	$1,564	$ 0
4. Medium User (with Hospital)	$1,564	$1,564	$ 0
5. Heavy User	$1,564	$1,564	$ 0
6. Catastrophic User	$1,564	$1,564	$ 0
7. Average User with No Medigap	$1,363	$1,564	($201)
8. Low-Income Average User	$1,363	$1,059	$305
9. High-Income Average User	$1,564	$2,458	($893)
10. Big Loser	$ 553	$1,064	($511)

Conversion Factor Simulation

Baseline/Current Law



Chairman THOMAS. Thank you very much, Dr. Bristow.

Karen Ignagni, representing Group Health Association of America. It is good to have you with us again.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. IGNAGNI. Thank you.

Good morning, Members of the Subcommittee. I am delighted to be here to present GHAA's views and recommendations about Medicare restructuring. In our testimony, we present a plan for modernizing Medicare. We have two goals underlying our thoughts and proposals. The first is to make Medicare work more like the private sector system that is now in place for working families. The second is to preserve beneficiary access to services.

We have offered five specific recommendations. The first is to expand choice for beneficiaries. One example would be the recent efforts that we have been working on collaboratively with HCFA to expand POS options under Medicare risk contracts. That would be an example of the kind of choice along with PPOs and other kinds of delivery systems that are now in the market for working families.

The second proposal that we have submitted for your consideration is to improve information going to beneficiaries and to set up a structure where beneficiaries now receive information about the kind of plans that are available in the market and they can make decisions and evaluate on the basis of quality, service, and price. We also would recommend that this type of information be sent to beneficiaries prior to retirement, so they might have time to confer with their physicians, relatives, and make appropriate and informed decisions.

Our third recommendation is to consider that any proposed restructuring that contemplates modernizing Medicare and embodying within Medicare some of the principles that are in existence in private insurance for the under-65 population will not work without standards for fair play across the board.

We have talked quite a lot with you in past appearances about the importance of leveling the playingfield. What I mean by standards are particular issues related to solvency, quality assurance, data disclosure, reporting, and issues you have discussed over the years. But I think that as you move to a more patient empowered system with quite a lot of choice, you do want to have similar standards for the plans that are in the system.

The fourth point we make is that it is very important to consider what this does to the current administrative structure for the program. We would see the structure moving from the present form to more standard-setting, providing accountability mechanisms and monitoring what is going on, much like the functions of employers in the private marketplace today.

The next proposal we have submitted, the fifth is to transition to an improved payment methodology. There has been a lot of comment on FEHBP-like systems and competitive bidding particularly. We think that those proposals might be useful to investigate for the long term, but the point is what do you do today. What we have

tried to do is provide a framework for you to begin working today, begin transitioning from where we are today to make the kinds of changes I think you are considering, while we are exploring different suggestions for the longer term.

Some of that is already under way, and we would encourage the continuation of that. But that will take time and study. We have tried to offer you a road map of how to begin to make the changes now. We would begin with total expenditures, in other words, where we are today, translate that into per capita payments on both sides, fee-for-service, and anything in the so-called "managed care" arena. On the fee-for-service side, that would probably bring together many of the initiatives that you have already launched in terms of RBRVS and prospective payment. It would bundle care. It would capitate. It would move to integrate and coordinate care on the fee-for-service basis, as well as on the managed care side.

We would propose that there be lookback mechanisms to enforce the capitated payment on the fee-for-service side, and on the managed care side much as the AAPCC acts as a budget, our proposal would involve the per capita payment acting as a budget. In that environment, you would have a structure to debate and discuss the point of where you start the growth and how you phase down over what period of time.

In sum, Mr. Chairman, we hope that our thoughts have provided you a mechanism to begin thinking about what you do today. We thought that was our charge and we have worked very hard to be helpful in this regard, at the same time balancing all of the interests that are certainly on your mind with respect to the solvency of the trust fund, as well as the goal of preserving beneficiary access.

Thank you.

[The prepared statement follows:]

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. Chairman and members of the Committee, I am Karen Ignagni, President and CEO of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs). Our 385 member HMOs serve 80 percent of the 50 million Americans receiving health care through HMOs today.

We are pleased to be asked to testify as the Committee explores the future of the Medicare program, and look forward to working with the Congress and the President on a bipartisan fashion on Medicare. GHAA believes that Medicare must be modernized to reflect the dramatic developments that have occurred in the private sector since Medicare was enacted 30 years ago. Medicare can best be strengthened by offering beneficiaries the same kinds of choices that are already available to millions of working Americans both in the private sector and in the federal government. Today, I would like to:

- o review the environment for change in the health care marketplace, and in Medicare;
- o review the current status and experience of the Medicare HMO contracting program;
- o review GHAA's guiding principles for discussion of Medicare reform; and
- o present GHAA's recommendations for "where to begin" -- initial steps in a transition to broader reform of the Medicare program.

The Changing Environment

When Medicare was enacted in 1965, the health care environment for which this vitally important public program was designed was substantially different than it is today:

- o the overwhelming majority of insured Americans received their health care under the then-predominant fee-for-service approach;
- o health care services were more focused on inpatient hospital care;
- o health care was less complex and bewildering than today, so coordination of care was not as essential;
- o the advantages of coordinated care -- including preventive care, quality measurement, management of chronic conditions, and the ability to provide comprehensive care within a budget -- were not yet fully apparent;
- o treatment costs were a fraction of what they are today, so cost containment was not as urgent a national concern; and
- o health maintenance organizations and other organized systems of care were not yet available to most Americans.

Medicare was in many ways a "market-based" health system in the environment that prevailed in 1965. And measured in terms of the security that it has brought to the elderly, the disabled, and their families, Medicare has been a success. However, in 1995, thirty years later, the environment in which Medicare operates has changed dramatically:

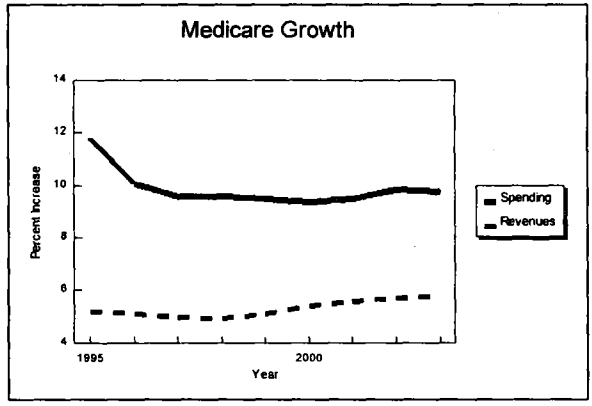
- o fee-for service coverage is no longer the predominant approach to coverage in the market;
- o more consumers are choosing coordinated care through organized systems of care because of the disadvantages of the fee-for-service approach in an increasingly complex medical system;

- Americans by the millions have joined HMOs and are overwhelmingly satisfied with the care they and their families receive;
  - more than 60 percent of all working Americans with private health coverage now receive their care through HMOs or other organized systems of care;
  - about 35 percent of federal employees have chosen HMOs from among the wide array of choices that are offered;

Medicare too is changing, but slowly -- only about 10 percent of today's Medicare beneficiaries are in HMOs. The result is that Medicare has fallen behind the evolving market environment -- Medicare beneficiaries no longer have coverage that is typical of that available to the working population, and do not derive the benefits of the choices available to other Americans.

Without reform, Medicare faces insolvency in a few years.

Figure 1



But modernization of Medicare is feasible and within reach. The key is to provide Medicare beneficiaries with the health plan choices that are already available to Members of Congress and other working Americans.

Guiding principles for discussion

Given the changing environment, Medicare must be updated to reflect the dramatic changes that have occurred in the private sector during the three decades since the program began. GHAA believes that Medicare can best be strengthened by giving beneficiaries the same kinds choices that are already available to millions of working Americans both in the private sector and in the federal government. Medicare -- and the Health Care Financing Administration (HCFA) -- should be reoriented toward a model in which Medicare beneficiaries have the opportunity to choose from among a broad array of options that compete on the basis of quality, service, and cost, and are held to comparable accountability standards. When beneficiaries can choose the option that best meets their needs, Medicare will benefit from the progress that has been made in the private sector.

- **Beneficiary choices**: Medicare reform should be consistent with the promise of providing access to basic Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population.

- **Medicare standards**: Our experience also tells us that standards are vitally important. All organized systems of care, as well as providers under the fee-for-service Medicare program should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency. Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.

- **Medicare payments**: Medicare payments should permit widespread availability of organized systems of care, as well as the traditional fee-for-service option, for Medicare beneficiaries nationwide. The Medicare program should act in a fashion similar to private sector purchasers. This can be done by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis, with an equitable allocation of resources between organized delivery system options and the fee-for-service program. Total expenditures should be trended forward on an appropriate basis to meet program goals.

The current status of Medicare HMO coverage

In developing proposals for modernization of Medicare, it is useful to review briefly the current status of Medicare contracting with HMOs and competitive medical plans (CMPs)[1] because that program can provide a platform for future changes in Medicare.

The Medicare HMO risk contracting program was enacted in 1982 as part of Tax Equity and Fiscal Responsibility Act (TEFRA), after a number of years of successful demonstrations of this contracting approach. The TEFRA program provided for Medicare contracting with HMOs and CMPs, and authorized payment to those plans of 95 percent of the estimated cost of fee-for-service Medicare in the geographic area (the county) -- the adjusted average per capita cost, or AAPCC.

While the specifics of the AAPCC calculation are complex, the methodology incorporates four basic steps:

- calculation of the national per capita cost for care under Medicare (this is the United States Per Capita Cost, or USPCC);

- estimating the county per capita cost of fee-for-service care by:

  - applying a county adjuster to the USPCC (the county adjuster is a moving five-year average of the ratio of county per capita costs to national per capita costs);
  - adjusting for county HMO expenditures; and
  - adjusting for the demographic mix of the county's beneficiaries;

- multiplying the county per capita cost by 95 percent; and

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[1]Competitive medical plans (CMPs) are HMOs that have not chosen to become federally qualified but meet similar federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMOs and CMPs.

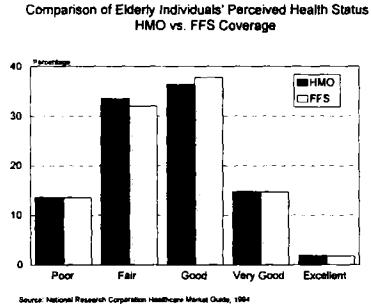
- o applying the actuarial risk adjustments developed by HCFA to account for age, sex, Medicaid status, institutional status, and employer-based coverage of the beneficiary.

As of this year, roughly 3.1 million Medicare beneficiaries have chosen to be served through one of the HMO contracting options offered by the Medicare program. Since 1990, enrollment in Medicare risk plans has doubled while combined enrollment in all HMO options has grown by 70 percent.

The Medicare HMO contracting program has proven successful in a number of ways -- it has achieved a broad enrollment base, member satisfaction, documented quality, and savings.

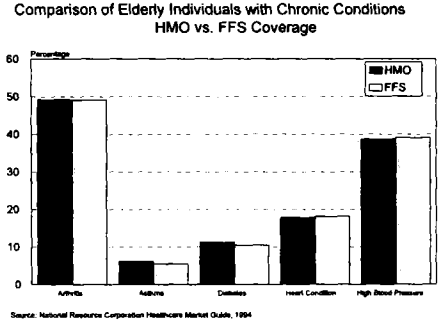
Broad enrollment base: The National Research Corporation found that seniors enrolled in HMOs and in fee-for-service Medicare are very similar in terms of overall self-reported health status and incidence of chronic medical conditions. As shown in Figure 1, 16.7 percent of HMO members reported that they were in "excellent" or "very good" health, compared with 16.5 percent of fee-for-service enrollees. The percentage in both populations reporting "poor" health was the same, 13.6 percent.

Figure 2



Further, the percentage of Medicare HMO enrollees with selected chronic conditions is generally similar to the FFS sector, as shown in Figure 3. For example, 49.2 percent of seniors enrolled in HMOs reported suffering from arthritis, compared to 49.1 percent in FFS Medicare.

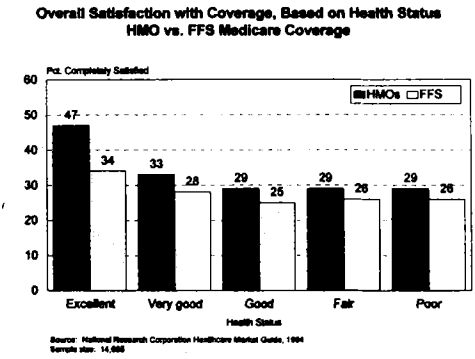
Figure 3



These data are inconsistent with the often-cited Mathematica Policy Research study on favorable selection in the Medicare HMO program -- a study that was based on beneficiaries who enrolled in 1987 or 1988 (seven to eight years ago). Since 1987 -- when the risk contracting program was just two years old -- enrollment in Medicare risk HMOs has more than doubled, and as that enrollment has grown, the characteristics of the HMO population have become increasingly similar to those in the fee-for-service population.

Satisfaction: Medicare HMOs attract a broad mix of enrollees, and those enrollees are satisfied with their care. During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied overall with their health plan than fee-for-service subscribers. A National Research Corporation survey of over 19,000 elderly Americans found that, for all levels of self-designated health status, the elderly enrolled in HMOs are more satisfied with their coverage than the elderly receiving services under the traditional Medicare fee-for-service program. Figure 3 highlights these data -- indicating that HMOs achieve higher subscriber satisfaction not just among the healthy, but also among the sick.

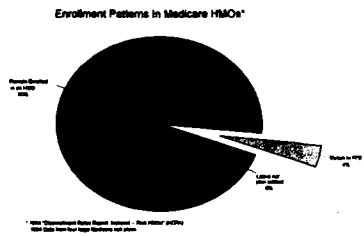
Figure 4



This level of satisfaction is highlighted further by the fact that Medicare beneficiaries who choose HMOs stick with them. A recent study of Medicare HMO enrollees in 1994 showed that:

- o 84 percent remained with their HMO;
- o 6 percent switched to another HMO in their area;
- o 6 percent left for reasons unrelated to the plan (e.g., they move out of the area);
- o 4 percent returned to local fee-for-service care.

Figure 5

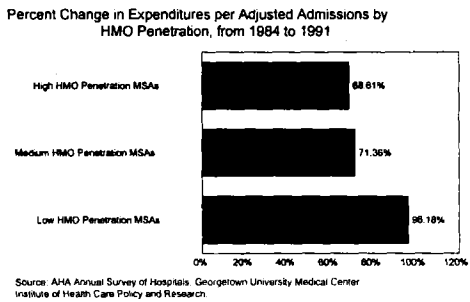


Quality: Medicare HMOs offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service sector. This is due to coverage of and improved access to preventive care under comprehensive HMO coverage, which is also highlighted in a study by the Centers for Disease Control (CDC) and the National Center for Health Statistics that showed that women in HMOs are more likely to obtain mammograms, pap smears, and clinical breast exams than those in the fee-for-service sector. Another study, comparing care for patients age 65 and older with acute myocardial infarction (heart attack), concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.

Savings: Finally, HMOs lower the rate of increase in spending on health care in two ways -- by holding down costs in their plans, and by producing savings in the marketplace as a whole (the so-called "spillover" effect).

By promoting competition in an area, HMOs lead to reductions in fee-for-service costs. W.P. Welch of the Urban Institute estimated that for metropolitan statistical areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Studies by Glenn Melnick and James Robinson found that hospital costs increase less rapidly in areas of California where HMOs had a larger market share. Jack Hadley and Darrel Gaston of Georgetown University report that hospital costs per admission increased 69 percent in high HMO penetration markets from 1984 to 1993, compared with 96 percent for low HMO penetration markets, as shown in figure 6 below.

Figure 6

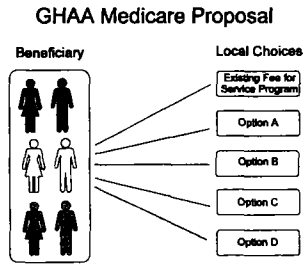


The current program is a promising start, and demonstrates that HMOs can successfully serve the Medicare population. But despite recent enrollment growth, Medicare still lags considerably behind the private sector in the HMOs and other organized systems of care it offers to beneficiaries.

Where to begin

Looking at the current Medicare program and using the GHAA principles as a guide, the question, of course, is how to begin to take the steps necessary to modernize Medicare. Based on the practical and proven experience of our member plans in serving tens of millions of Americans, including three million Medicare beneficiaries, we are recommending a series of changes to transition from the current approach to a model based on beneficiary choices.

Figure 7



The changes are designed to foster expansion in existing Medicare markets, encourage new Medicare markets to emerge, permit the development of increased capacity for Medicare beneficiaries to enroll in organized options offered by HMOs and other entities, and provide the experience necessary to permit informed decision-making by the Congress on the future design of the Medicare program. We recommend changes in the following five areas:

- o improve beneficiary information, awareness, and enrollment process;
- o expand the infrastructure of health plan choices available to beneficiaries;
- o maintain strong standards for health plans participating in Medicare;
- o begin to transition HCFA from the current regulatory approach to the beneficiary choice model; and
- o transition to improved Medicare payment methodologies.

Improve beneficiary information, awareness, and enrollment process: Mr. Chairman, we should start with the basics. We cannot expect beneficiaries to make informed choices if we do not inform them about their choices, and make it easy for them to enroll.

- o Information/awareness: The Health Care Financing Administration (HCFA) should work with entities that participate in the Medicare program, including HMOs and in the future, other arrangements, to develop information that HCFA could disseminate to beneficiaries about the enrollment options available to them, including educational information about the basic characteristics of those choices. This information should be sent to all prospective beneficiaries in the six-month period prior to their becoming eligible for Medicare, and periodically thereafter.
- o Enrollment: HCFA should develop a mechanism that would allow newly-eligible beneficiaries to elect HMO enrollment that is effective the first month that they become entitled to Medicare, rather than requiring them to wait (and be uncovered for supplemental benefits) until the second month.

Expand the infrastructure of options available to beneficiaries: Second, the choice model requires that we increase the array of options offered by the Medicare program.

- o Expanded array of choices: A broader spectrum of offerings should be phased-in for Medicare beneficiaries by encouraging participation of an expanded array of

benefit options by HMOs and other entities under rules that permit all to participate on an equal footing.

- o Self-referral option: HCFA should continue its work to develop guidelines that would permit HMOs to offer a point-of-service (POS) product through what HCFA is referring to as a "self-referral option" (SRO) for Medicare beneficiaries. Plans would then be allowed to offer beneficiaries a product that enables them to go outside the HMO network to receive covered services.

Maintain strong standards for options participating in Medicare: As we expand the infrastructure of offerings, it is vitally important to maintain strong and comparable standards for all options.

- o Comparable standards for all options: All organized options, such as those offered by HMOs, PPOs, PHOs, as well as providers under the Medicare fee-for-service program, should meet comparable standards designed to address quality of care, access, grievance procedures, and solvency. Standards should include:
  - -- Quality: all offerings and providers should have the capacity to develop reports on performance that permit comparisons among options and providers.
  - -- Access: all offerings and providers should accept all beneficiaries who wish to enroll or who select those providers up to the limits of the capacity of such offerings/providers and without regard to health status.
  - -- Grievance procedures: all offerings and providers should make available to beneficiaries procedures for hearing and resolving grievances under the Medicare program.
  - -- Solvency: all offerings should be fiscally sound and meet standards for an initial deposit, initial net worth and ongoing solvency.
- o 50/50 rule: Statutory criteria in connection with waiving the 50/50 enrollment requirement for HMOs and other organizations offering organized options should be developed.
- o Anti-managed care: Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.
- o Deemed status: To enhance and streamline Medicare's quality assurance program, organized offerings that meet accreditation standards of private sector organizations designated by the Secretary should be deemed to comply with applicable Medicare quality standards.

Begin to transition HCFA to implement new model: Changes in HCFA's focus on individual claims payment and basic improvements in administrative mechanisms can help enhance the modernization of the choices available to beneficiaries.

- o Transition to new model: HCFA needs to begin the process of reorienting its approach from management of the transactions in a fee-for-service system to implementation of a beneficiary choice model.
- o Administrative procedures and processing of applications: In the short-term, HCFA should take immediate steps to improve administrative procedures and processing time:

- -- reduce the time it takes to process and approve two types of applications from HMOs: initial applications to serve Medicare beneficiaries, and applications from approved plans to expand their service area and be able to serve additional Medicare beneficiaries;

- -- simplify administrative procedures for submission and processing of applications (i.e., permit information associated with the application to be submitted on computer disk); and

- -- streamline oversight of multi-state organizations, for example by eliminating duplicative filing requirements and facilitating communications among regions.

- o Policy guidance/ regional variations: HCFA should take steps to identify and narrow the variation in interpretation of policy by regional offices and promote consistency in decision making in such areas as review and approval of contracts, products, and marketing materials; this should include the development and issuance of guidelines for regional offices.

Transition to improved Medicare payment methodologies: Finally, the program needs to begin the transition to improved Medicare payment methodologies. We present this as the final component of our plan, because it requires attention to a number of issues. We include implementation of a transitional payment approach designed to meet current program and budget objectives, and steps to set the stage for future decision making about payment policies.

Transition to Medicare payment mechanism: Medicare should implement a method of payment that would provide greater incentives for beneficiaries to choose options that deliver high quality, cost-effective care. The payment mechanism should permit these options to establish premiums for the benefits they offer and should establish a government contribution based upon the per capita cost to the Medicare program of providing Medicare-covered benefits to all eligible beneficiaries.

In general, the starting point should be the payment methodology under the current Medicare program.

- o The total Medicare budget should be established and a per capita amount should be calculated based on the total number of beneficiaries. The per capita amount should be trended forward on a basis appropriate to meet program goals.

- o The allocation for the fee-for-service program should be established by aggregating the per capita amounts associated with the beneficiaries who select the current program. Medicare would continue to pay claims for covered services provided to these beneficiaries. A periodic determination should be made about whether expenditures are within the desired range, and a framework should be established, perhaps in the annual budget process, for making adjustments to the program in light of this determination.

- o The payment for all other options should be based on the same per capita costs.

- o Changes from the current methodology for determining per capita payments should be phased-in over a period of years. Such changes would be designed to address the problem of low payment rates in under funded areas and promote new markets for private sector offerings for Medicare beneficiaries. This process should ensure that health care for beneficiaries who have already elected HMO membership is not disrupted and preserve the vitality of markets in which significant numbers of Medicare beneficiaries have already joined HMOs.

- o Under this system, health plans would have the flexibility to offer benefit

packages that include at least the standard Medicare benefits, and perhaps greater coverage, for the premiums they have developed.

Demonstrations on alternative payment methods: To set the stage for future decisions about Medicare payment approaches, HCFA should continue to explore the feasibility of alternative payment systems, such as other market-based approaches and mechanisms that will support participation by entities offering organized options in rural and other less populous areas. The projects should continue to encourage voluntary participation and should identify issues related to the design and implementation of alternative systems.

Risk adjusters: One of the most misunderstood features of the Medicare HMO contracting program relates to risk selection and risk adjustment in payments. First, as noted earlier, the fact of the matter is that Medicare HMOs today attract a cross-section of beneficiaries -- sick and well -- comparable to those in the fee-for-service sector. The often-cited Mathematica report on risk selection is simply out-of-date. Second, Medicare already makes a number of actuarial adjustments in its payments to HMOs based on enrollee age, sex, Medicaid status, institutional status, and employer-coverage. These are efforts to assure that payments are as accurate as possible in reflecting the relative risk of the enrollees.

GHAA has consistently expressed support for improvements to the AAPCC that will enhance its accuracy. However, adjustments should be tested to determine if they will serve this goal in a cost-effective way. We believe that the Health Care Financing Administration should undertake demonstrations designed to identify the administrative issues and costs involved for HMOs and for HCFA in implementing risk adjusters that appear promising. Progress on these issues will permit the agency to work with participating entities to move to the next step of implementing appropriate risk adjusters beyond those currently in place.

Maintain comprehensive, capitated approach: As the private health care market imposes more competitive pressures on the health system, and Medicare is modernized as well, the committee will be confronted by pressures to fragment Medicare's capitated payment in a variety of ways. We understand, for example, that proposals have been made to split out Medicare medical education payments from the AAPCC, and to make those payments separately and directly to providers on a fee-for-service or other basis.

At this point, rather than re-fragmenting the payment stream, we believe that the comprehensive, integrated approach offered by HMOs -- and the enhanced competitive pressure that is being generated -- is exactly what is needed in our health system. The reality is that HMOs must contract with academic health centers for compelling health care and competitive purposes -- beneficiaries want access to the prominent institutions in their community, and HMOs, to be successful in meeting beneficiary needs, contract with them.

Creating a stable and equitable payment environment: We need to secure for Medicare and seniors the benefits of the choices and changes that have reshaped the private marketplace, by creating a stable payment environment whose predictability supports expanded participation by HMOs and other organized systems. Such a strategy will allow you to bring Medicare spending growth in line with private sector health spending.

Conclusion

GHAA appreciates this opportunity to present our views about modernizing the Medicare program. We look forward to working with the Committee on this issue, and I would be pleased to answer any questions that you may have. Thank-you.

Chairman THOMAS. As usual, we appreciate the positive way in which you are approaching change that is absolutely necessary based upon the trustees' report.

Dr. Butler, welcome back.

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT AND DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, HERITAGE FOUNDATION

Mr. BUTLER. Mr. Chairman, I appreciate the opportunity to testify.

Mr. Chairman, quite separate from the budget debate, there is a growing consensus which I think you have already heard on this panel that we do need to move Medicare in the direction of giving the elderly the option of using a defined contribution to select from a wide range of private plans.

One question that follows from this is what is the framework in which such a choice system would operate so that plans truly serve the customer, and that information is made available to the elderly of the kind that Ms. Ignagni has already mentioned. I believe a working model does exist for that framework; namely, the Federal Employee Health Benefits Program, the program that serves 9 million Federal retirees and active workers and their dependents.

Both the FEHBP and Medicare are run by the Federal Government. Both provide comprehensive health coverage to millions of people. But, whereas, Congress is struggling to deal with the deep problems of Medicare, the FEHBP is in good shape and works relatively well. Significantly, most Americans have not heard of the FEHBP and it is really mentioned in the press. In my mind, that is a sure sign that it is working.

The secret of the FEHBP's three decades of success is in its basic design. Indeed, according to the 1989 analysis of the program by the Congressional Research Service, "That the FEHBP has continued to work over the years despite major changes in the environment in which it has operated reflects the basic soundness of its design." That design is quite different from Medicare.

Federal workers and retirees receive a degree of financial assistance from the government, essentially a defined contribution, and they apply this toward the cost of an approved private insurance plan of their choice. A refined version of this program could provide the framework for a new Medicare system which widens choice and keeps costs under control through consumer choice.

Under the FEHBP, workers and retirees typically have a choice each year of between one dozen and two dozen plans. Many of these are organized through unions and other voluntary associations of workers and retirees. The plans differ not only in the way in which services are delivered, but also in the services included in the plan. Thus, a Federal worker or retiree might choose a plan with a drug benefit or comprehensive dental coverage not available in some other plan.

But with a defined Federal contribution, the more generous and costly the chosen plan, the more the beneficiary must pay out of pocket. That encourages beneficiaries to look for the best value for their money and it helps keep costs down. This incentive to choose value for money in a market of competing health plans has helped

keep the rate of Federal spending on the program at about one-half the rate of Medicare, and enabled the average premium to fall this year.

And to help beneficiaries choose the best value and the most appropriate plan, consumer organizations and Federal associations provide FEHBP beneficiaries with information on cost benefits and consumer satisfaction surveys. The National Association of Retired Federal Employees even recommends particular plans for those suffering from certain chronic ailments.

A new Medicare system similar to the FEHBP would provide the elderly and disabled with a voucher which they could put toward the cost of a Medicare approved plan of their choice. The voucher would be based on a budgeted defined contribution from the government, in keeping with expenditure levels set by Congress. For any individual, this average amount would be adjusted up or down according to three factors.

First, primary risk factors; namely, age, sex, reason for eligibility, institutional status, and ESRD status. Thus, older, generally sicker beneficiaries would receive a larger contribution. Second, there would be a means-tested adjustment applied to one-third of the voucher to be equivalent to means testing today's part B premium. And, third, there would be an adjustment to reflect the actual costs of typical approved plans available in the area.

To be eligible to market to Medicare beneficiaries, plans would have to meet certain threshold requirements laid down by the Federal Government. There would be no restriction on the number of plans, however. In addition to basic solvency and similar requirements, a plan would have to include a core set of services which is much leaner than the Medicare system today, but would include catastrophic protection. It would have to set premiums according to the same risk factors used to determine the voucher, file standardized information on rates and costs with the Federal Government, and accept any Medicare beneficiary during an annual open season.

As with FEHBP, the government would act as a clearinghouse for the standardized information provided by the plans, and it would negotiate service areas and perhaps rates with each plan. During an annual open season, the government would distribute plan information and an enrollment form, and once the plan had been chosen, the government would send the appropriate voucher to the plan chosen and the beneficiary would be responsible, of course, for the remaining premium amount.

In addition, the government would establish a Federal corporation under our proposal to operate a Medicare standard plan roughly similar to today's Medicare Program. The standard plan would be available everywhere and, in our view, should have a premium. It would have to compete on equal terms with the private plans.

Mr. Chairman, Medicare is hemorrhaging money and it is 20 years out of date. It is time for the program to incorporate the lessons of the private sector an those of the government's own FEHBP. Those lessons suggest that the key is to increase consumer choice and control and to spur innovation by creating a market of competing private plans. That works well for the Federal retirees of the FEHBP. It will work just as well, Mr. Chairman, for seniors who have not worked for the Federal Government.

Thank you.

[The prepared statement follows:]

STATEMENT OF STUART M. BUTLER, PH.D.
VICE PRESIDENT AND DIRECTOR
DOMESTIC AND ECONOMIC POLICY STUDIES
THE HERITAGE FOUNDATION

Mr. Chairman, my name is Stuart Butler. I am a Vice President at The Heritage Foundation. I appreciate the opportunity to address the subcommittee on the issue of Medicare. I emphasize that the views I express are my own, and should not be construed as representing any official position of The Heritage Foundation.

The problems of the current Medicare system derive from its two central characteristics — it is a defined benefit program and for its organization and cost constraint it relies on central planning and elaborate price controls. This structure encourages cost escalation and inefficiency because it lacks strong incentives for beneficiaries to seek value for money and because centralization slows the introduction of innovative management and delivery techniques to reduce costs while increasing efficiency.

To control costs while improving value and choices for beneficiaries, Medicare should be converted into a program in which the government provides beneficiaries with a defined contribution which may be used to purchase a Medicare-approved health plan. Such a system would be, in effect, a modified version of the Federal Employee Health Benefits Program (FEHBP), which currently makes 400 competing private plans available to nine million active and retired federal employees and their family members.

It should be noted the FEHBP population is not an ideal insurance pool, and on the face of it the program should not be successful. Enrollees tend to be older than the general population and the proportion of retirees covered is 40 percent and growing. Enrollment is optional and eligibility requirements liberal. Moreover, beneficiaries can switch plans annually without regard to their health condition and without any waiting period or exclusions, and the plans must community rate their premiums. Yet despite its seeming vulnerability to adverse selection, the FEHBP works remarkably well. As the Congressional Research Service in a comprehensive review of the program in 1989, "That the FEHBP has continued to 'work' over the years, despite major changes in the environment in which it has operated, reflects the soundness of its basic design."

The FEHBP functions in ways that could and should be incorporated in a reformed Medicare system. Federal workers and retirees in any particular area typically have access to between one dozen and two dozen plans. Nobody has a choice of fewer than seven plans. These range from traditional fee-for-service plans to HMOs, PPOs, IPAs and various point-of-service plans. All the plans cover basic hospital and physician services but beneficiaries can pick plans with different additional benefits, such as dental, prescription drug, or mental health benefits. Whatever the cost of their chosen plan, the government pays a fixed amount (with the proviso that it will pay no more than 75 percent of the premium of any plan).

Retirees, like active employees, are given a great deal of assistance in choosing plans in the FEHBP. Local Members of Congress commonly sponsor "health fairs" to review plans in their districts. *Checkbook's Guide to Health Insurance Plans for Federal Employees*, published by a consumers organization, outlines plan features and costs, gives general advice on picking a plan, and provides "consumer satisfaction surveys." These surveys rate plans in such areas as the ease of getting appointments, access to specialists, waiting times in doctors' offices and the quality of care. The National Association of Retired Federal Employees also provides information and recommends plans for retirees with particular ailments.

The law governing the FEHBP is just 26 pages long. The program is run by OPM, which has authority to contract with plans for inclusion in the system. OPM's small staff "negotiates" prices and benefits — best characterized as "jawboning" — but does not impose price controls, fee schedules or benefit requirements. OPM also provides beneficiaries each year, before an "open season,"with standardized information on costs, services etc. for each plan, and a form for indicating their choice.

A new Medicare system structured much like the successful FEHBP, but with modifications to refine the government contribution, to make the new program even less susceptible to destabilizing adverse selection than the FEHBP, and to provide beneficiaries with better information on which to make choices. This new program would have four core elements.

1) Entitlement to a defined contribution. Elderly and disabled Americans would have an entitlement not to a defined set of benefits, but to a voucher worth an amount based on a number of factors. The total expenditure on the voucher system would be limited to a program budget, with the voucher amount adjusted each year according to the budget.

2) Voucher amount. The base for the voucher would be budgeted Medicare expenditure (the combined net expenditures on part A and B) divided by the eligible population. This base would then be adjusted up or down according to three categories.

a) Primary risk factors, namely age, sex, reason for eligibility (age or disability), institutional status and ESRD status.

b) The second would be an income adjustment applied to one-third of the voucher, to be the equivalent of means-testing today's Part B premium.

c) The third would be a local market variance, to reflect the weighted average enrollee cost of a "basket" of typical plans in any area. This would permit adjustments to be made on the basis of the plans available in the area. This basket would consist of "typical" plans, such as the Medicare Standard Plan (see below), a catastrophic/MSA plan, a Blue-Cross standard plan, and a comprehensive HMO plan. This is a refinement of the "big six" formula used by OPM to set the government contribution to the FEHBP. Since the plans would have to submit detailed information on their prices and benefits before an annual open season, this adjustment would reflect the actual future market that the beneficiary would encounter in the following the year.

3) Standards of participation. To be permitted to sell to Medicare participants, plans would have to meet certain threshold requirements. Beyond these they could offer varieties of benefits and delivery systems. There would not be a restriction on the number of plans — what one might call an "any willing plan" arrangement. The requirements would for a plan to be Medicare-approved would be that it:

a) Has a license to issue health insurance in the state, or obtains approval from HHS.

b) Will provide services in a service area acceptable to HHS.

c) Meets solvency requirements.

d) Includes a core of basic coverage determined by legislation. The basic package would have to cover "medically necessary" acute medical services, including physician services, inpatient, outpatient and emergency hospital services, and inpatient prescription drugs, with a catastrophic stop-loss amount for these services. A plan thus could offer a much leaner package than today's Medicare (although it would have to provide catastrophic protection, unlike Medicare), but it could offer a range of services beyond the base coverage. For example, some plans might offer dental benefits, or drug coverage, or an MSA. States would be preempted from mandating additional benefits for plans serving the Medicare population. The Medicare Standard Plan (see below) initially would provide the services available today under Medicare parts A and B. This Standard Plan would

not be required to add catastrophic protection unless its board chose to do so or Congress required such a change in benefits.

e) Files with HHS a standardized statement of benefits (including exclusions and copayments etc.), a table of rates for the same actuarial categories used to determine Medicare benefits (age, institutional status etc.) and consumer information as determined by an advisory board. This consumer information might include such items as the results of enrollee satisfaction questionnaires, turnover rates, average out-of-pocket costs paid in the previous year by enrollees for the treatment of certain illnesses, and perhaps ratings by certain organizations. This price, benefit and consumer information also would have to be available to any Medicare beneficiary upon request.

f) Accepts and continues coverage for any Medicare beneficiary applying during an annual "open season" or for any newly-eligible beneficiaries unless the plan receives a waiver from HHS because of capacity concerns. This requirement would apply to plans marketed by affinity organizations, such as churches, unions or elderly groups, not merely to plans marketed by insurers or provider organizations.

4) The government's role. In the new system, HHS would no longer regulate the prices charged by providers, and instead would take on functions more like those carried out by OPM in the FEHBP system. The government would have three important roles:

a) The government would establish a federal corporation, governed by an appointed board, to run a Medicare Standard Plan similar to the current Medicare program. The Standard Plan would be available in all markets and the board would set premium prices to meet long-term solvency requirements. Subject to congressional approval, the board could adjust benefits, out-of-pocket costs and payment levels in the Standard Plan.

As an alternative, the Standard Plan could simply be the traditional Medicare program, without a set premium and funded directly rather than by vouchers. While this alternative might have political advantages, however, the lack of a premium would make it more difficult for beneficiaries to compare with Standard Plan with the competing private plans.

b) HCFA would calculate the voucher amount for each beneficiary, setting that amount after the plans had filed their price and benefit information for the following year.

c) HHS would conduct a Medicare open season, much as OPM does for the FEHBP. Before open season, each Medicare beneficiary would receive an information kit from HHS, including the amount of their voucher and the standardized information on prices, benefits and consumer satisfaction for Medicare-approved plans in their area, including the Standard Plan. Beneficiaries would also receive a selection form on which to indicate their choice. Once the selection had been made, HCFA would send the beneficiary's voucher to the chosen plan. The beneficiary would be responsible for any difference between the voucher and the premium costs, but could elect to have the government pay that difference and reduce the beneficiaries Social Security check (similar to the part B option today). If the voucher amount exceeded the plan premium, the difference would be deposited by HCFA into a Medical Savings Account of the beneficiary's choice. Disbursements from MSA accounts could be used only for medical expenditures eligible for the Schedule A tax deduction.

Thus Medicare would operate much like the FEHBP serves retired federal workers and retirees. Medicare beneficiaries would be able to pick a private plan which included the services they wanted (beyond the core package), delivered in the way they wanted, and, if they wished, perhaps through an organization with which they were affiliated (as many FEHBP enrollees do). Or they could decide to put their voucher towards the premium of the Medicare Standard Plan. Because beneficiaries would receive a voucher of a specific amount (paid directly to the plan of their choice), they would have a strong economic incentive to pick the plan that best met their objectives of price, quality, and services.

The organization of services, the selection of benefits, and payments to providers would be in the hands of the plan managers competing for enrollees. Unlike the federal officials managing Medicare today, these managers would have the freedom and the financial incentive to experiment with new ways to deliver care at a competitive price. And the voucher approach, in contrast to the AAPCC payment system, would give all plans an incentive to strive for the best pricing, and not consider the voucher as a floor price.

In stark contrast to today, HCFA would have no role in setting the provider reimbursement rates, deductibles, or cost-sharing levels of any private plan, nor any role in requiring benefits. However, while it is doubtful that the price-maker theory actually explains the FEHBP's success, HCFA could carry out for Medicare the "jawboning" role in premium setting and agreeing on service areas that OPM undertakes for the FEHBP. Reaching an agreement on service areas would substantially reduce the possibility of "redlining" by health plans.

Since Medicare would become a defined contribution program, the government's share of Medicare spending could be held in check by a budget. But would this merely shift costs to beneficiaries because average premiums grew much faster than the voucher? There are good reasons to believe that the incentives in the new Medicare system would, in fact, force a moderation of health care costs for Medicare beneficiaries. Both the CRS and Lewin-ICF reported in their studies that FEHBP cost increases were lower during the 1980s than those of the private sector. More recently, FEHBP beneficiaries have seen a drop in average premiums. The GAO notes also that programs with some similarities to the FEHBP, such as CalPERS, have succeeded in controlling premium increases.

Further, Congress could, as some experts have suggested, build a "look-back" mechanism into a reformed Medicare system. Under this arrangement, HCFA would review total Medicare spending in the previous year. If spending exceeded the budgeted amount, automatic reductions would be made in payment rates to physicians and hospitals in the Medicare Standard Plan, together with increases in deductibles and premiums for that part of the program. Revisions to the voucher calculation also could be made if that was considered a factor in the budget overrun.

Adverse Selection. Even though adverse selection is not a severe problem in the FEHBP, the design of the proposed Medicare program would be even less susceptible to that problem. The main reason for this is that plans could vary their premiums according to age, institutional status and other major risk factors, which FEHBP plans cannot do. The ability to vary premiums in this way would also help protect the "residual" Medicare Standard Plan from adverse selection. And because private plans could vary benefits and would provide catastrophic coverage, it is by no means clear that sicker individuals would gravitate to the Standard Plan.

Consumer Information. A refined FEHBP structure for Medicare would also provide beneficiaries with far more usable information for choosing plans than they are given to pick doctors or hospitals today. With the advice of a Consumer Board, HHS and private organizations could circulate before Open Season such standardized price and benefit information on available plans, benchmark treatment costs, and patient report cards.

Impact on the FEHBP. The proposed Medicare program would have implications for some existing health programs and plans. It would be wise to eliminate the overlap between Medicare and the FEHBP, to avoid the potential for adverse selection effects by enrollees (a feature of overlapping eligibility today). One way to do this would be to give federal retirees a one-time choice between Medicare and the FEHBP when they become eligible for Medicare. Another option would be to end FEHBP eligibility for those eligible for Medicare.

Impact on Medigap. The Medigap market likely would shrink considerably, and perhaps disappear, under a reformed system based on this proposal. The main reason for this is that the primary function of Medigap — virtual catastrophic protection — would become a standard feature of all plans. Another attractive feature of Medigap coverage today is that it allows Medicare beneficiaries to purchase additional insurance for certain services, such as prescription drugs or preventive care, on top of their Medicare coverage. But such additional features typically would become optional features of Medicare-approved plans under the reform. Further, Medigap plans today must by law reimburse Medicare beneficiaries from certain routine copayments (and many categories of plan must also reimburse deductibles). This reduces cost consciousness. No such utilization-increasing requirements would accompany to plans offering additional services in the proposed system.

Impact on Medicaid. The proposed Medicare reform likely would not have a significant impact on Medicaid, however, whether or not that program undergoes significant reform this year. Just as states may today "buy in" to Medicare, states could decide to supplement a Medicaid-eligible person's Medicare voucher to enable that person to afford coverage under a certain Medicare plan.

Chairman THOMAS. Thank you very much, Mr. Butler.

The gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

I thank all of you for your excellent testimony. Dr. Bristow, I have read the AMA's proposal and I think it certainly has a lot of merit. I am looking forward to learning more about it in the days ahead.

Ms. Ignagni, your testimony is right on and, as usual, you are very eloquent in presenting it.

Ms. IGNAGNI. Thank you, sir.

Mr. MCCRERY. Dr. Butler, of course, you and I have talked about the problems in not only the Medicare system, but the health care system generally, and I am in agreement with your basic analysis of what the problem is and where we ought to go.

In fact, all three of you touch upon the need for more market forces to be put at work in the Medicare system or in the health care system. I think that is the bottom line of what you all said. I think this points out the basic problem that Dr. Bristow mentioned in his opening testimony, which is that seniors in this case, when we are talking about Medicare, simply have been disconnected from the cost of delivering medical care because it is paid for by a third party, either Medicare, Medigap, or the combination of the two.

I think that is certainly true not only in Medicare, but in our health care system at large, because we have a very pervasive third-party payment throughout the health care system—employer provided insurance, many times first dollar coverage insurance or low-deductible coverage. So I would like for you to address perhaps two things before my time is up.

First, do you think by going to the type of system that all three of you have talked about—which is giving more choices to seniors and creating more of a market atmosphere for seniors—helps us to achieve a more seamless healthy care system between the work force and the retired population; and is that good, is that necessary?

Second, Dr. Butler talked about the difference in increases in costs between the FEHBP and the Medicare Program. I know that one thing that jumps to many people's mind when that comparison is made is, Well, that stands to reason because the elderly population requires more health care. I would like for you to address that conclusion and debunk it, if you will, or confirm it if you think it is accurate.

Dr. BRISTOW. Congressman, I would like to at least start. I am sure everyone else will want to comment on this. We think it is terribly important to change the incentives in the entire system ultimately. Of course, the focus of this particular hearing has to do with the Medicare Program, but it is a large part of the system and it is an excellent starting point to bring sharp focus to the need for positive incentives, if you want Americans to do something. They respond much better to the carrot than they do the stick.

I think there is already existing within the under-65 population a certain measure of that. We would like to see ultimately perhaps increased utilization of the positive incentive to patients to be cost conscious in how they use the system. So I think it is very impor-

tant that we make this strong start at this point, which says to patients you are not going to be punished if you overutilize the system, but in fact we will reward you if you are judicious in how you use the system.

Mr. MCCRERY. Thank you.

Ms. IGNAGNI. May I? I was looking at the red light and making sure——

Mr. MCCRERY. Me, too, but it is yellow right now.

Ms. IGNAGNI. I would like to take a crack at this question. I think that basically the situation you all are in is that Medicare is about 10 years behind where employees were. Ten years ago, in the mideighties, employers faced the similar problem and working Americans faced a similar problem. Working Americans were very concerned about preserving health care coverage. You can look at the kinds of changes that are before you as frankly a way of maintaining health care benefits and coverage and doing that in a way that is more efficient and cost effective.

I think that the changes that have been made really provide quite a body of evidence for you to take a look at, to think about how it has worked. Without a doubt, about two-thirds of American working families have chosen now some kind of managed care, but there is still a strong fee-for-service system, and I think that is the balance that you seek to create, to provide options, to give beneficiaries the choice, and that is why our proposal is designed to perhaps submit some recommendations about how you begin that process now.

I think it also deserves to be mentioned that, like employers, you want to set up a process that you can continuously evaluate. This is a terrible thing for the witness to come to the Ways and Means Committee and say, But the truth of the matter is I do not think any of us know at all right now. I think what you want to do is put in place a series of changes that you can continuously evaluate, look at how the system is working, how effectively it is working, and monitor it as you go along, and that is the spirit in which we have come with our recommendations, and certainly I think the spirit in which we have seen employers and workers face some of the choices that they did during the eighties.

Mr. BUTLER. I would like to answer your question quite briefly, Congressman. First, of course, today you have a situation where somebody is 64, turns 65 and goes into Medicare and in many cases has to give up a plan that has satisfactorily provided, say, drug coverage, catastrophic protection, and so on, and they must go into Medicare and give up a lot of these things, or buy Medigap insurance on top of everything else. Therefore, a system which allows people to choose, to keep roughly a similar plan, maybe an identical plan, and to get a contribution toward it seems to me to make a lot of sense.

As far as the FEHBP and Medicare, the issue is a rate of increase, not a base amount. The base amount of FEHBP, of course, is lower than we are talking about in Medicare, and it is important to understand in FEHBP that what we have seen is a growing proportion in the FEHBP of retirees and, therefore, generally sicker people.

The proportion of retired Federal workers in the FEHBP, if my memory is correct, has risen from about 27 percent in 1975 to 40 percent in 1992. Therefore, as a pool, it requires more intensive care. Yet, the Federal contribution has increased and is projected to increase at roughly 6 percent. The employees' share of premium costs in the FEHBP has also fallen, in fact, actually reduced as a total proportion during the eighties. I am not sure about more recent numbers. And premiums, as you know, have fallen in the last couple of years.

So when you are actually trying to compare like with like, you actually see a better performance by the FEHBP than even the basic numbers suggest, not a worse one.

Mr. MCCRERY. Thank you very much.

Chairman THOMAS. The gentleman from California will inquire.

Mr. STARK. Thank you, Mr. Chairman.

Dr. Bristow, let me see if I understand the AMA's proposition here. You are supporting the $270 billion in Medicare cuts, correct?

Dr. BRISTOW. I do not think you will see that anywhere in our statement, Congressman.

Mr. STARK. I understand you are, and you certainly are not opposing $182 billion in Medicaid cuts. Now, are you for the $270 billion in Medicare cuts?

Dr. BRISTOW. Sorry?

Mr. STARK. Are you supporting the Republican plans, the $270 billion in Medicare cuts?

Dr. BRISTOW. What we are doing is we have——

Mr. STARK. Yes, or no? Are you supporting the $270 billion in cuts?

Dr. BRISTOW. Sir, I cannot answer you a yes or no.

Mr. STARK. OK. It is interesting, because let us assume for 1 minute that you do. Certainly, we have heard no opposition to it this morning. That means that out of the 30 million Medicare beneficiaries, they will be cut around $9,000. Another interesting figure is that in your plan you do propose—this is from your plan—spending an extra $14 billion on doctors. Now, there about ½ million doctors, so in your plan, each doctor will average an increase in income of $28,000.

It is interesting to note that the median net worth of people over 65 is only $26,000. So if I understand the very richest class of people in America, doctors, with an average net income of over $189,000, according to your own survey in 1993, are proposing to cut retirees $28,000, their entire net worth, and increase doctors by that amount.

I wonder if that does not violate the Hippocratic Oath which says do no harm, or whether or not physicians ought not to be ashamed of the greed that underlies a program, who would come here and ask us to give people who make $189,000 a year on average $14 billion more and cut retirees $9,000 apiece, while the members of your association make on average $189,000. There is something, Doctor, that is not right about that. Why would you want so much money for the very rich doctors in America taken out of the pockets of the poor?

Dr. BRISTOW. Congressman, I am glad you brought up those subjects, because I am happy to address each of them. First of all, the

doctors that you are speaking of work in excess of 60 hours a week, they have put in over 13 years of education beyond high school in order to develop the knowledge base that will allow them to willingly get up at 3 o'clock in the morning to respond to the needs of their patients, and they are productive——

Mr. STARK. I have got a father-in-law who works more than that and gets up at 4 o'clock in the morning and he does not make $40,000 a year. Doctor, do not bleed for these wealthy people, but go ahead.

Dr. BRISTOW. Do you want an answer?

Mr. STARK. What I am getting is a sermon. I would like an answer, but go ahead.

Dr. BRISTOW. Let us address the other issue of the $14.5 billion that you are saying doctors are getting in addition.

Mr. STARK. That is your figure.

Dr. BRISTOW. That is an issue that we would have been bringing to this Subcommittee, if there were no discussion about the transformation of Medicare——

Mr. STARK. It is your number, Doctor.

Dr. BRISTOW. I am not denying that, but I am trying to explain it, Congressman. That is an issue we would have been bringing to this Congress, even if there were no effort to transform Medicare, because it is an effort to correct a flaw in the way the update was created for the Medicare Program.

Let me briefly explain that. When OBRA 1993 was passed, there was a decision made that the update for physician conversion factor would be dependent upon the historical trend in volume of services over the preceding 5 years, and then an arbitrary 4 percent would be subtracted from that.

Now, in fact what has occurred is in recent years the volume of services that physicians have provided to patients in the Medicare Program has been less than 6 percent for several years. And when you apply that historical trend of less than 6 percent and then take 4 percent arbitrarily from that, what you create is a flattening curve and a predictable downslope at some point in time. That point in time is going to be 1997, and from 1997 onward the conversion factor for physicians will continue to go down in a negative fashion, even though physicians have been doing everything that the Congress has asked them to do as far as volume performance is concerned.

We believe that was an error on the part of the Congress and——

Mr. STARK. How high should that income go, Doctor? Should it go to $200,000, $220,000, $250,000? What figure?

Dr. BRISTOW. What we are asking, Congressman, is that from 1996 on that the conversion factor be frozen, that it not go up, not go up for 7 years.

Mr. STARK. What about the income, Doctor?

Dr. BRISTOW. In order to keep it from going up for 7 years, it would require putting in $14.5 billion. That is how much of a disparity was created by arbitrarily taking 4 percent off the anticipated volume, no matter how well we have performed.

So what we are saying is keep us frozen at the conversion factor of 1996 for the next 7 years, and if you do that, we anticipate that it would cost $14.5 billion to get us level. In the meantime, if you

do the other things that we are talking about in our proposal, increasing the choice for patients and increasing competition, we anticipate physicians will receive a loss of $20 billion over those 7 years in revenue because of less utilization by patients, which we are encouraging. That is how much we——

Mr. STARK. What you are encouraging is taking this money out of the pockets of poor Medicare beneficiaries, $270 billion out of the pockets of Medicare beneficiaries to pay for tax cuts for the rich and $14.5 billion more to rich doctors.

Dr. BRISTOW. Congressman——

Mr. STARK. I am afraid that is one that does not sell, Doctor. Thank you very much.

Dr. BRISTOW. Congressman, I live in a retirement community and I think you know people who live in that retirement community, too, and the income level in that retirement community is substantially above the level that you are talking about. We are only talking about having a decrease in the subsidization of the wealthy elderly. In fact, our program, if implemented as we have talked about, would have no change in the expenditure for 50 percent of the Medicare population. It would have a savings in expenditure for 40 percent of the Medicare population, and it would have a modest increase in expenditure for only 10 percent of the Medicare population. Those are the facts, sir.

Chairman THOMAS. The gentleman from Nevada will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

I think what Mr. Stark brought up brings up a few interesting points, because one of the reasons that I came to Washington is that I saw people that were running this institution that had the attitude—and I think that it was just brought out—that we are too inept as an institution to design a system that includes a $1,900 per year increase. We call it a cut, first of all.

Second is that we are not smart enough to design a system with efficiencies built into the system that we can provide better service, we can do basically what the private sector has done. We had leadership here and apparently we still have some people here that are saying to the American people that we are not as smart as the private sector, we cannot control costs as well as the private sector, we are not smart enough to design systems that will build these types of efficiencies of market forces in that the private sector has done to be able to control the rate of medical inflation.

Obviously, we are not even trying to achieve the same low rate of medical inflation that the private sector has. We are trying to do it a little over 6 percent, and if we can do that, we can obviously save Medicare.

I do want to ask one fundamental question. If we were smart enough as an institution to design savings through efficiencies to make our systems better, we are providing better quality, similar to what the private sector is—maybe we can give some prescription drug coverage and some other benefits that seniors right now do not get—if we were smart enough to do that and spend less money in the meantime, does anybody on the panel consider that a cut, if we spend less money than what is projected?

Dr. BUTLER Obviously not, and you are quite right, Congressman, that if you actually look at the private sector, as we have all

commented on, you can see in some cases very dramatic reductions in actual costs, with an improvement in service and better coverage and more complete care and comprehensive care for people, and that is obviously the objective we want.

Again, just to go back to the FEHBP, that is essentially the pattern we have seen of continuous innovation in both the types of service, the methods of service, and so on. The fact is the retirees in the Federal employee system and the active workers are extremely enthusiastic about that system. Indeed, they were one of the central forces in defeating the Clinton health plan last year, because they did not want a change in that system.

Obviously, you can combine innovation, improvements, and cost control without simply passing the tab for a broken system to the beneficiaries, which is how these reforms have been characterized.

Mr. ENSIGN. Dr. Butler, you mentioned in your testimony about the population that is within the Federal health are system, and that it is an older population, they have a lot more retirees than normal. Yet, even within that system, the inflation rate over the last several years has only been about 5 percent. I think because of some of the market forces, and I do not think they are ideal market forces, they are a lot better than what is in the Medicare system that we currently have as far as market forces working. Even within that system, if we can just achieve that rate of inflation, we will save Medicare.

Mr. BUTLER. If you achieve that rate, you will in fact hit the targets easily in the budget resolution, and that is what we are talking about.

Mr. ENSIGN. Yes.

Mr. BUTLER. Another thing I would just say very quickly is that in fact one of the paradoxes of this is as we see in the private sector, the more you start with a system that is out of date, the more rapidly you can achieve dramatic savings. If you look at corporations that have moved from first-dollar coverage traditional indemnity plans to managed care and to other types of innovation, sometimes the savings are quite dramatic, and yet the level of care actually improves. So you are actually in a good position, given how bad the current Medicare structure is.

Mr. ENSIGN. Dr. Bristow, I would also like to come to your defense just a little bit and ask how would the physicians like to have been able to vote for their own pay raise. In 1989, I believe the Congress voted for a 40-percent pay raise. How would the physicians like to give themselves a 40-percent pay raise? Remember who was in control that did that.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Maryland.

Dr. BRISTOW. The point is well taken, Congressman.

Thank you.

Mr. CARDIN. Let me thank all three of you for your testimony here today.

I think there are a few points that the American people would like to see in any reform that we bring forward. We might have an agreement among our panel and among the witnesses, and that is that the patient should have freedom of choice, freedom of choice of which plan, freedom of choice as to which doctor or hospital that

they wish to use, and that there should be more market forces in determining the activities within the market.

What concerns me is that we are all speculating on what the plan will be in our budget this year. We do not have the specifics of how these huge Medicare savings will be achieved. The Medicare savings are much larger than we ever anticipated last year, and which at that time the Republicans who were in the minority suggested that they would devastate the Medicare Program. So we are speculating.

We do not know how they are going to be implemented. That is unfortunate and I think unfair, and we probably will not get the specifics until right before we have to vote on it, and I think that is wrong. I think it should be subject to hearings, and we should have the input from the three of you and others on the specific recommendations. We are not going to be able to get that.

We do have some documents that have been produced to give us some examples of how it would work. I favor more choice with our seniors, if it truly is more choice. But the problem you might have—and I really want your response to this—is that if not enough resources are put into the program, then the seniors do not have a choice.

They are going to be required to go into a plan that they can afford, which may not give them the ability to choose their own doctor. And if you cannot choose your own doctor, you lose the ability of having the highest quality care out there, because people vote by their decisions as to what physician to use. If that is taken away from them because not enough resources are put forward and the vast majority of seniors are forced into a plan that does not give them choice, we run the risk of bringing down the quality of care.

Dr. Butler, you referred to the Federal Employees Health Benefit Plan. I think it is an excellent plan, I agree with you. But in that plan, the Federal Government for its employees puts up enough funds to guarantee that the employee really does have the right of choice. But as I understand the suggestions being made here in this budget, the Federal Government is going to put up a defined amount of money into the health care plan which may not be enough money to guarantee that the person actually has the right choice.

You refer to market fores, and I agree with that. What is happening in the private sector, the growth projections that we are using for the Medicare savings will mean that the government has to outperform the private sector, because our per capita costs are projected to grow at a slower growth rate than the private sector. That would be a first, if government outperforms the private sector.

I welcome your comments on it, because I do think this is constructive. We only have one-half. All of us want to see more choice, but if you do not put up enough resources, will we really have choice, or will we be forcing people to go into plans that they really do not want to go into?

Mr. BUTLER. Well, I can certainly respond to that. Obviously, it is as truism to say that if you do not provide enough support then there will not be enough choice and people will be hurt, in that sense. So the issue then is the kind of projections sufficient.

I think there are a couple of things to bear in mind. One is that we are talking about just under 6-percent growth.

Mr. CARDIN. But that is the low with the private sector on a per capita basis. We are assuming better cost savings in Medicare than the private sector. Is that realistic?

Mr. BUTLER. On the other hand, you are talking about moving from a certain base right now and introducing structural reforms of the system. Now, the private sector, elements of the private sector that have introduced structural reforms has seen a much sharper improvement.

Mr. CARDIN. If you can support that, I would appreciate it. What we have seen is 1-year savings, but not long-run savings. We have had employer-sponsored people before us who have indicated that they have not had the long-range projections.

Mr. BUTLER. But if you could move the base down, you have got a much greater flexibility over the next 5 to 7 years in terms of meeting the overall targets.

The second thing I would say is when you talk about a choice, you are allowing people who today must pay extra for services that are not included in Medicare, such as drug coverage, catastrophic, and others, you are now allowing them to pick a plan that may include those services. So choice also allows individuals to reduce their expenditure in many cases, and that is very important for the low-income elderly who today are often vulnerable, that are not able to get that coverage.

Mr. CARDIN. My time is running out. I think Dr. Bristow wanted to respond and I want to make sure he gets a chance.

Dr. BRISTOW. Thank you, Mr. Cardin.

I think you have to keep in mind that what we are talking about is introducing a vital new factor and that is having patients become cost conscious, because it will be rewarding to them to do so.

That is a factor that has been sadly missing, unfortunately, and we think we have offered an innovative approach in which the government spends no more than it would normally plan to spend, but it provides an inducement to patients to exercise some judgment as to whether to go to the emergency room this evening or go to the doctor's office tomorrow morning. It is as simple as that. When that is compounded 37 million times, we believe it is going to result in substantial savings and a considerable modulation of how costs are increasing.

As I said, we already project that there is going to be enough reduced utilization so that physicians will lose $20 billion over the next 7 years. That is a sign of our commitment. We say fine, but let us make a healthy system.

Mr. CARDIN. Very quickly, I would feel more comfortable if the Federal Government was saying, OK, whatever the results are, we will do the best we can, but we will guarantee that we will put up at least 75 percent of the funds. We are not saying that, as I understand these proposals. The government is going to be putting in a flat dollar amount, and if they are wrong, the seniors lose their choice.

Ms. IGNAGNI. Mr. Cardin, I would be delighted to provide some data to you about the track record in the private sector to the point that you proposed to Mr. Butler.

I would also say to your point about people not being satisfied or perhaps a potential perception that they would be forced into certain delivery systems. We have provided some data about beneficiary satisfaction in HMOs under Medicare, and I think they are quite compelling in terms of the numbers of people who are making the choice and who are choosing to stay there, the number is 90 percent. Only 4 percent of the people choose to go back to fee-for-service. So we would be glad to provide some more data there.

Mr. CARDIN. Certainly.

[The information is being retained in the Committee's files.]

Chairman THOMAS. The gentleman from Washington will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Bristow, do I understand under your proposal that the current restrictions on physicians' ability to charge Medicare beneficiaries would be abolished?

Dr. BRISTOW. We are saying that price controls would be removed, yes.

Mr. MCDERMOTT. So when Dr. Ensign is talking about the fact that you do not set your own salaries, in fact, what you want to do is set your own salary every day with every patient. That is basically what you are saying.

When I look at this and I look at the fact that Medicare beneficiaries, 11 million of them are widows making less than $8,000 a year, and that the average Medicare beneficiary's income is $17,000 a year, with 80 percent of them having incomes under $25,000, and the average out-of-pocket expenditure by Medicare beneficiaries is 18 percent of their income, I cannot believe that you would sit here representing the American Medical Association and tell people that they have to spend more out of pocket to be cognizant of what it is costing them and where their health care is coming from.

I do not know what the American Medical Association thinks is the proper figure. Fifty percent of their out-of-pocket money should go to doctors and hospitals and then they would pay attention? I think 18 percent, if you are living on $8,000 a year as a widow, is an awful lot of money. Let me tell you, those old people know what they are spending. They all sit there and look at those bills and decide shall we pay the bills to the doctor and the hospital, or shall we buy food, or shall we buy medication.

I personally think the American Medical Association has not moved since 1965. It could just as well be Dr. Annis here talking as he did when I was graduating from medical school, saying Medicare is a bad idea. You are more facile with this proposal from the AMA, but I think Uwe Reinhardt is correct. Every doctor who subscribes to this proposal will be a serf of an insurance company by the year 2000, because if you put this kind of voucher out there that is inadequate, these old people will be forced into HMOs, the cheapest HMO, because they will not be able to buy all this choice.

These 11 million widows are not going to be able to take that fixed amount voucher and get an adequate policy, unless they go into something like an HMO. They will have no choice whatsoever. So I really think that it is a bad proposal. It is a sad day for me to feel this way about the AMA, that you would come here with a

proposal that rolls back to 1965, taking away the guarantee of health coverage from senior citizens. Putting 30 million old people on the street with a voucher looking for a friendly insurance company is not my view of a step forward in health care.

I want to ask Ms. Ignagni, do you think——

Dr. BRISTOW. Congressman, may I respond to you after you have had those rather harsh statements to make?

Mr. MCDERMOTT. Surely. Do not take all the time, though, because I want to get to her.

Ms. IGNAGNI. I can't wait. [Laughter.]

Dr. BRISTOW. First of all, it should be obvious that this is not Ed Annis sitting before you at this point. That is to take nothing away from Ed Annis. But the AMA is trying to be as innovative and as creative as we know how to try to address what we consider to be an American problem, one that we live with and work with every day.

You are telling me about what patients feel? I see patients every day, Congressman, so I am keenly aware of the distress that they have. Our proposal would result in no increase in the expenditure for 50 percent of the Medicare population and a reduction in expenditure for 40 percent of the Medicare population. It would increase for approximately 10 percent of beneficiaries, and we acknowledge that. But we say most of those would be in high-income individuals, the vast majority.

I urge you to please read our proposal carefully or let us explain it to you more fully. But our objective I believe is consonant with yours. We want to have affordable health care, high-quality care for every American, and we want them to have as much choice as possible. We simply feel the way to do that is to change the incentives. That is all we are talking about, and we do not want to hurt patients. We want to help patients.

Mr. MCDERMOTT. You are saying that the old people will not have any increased costs in your program below what level of income? What level do you feel they should pay more at?

Dr. BRISTOW. We are saying that those above the level of $50,000 income as an individual or $100,000 income as a couple will be paying more.

Mr. MCDERMOTT. And everybody else will do better in the hands of the insurance companies?

Dr. BRISTOW. Fifty percent will have no change, but 30 percent will actually spend less.

Mr. MCDERMOTT. When you say no change, you mean they are still going to pay the 18 percent out of pocket they are presently paying?

Dr. BRISTOW. Well, they are not worse off——

Mr. MCDERMOTT. The amount they are paying for a Medigap policy, that will be not changed? They will still buy the Medigap policy?

Dr. BRISTOW. That is true, but we will have helped 40 percent.

Mr. MCDERMOTT. I doubt it from the figures that Mr. Stark gives, and I agree with those figures. If you take $14 billion more, it is hard for me to figure out how doctors are not going to come out better and the patients are going to be worse off.

When I think about a voucher system and I think about my father or think about anybody in the 85 and above range of age—and medicine has been very successful—you put those people out there looking for an insurance company that wants them, you have got to really have the ability to believe in the tooth fairy to believe there is an insurance company that will want those kinds of patients in their patient mix. They do everything they can right now to select those people out.

Dr. BRISTOW. This will take less than 30 seconds, sir.

Mr. MCDERMOTT. That is all I need.

Dr. BRISTOW. What we did was to approach the problem from the perspective of trying to figure out what should be done. We had it costed out afterward by Price Waterhouse. That is how those figures came out of $162 billion, and that is how the estimate of saving money for 40 percent, no change for 50 percent, an increase for 10 percent, that is where they came from, sir. It is not from AMA, it is from Price Waterhouse.

We are simply trying to act as doctors looking at the problem from the perspective of what can be done "sensibly" without sacrificing the quality of care. That is what we are putting on the table. We are not trying to solve the problem that you have, which is a tremendous problem. But we are putting that on the table, sir, and if you have a contention, it is with Price Waterhouse's response to their analysis.

Mr. MCDERMOTT. I would only say that you gave them the assumptions, and you are right, you do not care about our problem. What you care about is the problem of the doctors, as you should. But I think that we have a different set of priorities here and I do not think that the American Medical Association is being very helpful in figuring out what is best for all the American people.

I guess I will have to wait for Ms. Ignagni later.

Chairman THOMAS. Dr. McDermott, old people? Old people?

Mr. MCDERMOTT. Maybe I misstated something.

Chairman THOMAS. You said old people, and I did not know if that was a politically correct term now.

Mr. MCDERMOTT. Well, I am 58, so I think I am free to talk about old people.

Chairman THOMAS. The gentleman from Wisconsin.

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Bristow, I think the AMA should receive some congratulations for taking the effort to come together before this Subcommittee with a plan, one which we might not agree with, but I think it shows us and it shows at least your association that it is not going to be an easy task to correct the problem that we are facing.

I should add that after your exercise, you still only came up with a cut of $162 billion, clearly $100 billion short. We do not have the luxury of coming close like that. We have to probably go all the way to $270 billion.

I think it is interesting that part of your proposal—and I guess it is drafted by you, so you have the luxury to do so—does increase physicians' payments, and to your brethren in the hospitals, if my figures add correctly, you decrease their reimbursements by some $100 billion. I am assuming when the hospital association comes before us, they are going to decrease your reimbursements by $100

billion and increase hospitals by $14 billion, and I think that would be very fair. But that is the problem that we are facing.

But for you to say, after your analysis and after you have come up with a plan, that only 10 percent of the Medicare population will be paying more, to make up $162 billion is totally false. Unless the hospitals are going to take a bigger cut than I assume here, there is no way you are going to extract that many dollars out of that small population of Medicare recipients.

I think what will happen here is that, if all controls on billings are removed, you are going to see a ton of increases in the copays. It is nice to talk about cost sharing, it is nice to talk about incentives and having people being cost conscious. Those are all nice, but in the real world they do not work. The reason is—and we have all been hospitalized at one point or other, and in fact a lot of my seniors have been—once you are in the hospital, without the medical education that you have and other people in the room have, you are subservient.

Once you are admitted to the hospital, two or three doctors could come in and visit you under some type of a consultant arrangement, and you know nothing about it. You are not in any position laying in that bed to question the doctor, who are you, who sent you, what is your fee. And after the hospitalization, the person is stuck with the bill. If in fact you take controls off, those deductibles and out-of-pocket payments are going to increase dramatically.

The same is true for the lab people. Every hour on the hour, the lab folks come in with their little kit and they pull blood and blood and blood, and you do not know what tests are being repetitive. And the consumer laying there in that hospital bed is not educated to question that. You do not know if it is a life or death test that they are doing today or tomorrow, or if it duplicates what they took last Friday.

So to say we are going to have a more educated medical consumer in this country does not mesh with reality. It is impossible to do so, and the end result is that we are going to have a consuming medical public through these proposals, yours and others that are floating around, that are going to pay more, or the problem they are going to face is, after one of these hospitalizations, the next time they need to go, they are going to stay home because they just cannot afford it.

So what we are talking about with the $270 billion cut that we are looking at for the Medicare Program is health care rationing. For all the criticisms the administration took on their health care bill, I think once the Majority party in the Congress comes up with theirs, they are going to be subject to the same type of ridicule and the same type of opposition. And to say that we are going to resolve all the problems of this country through vouchers, Medisave plans, or IRA plans is totally unrealistic, in my estimation.

I am surprised that none of the panelists this morning have mentioned the savior to the system called Medisave, which I think is a farce, and maybe some of the other witnesses that will follow you will say more about that.

Dr. Bristow, if you want to respond to any of the statements, you are entirely welcome to.

Dr. BRISTOW. Thank you, Congressman.

I think you put your finger on a number of really key points that I hope I can clarify in a very brief period of time. First of all, what we are talking about are not cuts, sir. We have proposed a series of areas in which we believe there can be substantial savings. As it turns out, those savings amount to $162 billion.

The second point I wanted to respond to is what we are talking about is having patients get the information before they see the doctor as to what his fee structure is going to be. By knowing his conversion factor and knowing what that insurer has as its conversion factor, they will know immediately whether they will have to pay anything different or perhaps make a savings.

Mr. KLECZKA. But a fee-for-service person sitting in a hospital, even though they might know coming in, all of a sudden all the doctors' friends come in to take a little poke at the patient and provide for separate billing, at that point the health care consumer or the sick patient has no control.

In using my example of billing not only from the consultant type of activity, but the lab stuff, the x rays, I and none of the constituents I represent know when to say no to an x ray. If it is called for, you lay on a gurney, get the x ray, and you are never going to inform the population different, unless we all go to medical school, which naturally is an impossibility. So you guys still have us by the ears.

Dr. BRISTOW. We think that it is going to be important for the public to have the kind of information they need. We want you to have the information you need in order to be able to make good choices.

Mr. KLECZKA. Then give me the intelligence to say no to a doctor coming into my room just to look at the incision and charge me $200. That you cannot give me, that will never happen, and that is where the copays and the patient are really going to take it on the chin.

Dr. BRISTOW. Two last quick points, sir, and that is we believe competition will work for the same reason that when VCRs came out, in my community they cost $500 or $600. The same VCR, in fact a better VCR now can be purchased for $200 because of competition, an improvement.

Mr. KLECZKA. But most people who purchase VCRs are not on their deathbed, and so they are of the mind that they can make a decision. Once you are laying at St. Luke's Hospital ready to go through the heart transplant, you are not that alert to say, "No, doc, I don't think I need you today, just don't do that."

Let me finish by saying we are cutting back expenditures—not even cutting back—we are reducing the growth. If in fact you have a zoning population that is in need of health care, and if medical costs through innovation and other inflationary factors are going up and you say these factors equal *x* amount, yet, we are going to cut the growth by $270 billion, there are only two things that can happen. Either the patient is going to pay more or you are going to get rationing.

There is no way all of a sudden you are going to get a healthier population by the threat that between now and the next 7 years we are going to cut $270 billion, and magically and miraculously the health care population and the Medicare Program become

healthier because they do not want to go without health care. It is not going to happen, and to think so is being very naive.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Kleczka.

The Chairman notes we have three visitors with us who are not Members of the Subcommittee, the gentleman from Pennsylvania Mr. Coyne, the gentleman from Michigan Mr. Levin, and the gentleman from Texas Mr. Laughlin. My assumption is that you are here to watch and listen and I will not make the offer to Sandy, because I know he will take me up on it. So I will simply assume that you are here to watch and listen.

Mr. KLECZKA. Mr. Chairman, because of the importance of the issue and the fact that the Members did take time from other things to be here, I would think that they should be afforded some opportunity to speak maybe, a little first amendment right, or even if I could go to——

Chairman THOMAS. I will tell the gentleman from Texas, that Mr. Laughlin and the gentleman from Pennsylvania Mr. Coyne have both indicated through nonverbal communication that they do not have an interest to speak, so you are championing the gentleman from Michigan Mr. Levin.

Mr. KLECZKA. Any day of the week. [Laughter.]

Let me ask the Chair a question. Is this subject matter and any legislation going to be subject to a Full Committee hearing so that these non-Subcommittee Members could have an opportunity to question?

Chairman THOMAS. If we could figure out a way to bring this to the floor without going to any Committee, we might try to do that, but I think you will find——

Mr. KLECZKA. Especially if we could do it at night with no lights and stuff, wow, that would be really great.

Chairman THOMAS. If we can get it to the President's desk, since he understands there is a problem and wants to do something about it, we would probably have a better chance of dealing with the issue than with folks who refuse to even address the problem, based upon the questions asked the witnesses.

Mr. KLECZKA. I will champion for Mr. Levin.

Chairman THOMAS. Sandy, do you want to say something?

Mr. LEVIN. A silly question.

Chairman THOMAS. The gentleman's time has expired. [Laughter.]

Mr. LEVIN. The light never went on. I was waiting for the green light to go on. I think the subject is important enough so any Member of Ways and Means who comes here should be able to participate. You have the decision.

Chairman THOMAS. And that is why you have an opportunity to participate. The other two gentlemen indicated they were simply at this point observers. So if you want to ask a question, you certainly may.

Mr. LEVIN. Thank you. I assume if other Members come, they would be able to do the same thing.

Let me plunge in. Mr. Chairman, I appreciate your indulgence, and also Mr. Kleczka's support. But I think it is important enough that whoever wants to participate should so do.

Let me press the issue that was raised before. It seems to me to take all the rhetoric away and some of the vitriol, there is a basic issue here. The three of you are essentially saying move away from a defined benefit plan to a defined contribution approach. The government will put a certain amount and if that is exceeded, the risk will be borne by somebody else.

With a defined contribution plan, that is the way it works. We are going to put up a certain amount of money, and if the cost exceeds that, who picks it up? Dr. Bristow, you say it is not the physician, because you have removed any cost containment for the physician. Those for managed care are willing to bear that risk. Dr. Bristow, you do not take the controls off the hospitals, but you do off the physicians, I think. You also raise the age at which Medicare kicks in over a period of time. It is in your proposal.

The real issue, more than any other, I do not think is choice. You can have choice within the present structure, and you do. You can increase choice dramatically within the present structure. The issue is not expanding choice. I think the basic issue is, if the inflation in Medicare continues beyond the level that would be set by us, who would bear the brunt of it.

The three of you are coming here today and essentially saying—you would not call it a gamble, but I think it is—that the loser potentially is the senior.

Ms. IGNAGNI. Mr. Levin, let me jump in. What we are talking about, speaking for GHAA, is a process where you would start with the Medicare benefit package in our proposal. Once you start there, you start from where you are today in terms of total cost. We are not proposing a system where you get to your number or your growth rate from the bottom. We are proposing a system where you start from where you are today, from the top, and you begin to look at imposing equity and efficiency on both sides, both the fee-for-service and the managed care.

Mr. LEVIN. I understand that, but at the end of the day, if we are going to reach $270 billion, we are going to move toward a set amount by the government, and if that proves—I think your reference, Dr. Butler, to the Federal plan really in a sense proves the other case, because, as Mr. Cardin said, the government guarantees a certain percentage of the cost. It is not a defined contribution. All you do is phase it in over a period of time, but the real question is, at the end of the day, if we are wrong and if the market forces do not bring the cost down, who pays for it?

I think the answer of the three of you is the consumer in this case. It is the senior, is it not? Dr. Bristow, who is it? It is not the physician. Who is it?

Dr. BRISTOW. Well, the way we view this approach, the only time that patient would be at risk would be if they select a medical savings account in which they are assuming the control of their own issue, with the exception of a catastrophic insurance policy that they would have. Everything else is virtually a prepaid policy, because they are going to be dealing through some entity or the other.

In our proposal, we have said maintain a transformed improved Medicare Program for those who do not want to leave Medicare, but also make available an FEHBP type panorama of choices that

they can select from. They may select one that has the same actuarial cost as their Medicare Program, in which case——

Mr. LEVIN. My time is up, but logically the proposal of the Majority—and they have not presented it, and if they are proud of it, I think they will present it in time for us to have hearings on it—there has to be a eduction somewhere to meet the $270 billion. Where does it come from?

Dr. BRISTOW. Let me try to offer you a little bit of help with that. I did not say we have no concern about what you are doing over the $270 billion. I simply said that, as physicians, we addressed what we thought could best be done for patients without sacrificing quality.

You have a problem because you have got to score things. I can point out to you substantial savings which apparently cannot be scored, and that is in professional liability reform. In California, where we have had reform 21 years ago, I paid $4,000 a year as an internist in the Bay Area for my insurance. My counterpart, an internist in Long Island, also paid $4,000. We led the Nation 21 years ago. We passed the kind of reform that we are asking the Congress to insert. Twenty-one years later, I pay $5,500 for the same coverage. My counterpart in Long Island is paying $18,000 a year for the same coverage.

Mr. LEVIN. My time is up and we will have to go into that some other time.

Dr. BRISTOW. My point is there is money that can be saved and can help with what your bigger problem is, but you are going to have to explore some other avenues to get those additional dollars. That is all I am saying, sir.

Mr. LEVIN. Thank you. I appreciate that.

Mr. MCCRERY. Mr. Chairman, before this panel leaves, I would like to thank each of them for coming forward with a specific proposal. As you know, Members of this Subcommittee—certainly on the Republican side—have been out there asking for suggestions for months now at our town meetings, meetings with seniors, meetings with the hospital associations, with the doctors, with nurses, groups that are concerned about problems facing the government and the people, you at least have come to the table with a specific proposal, and I for one appreciate that, because it has helped us to consider a number of options that I think could be part of a plan that could help save the system.

Ms. IGNAGNI. Mr. Chairman, could I make a comment quickly on Mr. Levin's point about where this shift comes from and to whom the money flows, in an effort to be helpful?

Chairman THOMAS. Certainly.

Ms. IGNAGNI. Mr. Levin, I think your conclusion would be correct, if in fact it were the case that there were no efficiencies to be drawn from the current system. I think that hypothesis is wrong. I would ask you to consider some of the discussion that went on years ago when the PPS initiative was launched and then when the RBRVS was launched.

In our proposal, what we talk about is providing an opportunity to integrate both part A and part B and take advantage of efficiencies. The growth is 10.3 now in Medicare, and I do not think

you need to bring the growth down to 4 or 5 immediately. I think you can phase down the growth.

Mr. LEVIN. I do not say that there are no inefficiencies. I think there are. The question is that if the guess about the amount of inefficiencies is wrong, the amount of savings is wrong, and who bears the brunt of that mistake? I think the answer that we are hearing from the three of you is the seniors of America do. That is a legitimate issue, if that is where the brunt should fall.

Ms. IGNAGNI. I think what you need to decide—and there are a number of issues that you——

Chairman THOMAS. I was not aware that this was an extension of the gentleman from Michigan's time.

Mr. LEVIN. Thank you. I appreciate it.

Chairman THOMAS. I extended it prior to that with the red light on for more than 1½ minutes.

I think one of the problems we have here is that there are some folks who obviously are interested in playing politics more than they are saving Medicare. There is nothing wrong with the challenge made by the Ranking Member to lay your plan on the table. The fact of the matter is we do not have a plan to lay on the table. We are listening to as many groups as we can who participate in this process currently to see if they have some ideas to help us.

I thought it was rather humorous yesterday. Some folks may have read the article in the New York Times which purported to report on an internal staff document which was looking at some options. I happened to be interviewed by Charles Berbauer yesterday on Medicare, and he said that he was on vacation in Colorado and got a hurried phone call would he please look over this new material.

He looked it over and said there is nothing new here, I had interviewed Thomas 6 months ago and basically he was saying the same thing then in terms of the options that are available to us in creating choice, the idea that obviously if we do nothing, Medicare is going to go broke, that everybody involved in the process has to participate, you cannot write a plan that basically solves Medicare's problems by only taking out of the hide of the providers, you cannot write a plan that says beneficiaries are not going to be part of the solution at all in saving it from bankruptcy, and, frankly, you are also going to have to look at taxpayers to a certain extent.

So he chuckled a little bit, having been out of it on vacation, coming back into the fray and looking at what people are trying to do to hype the situation. It was very refreshing to hear someone from the news media indicate you guys basically are continuing along the path that you said that you were going to try to continue along, and that is, if we do nothing, Medicare will go bankrupt.

I have got a little chart over here, if they will turn it over, and I think it puts it in pretty graphic terms. I waited until all of the Members on the Minority side testified, because I was looking to hear for some kind of an option that they might provide to the problem that we have in front of us.

For those of you who cannot see it, basically, the current Democrat Medicare plan has a check dated this year for $4,800, which is currently what we pay to each Medicare beneficiary. In the year

2002, which is the bottom check, they get zero, because that is what is going to happen if we do nothing.

Mr. KLECZKA. Mr. Chairman, you chastised the Subcommittee for playing politics with this, and look who is playing politics with the Medicare Program.

Thank you.

Chairman THOMAS. All I am saying is that at least what the Republicans have indicated of their plan, which we will continue to perfect, is that we will match the Democrats, obviously, with the current rate of $4,800, and in the year 2002 the beneficiary under our plan will receive $6,700.

Now, what I have heard from the Democrats is basically that this strange thing under the choice option of managed care, whether it is coordinated care under a PPO or an HMO, is basically experimenting on seniors in terms of jeopardizing their health by offering some alternatives.

All you have got to do is look at the real world today and realize that seniors are the ones who are being cheated in the Medicare Program because they are being denied the right to have the broad basis of choice that more and more Americans every day are having, and that in fact in California, a majority of Americans have available to them.

If the Democrats had their way and we did nothing in terms of creating a real choice structure in Medicare, more and more beneficiaries who are retiring will in fact, as Mr. Butler said, on Friday, have a plan they are comfortable with, that provides prescription drugs, preventive procedures that are supportive, and then on Monday when they retire and go into the Medicare Program and find out that they cannot have the same program that they had at work.

I think that is wrong. I think we ought to create a broader choice structure under Medicare. The numbers game that the gentleman from California referred to as a shell game—and I do this with some trepidation, given his education at an institution that obviously deals with numbers a lot——

Mr. MCDERMOTT. Mr. Chairman.

Chairman THOMAS. I am sorry, I did not interrupt any of you guys when you were talking. I get my 5 minutes, or am I bothering you by giving back to you what you gave to this panel of witnesses for 25 minutes?

Now, it is a shell game to say that you take the current baseline and seniors are going to pay more. That is hogwash, because everyone agrees you cannot continue to have seniors pay more, because you cannot continue the current Medicare Program. It will go bankrupt.

Even the President has offered a program which will reduce the growth in Medicare. If the program is to reduce the growth in Medicare, the dollars by 2002 will not be as great. They will increase from year to year, but when you multiply off the current base, that is the shell game, because that current base goes to zero in 2002.

And when you talk about percentages, if you take 25 percent of $100, that is more dollars out of the pocket of the beneficiary than 33 percent out of $66. So if you want to play political games, continue to play political games. Frankly, we are going to try to solve

the Medicare problem in front of us, and the way you solve it is to talk to the providers and work with them to come up with new and novel solutions where we share in a reduced growth structure.

It is to talk honestly to beneficiaries and say, frankly, at 11 percent or 10.5-percent growth a year, the program is going to go bankrupt and we cannot continue to do it. The wealthiest of Americans ought not be subsidized 75 cents out of every dollar by young people who are working hard today trying to keep their heads afloat. That is wrong, and you people know it, and it should be changed. Instead, you are making political hay out of it.

Frankly, there are some taxpayers that are not paying their fair share right now, but once they get into the Medicare Program, they consume the goods and services just as much as anybody else, and those people should be paying into the Medicare Trust Fund part A while they are working, instead of not paying into it and then receiving benefits afterward. It is a partially flawed system in that regard.

If we are going to solve this problem, it is going to be providers, beneficiaries, and taxpayers working together. And to the degree you people continue to assault this by rubbing what you believe to be politically sensitive spots in the hope that people will react, then you are doing all Americans a disservice. We are going to go forward and we are going to solve this problem. You can be part of the solution or you can continue to act the way you are.

I want to thank this panel very much for trying to be part of the solution. Nobody has all the right answers. We are going to have to look at everybody's suggestions. But I frankly think it is a very positive side that providers who clearly benefit from participation in this system are willing to rethink their role. Frankly, no one is going to be completely right in this.

We are going to have to pick and choose and come up with the program that makes sure that Medicare does not go bankrupt in 2002, as the President's trustees now say it is going to. More importantly, people are paying in in their twenties and their thirties and have a right to believe that all of that money that they are going to pay in for 30 to 40 years or the rest of their life will have some benefit available to them at the time that they retire, as well.

For people who play to the fears of seniors today, you are doing a disservice to the rest of America who are going to be paying in for a long time. So keep up your game of trying to bait the seniors through their associations and organizations to try to say, No, we want to continue to have the program that is going bankrupt, and you are doing no service to the rest of us.

I want to thank this panel very much.

Mr. MCDERMOTT. Mr. Chairman, would you ask Ms. Ignagni about medical savings account? Would you ask her? That is one of the suggestions before the Subcommittee. I wondered if you would allow her to comment on whether she thought medical savings accounts would help in——

Mr. MCCRERY. Mr. Chairman, we have got a lot more panels. Each member of this panel has had an opportunity to question the witnesses and I say let us move on and get on with it.

Chairman THOMAS. As I recall, we held a hearing on medical savings accounts and we will probably come back and have another

hearing on medical savings accounts. I am going to assure you everybody is going to have plenty opportunity to present their point of view before this panel before we move forward.

I know the gentleman from California and the Democrats have urged us to show our plan now, but I think the proper and logical course is to get all of the testimony from all of the various groups, take a look at what it is and then compile a plan. I know that does not serve your political agenda. I do believe it solves our problem of trying to fix Medicare for all Americans.

I thank this panel very much.

Not coincidentally, our next panel consists of representatives of seniors: Jake Hansen, vice president for government Affairs, Seniors Coalition; Hon. Beau Boulter, our former colleague, who is Legislative Counsel, United Seniors Association; Martha McSteen, president, National Committee To Preserve Social Security and Medicare; and joining us once again is Dr. Beatrice Braun, who is a member of the Board of Directors of the American Association of Retired Persons.

For those of you looking at me from my left to your right, it is Hansen, Boulter, McSteen, and Braun. We should put little plaques up on the other side so you can see where you are. I want to thank all of you for joining us. I would say that any of your written testimony will be made a part of the record, without objection, and we will invite you to enlighten us in any way you see fit in the 5 minutes that you have.

Why don't we move from my left to the right. Mr. Hansen, if you will.

STATEMENT OF JAKE HANSEN, VICE PRESIDENT FOR GOVERNMENT AFFAIRS, SENIORS COALITION

Mr. HANSEN. Thank you, Mr. Chairman.

My name is Jake Hansen, and I am vice president for government Affairs for the Seniors Coalition, an organization representing over 2 million older Americans.

I am not an expert on health care or Medicare, Mr. Chairman, but I do believe I am qualified to represent concerns of the members of the Seniors Coalition on this topic, because they are the real experts on how Medicare affects their lives and their access to quality health care.

They have asked me to speak to you and to the Subcommittee on their behalf.

I have five points to make.

Chairman THOMAS. Mr. Hansen, I will tell you these microphones are horrendous and you need to speak directly into them or your message will not be heard. It is tough at an angle. You really need to speak directly into them.

Thank you very much.

Mr. HANSEN. I have five points to make. Number one, seniors are truly frightened about the financial crisis facing Medicare. They know it is going bankrupt, they know action, substantive action needs to be taken immediately, if they are going to avoid a catastrophe. They are deeply worried about what will happen when the system upon which they must depend can no longer provide them with basic health care that they need.

Number two, seniors want protection. They want to know that the Medicare system will be there functioning when they need or want to use it, today, tomorrow, next year, and beyond. They are looking to Congress, to their health care providers, to the private sector insurance companies and everyone else involved in the process to find a solution that will make this possible.

Number three, seniors want the waste and fraud involved in Medicare to end. Older Americans are expert at many things, Mr. Chairman, because they are experienced consumers, and experience is as very masterful teacher.

They read about, hear about, and experience firsthand the waste and cheating that goes on in Medicare. Survey after survey reports that most seniors believe they are being taken to the cleaners by various parts of the health care system. They want the bureaucratic tangle of redtape that permits this corruption to occur cut out once and for all.

Number four, seniors want to have the same health care options as other segments of the population. Medicare was created in a very different world, Mr. Chairman. Until the middle of the 20th century, there had never been in the history of the world a significant number of people who grew old before they died.

In 1965, when Medicare was created, we knew very little about the biology or sociology of aging. Whether or not we are willing to admit it, most people then equated age with fragility and diminished capacities. We now know that such thinking is wrong—it is ageism of the worst kind. I would submit that the Medicare system is built upon such premises in that it proscribes what seniors must have in, rather than empowering them with the freedom to make choices for themselves.

We know that the differences which make us unique individuals increase with age—that, if you will, we become more and more ourselves as we grow older. Thus, a one-size-fits-all program is not only inadequate, but it also eliminates the most basic element of dignity from older Americans, the right to be themselves and make choices accordingly.

Seniors are both incensed and deeply concerned about the exploding cost of health care under the Medicare system. Medicare is a system that in many ways strangles competition, Mr. Chairman, and that is a key factor in spiraling costs.

In the last 30 years, technology has literally revolutionized medical care. Usually, technology reduces the cost of delivering goods and services. In medicine, however, the effect has been the opposite. We believe the Medicare system is a part of the problem which allows this to happen.

Similarly, Medicare was established before there were so many innovations in the operation of the practice of medicine. I am speaking of HMOs, PPOs, and the like. We have tried to make both technological advances and new forms of medical practice fit into the Medicare system by amending it, adding onto it, and so forth, but to what end? Our adjustments have not necessarily contributed to better health care, and most certainly they have not driven down costs. In truth, seniors cannot benefit from free market competition in health care because the Medicare system itself is in the way.

STATEMENT OF JAKE HANSEN
VICE PRESIDENT FOR GOVERNMENT AFFAIRS
THE SENIORS COALITION

Mr. Chairman, my name is Jake Hansen and I am Vice President for Government Affairs of the Seniors Coalition, an organization representing over two million older Americans.

I am not an expert on healthcare or Medicare, Mr. Chairman, but I do believe I am qualified to represent the concerns of the members of the Seniors Coalition on this topic because they are the real experts on how Medicare affects their lives and their access to quality healthcare. And, they have asked me to speak to you and the Committee on their behalf.

I have but 5 points to make:

1. **Seniors are truly frightened about the financial crisis facing Medicare.** They know it is going bankrupt. They know action, substantive action, needs to be taken immediately if they are to avoid catastrophe. They are deeply worried about what will happen when this system upon which they must depend can no longer provide them with access to the healthcare that they need.

2. **Seniors want protection.** They want to know that the Medicare system will be there FUNCTIONING when they need or want to use it... today, tomorrow, next year and beyond. They are looking to Congress, to their healthcare providers, to the private sector insurance companies and everyone else involved in this process to find a solution that will make this possible.

3. **Seniors want the waste and fraud involved in Medicare to end.** Older Americas are expert at many things, Mr. Chairman because they are experienced consumers, and experience is a very masterful teacher.

They read about, hear about, and experience first hand the waste and cheating that goes on in Medicare. Survey after survey reports that most seniors believe they are being taken to the cleaners by various parts of the healthcare system. They want the bureaucratic tangle of red tape that permits this corruption to occur cut out once and for all.

Consider this example: In 1965, a 3-minute phone call from New York to Los Angeles took approximately 20 seconds to go through and cost about $2. That would be about $10 in 1995 dollars, when they are adjusted for average overall inflation. But today, Mr. Chairman, if that same call were placed, it would go through in about 3 to 5 seconds and cost 85 cents.

In short, Mr. Chairman, seniors are depending upon Congress to find a way to save Medicare. At the same time, they want you to keep Medicare from being a system that holds them its prisoner.

They want choices, Mr. Chairman. They want value, Mr. Chairman. They want to be reempowered with the ability to have control over the major decisions of their life.

We believe that this must be done and it can be done, and we stand willing to help in any way we can to bring this about.

Thank you.

[The prepared statement follows:]

4. **Seniors want to have the same healthcare options as other segments of the population.** Medicare was created in a very different world, Mr. Chairman. Until the middle of the 20th century there had never been, in the history of the world, a significant number of people who grew old before they died.

In 1965, when Medicare was created we knew very little about the biology or sociology of aging. Whether or not we are willing to admit it, most people then equated age with fragility and diminished capacities. We now know that such thinking is wrong -- it is ageism of the worst kind. I would submit that the Medicare system is built upon such premises in that it proscribes what seniors must have in rather than empowering them with the freedom to make choices for themselves.

We now know that the differences which make us unique individuals increase with age -- that, if you will, we become more and more ourselves as we grow older. Thus a one-size-fits-all program is not only inadequate, but it also eliminates the most basic element of dignity from older Americans -- the right to be themselves and make choices accordingly.

5. **Seniors are both incensed an deeply concerned about the exploding cost of healthcare under the Medicare system.** Medicare is a system that in many ways strangles competition, Mr. Chairman, and that is a key factor in spiraling costs.

In the last 30 years technology has literally revolutionized medical care. Usually, technology reduces the cost of delivering goods and services. In medicine, however, the effect has been just the opposite. We believe the Medicare system is a part of the problem which allows this to happen.

Similarly, Medicare was established before there were so many innovations in the operation of the practice of medicine - I am speaking of HMOS, PPOs and the like. We have tried to make both technological advances and new forms of medical practice fit into the Medicare system by amending it, adding on to it, etc., but to what end? Our adjustments have not necessarily contributed to better healthcare and most certainly they have not driven down costs. In truth, seniors cannot benefit from free market competition in healthcare because the Medicare system itself is

in the way.

Consider this example, in 1965 a three minute phone call from New York to Los Angeles took approximately 20 seconds to go through and cost about $2.00. That would be about $10 in 1995 dollars when they are adjusted for average overall inflation. But today, Mr. Chairman, if that same call were placed, it would go through in about 3 - 5 seconds and cost $. 85 -- exclusive of whatever discount rates were being promoted by all of the long distance carriers from whom we can now choose. Is there not some lesson here which might be of value?

In short Mr. Chairman, seniors are depending upon Congress to find a way to save Medicare. At the same time, they want you to keep Medicare from being a system that holds them its prisoner.

They want choices, Mr. Chairman. They want value, Mr. Chairman. They want to be re-empowered with the ability to have control over the major decisions of their life.

We believe this can and must be done, and we stand willing to help in any way we can to bring this about.

Chairman THOMAS. Thank you, Mr. Hansen.
Beau Boulter.

STATEMENT OF HON. BEAU BOULTER, LEGISLATIVE COUNSEL, UNITED SENIORS ASSOCIATION, INC.; AND A FORMER REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BOULTER. Thank you, Mr. Chairman.

Medicare is a very, very popular program. A large segment of our society continues to depend on Medicare, but there has been a problem with Medicare and it has been there for a long, long time. The trustees' report was out there last year and hardly anybody was talking about it, not the administration, really not the leaders of Congress. So it is the new leaders of Congress this year, Mr. Chairman, that have really brought the problem to the attention of the American people.

For the United Seniors Association, I want to congratulate the Republican Majority, especially in the House, for doing this, because until you started talking about it, nobody was talking about it. The problem is that there is more going out of the system than is coming into it, and the options are very, very few. And you pointed out that if we do not do anything by 2002, there will not be any money in it—the part A trust fund—at all.

I could not come here and recommend for United Seniors Association borrowing the money. I could not come here and say just raise taxes. I could not come here and say raise part B premiums by 300 percent. I certainly could not come here and say federalize the whole national health care system like the President wanted to do last year and make it all like Medicare. I do not think that would work at all.

I am not wed to the $270 billion or anything like that, but it seems to me that you are doing what you have to do, that you do not have any real options except to go forward and do what you are doing, because Medicare is broke.

I know that United Seniors Association has a lot of contact with our 400,000-plus members, plus seniors in general. We participate in focus groups, townhall meetings, we have a national television show, we get a lot of call-ins, and we try and stay in touch.

What we found out, Mr. Chairman, is that I guess seniors are now beginning to understand that the program is broke. They have not understood that long, but they think that it is like an airline that is bankrupt, it is going to be magically fixed or something. There is still some information they do not have.

A lot of seniors, I think most seniors perhaps, think that basically they get out of the system what they have put in, when in fact for a two-earner couple retiring in 1995, they will take out of the system $117,000 more than they have put in. Most seniors do not know that to maintain the current program, just what they now have for workers who are coming online and retiring down the road, that their premiums would have to be increased by 300 percent or something like that.

They do not know, Mr. Chairman, what you brought out today, that, on average, they get $4,800 a year now, and that by 2002, they will get $6,700, and that that is a 6-percent annual increase.

I think it needs to be pointed out, Mr. Chairman, that the Medicare population is growing at a rate of 1 percent. The CPI, including the health care component, is growing slightly over 3 percent.

As I understand what you are proposing, you are proposing to increase Medicare funding by 2002 by around 6 percent. Senior Americans do not know this, and we have got to do a better job of getting it out.

We have had a program, Mr. Chairman, United Senior has had a set of specific reforms since April 1994, and it is supposed to be in everybody's offices. I do not know how many of you have seen it, but it is detailed and I would like for it to be part of the record. There are a lot of things in there, but two main things are choice, giving seniors full control of their Medicare funds, giving them 100 percent of the average annual Medicare expenditure per beneficiary and allowing them more options, including a medical savings account. I would be happy to answer more questions about that, but we do support responsible reform.

[The prepared statement follows:]

Testimony of The Honorable Beau Boulter
on behalf of United Seniors Association, Inc.

Before the
Subcommittee on Health
House Ways and Means Committee

Hearing on Medicare Reform
Wednesday, July 19, 1995

Good morning Chairman Thomas and Members of the Subcommittee. I am Beau Boulter, Legislative Counsel for United Seniors Association. As a former Member of the Congress, it's always good to see many of my old friends and colleagues.

As all of you know, the Medicare system faces an impending financial collapse. The Board of Trustees of the Hospital Insurance program have concluded that the HI trust fund will be broke by 2002.

The current spending growth is unsustainable. Maintaining the program with no change would require a 250 percent to 600 percent increase in the payroll tax to pay benefits to today's young workers. Financing all promised Medicare benefits would also require an equivalent increase in the monthly premiums paid by the elderly for Part B from 400 percent to 700 percent.

In short, unless we act soon, continuing the current system unchanged means dramatic increases in premiums and payroll taxes in the not too distant future.

It would be nice to be able to sit here and say... as I'm sure representatives of some seniors groups will... that Congress has to keep its hands off Medicare and that you have to simply find the money elsewhere to solve these problems.

It would be nice. We could go back to our members and tell them that we are fighting tooth and nail to protect their interests and benefits no matter what.

But it would be irresponsible and a disservice to our members to do that. Our members weren't born yesterday and neither was I. They know that to <u>really</u> protect their legitimate interests we have to recognize these problems and work with you to find solutions to them.

That is why United Seniors Association has put forth a comprehensive and responsible plan to deal with Medicare's financial crisis, (and, to our knowledge, we are the only seniors organization with such a plan). We also look forward to working with groups like the American Medical Association and the Heritage Foundation who have proposed their own Medicare reform plans with similar goals.

If any of us ignore the impending crisis, the system is going to crash ... and that's in no one's interest.

In fact, our members, and millions of other seniors, are already beginning to suffer from the band aids previous Congresses and Administrations have applied to avoid the overall reforms we all know are necessary and inevitable.

The looming Medicare financing crisis already poses threats to the quality of care available to seniors. The federal government, starting in 1983, has imposed a series of new controls, restrictions and procedural regulations, restricting medical treatments doctors can choose to provide and second-guessing the choices doctors are allowed to make.

The result is rationed care. Every year, more Medicare beneficiaries report difficulty finding a doctor willing to take them as patients. Bureaucratic rationing has led to more Medicare beneficiaries discharged from the hospital in unstable condition, with a greater likelihood of death for those discharged unstable.

Clearly, the system must be fixed. United Seniors Association's plan to revamp the Medicare system allows seniors greater choice, thereby creating competition to control the growth in Medicare spending. The first step of our proposal is a prohibition on tax increases and limits on Medicare premium increases. These bold steps address two problems. One, capping revenues into the system forces Con-

system is completely lacking in any such discipline. Two, these financing reforms give Congress sorely needed credibility as it proceeds with systemic program reforms.

Systemic reforms are then required to match program outlays with capped revenues. First, Congress should delay the retirement age. Life expectancy has grown significantly since Medicare was adopted, and eligibility began at age 65; it now stands at 80 for males and 84 for females. Raising the eligibility age to 70 would eliminate about 40 percent of the projected Medicare deficits. You will be interested to know that as recently as two years ago we asked our members which reforms they thought ought to be adopted and a significant majority said that they would support raising the age of retirement and eligibility.

But the most important changes to the Medicare system are those that realign incentives for beneficiaries in the program. Today, Medicare encourages over consumption of medical services, through low deductibles and coverage of routine care. The current rationing scheme seeks to limit the availability of services to compensate for the incentives in the system. Instead of bureaucratic centralized rationing, our approach puts the incentives for saving into the hands of seniors themselves. Our approach would replace the current laundry list of limits on the use of each specified Medicare benefit with comprehensive coverage of all listed benefits once beneficiaries have satisfied a reasonable deductible.

The vast majority of seniors already purchase Medigap insurance to cover the services Medicare does not cover. The premiums spent on Medigap plans, combined with the savings from capping future Part B premium increases, will provide seniors with significant cash reserves to cover the higher deductible. Seniors could choose to buy comprehensive Medigap coverage designed to match up with the new Medicare benefits package, or they could pay out-of-pocket for expenses below the deductible. Under either approach, seniors would have a vested interest in seeking cost-effective coverage for routine services.

Our proposal would allow the Medicare deductible to increase in the future to ensure that Medicare spending does not exceed revenues. While the deductibles would remain fairly low under this provision for the next several years, over time the deductible would increase substantially. None of us want to see that happen, but we see it as necessary to real reform. We propose expanding current IRAs to allow baby boomers and younger workers to save now in preparation for the deductibles they will face after retirement. Allowing tax-free withdrawal of funds after age 65 for medical expenses would provide seniors with the cash they need to cover the new Medicare deductible without distorting the incentives for seniors to seek cost-effective care.

Finally, we recommend allowing all seniors to take the funds spent by Medicare for their care and purchase any private insurance plan of their choosing. Seniors would have the choice of remaining in the restructured Medicare program, purchasing expanded benefit coverage through an HMO, or buying traditional insurance coverage from a private insurer. Our proposal also recommends health insurance vouchers for the poor elderly, to ensure that the added deductible in the Medicare package will not prevent low-income elderly from obtaining needed care.

We firmly believe that any reform of the Medicare system must be undertaken to save the system and ensure that it continues to fulfill its role of providing health benefits to seniors. Addressing the financial structure and the benefit structure to improve the Medicare program will also have the beneficial effect of helping Congress address the nation's budget crisis.

Seniors want to leave their children and grandchildren a better world than they inherited. They support responsible government and believe the federal budget should be balanced, but reforms adopted simply to achieve this goal could prove disastrous for current and future retirees who have planned their retirement assuming the existence of Medicare benefits now available to them.

Seniors will support Medicare reform that serves both their own interests and the interests of future generations. Our proposal does that. It eliminates the long-term financing crisis, while at the same time allowing the elderly full control over their Medicare funds. Saving the system from bankruptcy is important to all seniors. It is today's seniors who will bear the burden if the system collapses under its own weight. I urge you to consider our proposals to reform Medicare in order to strengthen it and save it from bankruptcy. That approach will garner support for reform from seniors around the nation.

Thank you.

Chairman THOMAS. Thank you very much.
Ms. McSteen.

STATEMENT OF MARTHA A. McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. MCSTEEN. Thank you.

A comprehensive systemwide approach to health care cost containment is necessary to make meaningful long-term progress toward controlling the growth of Medicare spending and improve the balance sheet for Medicare Part A Trust Fund. Unless real progress is made in controlling health care costs generally, however, Medicare and Medicaid costs will continue to grow. This critical element is missing in the current debate.

Medicare has enhanced the life of millions of Americans and their families. Despite pessimistic commentary, Medicare is a remarkable success story. It provides universal coverage to seniors in an era when the private sector makes no such promise, because it takes in all individuals who could be entitled.

Medicare outlays over the past decade per enrollee have grown much more slowly than outlays for private insurance patients. Medicare's administrative costs average only 2 percent of program outlays, compared to 25 percent in the small group private market, and 5.5 percent in the large group private market. Certainly, Medicare rates for hospitals and doctors are at deep discounts.

Medicare is already a large nationwide preferred provider organization. Citizens want prudent spending, but they also want the insurance they pay for to be in place when needed. Certainly, Medicare is no different from any other large system. Innovations may be found that will increase efficiency, hold down costs and eliminate waste. But let us not jump just at any strategy that is advertised as "cutting costs."

We can make changes within Medicare to allow for more managed care options with appropriate consumer safeguards. The private market holds no magic bullets for Medicare. Its record on coverage and cost containment are inferior to Medicare.

The National Committee endorses certain principles for any Medicare reform plan. Universality: Certainly the National Committee opposes opting out of Medicare at this time, but increasing choice of plans is acceptable, as long as the choices are within the Medicare framework of access to a defined set of benefits. It is important that HCFA search for cost-effective means of delivering services to seniors such as PPOs and HMOs, as long as quality standards, access and comprehensive benefits are assured. Affordability is certainly a concern of every senior, because we keep seeing increased out-of-pocket costs.

Quality: Medicare promises seniors access to high-quality health care. The enthusiasm for managed care should be balanced with the realities of access to care and quality. Of course, cost and cost containment must be considered. Proposed reforms should not only address the solvency of the Medicare Program, but should also contribute to controlling overall health care costs.

Medicare cuts alone are not real cost containment. Fairness to providers is an element that we would insist be a part of the package.

We believe that the budget resolution has been driven more by political promises to balance the budget and cut taxes than by concern over the solvency of part A. When the deficit spending on all general revenue fund programs, including interest, is compared, Medicare part B accounts for only 6 percent of the deficit spending.

Certainly, we must address balancing the budget, but at the same time remember that Medicare provides valuable insurance protection that would be difficult for many to obtain in the private market. Attempting to abruptly dismantle Medicare will not solve the problem. We must continue to improve and refine Medicare, as we search for a resolution to this Nation's overall health care dilemma.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARTHA MCSTEEN, PRESIDENT
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

The National Committee to Preserve Social Security and Medicare, a grassroots education and advocacy organization representing millions of senior Americans, is pleased to testify on the subject of Medicare reform. The National Committee's mission is to protect, preserve, promote and ensure the financial security, health, and the well being of maturing Americans of current and future generations.

A comprehensive, system-wide approach to health care cost-containment is necessary to make meaningful long-term progress toward controlling the growth of Medicare spending and improve the balance sheet for Medicare Part A trust fund. Unless real progress is made in controlling health care costs generally, Medicare and Medicaid costs will continue to grow significantly. This critical element is missing in the current debate.

MEDICARE'S SUCCESSES

Before Medicare, health care for a retired or disabled person depended upon individual wealth or the generosity of family, friends, physicians or local health care institutions. When this wealth and generosity were not available, retired and disabled people often went without care when they needed it most. Medicare was started because the private market did not insure health care for most seniors.

Medicare has enhanced life for millions of Americans and their families. While increasing productive years of life for beneficiaries, Medicare has also helped support the development of health care facilities and medical education. In the years since 1966, when Medicare was implemented, much has been learned about reversing life-threatening illness, relieving pain and recovering lost functional capacity. Americans of all ages and degrees of health are benefiting from this program, because it protects whole families from much of the cost of acute health care for senior or disabled family members.

Despite pessimistic commentary from many politicians and a few interest groups, Medicare is a remarkable success story. It provides universal coverage to seniors in an era when the private sector makes no such promise. It takes all eligible seniors and disabled individuals entitled to Medicare regardless of health status. It does not control costs by dropping coverage for sick individuals, dropping dependent coverage or refusing to pay for medically necessary services. Over the past decade, Medicare outlays per enrollee have grown more slowly than outlays for private insurance patients. Medicare's administrative costs average only 2% of program outlays compared to 25% in the small group private market and 5.5% in the large group private market. Medicare rates for hospitals and doctors are at deep discounts, approximately 70% of what private insurers pay. Medicare is already a large, nationwide preferred provider organization.

Citizens want prudent spending but also want the insurance they pay for to be in place when needed. In general, large systems require continuous evaluation and refinement, and Medicare is no exception. "Innovations" may be found that will increase efficiency, hold down cost and eliminate waste, but let us not jump at just any strategy that is advertised as cutting cost. We must ask "whose cost is being cut?" and "who benefits from these cuts?" Will Medicare really pay out less? Will individual beneficiaries get less choice, coverage and quality of care? Most importantly, does a reform plan leave Medicare as one universal program? We can make changes within Medicare to allow for more managed care options with appropriate consumer safeguards. The private market holds no magic bullets for Medicare-- its record on coverage of individuals and cost containment is inferior to Medicare. Providing seniors and the disabled with vouchers with which to purchase private insurance is a type of reform which may well undermine Medicare and threaten the health security of seniors and the disabled.

In seeking ways to improve Medicare, this Congress must commit itself to maintaining Medicare as a federal program which guarantees comprehensive health care to all entitled seniors and the disabled. Medicare's 35 million beneficiaries are overwhelmingly satisfied with this insurance which assures portability, renewability, wide choice of providers, does not exclude preexisting conditions, does not change the ground rules of coverage when people are sick and need care and gives the individual standing to dispute decisions about coverage. Some of the changes being promoted as Medicare reforms would diminish or even end these protections.

The National Committee endorses the following principles for any Medicare reform plan: *Universality* - Medicare must remain a universal program covering all entitled senior and disabled Americans. Universality permits the pooling of risks, making insurance affordable even for the chronically ill. The National Committee opposes opting out of Medicare. Increasing choice of plans is acceptable as long as the choices are within the Medicare framework of access to a defined set of benefits. It is important that HCFA search for cost-effective means of delivering services to seniors, such as PPOs and HMOs as long as quality standards, access and comprehensive benefits are assured.

Affordability - The average senior spends over $3,000 annually for out-of-pocket health care, including premiums, deductibles and co-payments for Medicare, and uncovered care, including prescription drugs and long-term care. This amount represents a greater percentage of out of pocket costs than before Medicare was created. Increasing premiums,

deductibles and co-payments will place unacceptable fiscal and physical hardships on moderate and low income seniors and the chronically ill. These types of increases are penny wise and pound foolish solutions as they will result in seniors putting off needed medical care, which will result in ultimately higher cost medical solutions.

Quality-Medicare promises seniors access to high quality health care. The enthusiasm for managed care should be balanced with the realities of access to care and quality. Medicare beneficiaries in managed care plans should have national quality standards, clearly defined appeal rights and access to specialty care.

Means Testing-Means testing violates the universality of Medicare and singles out higher income Medicare for discriminatory treatment. A study by Lewin-VHI conducted for the National Committee demonstrates that the Medicare Part B subsidy for upper income beneficiaries will be more than made up by Medicare Part A taxes in excess of Part A benefits over a lifetime.

Choice-Seniors should continue to have their choice of doctors, specialists and other medical providers.

Cost Containment-Proposed reforms should not only address the solvency of the Medicare program, but should also contribute to controlling overall health care costs. Proposals that shift Medicare costs to beneficiaries or the privately insured are simply cost shifting proposals and are not real cost containment reforms. Medicare cuts alone are not real cost containment.

Fairness to Providers-Fair reimbursement to providers is the only way to guarantee access to quality health care.

MEDICARE SPENDING AND THE DEFICIT

The budget resolution calls for a reduction of $270 billion in current law levels of Medicare spending over a seven year period. Reductions of this magnitude are unprecedented--several times larger than the $56 billion in reductions over five years enacted as recently as 1993 as part of the reconciliation bill. The Medicare program cannot sustain the level of cuts discussed recently by some Congressional leaders without significant hardship to seniors and the disabled.

We believe that the budget resolution has been driven more by political promises to balance the budget in seven years and cut taxes than by concern over the solvency of Part A. In the last Congress, alarms were sounded over the proposed $157 billion in Medicare reductions over seven years proposed by the President as part of health care reform. Members of Congress predicted the cuts would destroy quality and access for beneficiaries or even the program itself. The same is even more applicable to the current budget resolution. At least the President's proposal maintained the Medicare program for all beneficiaries and added new benefits and attempted universal cost containment.

The current debate over Medicare costs is driven largely by the deficit problem. It is important to note that Medicare Part B has contributed a relatively small amount to the current deficit. (See attached chart) Medicare Part A has contributed nothing to the deficit. When spending on all general revenue fund programs, including interest, is compared, Medicare Part B accounts for only 6% of deficit spending in fiscal year 1994. Yet the budget resolution targets Medicare Part A and B for 35% of the funds for deficit reduction. Similarly, Medicaid accounted for only 11% of 1994 deficit spending yet is targeted for 24% of the dollars for deficit reduction. Defense spending contributed 36% of G10
deficit dollars in 1994, but will contribute nothing toward deficit reduction in this budget resolution. Apparently, the over two trillion dollars the government will forego over the next five years in tax entitlements will also escape virtually unscathed. Medicare and Medicaid are asked to shoulder an unfair portion of deficit reduction.

We do not believe our members, or most Americans, will support a budget reconciliation bill which reflects this disproportionate and unjustified treatment of Medicare and Medicaid.

MEDICARE PART A

The most recent report of the Medicare Trustees projects that Medicare Part A trust fund will be depleted in 2002. Of course, the Trustees predicted that bankruptcy was only two years away as far back as 1970, and Medicare is still here today. The reasons for this are the determination of the Congresses over the intervening years to maintain the program and the full support of the public for doing so. We are convinced that large majorities of Americans of all ages still fully support preserving the Medicare program.

This Congress can make reasonable changes to extend for several more years the solvency of Part A, while continuing to work toward long-term structural and cost-containment approaches. Our testimony today suggests changes which will add $150

billion to the Part A trust fund through both savings and revenues and slow the growth of Part B.

It is important to note that the unprecedented level of cuts proposed by this Congress in the budget resolution only extends the solvency of the program by two or three years. The Medicare program will not be "saved" by these budget cuts. The reason is that arbitrary cuts do nothing to solve the underlying problems of health care inflation and an aging population. These issues must be addressed in a bi-partisan fashion, outside of the budget process, and all reductions or savings must be directed toward maintaining and improving the program for current and future beneficiaries.

OTHER REFORM PROPOSALS

The National Committee has looked at proposals by the American Medical Association (AMA) and the American Hospital Association (AHA). They both rightly focus on the long-term. We oppose privatization of Medicare. The National Committee recognizes the potential benefits of managed care or "coordinated care" advocated by the American Hospital Association, but does not believe that sufficient evidence exists establishing significant savings for Medicare from managed care.

Cost Containment

Medicare cost containment must be part of a comprehensive plan to control national health care costs. Without a comprehensive program of cost containment, Medicare reductions will result in higher costs to beneficiaries, reduced payments to providers, increased cost shifting and access problems for beneficiaries. The recent steep increase in Medicare costs is typical of health care costs in society in general. It does not appear that costs will be contained by lifting the current limits on balance billing.

Medicare is a far more efficient program than it is given credit for being.

- Over the past decade, Medicare outlays per enrollee have grown more slowly than outlays for private insurance patients. The reduction in private sector growth in just the last two years does not necessarily represent a long-term trend. Insurance companies can hold down premium increases for a short time by reducing reserves.

- Medicare has an excellent record on administrative costs--averaging 2 percent of program outlays compared to 25 percent in the small group market of the private sector and 5.5 percent in the large group market.

- Medicare rates for hospitals and doctors are at deep discounts, approximately 70 percent of what private insurers pay. Medicare is already a large, nationwide preferred provider organization.

- The notion that cost increases are due to a lack of cost consciousness on the part of beneficiaries is false. Medicare pays less than half of senior health care costs, including long-term care, and many seniors face financial hardship as a result of health costs, despite Medicare and Medicaid. An AMA idea to limit benefits for those who supplement Medicare with first dollar medigap coverage using after tax dollars is unreasonable, especially if there are no limits on tax breaks for first dollar health insurance coverage for corporate executives.

Controlling Fraud

A major effort to prevent fraud and abuse is essential and appropriate. According to the General Accounting Office and the Inspector General of HHS, fraud and abuse in the Medicare and Medicaid programs are rampant. Current estimates are that Medicare and Medicaid lose up to $31 billion annually to fraud and abuse. The government must commit resources to fighting fraud and provide increased opportunities for beneficiaries to make confidential complaints about fraud, perhaps through designated personnel at local Social Security offices.

- A June 1994 report by Senator William Cohen, R-Maine, Chairman of the Special Committee on Aging, concluded that major patterns of fraud and abuse have infiltrated the following health sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services and rehabilitative services in nursing homes.

- The HHS Inspector General reports $80 in savings for every dollar invested in efforts to control fraud. Yet, Congress has yet to make meaningful efforts to prevent fraud of taxpayer money in the Medicare and Medicaid programs.

- GAO conservatively estimates that Medicare could save $650 million a year just on Medicare Part B physician and supplier services by using state of the art commercial software to eliminate abusive and fraudulent billing practices. Commercial insurers using this software typically save 5 to 10 percent.

Managed Care

Managed care options should be made available to Medicare beneficiaries within the context of the Medicare program on a voluntary basis as long as federal standards, safeguards and appeals rights are assured. Many health care consumers do not have the expertise to judge their own health care requirements and the relative risks of cost saving choices. Health care is not a typical market commodity because it involves specialized knowledge beyond that of many consumers. Often medical care is not optional because basic survival is at stake and as a result people do not have the luxury of shopping around for care. Citizens need the protection of some basic cost and quality controls, as they do with necessary utilities. For this reason, the National Committee has endorsed H.R. 1707, the Medicare Beneficiary Protection Amendments of 1995. Consumer safeguards are a critical component of any legislation which increases the use of managed care by Medicare beneficiaries.

- Some seniors prefer managed care arrangements due to more comprehensive coverage and/or lower out of pocket costs. Beneficiaries should not be required to join managed care plans and should have the option to seek care outside the plan when special expertise is needed.

- Expectations that managed care will lower spending may be unrealistic. Adequate risk adjusters are not yet developed to insure that Medicare does not pay too much for healthier beneficiaries who choose managed care. An expansion of managed care options could actually increase overall costs if healthier, lower cost beneficiaries choose managed care and sicker beneficiaries remain in fee for service Medicare.

- Quality managed care plans coupled with consumer education about managed care could increase participation of Medicare beneficiaries and reduce costs over time.

Means Testing

Subsidies for low income beneficiaries make sense, but income-based premiums do not. Medicare is not a welfare program. Means testing the Medicare part B premium would undermine broad based support for Medicare. If the concern is that Medicare is not progressive enough, Congress has already acted to make Medicare more progressive by raising the taxable wage base for Medicare payroll taxes in 1990 to $125,000 and eliminating the wage base altogether in 1993. In the long run, the Medicare Part B subsidy for upper income beneficiaries will be more than made up by Medicare Part A taxes in excess of Part A benefits, according to a study by Lewin-VHI commissioned by the National Committee. Financing the so-called subsidy through income taxes falls most heavily on upper income taxpayers.

Vouchers and Medical Savings Accounts

One of the most serious threats to the integrity of Medicare is the idea of vouchers. Policy makers extol the virtue of consumer controlled health care, even though consumers would lose the more substantial bargaining power of the government. Consumer control would be meaningless if Congress slowly reduces the purchasing power of the voucher. Under the budget resolution, most savings are in the final two years and would require a cap on voucher amounts far below the cost of private policies. It is a bad bargain for seniors to trade in the universal, guaranteed coverage under Medicare for the risks and high costs in the private insurance market.

Innocuous sounding proposals to make vouchers available for medical savings accounts on an optional basis are really the worst of both worlds. They would appeal to the healthy but leave the more expensive beneficiaries in Medicare. This very predictable "adverse selection" makes many proposals actuarially unsound and would undermine Medicare, making it more costly.

Potential Savings

The National Committee can support careful and equitable efforts to restrain health care inflation necessary to secure Medicare's long-term stability. We recognize the need to look for reasonable savings to slow the growth of Medicare in the short-term. Some short-term and long-term proposals that the National Committee has endorsed or would consider as part of an equitable proposal are listed below. If all these proposal are adopted, it would save over $150 billion in the Medicare Part A trust fund and slow the growth in Medicare Part B spending.

- In the recent budget, the President proposed to save $10 billion over five years by making permanent several temporary provisions in current law, including setting Part B program premiums at 25 percent. Other provisions included extending Medicare secondary payer provisions and permanently lowering payments to home health agencies and nursing homes. These "extenders" were adopted by the Ways

and Means Committee but the revenue was not used for deficit reduction or to shore up the Part A Medicare trust fund. Instead, the savings were diverted to help pay for tax cuts. The National Committee believes that these savings should be used to strengthen Medicare.

- The National Committee supports the extension of Medicare coverage to include state and local government employees not now covered. This would not only raise $7 billion over five years, but it would also extend Medicare coverage and insure that all future Medicare beneficiaries contribute toward Medicare.

- Increasing the tobacco tax to $2 per pack will generate $15 billion a year for Medicare Part A in addition to $1.5 billion for medical research. (H.R. 1455)

- A reevaluation of Medicare payments for hospital capital costs and professional education could reasonably save between $7 billion and $23 billion over five years.

- Formula driven overpayments to hospitals for outpatient surgery and radiology also can be reduced $20 billion over five years according to a recent HHS study, but these savings should be used to offset the cost of reducing beneficiary co-payments, which averaged 43 percent of total payments rather than 20 percent in 1993.

- Stricter utilization review and streamlining of Medicare administrative costs, including combining Part A and Part B.

- Increasing the eligibility age for Medicare by tying it to eligibility for Social Security will create savings beginning in 2003. This is also supported by the AMA.

Conclusion

Medicare provides valuable insurance protection to millions of entitled seniors and disabled individuals, insurance that would be difficult for many to obtain in the private market. The problems in the health care system in this country must be addressed, but attempting to abruptly dismantle Medicare will not solve the problem. We must continue to improve and refine Medicare as we search for a resolution to this nation's overall health care dilemma. The National Committee is committed to finding solutions which preserve Medicare as a universal, comprehensive federal health care program for all entitled senior and disabled Americans.

Chairman THOMAS. Thank you very much, Ms. McSteen.

Dr. Braun, it is nice to have you back again.

STATEMENT OF BEATRICE S. BRAUN, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. BRAUN. Thank you, Mr. Chairman.

Members of the Subcommittee, I am Beatrice Braun from Spring Hill, Florida. I am a member of the Board of Directors for AARP, the American Association of Retired Persons. I appreciate the opportunity to testify today on the future of the Medicare Program.

For three decades, Medicare has protected the economic security of older and disabled Americans by assuring them access to affordable quality health care. AARP is committed to maintaining and strengthening Medicare for current and future beneficiaries, but the status quo is no longer acceptable.

Unless adjustments are made in the Medicare Part A Hospital Insurance Trust Fund, as we have heard so often this morning, it will be completed in 7 years. Moreover, Medicare may be able to benefit from some of the innovations in the private market. But changes to Medicare must be made cautiously and carefully. The goal of changing Medicare must be to strengthen the program, not simply to reach artificial budgetary targets.

The $270 billion in Medicare spending reductions in the budget resolution is excessive. It is beyond what the program can absorb without jeopardizing quality and access, and beyond what is necessary to keep the Hospital Insurance Trust Fund solvent for the next 10 years. In short, it is too much to fast.

Spending reductions of this magnitude will fall heavily on beneficiaries. If we assume that one-half of the required spending reductions would come directly from beneficiaries, $3,400 would be added over 7 years in premiums, deductibles and coinsurance to an already extraordinary—by a percentage with other sectors of the population—out-of-pocket burden.

Let me now turn my attention to Medicare reform. AARP believes that Congress should address Medicare solvency issues in a two-stage process. First, assuring solvency of part A for the next decade, and then proceeding on a separate track to deal with the longer term financial stability of the program.

As we begin this process, it is important to understand what the public needs and wants from Medicare reform. Like you, we devote a great deal of time and effort in trying to understand these views and have included a number of findings in our written statement.

In order to guarantee Americans a Medicare Program that meets their needs, changes to Medicare will be necessary. However, these changes should be accomplished in carefully designed increments. One of the important lessons of last year's health care reform debate is that the Congress should not try to make all decisions and steps required to change the Medicare Program for the coming years in 1 year.

There are a number of reform options now being talked about that bear careful scrutiny. These include vouchers, managed care, medical savings accounts, and changing Medicare's eligibility age. We raise a number of questions in our written statement about

how these kinds of approaches would work for Medicare, and we do not think there are answers to all of those questions yet.

While structural changes in Medicare can and should be a part of the program's future, some of the changes under consideration pose potential hazards to beneficiaries and the actuarial soundness of the program.

Looking ahead just a few years, it seems legitimate to question whether Medicare can in fact provide the standard benefits for the amount that will be paid. Fundamentally, a question that we all face today is whether in the future the Medicare Program will continue to provide a health care plan on which older and disabled Americans can rely.

Older Americans rely on Medicare as their health care plan, but they also view it as the cornerstone of their financial security. If in the future the program no longer pays for the costs of needed health care and these costs are simply shifted on to beneficiaries, all the structural reforms that may have succeeded in lowering the Federal Government's costs will not have achieved the goal of providing quality affordable care smarter and more efficiently than we do today.

Mr. Chairman, all of us share in the desire for a strong and viable Medicare Program now and in the future. The program does need to be modernized and its financial stability does need to be strengthened. The time to start is this year, and the way to start is to make some specific incremental changes.

We look forward to working with you and other Members of Congress in that effort.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF BEATRICE BRAUN
MEMBER, BOARD OF DIRECTORS
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Committee, I am Beatrice Braun from Spring Hill, Florida. I am a member of the Board of Directors for the American Association of Retired Persons (AARP). I appreciate the opportunity to testify today on the future of the Medicare program.

As we celebrate the 30th anniversary of Medicare, it is appropriate to consider the valuable contributions this program has made. For three decades, Medicare has protected the economic security of older and disabled Americans by assuring them access to affordable, quality health care. For the 37 million beneficiaries and their families, Medicare is not just a policy, budget or political issue -- it is the health insurance program upon which they depend. Recent research conducted for AARP by DYG, Inc. found that:

- Medicare, like Social Security, is viewed as a linchpin of economic security: 87 percent of the public -- across all ages -- says Medicare is vital to the financial security of older Americans so they are not dependent on their children or families.

- The support for Medicare extends across generations -- nine out of ten Americans under the age of 65 (including 87 percent of those age 18 to 29) want Medicare to be there when they retire.

AARP is committed to maintaining and strengthening the Medicare program for current and future beneficiaries. The status quo is no longer acceptable. The rate of growth in the program is not sustainable. Moreover, Medicare may be able to adopt some of the innovations occurring in other parts of the healthcare system, including the private health care market. But changes to Medicare must be made cautiously and carefully. The goal of changing Medicare must be to strengthen the program -- not simply to reach arbitrary budget targets. Otherwise, we risk heightening the fears of beneficiaries and their families that their health insurance plan is at risk -- a fear that could make real and lasting reform even more difficult in the future.

Trust Fund Solvency

A key issue for Medicare is the financial viability of the Part A Trust Fund. While last year's health care reform debate did not focus explicitly on this topic, we recognized that system-wide cost containment would have strengthened Medicare's financial stability. In the absence of such reform, we believe that Congress should address the solvency issue in a two-stage process -- assuring solvency for the next decade, then proceeding on a separate track to deal with the longer-term financial stability of the program.

The first stage -- assuring solvency in the program for the next ten years -- would return Medicare to its historic average term for solvency as reported in the annual Trustees' Report (See Chart I). Congress has always kept the HI Trust Fund with about 7-10 years of projected financing, and there is no need to go beyond that this year. Part A savings of about $110 billion over the next seven years would improve the near-term status of the fund by delaying the date when the program has to begin dipping into reserves, and extend the life of the fund through 2005 -- a decade from now.

Extending the near-term solvency of the Trust Fund would provide sufficient time for Congress to move to the second stage -- crafting the best policy options for longer-term financial stability. This stage is by far the more difficult because we must deal with the financing and health delivery issues related to the retirement of the "baby boom" generation in the years following 2010.

While Congress can and should begin to consider these longer-term policy options this year, final decisions about such changes should not be made in haste. It will take time to consider options fully and to evaluate their impact on beneficiaries and providers. This stage should involve extensive public education and opportunities for discussion to minimize the risks for the program and the anxieties of those who depend on it. At this point, there are many unanswered questions about reform options and the potential risks for Medicare are enormous.

Medicare and the Budget Resolution

AARP believes that Medicare should play a role in reducing the federal budget deficit. Our members want a strong economy for their children and grandchildren. The Association is committed to working with Congress to determine the appropriate level of Medicare savings and to determine what policy changes might best achieve this goal. However, the $270 billion in Medicare spending reductions in the Budget Resolution is excessive. It is beyond what the program can absorb without jeopardizing quality and access and beyond what is necessary to keep the HI Trust Fund solvent for the next ten years. It jeopardizes chances for reforms that assure affordable health care for older and disabled Americans over the long-term. In short, it is too much, too fast.

The Budget Resolution proposes to achieve nearly half of its deficit reduction over the next seven years out of Medicare and Medicaid. In both programs these are the largest cuts ever proposed. The $270 billion Medicare reductions are about 22 percent below what CBO projects the current program would cost in the year 2002 and about 16 percent below CBO projections for spending over the seven year period 1996-2002. This is excessive by any definition of a "fair share" allocation of budget savings.

Regardless of whether these proposals are called "reducing the rate of Medicare growth" or "cutting" the program, the outcome is the same -- higher cost-sharing for Medicare beneficiaries and lower reimbursements for providers. When the specific policies needed to reach budget targets are examined, it becomes apparent that the magnitude of the Medicare savings is neither fair nor equitable -- nor is it in the best interests of Medicare reform. In addition, the combined Medicare and Medicaid reductions are so large -- over $450 billion -- that if enacted, they will have negative impacts on the entire health care system.

The Impact of Proposed Spending Reductions on Beneficiaries

An increase in beneficiary payments would come on top of the already heavy out-of-pocket obligations beneficiaries face today for health costs. Older Americans currently pay about 21 percent of their household income on health care expenses, compared with 8 percent for Americans under age 65 -- yet older Americans' median household income is roughly half that of those under 65 (See Chart 2). This year, elderly beneficiaries will pay, on average, $2,750 out-of-pocket for Medicare premiums, deductibles, copayments, Medigap premiums, and uncovered services like prescription drugs. This does not include the additional costs beneficiaries face for nursing home care and some other long-term care.

Based on the assumption that increases in beneficiary payments constitute half of the $270 billion in savings required under the Budget Resolution, the increased costs for the average Medicare beneficiary would be $3,400 over the next seven years. Several options have been suggested this year to increase beneficiary out-of-pocket expenses to cover half the savings required in the Resolution. These include:

A New 20 Percent Medicare Home Health Coinsurance: For a beneficiary to qualify for Medicare home health coverage, a physician must certify that the care is medically necessary and that the client is homebound and in need of only intermittent or part-time skilled care (skilled nursing or therapy). In 1996, about 3.8 million Medicare

beneficiaries will use home health benefits. Approximately two-thirds of Medicare home health users are women; almost two-thirds are over age 75. Under current law, there is no coinsurance for persons who use Medicare home health services. This is intended to encourage the use of more effective, less costly non-institutional services. Some argue that because there is no coinsurance utilization is higher -- beneficiaries allegedly have no disincentive to deter usage. But this view ignores both the purpose of home health's zero copay and the basis on which beneficiaries find themselves using the service.

A new 20 percent coinsurance would require the average home health user to pay an additional $900 in 1996 and almost $1,200 out-of-pocket in 2002. The very frail individuals who need and use home health care the most, over 700,000 Medicare beneficiaries in 2002, would pay an annual coinsurance of over $3,800 in that year.

Imposing a new out-of-pocket payment would be a "sick tax" on the most frail and vulnerable elderly and disabled Americans -- those who can least afford it. Almost 80 percent of all Medicare home health users have annual incomes of less than $15,000 which means many beneficiaries would lose access to these necessary services.

Since physicians are responsible for determining eligibility for Medicare home health coverage, a new beneficiary coinsurance is not an effective method for controlling potential inappropriate utilization.

In fact, a 20 percent coinsurance could act as a deterrent to appropriate utilization. The rate of growth in home health care has exceeded most other Medicare benefits. However, we believe there are legitimate reasons for much of this growth and that overutilization by beneficiaries is not a factor. In our view, the evidence shows that growth rates are due, in large part, to court-ordered clarifications of coverage rules that previously had been very ambiguous and overly restrictive. This had caused artificial and illegal constraints on the availability of services for beneficiaries. Beginning in 1989, the issuance of new intermediary coverage rules responded to pent-up demand and increased the number of meritorious claims submitted for Medicare coverage.

If there is abuse of this benefit, then we must address it; but we should act based on sound diagnosis rather than symptoms. For instance, the data on home health does suggest some unaccounted for variations in utilization by region which is a legitimate reason for concern. However, imposing a 20 percent coinsurance does not address this problem and could create an overly restrictive environment similar to that which existed in the mid-1980s.

In addition, anticipated reductions and changes in the Medicaid program make it increasingly questionable whether Medicaid will continue to be required to pay for Qualified Medicare Beneficiaries (QMBs) -- leaving more beneficiaries vulnerable.

A Higher Medicare Part B Premium: Currently, the Part B premium is intended to approximate 25 percent of Part B costs; the remainder of Part B program costs is paid from general revenues. In 1995, the premium is $46.10 per month, $553.20 annually. It is estimated to grow to $60.80 per month, $729.60 annually, by 2002. The premium is deducted from most beneficiaries' Social Security checks.

To protect beneficiaries from some of the impact of health care costs that have historically risen 2 to 3 times faster than the Social Security COLA, Congress has set the Part B premium to equal or approximate 25 percent of program costs since 1982. In 1990, Congress set the premiums in actual dollar amounts -- intended to achieve a 25 percent ratio. Since 1990, Medicare Part B costs have actually risen more slowly than projected -- hence the premiums have come to cover 31 percent of Part B costs in 1995, even though they were intended to pay for 25 percent.

To achieve savings required in the Budget Resolution, some have proposed increasing the premium to 31 percent of Part B program costs. This could substantially increase the Part B premium over time, thereby shifting higher health care costs to Medicare beneficiaries. Under this proposal, the premium could jump to roughly $97.70 per month, or $1172.40 annually by 2002. That is $442.80 more than the beneficiary would pay under current law. Over the next 7 years, most Medicare beneficiaries would pay an estimated additional $1,590 for the Part B premium alone.

An Increase in the Medicare Part B Deductible to $150, Indexed to Part B Program Costs: Each year, all Part B enrollees pay the first $100 in approved charges for Part B services. This annual Part B deductible is not indexed. Roughly 80 percent of Part B enrollees meet the Part B deductible.

Increasing the Part B deductible from $100 to $150 would present a significant barrier to access for lower income beneficiaries. Moreover, anticipated reductions and changes to the Medicaid program make it questionable whether Medicaid would pay the additional costs for low-income individuals under the QMB program. Indeed, states have been reluctant, at best, to carry out their responsibility under the QMB program.

Indexing the deductible would increase out-of-pocket costs for the average Medicare beneficiary for each succeeding year. If the Medicare spending reductions in the Budget Resolution are divided equally between providers and beneficiaries, the deductible could grow from $100 today to $270 by 2002 (increasing from $100 to $150 annually, plus indexing to program costs). The total increase in the deductible over the 7 year period would be $384 per beneficiary. Beneficiaries with Medigap plans covering the Part B deductible would not be immune to the increased out-of-pocket costs, since Medigap premiums would almost certainly increase to cover the cost of the higher deductible.

A New 20 Percent Coinsurance for Medicare Skilled Nursing Facility (SNF) Care: Under current law, beneficiaries are eligible to receive up to 100 days of Medicare-covered skilled nursing facility (SNF) services following at least three consecutive days in a hospital. Typical diagnoses for SNF users are hip fracture and stroke. No coinsurance is imposed for the first 20 days of covered care. For days 21-100, beneficiaries must pay $89.50 per day in 1995 (one-eighth of the Part A Hospital deductible). In some cases, this amount has exceeded the cost of care per day. To our knowledge, this formula can result in one of the highest coinsurance percentages of any federal health program. Rather than looking for ways to get more money from beneficiaries using SNF services, the formula should be reviewed with the objective of making it more rational on policy grounds.

We have concerns about imposing a coinsurance amount during the initial 20 days of care because the average length of coverage is only about 30 days. Lower-income beneficiaries will not be able to afford the coinsurance and may be denied access to needed rehabilitative services in a SNF. This is particularly true if the proposal to cap and block grant the Medicaid program is enacted, because it could seriously jeopardize the only low-income protection available under current law -- including the Qualified Medicare Beneficiary (QMB) program. Without this help in paying for SNF coinsurance, many seriously ill low-income Medicare beneficiaries might not be able to get the rehabilitation they need, and could end up spending additional days in the hospital or needing to be readmitted to the hospital.

A New 20 Percent Coinsurance for Medicare Laboratory Services: Currently, Medicare beneficiaries do not pay a coinsurance for laboratory services. Labs are paid on the basis of a fee schedule and are required to accept Medicare payments as full payment. Since physicians order laboratory tests -- not beneficiaries -- a 20 percent coinsurance would shift onto beneficiaries costs for services over which they have no control. In addition, the low cost of most lab tests makes imposing and collecting a coinsurance administratively burdensome.

A New Income-Related Premium for Higher Income Medicare Beneficiaries: To achieve the savings required in the Budget Resolution, Congress could impose a new, income-related premium for higher-income beneficiaries. Some have proposed setting the thresholds at $125,000 for singles and $150,000 for couples. Others have suggested setting these thresholds as low as $50,000 for a single person.

At the highest income categories, beneficiaries could pay 100 percent of Part B costs. If the income thresholds for the proposed high-income premium are not indexed, each year a greater percentage of Medicare beneficiaries would be required to pay the new, higher premium. In the future, Congress could simply choose to lower the income threshold, thereby increasing revenues, and affecting more beneficiaries.

At the same time that an income-related premium would be imposed on Medicare beneficiaries, federal subsidies for health care costs for those under age 65 would continue, regardless of an individual's income. These subsidies come in the form of the tax deduction for employer-provided health insurance and the exclusion of health benefits from individual taxes.

As a result of the savings target under the Budget Resolution, Congress could impose higher health costs on higher-income older Americans but would continue federal subsidies for corporate executives, middle-aged millionaires, and Members of Congress with incomes substantially higher than any Medicare threshold. A recent Price Waterhouse analysis estimated that reducing federal subsidies for higher-income individuals under age 65 in the same manner as for Medicare beneficiaries -- using the same income thresholds suggested in the February, 1995 Joint Committee on Taxation analysis ($50,00 for singles and $100,000 for couples) -- would result in federal budget savings that are three and half times as large as the Medicare income-related premium savings.

Balance Billing: Beyond the direct impact of higher premiums, deductibles, and coinsurance, we are alarmed by prospects for more "balance billing." This subtle but very significant change could occur at three levels:

- some in the physician community have proposed allowing more "balance billing" so they are able to charge beneficiaries additional amounts over and above Medicare payments;

- as health plan choices are expanded, some health plans could seek the option to allow providers within the plan to balance bill beneficiaries amounts in addition to the health plan payment.

- as payments to private health plans are ratcheted down in the various budget scenarios, those plans will accept the "cuts" but insist on the right to charge beneficiaries higher premiums and/or copays; and

Allowing balance billing flies in the face of shared sacrifice. While these mechanisms may slow the rate of growth that the Congress is focused on -- the growth in Medicare spending -- they would only accelerate out-of-pocket spending by beneficiaries, shifting considerable costs rather than containing them. AARP believes that the objective of any reductions in Medicare spending should be to control health care costs, not simply shift them onto beneficiaries.

What Older Americans Need from Medicare Reform

As the Committee begins to address broader reform of the Medicare program, it is important to understand what the public, including older Americans, needs and wants from Medicare reform. Like you, AARP devotes a great deal of time and effort to trying to understand these views, and would suggest the following:

- As noted earlier from the DYG research, Americans value the financial security offered by the Medicare program -- and they will want to know whether, and to what extent, changes in the program affect their financial security.

- Americans want to know whether they will be able to depend on Medicare's protection or whether Medicare's "contribution" to their health care costs will diminish over time.

- The DYG study also suggests that Americans maintain a healthy skepticism about the elderly being thrust into the private health insurance market. Only 22 percent believe it very or somewhat likely that health insurers would sell insurance that is equal to Medicare to the elderly, and only 24 percent believe it very or somewhat likely that the elderly could afford private health insurance.

- As noted earlier, Americans of all ages want an affordable Medicare plan available when they retire -- not just one that shifts costs. There is strong intergenerational support, not tension, for Medicare.

- Americans want incentives -- not penalties -- to encourage the use of fewer and less expensive services, and they want affordable fee-for-service options for those beneficiaries who choose or have no option but to remain in it.

Broader Medicare Reforms

In order to guarantee Americans a Medicare program that meets these needs, changes to Medicare will be necessary. However, these changes should be accomplished in carefully designed increments. One of the important lessons of the recent health care reform debate is that the Congress should not try to settle in one year all of the decisions and steps required to change the Medicare program for the coming years.

To reiterate the point made earlier in this testimony, we believe that the Congress must undertake changes to Medicare in at least two stages. First, to assure solvency for the next ten years, Congress should adopt specific changes this year. Then, after a thorough public debate, Congress should move in the next few years to adopt policies that will address the program's longer-term financial stability. Such a two-step approach need not and should not be a source of delay. Rather, it should and must be a means to involve the public.

A case in point are the successes that have been attributed to large private sector purchasers of health benefits. It will be important to examine the strategies that have led to claims of cost reductions and more efficient service delivery in the private sector and to incorporate some of those approaches into Medicare as appropriate. But as many representatives of the private sector stated before Congress earlier this year, the most successful changes in the health care plans of some of the nation's major corporations have occurred because they were undertaken slowly, carefully and with considerable input from those directly affected by the changes. We urge you to carefully examine how well private sector approaches are working and which lessons apply to Medicare beneficiaries. For instance, is the recent slowing in the rate of growth attributable to real cost containment or merely a reaction to last year's health care reform debate? Have these approaches been truly tested in the private market? Do private sector approaches apply to the unique characteristics of Medicare beneficiaries?

There are number of "reform options" now being talked about that bear careful scrutiny. These include:

Vouchers: There is a lot of discussion of "vouchers" -- a term that appears to have a variety of different meanings at this point. It will be important to clarify what is meant

by a voucher program. For some, it implies that Medicare makes contributions to health plans that have been approved by Medicare on behalf of beneficiaries, much like an employer-sponsored plan. For others, it implies that Medicare provides a "chit" to beneficiaries to use in purchasing any health plan from private insurance companies.

It is useful to be precise in assessing what is really going on in the private market, because it does not appear to us that many large purchasers are providing open-ended vouchers. Rather, they are dealing with and rigorously screening and negotiating with health plans on behalf of their employees, who then make a choice among those plans. If this is the case:

- Will Medicare, like the typical large purchaser, perform that aggressive purchasing function?

- What guarantees will health plans give that they won't simply charge beneficiaries higher and higher premiums for coverage?

- How will the Medicare payment amount be set? How will it be linked to the benefit package to assure that it is sufficient to cover the already limited Medicare benefit package?

- Will specific insurance reforms be enacted to assure that all beneficiaries -- especially those who are older and sicker -- actually obtain coverage and benefits? will payment be risk-adjusted? Will beneficiaries be able to change plans regardless of their health status? Will premiums be community-rated? If not, will they vary by age/ gender/health status? Will all insurers guarantee issue and renewal?

- What marketing and enrollment standards and mechanisms will be set? Will Medicare be allowed to manage that process carefully, as do many other large purchasers of care?

- How will beneficiaries with low incomes be protected from higher premiums and copayments, especially in the context of Medicaid reform?

- What quality, access, solvency standards and beneficiary protections, such as appeals, will be set and enforced for health plans seeking to offer benefits?

Managed care: There is a clear movement to managed care in the private market, and a great deal of discussion of adopting more managed care approaches within Medicare. AARP has supported -- and continues to support -- assuring a choice for beneficiaries that includes health maintenance organizations (HMOs) and other proven managed care entities along with traditional fee-for-service. Genuine choice is critical -- particularly for older Americans who have forged long-standing relationships with physicians on whom they have come to depend for their health care. Financial barriers which force a beneficiary to sever their physician-patient relationships are not acceptable.
Once again, there are questions -- many of them similar to questions that arise about vouchers -- about how to proceed:

- What will be done to "encourage" enrollment in managed care? Will beneficiaries have to pay more to stay in the traditional Medicare fee-for-service program? Will premiums be increased? Deductibles and coinsurance?

- Will the current AAPCC payment method be changed?

- Will managed care plans have to meet the current health plan quality and solvency standards? Which ones? Will plans be required to maintain the current policy of

eliminating deductibles and limiting coinsurance, or will managed care simply be another way to cost shift through cost sharing?

Medical Savings Accounts: Medical savings accounts (MSAs) coupled with high deductible plans have been suggested as one of the Medicare options that should be incorporated into a Medicare choice model. This is a difficult approach to assess, because it has not been used very much by the large, sophisticated purchasers of health care in the private market that are the presumed model for reform. In fact, many are concerned about the actuarial implications of the potential for adverse selection if individuals are offered MSA benefit options, that appear to operate to the relative financial advantage of the healthy and to the relative financial disadvantage of the sick. As a result, broadly inclusive insurance risk pools could be endangered, reversing standard insurance principles. Therefore, we believe it is particularly important to address a number of issues central to an MSA approach:

- What is the MSA model, and where and how has it proved workable? How can we assure Medicare beneficiaries that they, and the actuarial stability of the program, will not be the subject of a multi-billion dollar social experiment?

- How will the deductible be set? How much Medicare will contribute toward the MSA amount?

- How will the catastrophic plan that insures for costs above the deductible be structured? Would traditional fee-for-service Medicare remain an option for beneficiaries? Will other options resemble the voucher approach? Will the catastrophic plan pay for the full cost of needed services above the deductibles, without regard to the type of plan a beneficiary chooses?

- For plans that cover costs in excess of the deductible, will there be risk-adjusted differences in payments (much like Medicare would risk adjust payments to health plans under the AAPCC)?

- For plans that cover any services, whether they be under or over the deductible amount of the MSA, what rules will apply for health plans and providers? Will they be able to charge anything they want? Is the beneficiary giving up all of Medicare's payment and balance billing protections?

- Given today's concern about the viability of the trust fund, how do we protect the program against the severe selection problems and threat to the risk pool that could arise under a choice model that includes a high-deductible, MSA plan?

Changing the eligibility age for Medicare: It has been suggested that Medicare's age of eligibility be increased to track the increase in Social Security eligibility for full benefits. This seeming parallel does not take into account that Social Security's age of eligibility for early retirement benefits remains age 62. Already the average retirement age is 62 and many older Americans in their late 50s and early 60s face growing problems of access to, or cost of, health insurance. If Medicare's eligibility age is increased, this problem will worsen. In addition, it creates a disincentive for employers to hire or maintain older workers because of the added expense of providing health care coverage for a few additional years.

- Will the changes be linked to eligibility for Social Security? Will there be a smaller package or early retiree benefits similar to the Social Security policy?

- Will employers pick up the cost for the extra years of coverage for those in retiree health plans? What is the cost of that provision for employers?

- Will private insurers be required to sell health benefits to those elderly individuals who are not covered under employer plans but are not yet eligible for Medicare?

Benefits: Finally, if we are to make Medicare more like the typical health plans operating in the private market, we need to confront the reality that the Medicare benefits fall far short of the benefits typical of the plans offered by the large purchasers. For example, prescription drugs and preventive services common to health insurance coverage for those under 65 are lacking in Medicare. Is the Congress going to proceed to truly modernize Medicare -- even in areas where benefits should be increased? How will such benefit improvements be funded in light of the budget targets?

Structural Changes in Medicare and the Budget

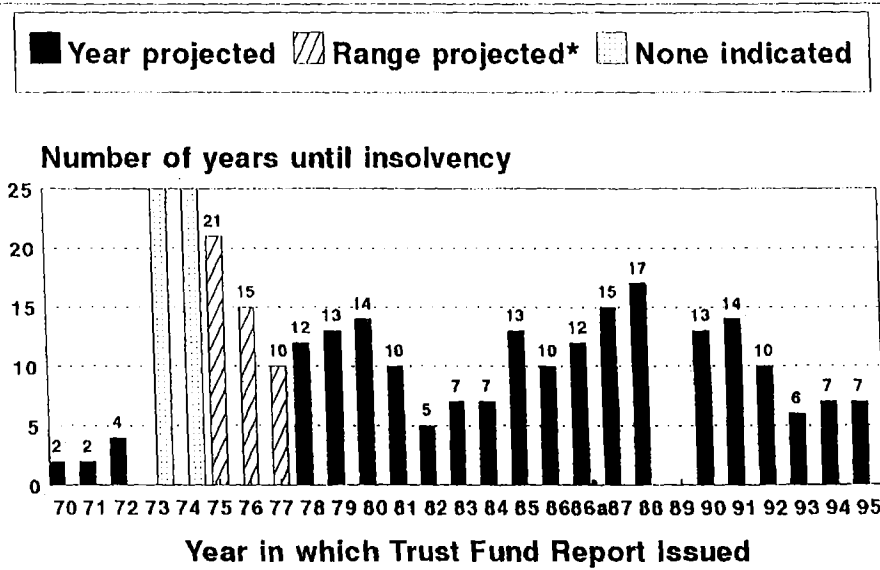
While structural changes in Medicare can and should be part of the program's future, many of the changes under consideration pose hazards to beneficiaries -- present and future. This is particularly true when proposals are viewed in the light of the extraordinary targets set in the current Budget Resolution. Looking ahead just a few years it seems legitimate to question whether Medicare can, in fact, provide its standard benefits (whether in traditional fee-for-service, voucher, managed care or MSA plus catastrophic coverage plans) for the amount the program will pay. Fundamentally, a question that we all face today is whether in the future the Medicare program will continue to provide a health care plan on which older and disabled Americans can rely.

Older Americans rely on Medicare as their health care plan, but they also view it as a cornerstone of their financial security. If, in the future, the program no longer pays for the costs of needed health care, and these costs are simply shifted onto beneficiaries, all the structural "reforms" may have succeeded in lowering the federal government's costs, but they will not have achieved the goal of providing quality, affordable care smarter and more efficiently than we do today.

Mr. Chairman, all of us share in the desire for strong and viable Medicare program, now and in the future. The program does need to be modernized, and its financial stability does need to be strengthened. The time to start is this year; and the way to start is to make specific, incremental changes. We look forward to working with you and other Members of Congress in that effort.

CHART 1

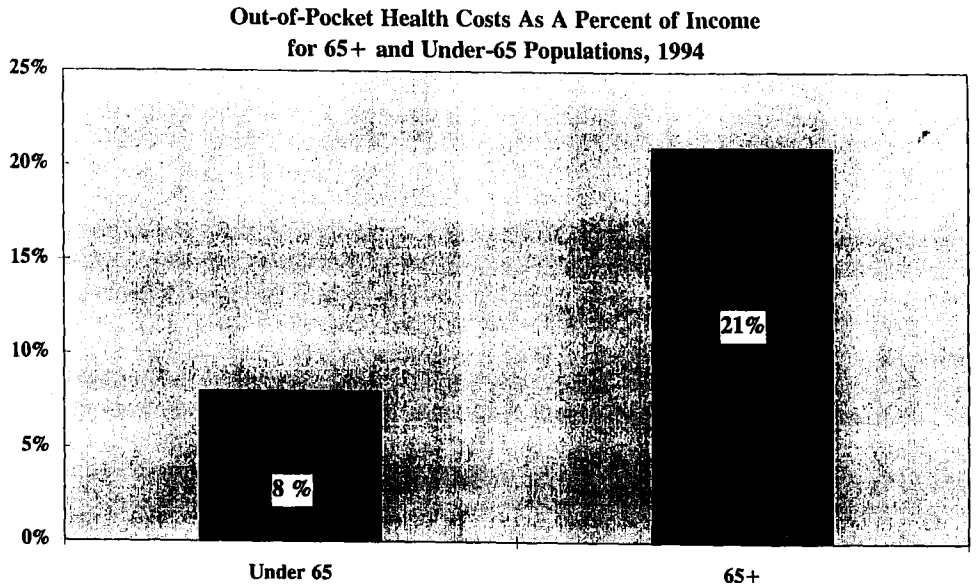
Projection of number of years until insolvency of Medicare HI Trust Fund by year of Trust Fund Report



Derived from CRS, April, 1995
No insolvency indicated (1973, 1974); no long-range projections (1989)
*Range - 1975 Report: late 1990s; 1976 Report: early 1990s; 1977 Report: late 1980s

Chart 2

Older Americans Already Spend A Large Percent of Their Incomes On Out-of-Pocket Health Costs



Source: "Coming Up Short: Increasing Out-of-Pocket Health Spending By Older Americans," prepared by AARP Public Policy Institute and the Urban Institute, updated February 1995. Does not include long-term nursing home costs.

Chairman THOMAS. Thank you very much, Dr. Braun. I thank the panel.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you.

I thank the panel for their input. I am pleased to be part of a Subcommittee and of a Congress that is confronting the seriousness of the crisis in Medicare. As a Member of this Subcommittee, we heard that testimony 2½ years ago. We heard that testimony 4½ years ago. We would have been in a far better position to solve these problems had we been willing to start earlier, and we were not willing to start earlier. So we do have a very serious problem now.

I also want to put on the record that there is not any disagreement about how we can save $180 to about $200 billion over 7 years. It is basically the last $50 or $60 billion over 7 years that is difficult and that we need your help on and we need to listen to you on, so that we can do that constructively. It is a program that spends $180 billion a year. The $50 billion over 7 years is something that I think, if we work well, we can do it together.

I would say, Dr. Braun, that your comments on the issue of copayments for home care are very well taken. As an example of what working together can accomplish, I would have to say that the home care industry is also conscious of how, as home care expenditures are rising, fraud is developing. They will tell you that themselves. They have offered us some very constructive suggestions about how we can do this right. That is the direction that many of us are thinking, and any input you have on that I would appreciate.

I want to ask you three or four short questions that come out of my conversations with seniors in my district through my senior citizen centers and town meetings and things like that.

First of all, one of them suggested, and everyone else agreed, that seniors who smoke ought to pay a different premium than seniors who do not smoke. Yes or no?

Dr. BRAUN. I think that is an interesting concept. I wonder whether administratively it would be worth going into, but I must say it is an interesting concept that we ought to think about.

Mrs. JOHNSON. Well, it is one I do want to think about, because I think it has some merit, but it is not easy.

The second thing that they propose is that they be a part of the fraud team.

Dr. BRAUN. I think that is very important, very important.

Mrs. JOHNSON. We have never done that. In fact, one of my frustrations as a Member of Congress is that I have had seniors come to me with concrete evidence, and I have not been able to get the government, because no government in Washington can possibly deal at that level to go after concrete evidence of overbilling and of fraud and abuse.

So I think helping to develop an instrument through which seniors themselves can say this was not a service delivered and that they can get some benefit, be part of the winning team when we save that money would be an important contribution to a reformed Medicare Program.

Dr. BRAUN. I would agree.

Mrs. JOHNSON. You have no objection to that, I assume.

The other thing that they keep saying to me over and over again is, Look, higher income earners pay more because we have lifted the cap on income. I did not initiate this, but they say it to me and I have now run for office five times on the position that higher-income seniors ought to carry more of their part B premium costs, because that is paid 75 percent by the taxpayers.

I do not have any problem with that. My seniors do not have any problem with that. That is one way we can strengthen the system and preserve a strong care giving system for seniors earning $11,000 and $15,000, and so on and so forth. Do you have any problem with that?

Dr. BRAUN. I think that is something that certainly needs to come into this discussion. But I would say, Congresswoman, that if we are going to consider that, we also ought to consider the Federal subsidies to the younger generation who have very high incomes and whose health costs are tax exempt. I think high-income individuals across the board should be considered if we are thinking of income relating Medicare part B. But I certainly think that is one of the considerations.

Mrs. JOHNSON. We do, of course, take into account income. The high earners pay more into Medicare.

Dr. BRAUN. You are right, that is one place that Medicare is already income related in the sense that higher income individuals are paying more into the program. But the fact that those under 65, even if they are a millionaire and have a very fancy health care benefits package, have health care benefits that are totally tax exempt. That is money that the Federal Government is not getting, and that is really a Federal subsidy to wealthy people. So maybe we should be considering that, if we are going to consider income relating Medicare.

Mrs. JOHNSON. That is an interesting concept, Dr. Braun, and useful.

I thank the panel for your comments today.

Chairman THOMAS. I thank the gentlelady.

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman.

I thank the panel for their testimony. I think it is important to remind the seniors—and I hope you will all respond to those members in your organization—that, however you classify these $270 billion in cuts, ostensibly the Republicans will tell you it is to save Medicare. They do not want us to talk about saving Social Security, because they remember that the seniors will recall that.

They will not tell us how many years that check is going to be good for. Save it for 2 years, 4 years? I do not know what their goal is. That has not been suggested. But there is a goal to give a massive $285 billion tax cut to the very richest. They talk about balancing the budget in 7 years and cutting $270 billion out of Medicare in 7 years. You begin to think that maybe there is some relationship here.

Are they cutting $270 billion out of Medicare to pay for the $285 billion tax cut to the richest 1 percent of the people in this country? I would suspect so.

Now, it is interesting to note that there is a clarion call for us to march and hurry up to save Medicare. But these same people who are babbling on about saving Medicare just last year suggested that—11 of the Republicans on Ways and Means last year said—and these were far smaller cuts, I might add—that the additional massive cuts in reimbursement provisions proposed in this bill, it was a bill we wrote, will reduce the quality of care for the Nation's elderly. That was 11 Republicans on this Subcommittee talking about $160 billion in cuts, and this year they are talking about $270 billion.

One current Member made the following charge last year, a Republican: "I just don't believe that quality of care and availability of care can survive these additional cuts." They are less cuts than they are suggesting this year. "And that is the price that is going to have to be paid to pay for these cuts." That was last year. This is this year, with bigger cuts.

Mr. Shaw, who is not here today, made the following indictment: "The Medicare cuts proposed by the President"—that was last year—"would devastate the Medicare Program. The Subcommittee must not approve these destructive Medicare cuts." Yet, he is supporting much more massive cuts this year.

A Republican Member of the Health Subcommittee this year and last year commented: "I would love to believe that we could achieve the level of cuts you have in this bill"—referring to the bill that Mr. Gephardt and I introduced last year with far fewer cuts. "But," this Republican goes on to say last year, "history tell us that isn't possible."

Now, we would have achieved $168 billion in Medicare savings, every penny of which would have been redirected to the health care system, not to tax cuts for the rich. This year, the Republican proposal, these same Republicans who are crying, anguish cries urging you, are now prepared to reduce Medicare spending by $283 billion and give all of it to the very richest people in this country, certainly not the Medicare beneficiaries.

So I hope that you will respond to your Members to let them know, and not these Johnny-come-latelys who are the mail order newcomers to this crowd who are basically Republican shills trying to sell themselves as representatives of the American seniors by buying out Viguerie and some of those shysters, but I am talking about respectable representatives of the seniors.

Please let your members know that the Republicans are increasing the cuts by hundreds of millions of dollars and trying to convince the seniors this will save Medicare, when really what it will do is destroy medical education, destroy care for the poor, destroy quality of care, restrict their choice. Your members will no longer be able to go to see the doctor they want to see. The Republican plan is to herd them into these cattle-car approaches of managed care where they will be forced to be restricted. So spread the word. It is important and they should know who is doing this to them.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. I thank the Chairman for recognizing me to ask questions like my colleague from California.

There is one big difference, of course, from last year to this year, and that is that this year the Republicans are in control, and last

year Democrats were in control. You certainly did not have a history that would lead one to believe we could make those kinds of cuts without gutting the provider community and further damaging patient-doctor or patient-hospital relationships. So that is a big difference that exists this year.

We are talking about making fundamental changes for the first time since 1965 in the Medicare Program, not simply cranking down the reimbursement rates, which was the modus operandi of the Democrats in control of this Subcommittee and the Full Committee and the Congress since 1965.

So there is a big difference. And that seems to be something that the Minority cannot quite get through its head, that we are talking about making fundamental changes in the program. They are accustomed to looking at everything with blinders on and crunching numbers and relating everything to the per capita expenditure for the beneficiary.

What we are talking about for the first time is making changes in how the care is delivered, how consumers of health care react to the delivery of health care and the cost of health care, so that savings will be accomplished. These savings will not necessarily be in terms of less quality or availability, but savings from fundamental changes in how we deliver health care in this country and how it is paid for, not only with the senior community, but, Ms. McSteen, as you pointed out, we are hopeful to make some changes in how health care is delivered across the spectrum.

By the way, your testimony was interesting because you alluded a couple of times to the need to get general health care cost increases down, and I agree with you. But do you not think that has been occurring in the private sector for the last couple of years, as the last employer community, for example, has been squeezed? They have come up with some innovative ways to get their employees involved in health programs and preventive care and all kinds of things that are now paying dividends in terms of the health sector of this country.

So I agree with you, but I think some things that the private sector has done we now need to do in the Medicare sector of the health care system, and that is what we are talking about trying to do. But those things that we are talking about are seemingly foreign to the people that have controlled this program for 30 years. All they want to do is ratchet down the providers, and that is why many of us, all of us last year said you cannot do it—you cannot squeeze blood out of that turnip any more, you are going to have to make fundamental changes, and they were not about to make fundamental changes. We are.

So I appreciate very much the testimony of each of you. We may not agree on all the details right now, and we may not agree on the final product. But at least you have come forward in a spirit of cooperation and wanting to work with us to arrive at some approaches to solving the problems that we all now admit are in the system.

There has been a lot of talk about the budget and the budget resolution. I freely admit that I do not believe we can as policymakers, responsible policymakers, allow any program in the Federal Gov-

ernment to increase at 10 to 12 percent every year, especially not a program as large as Medicare or Medicaid, for that matter.

Yes, I admit, I will just put myself out there and take the criticism, it is partially a budgetary matter, but it is also more importantly a matter of saving the government's ability to deliver to senior citizens at least a level of assurance that they are going to have health care in their later years. It is about both things, and I am not afraid to admit it is about both things.

By the way, I have had town meetings, meetings with seniors in my district, and they agree that the responsible approach is both to look at the budgetary impact and also the quality of service to them as senior citizens. I think any American that is concerned about the future of this country would agree with that.

I thank you all very much.

Chairman THOMAS. Any response to the question by Mr. McCrery?

[No response.]

The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman .

Mr. McCrery, I appreciate your frankness that the reforms and changes are at least in part driven by budgetary considerations, and I think that is the real problem here.

There are many of us on both sides of the aisle, both Democrats and Republicans, who believe in looking at improvements and reforms within the Medicare system. The difficulty which we are operating under is we are not looking at reform for what it will accomplish. We are looking at $270 billion and how can we achieve it. If it happens to be convenient with the reforms, so be it, but we need to achieve $270 billion of savings because of the budget that the Republicans have passed that so happens to equate to the dollars necessary for the tax breaks that are in their budget this year.

And that is what has many seniors very suspect as to whether we are going to see reform. What they are worried about is they are going to end up not saving the Medicare Trust Fund, but having seniors have less choice and paying more. If we are only concerned about the trust fund, we would be looking at just Medicare part A. But we are looking at Medicare part B. Medicare part B has nothing to do with the trust fund. Yet, the way this is being presented, one would think that Medicare part B is also part of the problems of the Medicare Trust Fund. It is not.

I am going to respond to Mrs. Johnson's point about we have not done anything. We did change Medicare in the last 2 years. We have in fact, when President Clinton became President, the trust fund under Medicare part A was scheduled to be in bankruptcy by the year 1999. That is no longer the case. We have changed the numbers. We have responded to it. So far this year, all the Republicans have done is take $87 billion out of the Medicare Trust Fund in their tax bill. So let us talk about reform. We want to work with you on reform, but we do not want it to be budget driven. I think that is a mistake.

I would like to ask a very specific question of Mr. Boulter and Mr. Hansen. Do you believe that $270 billion is the appropriate number for Medicare savings? Do you support that number of $270 billion that we must achieve in Medicare savings? Do your mem-

bers agree that $270 billion is the appropriate number for Medicare savings in this year's budget? A yes or no answer would be appreciated, and then you could explain your yes or no.

Mr. BOULTER. I will go first, since you mentioned my name first. Our members agree that the budget should be balanced. And once they know that Medicare is not being cut, that it is actually increasing 6 percent annually and that they are actually getting $117,000 more out of the system than they paid in, they know that cannot go on. If I say do you want to cut $270 billion, they say no. But if I say do you want to increase your Medicare by 6 percent and try and save the program and make some reforms which will change utilization patterns and hopefully hold down cost, then I think they would say yes.

Mr. CARDIN. Just so I understand, in context to the budget that has been passed by the Republicans, do you support the $270 billion——

Mr. BOULTER. In context, yes, because we do not see any other option.

Mr. CARDIN. Mr. Hansen.

Mr. HANSEN. I would say in context, yes. It is a tough number and it is going to be a challenge. Quite frankly, we believe that, with the right type of reforms, there will probably be greater savings than that. There will be savings that cannot be scored, but there are going to be efficiencies that are introduced that are going to make that a lot less painful than people are talking about.

Mr. CARDIN. Do you also agree then that we can achieve greater cost savings, that we can slow down the growth rate of Medicare faster than the private sector can slow down the growth rate of their health care costs?

Mr. HANSEN. Well, the private sector has been slowing down its health care increases a lot faster than Medicare has.

Mr. CARDIN. That is not necessarily the case. There is disagreement on that. We think the facts show that the opposite is the case. You all are representing health care policy changes. Starting from where we are today, you believe that Medicare can grow at a slower growth rate per capita than private health care costs?

Mr. HANSEN. I believe that it can grow at least at as slow of a rate.

Mr. CARDIN. No, that is not what we have before us. We are going to achieve greater cost savings in Medicare in growth rates than in private health care costs.

Mr. HANSEN. Well, the numbers that I have seen show that in the private health care system it is going slower. Now, I have not seen the ones you are talking about and I cannot comment on that. But I believe that we can match the type of growth rates that we have in the private sector.

Mr. CARDIN. Mr. Boulter, can we exceed the private sector?

Mr. BOULTER. I disagree with your premise, in all due respect. I think the cost in the private sector is rising much slower than the cost in the public sector, and I do think that we can control the rise in cost in the public sector by putting incentives into it and by bringing market forces to bear such as competition and choice and changing patterns of use by giving control of the funds to the

seniors themselves. I think that will make a real difference. That is the way the real world is supposed to operate.

Mr. CARDIN. Let me just make the point. You are not accepting the CBO projections. We go by the CBO projections. The President does not like the CBO projections right now. We go by them. You are not accepting that. If you accept the CBO projections, then what we are asking is for Medicare to outperform the private sector, and neither one of you are addressing that question. Medicare can outperform the private sector in the next 7 years?

Mr. BOULTER. I have not studied the CBO report. I do understand——

Mr. CARDIN. Yet the $270 billion, which assumes a better performance, and you are not——

Mr. BOULTER. I do understand that the private sector costs are increasing at a much slower rate, something like 4 percent a year than the public sector. I have not seen what you are talking about, but I know that that is as fact.

Mr. CARDIN. And you can get $270 billion without knowing this?

Mr. BOULTER. I am saying that we can certainly keep Medicare costs from increasing whatever it is now, something like 10 percent a year. We can hold that down to a much lower number by putting market incentives and bringing market forces to bear into the system. I believe that. Maybe you cannot prove it on paper by scoring it, but I believe that.

Mr. CARDIN. We have market forces to bear in the private sector, do we not?

Mr. BOULTER. Sir?

Mr. CARDIN. We do have market forces in the private sector. I think you acknowledge that.

Mr. BOULTER. We do, and the inflation is much less there than it is in the public sector.

Mr. CARDIN. But you are reaching a conclusion that we can outperform the private sector. You do not know the figures, but your conclusion assumes that. I would just urge you, you are representing a group of seniors, please know the facts.

Mr. BOULTER. I think I do, but there are some facts that we have to—we have to put the system in place before we really know the facts. I believe that the free market works.

Chairman THOMAS. The gentleman's time has expired.

Mr. CARDIN. Thank you.

Chairman THOMAS. I normally would not do this, but rather than wait for a later time to intervene, I think we do need to know the facts and I think we need to put them into proper context.

One year ago, the President said we had to fundamentally reform our entire health care system because the private sector was going to increase at 13 percent a year growth. They were using 3-year-old numbers to scare Americans. And when we presented some of the new reduced growth rates, the answer was, But how do you know those are going to continue into the future? We now have the gentleman from Maryland prescient enough to know what the future holds in terms of growth rates.

It seems to me that if you have got Medicare, I think most people agree that Medicare is currently increasing at a rate faster than the private sector, that there are some earlier options available to

us to make some savings. But I do think that we should at least just 1 year after the President was talking about a 13-percent growth rate realize the private sector has reduced that by more than one-half.

One other statement: The gentleman said that part A is not really related to part B in terms of the cost-driving problems, and that is not an exact statement. The gentleman does know that there is a percentage payment on part B, and currently it is $46.10. If we continue the current growth rate, that same 25 percent payment 7 years from now will be $113. That is virtually a threefold increase in the cost on the same percentage. So it does in fact directly relate, part B directly relates to part A.

If we can slow the growth even as the President has suggested, you would have then a smaller total number to multiply against. It has a direct relationship to part B. I frankly think an increase on seniors from $46.10 a month to $113 a month, which is what will happen if we do nothing and get a bankrupt program in the bargain, is totally unacceptable. If we can reduce that rate, if we can slow the growth, then the part B premium will be less than projected. I believe there is a direct relationship between the part A trust fund and the part B program.

The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

I would like to once again call your attention to the checks over there. My colleague from California had mentioned that the Republicans did not say how long those checks would be good for, and I guess I would submit that if the Congress had not acted not only on Medicare, but also on the rest of the budget, that none of the checks that the Federal Government writes in the future would be good.

That is what we are facing. We are facing the future of our country, and not just with Medicare, but we are also facing the future of our country in the financial stability of our entire country and the way of life that we know it.

Dr. Braun, I would like to address a couple of parts of your written testimony. On the means testing, reading in here, I am not really clear. Does AARP support or are they totally against means testing any or all parts of Medicare as far as the future is concerned?

Dr. BRAUN. The AARP is against means testing. As I mentioned, to some extent, the Hospital Trust Fund and payroll taxes, one might call them income related. The higher income people are already putting a lot more in and in the end will have the same program, hopefully.

However, I think one might differentiate means testing from income relating possibly with part B premiums, and that I think is a subject that is up for discussion. That is not something we have made any definite decision on, as I mentioned to Congresswoman Johnson before. But means testing, no, because we have a lot of concerns. If you means test the program, we know the problems that we have in the Medicaid system as a means testing, but——

Mr. ENSIGN. We know that the average Medicare beneficiary takes a lot more money out of the system than they ever pay in. If it was technically possible to somehow compute that, where they

would get their money out first and then be means tested, would the AARP be against that?

Dr. BRAUN. I would have to withhold any decisions on that situation. We would have to talk about it further and see what it would mean.

Mr. ENSIGN. It is something that I discuss in my townhall meetings with a lot of seniors, because most seniors at least that represent AARP that come to my townhall meetings are against means testing, because they feel they paid into a system and they deserve the money back. I fully understand that and support that concept.

However, once they have gotten back what they paid in, then people that are extremely wealthy and do not have a lot of bills to pay at that point in their life, I am not sure that it is not a point to at least look at how much money they are making and at that point think about means testing.

Dr. BRAUN. Also, I think one of the problems would be that that is sort of a sick tax. You are going to means test people that get sick, and the ones that do not are going to have that problem. Somehow that goes against the grain.

Mr. ENSIGN. Also in your oral testimony, you mentioned that $270 billion is too much too fast. How do we know that is too much too fast? How do we know? We have not seen the plan. In other words, How do we know we cannot achieve those kinds of savings with fundamental reform of Medicare?

Dr. BRAUN. I really do not think that is possible. But the other thing is that that much is not necessary in order to keep the part A trust fund solvent at least for 10 years. That would give you time to make structural changes. You are going to have to know a great deal more about many of the options that are being suggested. A lot of these things have never been tried. We have no idea how they are going to work out with this population.

Mr. ENSIGN. A lot of them have not been tried with this population, but they have been tried with other retirement populations, because those retirement populations have been part of these other plans that have worked. So it is not that these are completely untested type of programs. A lot of these programs we know do work and indeed do save money.

But just coming out with a statement from AARP that this is too much too soon I think is unfair. I think that you should wait to hold judgment until the plan comes out and is scored. I think we all have to work together on this.

Dr. BRAUN. I would agree with you.

Mr. ENSIGN. We have to say I have three grandmothers that are totally dependent on Medicare. We absolutely have to save this system. If we do not save the system, too many people will suffer. So what is the best way to fundamentally long term save the system?

Dr. BRAUN. Congressman, you could save the system for 10 years with $110 billion and with that you are buying yourselves time to do a long term.

Mr. ENSIGN. Why do potentially a short-term fix, if you can do a potentially long-term fix?

Dr. BRAUN. Because you need more experience with some of the things you are suggesting for the long-term fix.

Mr. ENSIGN. Why?

Dr. BRAUN. Because we really do not know how they are going to work for this population.

Mr. ENSIGN. We have experience——

Dr. BRAUN. We do not have report cards, for instance, on the chronic illnesses. What good is a report card of how many prenatal visits we want to make or how many——

Mr. ENSIGN. Those kinds of changes can be made during the progress, though. Those kinds of changes can be made during the next 6 or 10 years. We can make those changes, if we see something that is not working. I do not understand the opposition to fundamentally changing Medicare to be able to save it for the long term, shoot long term, have long-term thinking.

Dr. BRAUN. We need to do that, but I do not think we need to do it immediately. We need to buy ourselves more time in order to sit down and work out what is going to be the best. And we are learning, because we are getting more seniors into managed care. We are learning gradually more about that situation, and I think that we just need to buy a little more time and then immediately sit down and work out long-term solutions, but buy ourselves 3 or 4 years to do that.

Mr. ENSIGN. The only thing I would caution, just to finish, Mr. Chairman, is that it reminds me of what happens if you do not aim for a target, you are bound not to hit it. Sometimes if you do not set goals, if you do not set your mindset right, the thinking toward fundamental change and fundamental solutions long term, if you set for a 10-year solution, you can fix that. But if you looked for a longer term solution and a fundamental saving of Medicare over a longer period of time, I think you have a much better chance.

Dr. BRAUN. We need this, and if you put it off, you do not want to just totally forget about it just because you have got it saved for a few years, no, you need long term.

Chairman THOMAS. The gentleman's time has expired.

The gentleman from Wisconsin.

Mr. KLECZKA. Mr. Chairman, I have a series of questions, so I would like some quick answers from the panel. But I would like to say, Dr. Braun, that we have a lot of discussion in this Subcommittee on Medicare Select, and it looks and smells like a good program. We have extended it. One of the pilot States is my State of Wisconsin. But in your response, you indicated let us not rush headlong into this, not knowing what is going to happen.

We have had some years of experience in Medicare Select and we have found that the government has not saved any money from the programs. So I agree with you, if we put our entire population of Medicare folks into HMOs and we do not save $270 billion, the system blows up. We had some experience with Medicare Select where the beneficiaries are happy, but the government is not saving any dollars. Now, maybe over the long run we will.

A couple of questions of Mr. Hansen and Mr. Boulter. First of all, in answer to Congressman Cardin, you both agreed that the $270 billion reduction in Medicare expenditures is doable. You also agree with the plan by the American Medical Association where cost controls will be taken off physicians. In fact, their plan indicates that physicians will be receiving some $14 billion more.

Mr. HANSEN. Actually, I thought that all of the ideas have come through in the panel before.

Mr. KLECZKA. No, just the one. I have only a limited amount of time. Physicians are advocating no cost limits on doctors' billings. Does your group agree with that?

Mr. HANSEN. I would not be prepared to say. We do not have any specific comment on that. I think the plan has to be looked at.

Mr. KLECZKA. Mr. Boulter, does your group have any opinion on taking any cost controls off physician services?

Mr. BOULTER. We do not endorse the AMA plan, but we do not think the answer is just to keep——

Mr. KLECZKA. Just that portion of it I am asking about.

Mr. BOULTER. We do not believe in cost controls, Representative Kleczka.

Mr. KLECZKA. So doctors charge whatever they want—whatever the——

Mr. BOULTER. We believe in the marketplace. We do not believe in government controls.

Mr. KLECZKA. Right. Good.

I am aware that you surveyed your members and you asked the question of whether or not your members oppose cutting Medicare by $233 billion or more. Could you give the Subcommittee the outcome of that survey?

Mr. BOULTER. I do not have the exact figures on that, but I can get them. Would you restate the question?

Mr. KLECZKA. The question that you asked your members, Do your members oppose cutting Medicare by $233 billion or more? It was much less than $270 billion. This survey that you sent out to your members, do you recall what the outcome of that survey was?

Mr. BOULTER. I will have to get that for you. I will give it to you.

Mr. KLECZKA. 64 percent oppose that, and 19 percent supported it. So I am assuming that if you would ask the $270 billion cut question, probably more than 64 percent might oppose it. But you come here saying you are representing your group, while they are opposing even an amount of $233 billion.

Mr. BOULTER. I appreciate the question. I am trying to answer it, when Mr. Cardin asked roughly the same question. If you say to seniors, our seniors or anybody else's seniors, Do you want your benefits cut?, Do you want your premiums to go up?, Do you want all of that?, they say no. If you say do you want a check for zero in 2002, or do you want a check for $6,700, they want the check for $6,700.

Mr. KLECZKA. That is a figment of your imagination.

Mr. BOULTER. No, I think that is a real situation.

Mr. KLECZKA. Dr. Braun, I have a postcard, I received one postcard from a member of the Senior Coalition, and in the last paragraph of the postcard the person—it is a preprinted postcard—the person signed this statement: "I oppose any plan to turn Medicare into an AARP-style health care program. We need to open up Medicare to free market reforms . . . ."

My indication of your testimony was that AARP does support your changes in the Medicare Program, and I am sort of perplexed why this one senior group would be going after another senior group. Have you seen this postcard?

Dr. BRAUN. I have and I have requested——
Mr. KLECZKA. What is going on here?
Dr. BRAUN. You would have to ask them.
Mr. KLECZKA. You do not know?
Dr. BRAUN. I do not know.
Mr. KLECZKA. Mr. Hansen, what is going on here?
Mr. HANSEN. Last year, the AARP supported and endorsed the health care plans that most seniors did not support and we do not want to see Medicare pushed that much.
Mr. KLECZKA. Well, that was the health care plan that this Subcommittee worked on which, in effect, cut $160 billion under Medicare, put the bulk of those dollars back in through expanded physician or prescription coverage, and so forth, and the Republican Members oppose that. Now we are looking at $270 billion, and you think your seniors are going to buy that, when you claim they did not support the $160 billion last year?
Mr. HANSEN. It is a fundamental different way of going about it. We would not be supporting this, if all Congress were doing is talking about going in and chopping. But the idea of going in and actually making reforms to allow people to have more choices and more options we think are actually fairly——
Mr. KLECZKA. If you take off the controls like we talked about for physicians, that out-of-pocket expenditure for your seniors is going to go right through the roof. Where are they going to get the money from, I do not know. It is nice to show a check here in 2002—I cannot see it—of over $6,000, but that is based on a growth of 4.6 percent in that voucher. However, I know full well that medical health care costs are going to grow at 6, 7 percent and possibly higher.
In fact, I recently met with some health officials in my district, in Milwaukee, Wisconsin, and they indicated to me—and we are going to have some experts on other panels—they indicated to me that 1995 health care costs are running at a 15-percent increase. Now, we are not going to know the actual ending percentage until the end of the year, and we are not going to know the effect on premiums until next year.
But, my friends, the pressure is off for any major health care reform. When it was on, yes, we saw a 3- and 4-percent health care inflation. The pressure is off. The health care provider folks are getting reimbursed. I think no one is watching, and we see today—and you can respond, if you know better or worse—that health care costs are rising this year at 15 percent.
If you get a 15-percent inflation a couple of years during that 7-year period, that $6,000 is not going to buy much, if anything. If that is the voucher that we send to seniors under this new system or this new guise, I know full well that we will wipe them out with one illness, because the rest is going to have to come from out of pocket.
Providers are not going to accept less just to be generous. They do today, because we make them or they are forced to. But once we take the curbs off and inflation at 15 percent for a couple of years, we are going to have a real problem, no matter what that amount, especially if it is only $6,000.
Ms. McSteen, do you want to respond to that?

Ms. MCSTEEN. I think it is essential that we address these problems and with some reason. We do recognize, and I think my testimony reflects, that Medicare is a colossal system and it must be looked at like others. We would certainly plead for consideration of those seniors who really have not had an opportunity to be exposed to other voucher systems, MSAs, or whatever.

I think even though we have Medicare Select, we still have to have some more experiments and some test States before we can say to the very vulnerable senior—not all seniors are the same, but to the most vulnerable, that we want to make certain that out-of-pocket increase does not become prohibitive. It is already a problem in home and community care. The challenges of extra out-of-pocket costs will only severely impact those individuals who can do better at home and for less expense.

Chairman THOMAS. The gentleman's time has expired.

I want to thank the panel. We will recess——

Mr. GIBBONS. Are we through or what are we doing?

Chairman THOMAS. I am sorry, Sam, I did not know you had come. We were going to recess for 1 hour and come back at 1 o'clock. I checked with the guests to the Subcommittee. You were not here at the time that I checked. If the gentleman would like to inquire——

Mr. GIBBONS. Dr. Braun is almost a neighbor of mine. I used to go hunting up there at Spring Hill, in that area. I wanted to welcome you. You give us wise words of wisdom there.

Yes, none of us are defending the status quo. We ought to be looking at long-term changes in the Medicare Program, although I do not think anybody has got any magic in it. People do get old and they do get sick and Medical science moves ahead. But nobody knows what is really ahead for us except eventually we will die and dying is awfully expensive in our society.

What worries me about what I see here, Dr. Braun, is that we are going to do this in reconciliation. We are going to change a program that 39 to 40 million people are involved in. Eight million of them are women with incomes of less than $8,000 a year, and we are going to throw them into HMOs, which are in some places effective. In Florida, we have had some horrible examples of what HMOs can do to people.

I was going to make a political speech. The Republicans have been predicting the demise of this program before it was adopted, but I will not make that speech. But we are not going to take it up in this Subcommittee until after the recess, which means the middle of September, and we are going to have completed it by the end of September, along with all the other things we do.

Frankly, I have not seen a program yet that my friends on the Republican side are going to put forward. They have got the votes. If I were you all, I would really hold on and scream for help, because we are all going to need it. Nobody around here is smart enough to understand all the changes that ought to be made in that short a period of time, and we just have not seen any paper, we have not seen any program, we have not seen any design, and we are going to swallow it all in 1 week or so.

So I will be calling you up there in Spring Hill. Thank you for coming.

Mr. MCSTEEN. Thank you, Congressman.

Chairman THOMAS. I thank the gentleman from Florida.

Obviously, we are going to be moving forward in the legislative process. That is why we have held almost a dozen and a half hearings, and we are going to hold a significant number yet to come. I can assure the gentleman from Florida that we will provide him with paper over a longer period of time than the usual 48 hours, and I will place in the record the timeframe between when we were given paper on Chairmen's marks on major massive pieces of legislation in which there were 24- and 48-hour periods. And I want to assure the gentleman from Florida that we will not do that. So he can rest assured there will be plenty of time when we finish the work product to be able to take a long look at it, as we continue these hearings.

One other point I want to make just for the record. It is my understanding that Medicare Select was never scored as a program that was supposed to provide savings. It was scored for the purposes of offering a choice structure under the Medigap Program. And if it was going to save money, that would have been serendipity, because it was never structured for that purpose.

Mr. KLECZKA. Mr. Chairman, would you yield on that?

Chairman THOMAS. The gentleman from Wisconsin.

Mr. KLECZKA. Nevertheless, I think it is in order to ask the question which I did of HCFA when they were here. But the point remains that if in fact we are going to move the bulk of the population or a majority of the population of the Medicare folks into a Medicare Select or an HMO-type system and we end up saving no dollars, where on God's Earth are you going to get your $270 billion?

Chairman THOMAS. I would tell the gentleman that if he would look at the current Medicare Program, the way in which they score the risk selection is 95 percent of the fee-for-service structure which does not give you any indication of the kinds of administrative savings or other savings that are going on in the private sector.

If he wants to find savings, he should at least support the idea of a choice mechanism within Medicare which does not tie itself to such an arbitrary funding mechanism as 95 percent of the fee-for-service. So there apparently is some groundwork that we can work together on to create a system that truly reflects the kinds of savings in the private sector that would be reflected in a Medicare Program that had a choice for seniors.

Mr. KLECZKA. One further response to the Chairman. I would like to join with the Chairman and support that concept. But if in fact it does not get us to the goal, and let us say it is a 10-year or 15-year savings plan with that type of a shift, then we are going to have to look at other options for the 7 years, and I do not think we can sell the populous effect that this will occur in 7 years, if all our data says it is going to take longer.

Chairman THOMAS. I would tell the gentleman that some wise man one time said that, in fact, going is the goal, and if you do not start, you do not start going.

The Subcommittee stands in recess until 1 o'clock, at which time we will take up the other two panels on today's agenda.

[Whereupon, at 12:17 p.m., the Subcommittee was in recess, to reconvene at 1 p.m., the same day.]

Mr. ENSIGN [presiding]. Let us reconvene the Subcommittee hearing.

We have the next panel before us testifying: Richard Davidson, president of the American Hospital Association; and Thomas Scully, president and chief executive officer of the Federation of American Health Systems.

We welcome you both. Mr. Davidson, why don't you proceed with your testimony.

STATEMENT OF DICK J. DAVIDSON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. DAVIDSON. Thank you, Mr. Chairman.

Good afternoon. I am Dick Davidson, president of AHA, the American Hospital Association. AHA includes in its membership some 5,000 hospitals, health care systems and networks, and other providers of care all across America.

Just to open, Mr. Chairman, many of your constituents back home are going to be taking to the road this summer on their vacations, and you can bet they do not want to start their trips without a map to kind of guide them on their way. And I think Congress has made a clear determination that it is going to set out on a journey and you have decided on a destination some $270 billion in Medicare spending reductions over 7 years. That is a very significant destination, and now comes the hard and difficult part, and that is getting there.

Our testimony today is a roadmap of sorts designed to help you arrive at Medicare spending reductions—from our perspective—the right way. I am going to describe four principles, Mr. Chairman, that have guided the AHA and our membership throughout America through the budget process. In our view, by adhering to them, you can help ensure that high-quality health care will be maintained for the patients and the communities that we serve, and at the same time you can save money and make Medicare work better.

The first principle is changing the system itself. The majority of spending reductions in Medicare must be gained by improving the health care system overall, and this includes giving beneficiaries a lot more options like the ability to choose coordinated care plans provided by community-based organizations held accountable for quality.

And to achieve these kinds of goals, there are a variety of issues that must be addressed just outside of Medicare itself, and these are: Health plan definitions, eliminating patient referral restrictions, hospital antitrust reform, rejecting any willing provider requirements, eliminating burdensome regulations and, of course, malpractice reform, and you all have taken the leadership on that front.

These reforms can change the overall health care delivery system, but the real question is what about Medicare itself, and that leads to our second principle. We are calling for the creation of an independent national commission on Medicare to begin thinking long term. This year is the 30th anniversary of the enactment of

Medicare. It is a program that has served people well and needs to be looked at perhaps more carefully for the next 30 years, and we think that it is essential to have an independent commission do that. And hospitals and health systems are willing to do their share by accepting some reductions in the program, including reductions in provider payments.

We worked earlier, Mr. Chairman, this year with the Senate Entitlement Task Force on an approach that would get you $160 billion in specific Medicare savings mostly through restructuring. The remaining $110 billion can be achieved through the work of an independent commission to lay out what could happen after you reach the $160 billion.

In our view, creating an independent commission allows you to adhere to the budget resolution without having to make complex Medicare policy decisions too quickly. And the commission should be permanent, not a one-time commission to come up with a set of recommendations, but to exist on a permanent basis with oversight—on a continuous basis—of the Medicare Program. This is too important an issue not to move in that direction. We need to begin thinking in the long term, and our view of creating a commission is to find rational ways to constrain growth in the Medicare Program.

Speaker Gingrich has said on several occasions, and we strongly agree, that every penny saved on Medicare should be reinvested in the program. None of the savings should go outside to finance other initiatives. And financing brings us to our third principle, which is shared responsibility.

Incentives that move Medicare toward coordinated care can serve patients better and save money. But reaching the goal of $270 billion will mean a financial effect on everybody that has got a stake in the Medicare Program. That means hospitals, doctors, other providers and beneficiaries. In our view, doing business the old-fashioned way, which is just cutting provider payments, is not the answer. And to address Medicare's long-term problems, everything should be on the table, in our opinion—program structure, benefits, beneficiary cost sharing, eligibility, program revenues, and provider payments.

Making hospitals and health systems bear an inordinate amount of the burden is going to harm the quality of service, and so we need a fair and equitable approach at dealing with these things, which takes me to my final principle, Mr. Chairman, and that is ensuring access for the Nation's most vulnerable. We know that this Subcommittee does not deal with Medicaid, but our fourth principle concerns access to health care for our most vulnerable citizens, the elderly, poor children, and pregnant women, and the disabled. And the decisions that other Subcommittees make on Medicaid can have dramatic effect on providers of health services, and they need to be considered as we move ahead.

So we look forward, Mr. Chairman, to working with the Subcommittee to try to achieve your objectives in terms of the size of the reductions in growth. We want to look at these as opportunities. We are obviously not happy with the number, but we understand it is the number and we are prepared to work with you to help you achieve the objective.

Thank you.

[The prepared statement follows:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
House Ways and Means Committee
of the United States House of Representatives
on
Medicare Budget Issues

July 19, 1995

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. The AHA includes in its membership 5,000 hospitals, health care systems, networks and other providers of care. I am pleased to testify on their behalf about how the tough decisions you will be making could, if based on the principles I'm about to outline, result in a more effective and efficient Medicare program.

Congress has decided on its destination: a balanced budget by the year 2002, including $270 billion in Medicare savings. Now comes the hard part -- getting there. America's hospitals and health systems have long recognized that the brakes must be applied to a budget deficit that is running out of control. However, we remain deeply concerned about the magnitude of proposed reductions in Medicare and Medicaid spending. But we are committed to working toward a solution that takes us to our national goal of fiscal responsibility without sacrificing the promise of health care protection for older, disabled, and poor Americans.

Hospitals and health systems worked with the Senate Entitlement Task Force to develop an approach that would save $160 billion in Medicare spending over seven years, mostly through restructuring the program. And we've worked with the Republican leadership on how we can achieve further efficiencies in the program by dramatically changing the way medical services are provided and paid for.

Now, authorizing committees such as this one will try to chart a course to get Congress to its balanced budget destination. To help you along the way, hospitals and health systems offer a road map -- our four principles for the reconciliation process that we believe can help improve the entire health care delivery system -- and, at the same time, strengthen the Medicare program for older Americans and the people who provide their care.

These are our four principles:

- Change the delivery system to encourage more use of coordinated care -- cooperating groups of hospitals, doctors, and others who knit the fragmented delivery system together for patients and have powerful incentives to control costs.
- Change the process by which Medicare benefit and funding decisions are made.
- Make sure all stakeholders absorb spending reductions.
- Ensure access to high-quality health care for our most vulnerable populations -- the elderly, poor and disabled.

These principles have guided us throughout the budget process. The nation's hospitals and health systems hope that they will guide you as you make the tough choices required in the weeks ahead.

Change the delivery system

This is probably the most fundamental and essential of our principles. Quite simply, the Medicare program is a dinosaur. Change has infiltrated almost every aspect of the private health care sector, and public programs like Medicare must catch up to be effective in the future. The key is to restructure Medicare to encourage more use of coordinated care. Coordinated care is working in the private sector, and it can work in Medicare as well.

Coordinated care's responsibility for a range of health services can improve quality because an entire network of providers is held accountable for a patient's care. Coordinated care can also cut costs by shifting the focus of health care from sickness to wellness. Hospitals and health systems support efforts to make available to older Americans the same care, plan options, and health plan information that is available in the private market. Medicare must take advantage of the efficiencies that have been achieved in the private sector. Here's how Congress can help the program do that:

- **Expand the types of plans that Medicare beneficiaries can choose** -- Currently, beneficiaries can choose care through some health maintenance organizations (HMO) or from traditional fee-for-service providers. Medicare should also contract with the growing number of non-HMO networks of care that meet high standards for quality and public accountability, and offer a full continuum of services for a fixed premium. New kinds of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk.

- **Provide seniors with more information on health care plans** -- send information on available health care plans directly to Medicare enrollees. Give them an annual report that compares coordinated care plans to fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. This will make seniors more knowledgeable consumers and will highlight the benefits of coordinated care.

- **Provide financial incentives for beneficiaries** who choose coordinated care options available in their area. In most areas, these plans offer comprehensive services at lower than current fee-for-service prices. They often give seniors better value for their Medicare dollars by eliminating co-pays in deductibles or adding benefits such as prescription drugs.

- **Allow for an open enrollment period each year**, during which Medicare beneficiaries can elect to receive services from a coordinated care plan. And make their choice of a coordinated care plan valid for one year instead of the current 30-day period. That will enable the plan to better manage the patient's needs and practice preventive care.
- **Model Medicare after the Federal Employees Health Benefit Program** -- The government makes a fixed contribution and the federal employee chooses from a wide variety of plans. Medicare could do the same for its beneficiaries.

- **Fix the current methodology used to pay Medicare risk contractors** -- The current payment system is flawed; Congress has directed the Health Care Financing Administration (HCFA) to propose revisions by October. Current payment is based on the Adjusted Average Per Capita Cost (AAPCC) of care in a county, and it can vary from place to place. Medicare should eliminate geographic inequities in payment across counties, inequities due to variable health status of local populations, and inequities due to differential utilization of services in local areas, which affects costs and the calculation of the AAPCC.

At the same time, Congress must eliminate barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation -- the heart of coordinated care. For instance:

- Physician self-referral law (known as Stark I and Stark II), which prohibits referrals when a financial relationship exists between the physician and the entity to which the physician refers a patient, is unclear. It must be modified. The original goal -- to prevent physicians from referring patients for unneeded services based on the potential for financial gain -- remains valid. But the law was drafted in a different era of health care. Today, it creates an impediment to hospitals, physicians and others trying to work together to coordinate care and eliminate duplication. Because any truly coordinated system involves a variety of referral and financial arrangements, the law should be re-examined and fine-tuned.

- The "anti-kickback" law, which prohibits payment in exchange for referrals of Medicare and Medicaid patients, should be modified. The federal government is actively--and properly--working to ferret out waste, fraud and abuse. However, a vague law, broad interpretations, and expansion of the law's reach and sanctions without clarification, have combined to create confusion over what kinds of arrangements providers may establish. Congress should make basic changes to the law to clear up its intent and provide more precise interpretation.

- "Any willing provider" and related laws such as mandatory "point-of-service" requirements erode the ability of networks to maintain both clinical quality and standards and their ability to work with the most efficient providers. Congress should reject such measures. All health care providers qualified to be in a network should receive fair, reasonable consideration, and networks must have high standards for the number, type, and location of providers made available to enrollees. But in order for networks and systems to provide efficient, effective and better-coordinated care, they must be able to choose providers they feel will work best within the network's goals and objectives.

- Antitrust policy should encourage providers and their communities to assess local health care needs and act to address those needs. Where providers are uncertain how their activity will be viewed by federal and state antitrust enforcers and courts, the risk of high fines and long and expensive litigation can discourage innovative health care arrangements. Congress should consider a case-by-case review process that, where appropriate, protects a specific activity designed to provide high-quality, cost-efficient care. The process should streamline the administrative procedures for providers seeking to merge. And additional regulatory guidance on issues such as multi-provider networks, how antitrust policy applies in rural areas, and encouraging state attorneys general and courts to cooperate are also needed.

We also recommend legislative changes to encourage development of community-based delivery systems that coordinate care among providers and to tailor care community needs. Such changes should help define health plans by:

- Ensuring that all plans meet minimum standards, including coordination of care requirements. Standards should address issues such as solvency, market conduct, complaint and appeal processes, claims processing, quality assurance, and provider selection.

- Protect the public interest by ensuring that health plans have the financial capacity to provide covered benefits and protect against insolvency. But it is important to distinguish between insurance plans based on contracts to finance coverage, and service benefit plans based on commitments to care.

- Focus the system on keeping people well in addition to high-quality care when they're ill or injured. Minimum requirements for health plans should focus on the legal

obligation of a plan to its enrollees. But it is also reasonable to move all plans toward a greater role in improving the health status of the community by including preventive services in the benefits package and holding all plans accountable for their approach to improving enrollee health status.

- Encourage capitated payment arrangements. They create incentives for the prudent use of health care dollars. Central here is the need to be sure community-based delivery networks can contract on a capitated basis with health plans without becoming subject to insurance regulation.

- Ensure a high standard of public accountability for all health care providers and plans. All plans should report publicly on their cost, quality, performance, enrollee health status, and consumer satisfaction. While we still need to develop appropriate measures, it is time to respond to the public's demand for better information to help them decide where and how to seek coverage and care.

- Reform the insurance market to end barriers to coverage based on health status or the expected use of services. Basic insurance reforms--some of which need to be applied to employer ERISA plans as well as state-licensed plans--are important to the majority of people in this country. This is particularly true for people under age 65 who have private insurance, but are increasingly insecure about whether coverage will be there when they need it.

In addition, hospitals support the enactment of comprehensive federal legislation to simplify administration of the health care system. And as we move toward electronic data interchange (EDI), there is a critical--and simultaneous--need to protect the privacy and confidentiality of individually identifiable health care information.

A simple, effective system is critical not only to coordinate care and collect and report quality data, but to track financial obligations as well. Each practitioner, health care facility, and health plan will need a common language and understanding about how to share information with each other and the public.

Finally, a host of regulations should be eliminated. Many of them are duplicative because other protections are in place. Others would allow more reasonable approaches to reaching public policy goals. The administration recently said it would eliminate the Medicare requirement that physicians, in addition to hospitals, attest to the accuracy of the diagnoses and procedures coded on each inpatient hospital bill. This is a good first step, but there's more to be done. We'd be happy to provide a list of regulations that should be eliminated.

These recommendations for restructuring the health care system can go a long way toward making Medicare more efficient, effective and user-friendly for future generations. But it is just as important that the decision-making process for Medicare be overhauled as well.

An Independent Citizens' Commission on Medicare

This overhaul is best accomplished by the creation of a citizens' commission on Medicare. The members of this panel and others will be facing tough choices in order to achieve the savings proposed in Medicare spending. But, according to the recently approved budget resolution, those savings would only extend the viability of the Hospital Insurance Trust Fund (Part A) for a few years.

Meanwhile, the number of Medicare enrollees will continue to grow rapidly. When Medicare became law 30 years ago, 19.1 million people were covered; today's 37.5 million Medicare-insured Americans will increase to more than 40 million in five years. The average one-earner couple retiring in 1995 will use an estimated $126,700 more in Medicare benefits than they paid in taxes and premiums. In just 15 years, the nation's 77 million baby boomers will start turning 65. And not too long after that, there will be only two workers supporting each enrollee, instead of the four supporting each enrollee today.

Clearly, we must be thinking now about the long-term future of Medicare. While Congress must be held ultimately accountable, an independent commission could provide Congress an important level of public trust and debate. The American people have a right to know that what their nation spends on Medicare is buying the best benefits and the most efficient care. They should be confident that federal budget pressures won't entirely dictate how health services are provided for older Americans now, five years from now, or 30 years from now.

An independent citizens' commission can do this job, and put the "trust" back in the trust fund. The commission would annually assess how much money is needed to maintain current commitments. Then, Congress can set a target -- through its regular budget resolution -- for how much it wants to spend on Medicare. The commission would hold public hearings, translate the congressional budget target into recommendations for a benefit package and provider payment rates, and present Congress with its recommendations -- which would then be voted up or down as a package.

We believe a bipartisan, citizens' commission on Medicare should be permanent, with a life expectancy beyond the current crisis. Otherwise, older Americans will continue to be caught in the political crossfire obscuring the real issue: how to provide quality, cost effective health care to a growing number of people. Creating an independent commission doesn't mean that we won't constrain growth; it means we'll do it rationally and publicly.

Shared responsibility

Hospitals and health systems are willing to work to both reduce the budget deficit and ensure that the Hospital Insurance Trust Fund remains solvent. But both goals must be arrived at through shared responsibility. Initiatives that move Medicare toward our vision of coordinated health care can serve patients better *and* save money. But, saving the current goal of $270 billion over seven years will mean a financial effect on everyone with a stake in Medicare -- hospitals and health systems, physicians, other providers, and beneficiaries. Doing business the old-fashioned way -- just cutting provider payments -- is not the answer. To address Medicare's long-term problems, everything must be on the table: program structure, benefits, beneficiary cost-sharing, eligibility, and program revenues, as well as provider payments.

Since the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Medicare hospital spending reductions totalling at least $48 billion have had significant impact on hospitals and health systems. These include increases in prospective payment rates that haven't kept up with inflation. On Medicare inpatient and outpatient care combined, 1993 Prospective Payment Assessment Commission data show hospitals losing 11 cents on each dollar it cost them to provide care.

The effects of further "business-as-usual" Medicare reductions can be illustrated by an impact analysis AHA commissioned from Lewin-VHI, a health care consulting firm. We asked Lewin-VHI to model the impact on hospitals and health systems of Medicare spending reductions totalling $250 billion over seven years -- $20 billion less than those later adopted by Congress.

Based on historical patterns of previous Medicare spending reductions, the Lewin-VHI analysis assumes that a $250 billion reduction could translate into hospital PPS reductions of $94 billion over seven years. The Lewin-VHI findings show:

- Under this scenario, every type of hospital loses -- rural, urban, large, small, teaching, and non-teaching.

- By the year 2000, Medicare PPS inpatient operating margins could fall to negative 20.6 percent. Because most of the reductions are made in the first five years, margins could rise for the last two years, but still remain negative -- a negative 12.2 in the year 2002.

- Hospitals' PPS costs per case last year grew at 2.1 percent -- the lowest rate ever. Lewin-VHI estimates use a very conservative number for hospital cost growth, based

on last year's experience. If actual cost growth is higher than projected, hospitals could face substantially lower margins than those illustrated here.

In the past, hospitals coped with Medicare spending reductions by passing the difference on to other payers, like non-Medicare patients and their employers. That's called cost-shifting. But those days are fast disappearing, and these reductions are unprecedented. The market is shutting down the cost-shift option. Managed care contracts and a growing number of employers and private insurers who negotiate discounted prices are making it a thing of the past. They're tired of shouldering the burden of government underfunding.

This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or, ultimately, shut their doors altogether. Any one of these options takes us farther from our mission of providing the highest-quality care to the people we serve, including America's elderly, poor and disabled.

Ensuring access for the nation's most vulnerable

Ensuring access for the elderly, poor children and pregnant women, and the disabled requires a comprehensive approach. There are two keys to such an approach: Health plans should not be able to exclude areas where these most vulnerable populations reside; and poor, disabled or elderly individuals should not be systematically excluded from coverage by health plans on the basis of their previous or potential need for services.

While this committee deals with Medicare and not Medicaid, please understand that the decisions of other committees on Medicaid will also have a great impact on hospitals and health systems. The move toward converting Medicaid into a block grant program is something we feel strongly enough about to mention. The nation's most vulnerable citizens should be protected from an effort to convert Medicaid into block grants that can be used for purposes other than providing health care to those in need. States must be held accountable for using Medicaid funds for their rightful purpose. And the Boren Amendment, which requires that payments to providers be "reasonable and adequate," must not be unilaterally repealed. To do so would leave states with no accountability in paying providers fairly.

Conclusion

Mr. Chairman, I commend you for sending strong signals supporting two of our principles: restructuring and shared responsibility. And we appreciate the willingness of many in Congress to consider an independent commission and our ideas on access for Medicaid recipients.

But let's be clear about one thing: The issues we are talking about here are not just political issues -- they are people issues. The decisions you will make in the next few weeks will affect almost every American: the 37 million people who rely on Medicare benefits for their health care; the families of those beneficiaries; the millions of baby-boomers who are edging closer to retirement; the young workers who are paying into the system and rightfully expect Medicare to be there for them when they grow older and retire; and all our citizens who receive care from hospitals and health systems that could be adversely affected if change is not achieved the right way.

America's hospitals and health systems are proud of the high-quality health care they've provided Medicare beneficiaries over the first 30 years of the program. We look forward to providing even better care in an even better system for the next 30 years and beyond. We believe strongly that, by adhering to the principles I've described, we can achieve that goal.

Mr. ENSIGN. Thank you, Mr. Davidson.
Mr. Scully.

STATEMENT OF THOMAS A. SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. SCULLY. Mr. Chairman and Members of the Subcommittee, thank you for having me today.

For the last 6 months, I have been president of the 1,700-member Federation of American Health Systems, which is an association of the investor-owned and managed hospitals in the country. Many of our members, about half, are members of AHA, and we work very closely together.

My experience over the last 6 months has shown me that the hospital industry is changing rapidly, and I think changing in many ways that you probably like. In one of my prior lives, I had the painful experience of overseeing the Medicare budget for 4 years, so I think I have seen it now from the Federal side and from the hospital side. One thing that has convinced me is that there is no doubt that Medicare needs drastic reform.

I think we may disagree in the beginning of my testimony about our concern about the budget number of $270 billion, but the fact is that that is what the budget resolution is. We obviously think that is taking a little too much money out of the system too quickly, but the issue is you are there and our job now is to try to find the most reasonable way for you to get there.

So I will skip over a lot of that and talk mainly about the proposals that are in the appendix to our testimony, which is basically what we have already presented to the leadership, but here it is in probably a little more detail. I think we are now at the point where we probably have to stay with the details.

So just to comment generally, I really believe the number is big and I do not think there is much chance to reach it with traditional cuts. Our view is that if you are going to take that type of number out of Medicare, you have to fundamentally restructure, because if you do not, you are going to be really shaking Medicare to its core. The only real way to get these kinds of savings is to fundamentally look at just totally reshaping Medicare, and we advocate doing that.

We believe that Medicare is a very old-fashioned and inefficient fee-for-service single-payer health care system that is basically unmanageable. As good as HCFA is or as a government agency can be, there is no way in the world to track hundreds of millions of transactions every year. It is a broken old fee-for-service mechanism. All providers and all hospitals get the same payment, the same amount of dollars, regardless of their quality, regardless of their price, and it is just the system that, no matter what you do, you are going to get fairly good quality, but you are going to get a lot of wasted money, and there is no doubt it is going on now.

I know there are hearings going on in the Senate Finance Committee and the Energy and Commerce Committee I think today on fraud and abuse. Our view is that as long as you stick with the fee-for-service antiquated system, you cannot possibly avoid fraud and abuse. There is too much for the government to track. The way you

have to go is toward capitation, toward privatization, and toward making the Medicare system look more like FEHBP.

So our view is that if you need to save money, and obviously you are going to and that is what is going to happen this year, we prefer as hospitals to be squeezed by a system that responds to local market incentives where hospitals are, and not by a federally set rate-setting system that increasingly creates perverse incentives and just encourages inefficiency.

We believe that the right model for this—and there are some flaws to it and we would be happy to spend a lot of time discussing the details of those flaws—generally, the right model of the Federal Employees Health Benefits Plan, we believe that is the way you should go.

A lot of people talk about that as pushing people toward managed care. We do not look at it as managed care. We look at it as privatization. We think you should give seniors the choice of the traditional Medicare fee-for-service plan, private fee-for-service plan, the CIGNA or Prudential plan or some other private carrier, HMOs, PPOs, point-of-service contracts. Those are the types of choices that are widely available in the under 65 market, and even with Medicare Select, which is just scratching the surface, are almost nonexistent in the over 65 market.

We think that the government's role should fundamentally change from a purchaser of individual provider services for a purchaser of health care coverage, and that you really should use market competition and not price regulation to restrain the growth of Medicare.

So we put two fairly detailed options in the addendum, and the first one, which it sounds like the Subcommittee is going to structurally follow to some degree, is a more modest one, and that is one that basically says that if you have to save up to $160 billion, which is the level that we have said that we think is reasonable, that you should do basically a mix of traditional provider reductions and what is called the "lookback," which is basically kind of a little mini sequester to guarantee a move to private plans, and with that combination we think you can reasonably get to $160 billion in savings.

The second option, which says that we believe if you go above $160 billion, it is extremely difficult to get these kinds of numbers out of the traditional Medicare Program. And if you are going to do that, we think you should use a transition period, and we suggest a voluntary move to an FEHBP-like system for the first 4 years, but after the year 2000, just go to a pure defined contribution plan. It would work like the FEHBP until Blue Cross, CIGNA, Aetna. or whoever they are—and HCFA—that they are all going to get the same capitated rate and they are going to have to compete within that capitated rate.

Now, we obviously think with the limited money you are going to leave in the system, we are concerned that that capitated rate will not be enough. But if you are going to try to save the money in the baseline, and a lot of this is a budget issue and a scoring issue, the only way to get reasonable savings we believe in the long term and to get a reasonable structure is just to go to a pure defined contribution plan after the year 2000. And I just noticed that

is what the Jackson Hole group apparently came out with this week, too. Not that we always agree with them, but that that is what their new proposal is.

So our view basically is if you are going to take numbers out that are this big, and obviously that is what the budget resolution requires, that you have to be bold, you have to think big, and you have to do what I think a lot of health policy analysts thing in the long term is the right thing to do, which is go to a pure defined contribution capitated rate.

Again, just to summarize, Mr. Chairman, we are concerned that $270 billion, as you all probably know, is a large number. We think getting there in the traditional ways to reform and take funding out of Medicare is extremely tough, if not impossible. So if you are going to get to a number that big, we will work with you and we would like to help you, but we think you have to think very big and be very bold and do some things that may be controversial. As a result, we suggest that a move to pure defined contribution after 5 years.

Thank you.

[The prepared statement and attachment follow:]

Federation of American Health Systems

Thomas A. Scully, President and CEO
Federation of American Health Systems
Testimony on Saving Medicare and Budget Reconciliation
Before the Subcommittee on Health
Committee on Ways and Means
July 19, 1995

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today.

As President of the Association of the nation's 1,700 investor-owned and managed hospitals, I have seen that the health care delivery system is changing -- fast and often for the better. But, having overseen the Medicare budget for four years as Associate Director of OMB and as Deputy Assistant to the President for Policy, I also know that this public program is in dire need of reform, and that it can be reformed in ways that can generate significant budget savings for the federal government while continuing to provide access to high quality health care. The big issues are:

1. How much Medicare spending can you trim without throwing the system into chaos; and
2. How quickly can you phase in meaningful market reforms that will preserve the program while reassuring the seniors who rely so heavily on its benefits?

Medicare reform is at a crossroads in Congress. If Congress enacts massive spending reductions in the nation's largest and most politically sensitive health care insurance program without the benefit of fundamental restructuring, there will be no chance to bring Medicare into the next century as a high quality, cost effective health care system. If real restructuring doesn't accompany these totally unprecedented spending reductions, Congress won't be "saving Medicare" -- it will be shaking it to its very foundation.

Without Restructuring, The Enormous Budget Reductions Will Be A Disaster

Medicare desperately needs restructuring. With a new, privatized payment system replacing Medicare's outdated structure, Congress could achieve much of the deficit reduction savings it is after and improve a program that serves 36 million seniors and severely disabled Americans.

Reducing spending by $270 billion over seven years, as outlined in the Budget Resolution passed by the House and Senate, is simply too much too fast under the existing program structure. It is important for Congress to be cost conscious with the Medicare program, but traditional budget reductions of this magnitude would have a disastrous economic impact on hospitals, beneficiaries, and communities across the country.

Read almost any paper in the country and you will find that hospitals in many communities are already responding to market pressures by closing, contracting their levels of service, or laying off workers. Much of the intensifying market pressure may be good for the system, forcing a more cost effective delivery of services. But making traditional Medicare payment reductions of the magnitude proposed in the budget will be like pouring fuel on the fire of the hospital system's contraction. It will ignite an explosive reduction of services and the number of hospital employees delivering those services that will leave seniors, hospitals, and

communities feeling burned by the abrupt changes in services they will experience.

Don't underestimate the challenge before you. Let's put this into context. The savings targets in the Budget Resolution are at least five times the reductions in the 1990 Budget Agreement and four times the size of those in the 1993 Budget package. And those two previous provisions were enacted at a time when health inflation was higher, budget baselines were fatter, and each dollar reduced had less of an impact on each hospital. So attaining these budget levels will be very difficult, if not impossible to achieve through the traditional method of simply trimming reimbursement under the traditional Medicare fee-for-service system.

Stretching The Timetable Or Modifying The Targets Would Make Traditional Medicare Reductions Far More Achievable

Fortunately, the plan laid out in the Budget Resolution is not the only way to go. There are other options. Hospitals advocate adopting a slightly longer timetable for achieving Medicare savings that would help protect beneficiaries from abrupt changes in health care services while giving providers time to adjust to changes. We also call for an equitable distribution of reductions between providers and beneficiaries. Alternately, lowering spending reduction targets to about $160 billion over seven years (as originally proposed by the Senate Entitlement Task Force) is a reasonable option that also would produce significant budget savings while preserving and even improving the quality of health care now enjoyed by seniors. At this more attainable level, local communities would be spared some of the economic pain of the huge layoffs hospitals will be forced to make if the Budget Resolution target is enacted. Hospital costs are 50% to 60% personnel -- with the Budget Resolution's spending reductions, there is little place else to go to cut costs.

If Congress Must Hit These Budget Targets-- It Must Think Big and Act Boldly

If Congress truly insists on delivering more than $160 Billion in Medicare reductions (which we strongly oppose), it must THINK BIG and ACT BOLDLY. Savings of the magnitude in the Budget Resolution cannot be achieved by chipping away at the old Medicare program. It must be restructured from the ground up.

Medicare is an antiquated insurance program created in 1965. I like to compare Medicare to a 1965 Chevy -- it might have been a helluva vehicle 30 years ago, but its time has passed. Congress's traditional fiscal savings approach is to simply put less fuel (dollars) in the tank. But when you have an old gas guzzler that still only gets four miles to the gallon, that strategy won't take you too far. The answer is to design a better vehicle--using 1996 designs.

The Federal Employees' Health Program Is The Right Model For An Improved Medicare System

Ironically, Congress has an excellent blueprint for Medicare restructuring and rebuilding literally under its nose. The Federal Employees Health Benefits Plan (FEHBP) is a good example of what the Medicare program should and could be. FEHBP offers beneficiaries freedom of choice and flexibility, along with financial incentives for both beneficiaries and providers to wisely use their medical coverage.

Like the FEHBP, a restructured Medicare program could offer multiple private plans (both managed care and fee for service) as well as the traditional government sponsored Medicare fee-for-service plan.

An FEHBP-like approach will give seniors more coverage options -- and at the same time give Congress more options for containing cost growth. Congress can establish a defined contribution -- certificate or voucher -- that gives seniors the

ability to shop for their best health care deal. This option creates the opportunity to harness the power of the intense competition in the health care industry to lower costs, as an alternative to price regulation. In recent years, the health care system has proven that competition works as it has slowed the growth in private sector health care costs.

Only A Move To A Defined Contribution System Can Produce Big Savings For Congress And Provide A Higher Quality Of Benefits For Seniors

The single biggest benefit of moving to an FEHBP approach somewhat quickly, is that it offers the only realistic option for getting significant long term budget savings from Medicare. Only by eventually moving all seniors to privately managed systems operating under a **defined federal contribution** can the federal government truly restrain cost growth and drive efficiency into the system.

The government should operate Medicare like it operates its employees' health care (and as all private employers like GM or 3M also do) -- by purchasing coverage for seniors, not by purchasing individual health services. The Federation has advocated a smooth transition to this system. From, 1996 to 2000, all seniors could opt to stay in the traditional Medicare program or voluntarily choose a private plan. After 2000, all seniors would choose plans in a system like FEHBP, where all plans, including traditional Medicare, received a defined contribution[1].

Hospitals Want The Market To Reduce Spending In The System Efficiently -- Not Through Federal Price Regulation

Medicare is a wonderful system for seniors, but it is a payment dinosaur. All hospitals, and other providers, receive roughly the same payment -- regardless of actual price or quality. The incentives and pressures to operate efficiently are far less than under private payment schemes. It's no one's fault, but you get what you ask for (and pay for) -- good quality with lots of wasted dollars.

If the federal government purchased all Medicare coverage by giving seniors a choice from among a number of private plans and traditional Medicare, and held the annual inflation rate of its "defined contribution" to some reasonable rate, it would attain the budget savings needed and reform the system. And it would be done without gutting the existing delivery system by randomly slashing Medicare payments to health care providers. It would let the market squeeze the money out of the system -- not the usual "ratcheting down" on a federally set pricing system that makes little distinction between efficient and inefficient providers. Health care providers would compete for Medicare patients on the basis of price and quality -- as they increasingly do in the under 65 year old market.

As hospitals, if funding is to be removed from the system, we'd prefer to adjust and streamline in response to a local market that creates rational incentives, not cuts in the current Medicare price setting system that already has created thousands of perverse incentives that produce only inefficiency.

Congress Must Remove Barriers to Restructuring the Medicare Program

Providers have responded to pressures from private and public payers to reduce the cost of health care. This has resulted in unprecedented consolidation and contraction in the hospital industry. As cited in the Prospective Payment Assessment Commission's report earlier this year, many hospitals have closed, merged, or entered into joint ventures to reduce capacity and increase efficiency.

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[1] A more detailed document, outlining the specifics of the Federation's preferred approach, is attached.

Providers are developing health care delivery networks and integrated delivery systems, despite significant legal and regulatory barriers. Such activities should proceed at an even more accelerated rate under a truly restructured Medicare program, but only if Congress addresses these issues.

Currently, these barriers include:

- Physician self-referral laws prohibiting physicians from referring to entities when a financial relationship exists. The law needs to be revised so that hospitals and physicians can work as partners to deliver the full array of health care services to Medicare beneficiaries;

- The anti-kickback law prohibiting payment for referrals. This law needs to be clarified to provide clear notice as to what financial arrangements constitute a violation of the statute. Presently, the language of the statute is so vague as to have a considerable chilling effect on those seeking to develop health delivery networks;

- Any willing provider legislation impeding development of health care delivery networks;

- Antitrust laws that require clearer standards and guidances as to how they will be applied. We believe that such laws are necessary to maintain competition and provide consumers choice among providers and health plans, but must be rationally enforced.

- Burdensome regulations. The existing Medicare program should be revised to eliminate unnecessary regulations, help streamline the program, and enable providers to deliver health care services more efficiently. We have developed a list of such regulations after consulting with our member hospitals and will provide them to you.

<u>Medicare -- And Money-- Can Be Saved, But Only Through Major Restructuring</u>

Medicare can be restructured and money can be saved-- if it is done right. Now is the time to build on the successes already achieved in the public and private sectors. The market in health care has proven it can be effective when it comes to belt tightening and reducing costs. If Congress is to produce massive and unprecedented reductions in the Medicare spending growth rate, Medicare must be remodeled in a manner that takes advantage of changes that work.

Thank you for the opportunity to testify today.

Appendix

Testimony of Thomas A. Scully
President and CEO
Federation of American Health Systems

Medicare Restructuring: Slowing Growth By Providing Private Plans Choice and Bringing Competition to the Medicare System

The Federation of American Health Systems supports a total restructuring of the Medicare delivery system. The Federation believes a new, privatized payment system must be structured in a model that provides choice of multiple private plan options to beneficiaries much like the existing Federal Employees Health Benefits Program (FEHBP). This restructured program shall:

- Change the government's role from that of a purchaser of services to that of a purchaser of coverage;
- Offer a choice of multiple private plans, as well as traditional fee-for-service Medicare coverage to each senior;
- Pay a defined contribution on behalf of all seniors to purchase health care; and
- Utilize the power of private markets and competition, not government price regulation, to slow cost growth in the program.

Current Policy:

Medicare enrollees now have the option of choosing managed care by enrolling in Medicare "risk contracts," but fewer than 9% do so—as opposed to participation in some form of "managed care" by almost 80% of those under 65 years old. Over 90% of seniors use Medicare as a publicly managed, single payor fee-for-service insurer. The provider sends in the bill and it is paid at a federally set rate. This type of coverage has become a dinosaur among private health plans.

Why are so few in private plans?

- Because few seniors understand managed care and because the non-HMO private options are very limited. For most seniors, only traditional "closed network" HMOs are available and none of the most popular forms of managed care—preferred provider organizations and point-of-service plans—are available.
- In some parts of the country, Medicare managed care is profitable, in others it is not. The HCFA payment mechanism, the AAPCC (Average Annual Per Capita Cost) needs to be restructured and revised to more accurately reflect regional costs.
- Efficient Medicare managed care providers can't charge seniors less—nor can they return the savings in lower premiums to beneficiaries. As a result, all risk contractors in an area are paid exactly the same amount; therefore, they must try to attract seniors by expanding benefits (e.g., prescription drug benefits) or by reducing cost sharing.
- Market leverage is limited, because most seniors have Medigap plans that cover drugs, copays and deductibles—and it is difficult to convince them of the better value when they see no personal financial benefit.

- Seniors are understandably afraid of change and of having access to their physician limited. But, Medicare "risk contracts" need not be only managed care plans. Private carriers can also carry risk and provide traditional fee-for-service indemnity coverage for a defined amount. In rural areas, most private plans would not include a managed care component.

Proposed Policy:

- Replace the existing AAPCC with an improved per individual defined contribution system (certificate/voucher) that will encourage the growth of managed care and other private delivery alternatives nationwide.

- Adjust the payment mechanism to account for gender, age, geographic location, and certain high cost chronic conditions. HCFA has the capability to do this now – if legislatively directed to do so.

- Allow all seniors the option to choose a private plan (as in FEHBP) that will meet basic federal standards.

- Provide an "open season" once a year for seniors to switch plans – just as in FEHBP.

- Pay these plans up to 100% of a new Average Annual Per Capita Cost (AAPCC) – subject to the rebate provision below.

- Allow all seniors to keep their existing employer-based coverage, when they turn 65, if they choose and if their plan qualifies. By default, enroll seniors who do not choose to remain in their current plan or to join another private plan in the regular Medicare program. **All seniors can choose to stay in the regular Medicare program.**[1]

- HCFA would certify any plan that offered at least the standard Medicare benefits package and that meets defined quality standards. Each plan would have to publish a standard rate for each region (as they do in FEHBP) available to all seniors during a HCFA-administered annual open season and take all seniors in its defined area of operation.

- Provider-based health plans should be assured access to this new market.

Rebate Provision

- Health plans would be expected to compete for beneficiaries by offering plans for less than the AAPCC and by offering different benefit packages. Seniors would share in the savings below the AAPCC. Initially, the seniors would receive 75% of the savings in a rebate, the U.S. Treasury 25% of the savings, to encourage the move to more cost effective health plans. Seniors could roll the rebates into an MSA (tax deferred) account that would be used for health or long term care expenses only.

For example

The average 67 year old in Dayton, Ohio, under the existing (and flawed) AAPCC methodology, would be eligible for about $5,100 per year in 1995, if he/she enrolls with a Medicare "risk" HMO plan. The HMO now receives 95% of that amount to provide full Medicare benefits and any additional

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[1] After 2000 the traditional Medicare program may receive the same per capita payment as other private carriers (see Option B)

benefits it can.

Assume the new AAPCC would produce the same average payment amount. Under this proposal, if Blue Cross of Ohio offered a POS Medicare plan for $4,400 (a strong likelihood), a senior would receive a $525 rebate, and the Treasury would also receive a $175 per member savings. In addition, future growth of the program is limited because the growth of the per capita payment (AAPCC) could be restrained to well below the 10% annual growth rate of the current program.

Direct financial savings to middle income seniors are the most effective incentive for them to choose more cost-effective plans.

Existing Medicare risk contracts and private sector PPO and POS plans already show that substantial cost savings can be achieved -- but the system doesn't allow it. All savings must be paid back to the senior through additional benefits -- that often don't create enough of an incentive for seniors to switch from the traditional program.

OPTIONS FOR PRODUCING GUARANTEED BUDGET SAVINGS

A. Voluntary Move to Private Plans with "Look Back."

(Preferred if you need to generate up to $160 Billion for Medicare over seven years)

1) **Use traditional provider cuts and beneficiary cost sharing in existing Medicare program -- Hospitals, Physicians, labs, beneficiary copayments deductibles or premium policy, etc. to generate $100 Billion** in traditional baseline savings.

2) **Index the Medicare Per Person Payment to Ensure Reasonable Cost Growth.**

Medicare costs can be controlled and will be by the private health plans that are chosen by seniors. Private carriers and managed care plans can readily provide quality care for less than the AAPCC.

If seniors choose these private plans, this system will by definition generate significant savings. Savings will vary, depending on CBO's assumptions on how many beneficiaries will opt for private plans.

If seniors move into these plans in significant numbers as more and better private choices are available in the market, it will produce major spending reductions (baseline savings) simply because the annual AAPCC growth factor will be less than the existing Medicare baseline (about 10%).

Because the fee-for-service option through HCFA would remain as an option, the bulk of seniors could choose to remain enrolled, so CBO is not expected to project large savings. **Therefore, to guarantee scoreable savings for the remaining budget targets:**

3) **Create a new process or "Look back" to guarantee the savings will be produced, from the voluntary move of seniors to private plans. The approach would guarantee $60 Billion in over 7 years under reasonable mid-range assumptions.**

Each year HCFA would examine the entire projected Medicare baseline (as it does now with physician payments) to see if the reconciliation spending

targets from OBRA '95 have been met.

If the privatization/managed care options have held growth within the targets, then no additional cuts from the "look back"would be needed.

But, if the spending targets were not being met, a formula (like a sequester) would automatically make cuts in the program to produce the targeted spending levels.

The cuts should be allocated across-the-board as follows:

- Provider payments -- 50% of shortfall
- Beneficiary contributions or payments -- 50% of shortfall

Result:

- **About 2/3 of targeted budget savings are delivered up front -- in the traditional spending reductions.**

- **About 1/3 of targeted savings are left to be generated by savings created by the move to private plans and managed care -- with additional provider payment cuts and beneficiary adjustments built in to guarantee real savings if reforms don't deliver adequate savings.**

B. Move to "Pure Defined Contribution Plan"

If Congress is to actually attempt to deliver $270 Billion in Medicare baseline reductions over 7 years it must take **MUCH BOLDER ACTION.** There is no way to save $270 Billion under Option A, or any other approach involving reform of the traditional fee-for-service Medicare program that will not savage health providers. These enormous cuts in reimbursement will close hospitals and shake the foundation of the health care delivery system. While we oppose these budget targets, to get to these numbers, Congress must be bolder:

1. Adopt the system outlined in Option A for years 1996-2000. Seniors would have the option of choosing from numerous private health plans or staying in the unchanged traditional Medicare fee-for-service plan.

2. After the year 2000, move to a Pure Defined Contribution approach:

    - Seniors would still choose from multiple private plans as well as traditional Medicare.

    - But all plans, including HCFA's traditional Medicare, would receive the new AAPCC. HCFA would have to compete with other private plans for beneficiaries, under the same per capita payment.

Result:

- **For the first 4 years (1996-2000) savings come from a mix of**

voluntary move to private plans and savings from traditional fee-for-service Medicare.

- After 2000, all savings come from paying all plans -- private carriers and HCFA -- the same per capita annual payment. Establishing a defined inflation adjustment to the per capita payment after year 2000, will achieve the baseline savings necessary to meet the Budget Targets.

The Government Should Be Buying Health Coverage For Seniors, Not Paying For Health Services

This approach privatizes and reforms the system, saves money and will provide seniors and communities with better health care services.

Chairman THOMAS. Thank you both for your testimony.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

I thank both of you for your testimony and thank you for being constructive in offering to help us with these very challenging decisions.

I guess the thrust of the reasoned criticisms of the number that we have and any approach that might be taken to get to that number is one thing that Mr. Scully alluded to, and that is, even if you go to a defined contribution, even if you go to a capitated approach, there is a danger that the capitated amount will not meet the requirements of a basic health care plan for seniors. I think that is at the crux of what we have to look at and decide, as we go through this.

I guess there is no way we can know what the market will do. But you two are in the market, certainly your member institutions are in the market and are a large part of what makes the market work. I guess the other large part is the consumer. So we have got to look at it from both the standpoint of the provider community and the consumer and how we can get market forces at work in both of those large groups to come up with the savings.

I am just wondering, from your viewpoint and being a player in the marketplace, even though it scares you and even though you have doubts, do you think it is possible? Can you envision a marketplace that will be so dynamic, so robust, so innovative that it will be able to come up with a reasonable level of health care for seniors at the number that we are looking at for capitation in the year 2002?

Mr. DAVIDSON. I think one of the problems, Mr. McCrery, is the transitional question. First of all, it is very hard to forecast. I mean you could put six economists here and ask them that and have the best in the world and they could not forecast that with a certainty, and I think that is probably the way we feel about this.

We think the marketplace can respond, and the question is can we respond and treat seniors while maintaining cost growth at the same level as in the private sector. In Medicare, we have got a different set of demographics. That is one critical issue, with the largest growth cohort in seniors 85 years of age and older, and so there is a tremendous level of consumption of services which makes it very hard to forecast.

But the critical part is the transition; first, how we move forward in the interim, when—without sufficient numbers of seniors enrolled in coordinated care programs and HMOs—we are not ultimately getting the market to respond. The vast majority of places in rural America do not have access to these coordinated plans. Second, how to actually build the capability to make these plans available and then to get the seniors to move into something new when they are very pleased with what they have now. Of course, economic incentives could move them there quickly.

That is part of the reason that we are suggesting that there should be an independent national commission. You are all up against an enormous time crunch in making decisions that are so hard to forecast. If we could take some money out on the front end to get you part of the way there, an independent national body

could begin to construct the mechanisms to get you where you need to be for the rest of the dollar amounts during the remainder of the 7 years. There may be some greater rationality in trying that approach and being a bit cautious in trying to get to that goal.

Mr. SCULLY. If I could just answer that, too. I cannot tell you that if you took an AAPCC-like mechanism and had everyone in, including HCFA, in the year 2002 and you gave a capitated rate increase, at that point it would probably require about 5.5 percent a year, I think, that the market is going to fall hard and hospitals are going to fall by the hundreds.

The fact is there is a consolidation going on in health care and you are going to have hospitals closing anyway. As I said in my testimony, I think if you squeeze too much money out of the system, you are going to speed some of that up even more quickly as is happening anyway. There are not too many cities around the country where hospitals are not laying people off or closing. That may be good. I mean the market is doing that. You can make an argument that is squeezing more efficiency into the system.

My bigger concern, to be honest with you, is in the short term how you get there. I think we can adapt. We are not happy about $270 billion. But I think if you told us that in 7 years we were all going to be in a capitated FEHBP-like system with a certain amount of money in the system, we could probably get there. It is going to be painful and it is going to be difficult, and I am not sure it is going to be more difficult than you all vision. But you might get there.

My concern in the short term is the way that people seem to be getting there—to $270 billion—is this number. I think, as you know, a lot of these Medicare reductions in a prior life. I helped create some of those.

My concern is that when you do creative stuff like having the lookback, which we support and think is a good idea, that to capture what is "privatization managed care savings," that only gets you part of the way there. You are still left between now and 2002, even with the lookback, with probably $200 billion-plus of traditional reductions in Medicare.

And when you look at how to get there and you go through the laundry list of things—part A is obviously the center of the controversy of where you find the savings this year—when you go through and look at things that sound innocuous, like bad debt, Medicare DSH, all these things that are cosmic concepts that most people do not understand, fortunately for them, they all have a big impact on the hospitals, and taking a big hit out of traditional provider cuts to get there is a very tough way to go for the next 6 or 7 years. That is why we have said just go to defined contribution. We would rather deal with a capitated system to take money out of it.

This year we are already at the hospital marketbasket, which is our fundamental way of getting paid, it is up today to just 1.5 percent, and that is dropping. So we are very concerned that in the next 7 years we are going to have negative real updates for hospital payments.

I guess our real world concern is, Are there ways to get to $270 billion? Yes, but they are going to be politically tough and they are

going to be controversial, which is why we suggested the defined contribution. If you do it the old way, we are going to be hammered, and there is an awful lot of money that is going to go out of the system and it is not going to be pretty.

I guess our concern is, Can you get there in 2002? Yes, but there is an awful lot of ways to do it and some are a lot better than others.

Mr. MCCRERY. Thank you, Mr. Chairman. We are certainly not suggesting to do it the old way. We are looking for suggestions as to how to do it a new way. Although we may not be able to go to a capitated basis right away, which I think I hear you saying——

Mr. SCULLY. After 2000 we have suggested.

Mr. MCCRERY. Well, we would like to work toward that, but there are different ways to get there and we want to work with you to find the way that is most doable.

Thank you.

Mr. ENSIGN [presiding]. The gentleman from Wisconsin.

Mr. KLECZKA. Mr. Davidson, if I heard right, I believe Mr. Scully indicated that a $160 billion cut for Medicare would be more doable than the suggested figure of $270 billion. What is your view on what is doable and will it provide some real hardships for the hospitals around the country?

Mr. DAVIDSON. As we said, we supported the notion of the Gregg proposal in the Senate which took you to $160 billion. $60 billion of that in savings would be through restructuring of the program. That is where the major savings would be. With a lookback mechanism, that if in fact we did not achieve it, then we would make cuts "the old-fashioned way." But that would be dealing with marketbasket, making adjustments there to reduce growth for hospitals.

We had some recommended physician changes in there, as well, as well as some participation by beneficiaries in terms of own health coinsurance, lab coinsurance, income-relating part B premiums, but kind of a balanced package to come up with $160 billion.

Mr. KLECZKA. I am assuming that you saw the AMA proposal that we talked about this morning.

Mr. DAVIDSON. Yes.

Mr. KLECZKA. Do you have a similar one which would take $100 billion out of the physician reimbursement and maybe give you an additional——

Mr. DAVIDSON. No, we do not. As a matter of fact, we do not. We call for——

Mr. KLECZKA. You believe in shared sacrifice?

Mr. DAVIDSON. Shared sacrifice and hospitals take much bigger hits.

Mr. KLECZKA. Are you saying their's is not a shared sacrifice program?

Mr. DAVIDSON. I would not comment on theirs.

Mr. KLECZKA. Then do not. Now, let us use the AMA as a model, and if we are looking at about a $162 billion cut over 7 years and you folks are programmed to take about a $100 billion cut, what type of a cut or reduction in reimbursement would hospitals around the country face with a $270 billion Medicare Program cut?

Mr. DAVIDSON. Well, we had an independent study done, and it is in our written testimony, by Lewin-VHI on the basis of a $250 billion reduction in growth, and if we did it "the old-fashioned way," our reductions would have been about $94 billion. What that really means is that in the year 2000, the typical hospital would be paid approximately $1,300 less per case in Medicare than the actual cost of producing the care.

We have one out of four hospitals in America where 75 percent of their patient revenues come from treating senior citizens and medically indigent people, as well as in carrying bad debts of 5 to 6 percent. If that scenario played out, those institutions could not survive very long, and that is why we say we have got to find a better way to reach the number than the traditional ways with these kinds of reductions. These reductions turn into real cuts.

Mr. KLECZKA. But that is using the old method of hospital reimbursement. By using the new method and assuming a $270 billion cut, what would that do to hospitals, if we go from now through the next 7 years to a pure market approach, what would be the effect on hospitals doing that, using the $270 billion?

Mr. DAVIDSON. The number obviously would be higher. I do not know the number really computes to.

Mr. KLECZKA. So the $94 billion is based on a $160 billion——

Mr. DAVIDSON. No, it was based on $250 billion, and our portion would have been $94 billion. So if you took the $270 billion and used the old-fashioned way, you could escalate the $94 billion to $100 billion and it still does not look any better, obviously.

Mr. KLECZKA. By using the new-fashioned way, would not the $94 billion, based on a $260 billion cut, be less than the $94 billion?

Mr. DAVIDSON. Not enough.

Mr. KLECZKA. It is still the same number.

Mr. DAVIDSON. It does not matter, if we are talking about the $95 billion or $100 billion, it is all in the same ballpark.

Mr. SCULLY. The reason we prefer capitation, and we have done this with the AHA, is that we have done a lot more detailed look at hospitals. We have done some of our own hospitals, and we have found that our average hospital, say, with 450 beds, which is just a midsize hospital, probably in the fourth years under the current budget stream would lose about $7 billion in revenues. Most of our hospitals have over 50 percent Medicare payments, so it has a big impact.

The reason we prefer an FEHBP capitated approach is that we believe that, given a reduced amount of money——

Mr. KLECZKA. Well, let us go back to that Federal program, because everyone is touting it as the save-all for the program, however, know full well that, in fact, you do know that the capitation or the contribution is based on a percentage and not a fixed-dollar amount.

Now, if we could guarantee the Medicare folks that we are not going to have inflation over 4 percent for the next 7 years, maybe a fixed-dollar amount would work. But if you want to emulate the Federal health care program, let us also emulate one of the things that makes it work, and that is the fixed percentage. Mr. Scully, do you support that or not?

Mr. SCULLY. Well, our concern is that a fixed percentage may be too low, if you take too much out of the system. But I also think as a scoring——

Mr. KLECZKA. It will be too low?

Mr. SCULLY. I think the fixed dollar is going to be ultimately too low.

Mr. KLECZKA. Is there any evidence in your associations that we could be running a 15-percent increase in health care costs this year? I am told by some folks in Milwaukee that this year we are running 15 percent health care increases, health are inflation.

Mr. DAVIDSON. In terms of the insurance premium rate increases?

Mr. KLECZKA. Right, which would occur next year, naturally.

Mr. SCULLY. I think most of our hospitals are seen fairly flat, a 2- or 3-percent increase this year.

Mr. DAVIDSON. We do not hear any numbers like that.

Mr. KLECZKA. Well, I hope they are wrong.

Mr. ENSIGN. The gentleman's time is expired. We are going to have to go vote, so I want to make sure we give everybody a chance.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I want to thank the witnesses for the testimony today and for their time and your help, especially Mr. Scully. I know you said you are willing to work with us and you are wiling to help us get to where we need to get. As you well know, the Medicare trustees have already laid out the problem in terms of it is in serious need of repair.

When we began looking at how we could improve the system back in April, Mr. Davidson's organization took out ads against a number of Congressmen, as well as a number of people who were involved in this whole situation. I do not know if you remember, but these were the words just 2 months ago, "drastic Medicare reductions, hurt senior citizens, irresponsible, it is going to hurt people that need burn units, trauma care, intensive care," and it just goes on and on and on, fear mongering and scare tactics.

I realize that your agenda at that time was to try to scare enough people to get involved in the grassroots effort to try to bring that number down. Unfortunately, I think that it caused a lot of dissension in the ranks, and I do not think it helped the whole discussion at all.

Are you willing now, Mr. Davidson, to help us with this problem? We want your help. We want to work with you. We would like to have you give us some ideas. I know you have some. I read your whole testimony. One of the ideas that you have suggested is an independent citizens' commission on Medicare.

I think each one of us here, if not most of the most new freshmen, have independent commissions already. We set them up back in our districts. On my commission of 22 private citizens in Omaha are 2 heads of hospitals who are in your organization. I am seeking their input. I am listening to them. One individual heads up Clarkson Hospital and the other heads up St. Joe's. I think a lot of us have done it. I know Mr. Ensign has, as well, and I think Mr. McCrery also had a focus group just this past week in Louisiana.

So I think we have already done the independent citizens' commission that you are talking about.

You also talked about an idea that we need to have a bipartisan type of commission with the life expectancy beyond the current crisis. I think we have that in the new Congress. I am 32, Mr. Ensign is 38, Mr. McCrery is 30—[Laughter.]

You know, we have quite a broad perspective even from the standpoint of the Democrat side. Mr. Kennedy is 27 or 28. I think, as elected officials of the American people, we kind of represent a whole spectrum in terms of age, as well. So I am not sure that the independent commission idea is the way to go, because I see a lot of commissions and a lot of studies waste a lot of time and delay and delay and delay. Frankly, we have got to come up with some new solutions.

I know that my time is running short and I know Mr. Ensign wants to inquire. I just implore you to help us, to work with us and to not take part in some of the activities that happened a few months ago. I appreciate your help on this issue.

Mr. DAVIDSON. We look forward to working with you, sir.

Mr. CHRISTENSEN. Thank you.

Mr. ENSIGN. Before we take a break to go vote, let me just ask a couple of questions. By the way, for the record, I am 37. [Laughter.]

Mr. Davidson, you talked about simplification of the whole administration between HCFA and what they require out of hospitals, doctors, the whole thing. I have had a lot of townhall meetings and my Medicare task force on this whole discussion. I would just like to hear some suggestions actually from either one of you on general concepts on simplification.

Mr. DAVIDSON. We have a whole plan, Mr. Chairman, that outlines a series of recommendations which we think you would be very responsive to.

Mr. ENSIGN. The other thing that I hear in the townhall meetings with this simplification process is for seniors to be able to understand the bills that they get. A lot of times, they would like to check on something that was done to them, they do not think something was done that maybe was done, and they have trouble even understanding the bills they get either from the hospitals, insurance companies, or whoever it is. So do your reforms address that as well?

Mr. DAVIDSON. That is one of our most serious problems. If we would try to invent a confusing system, the hospital billing system is what we would have invented. It kind of happened that way and it is a product of so much diversity in the system, coupled with the governmental involvement, and be certain that it is very difficult for us to do this for a living, to understand some of these things. So we have got a long way to go on that front.

It clearly could be changed dramatically, if you moved to a Federal Employees Health Benefits Plan arrangement or some other kind of options in terms of the private insurance market. I think there are big opportunities there.

Mr. ENSIGN. Do you have any numbers on the impact that could have on hospitals or on providers across the country?

Mr. DAVIDSON. Certainly. It could save millions of dollars by streamlining the process, getting greater uniformity in data collection and all of the rest. We could make up almost any number and probably work a way to achieve it.

Mr. SCULLY. It is probably not a scorable number, unfortunately. But I think one of the things that is important, we also have a package that we have worked out with the AHA, as well. Our view is you are moving from a system in which the government is trying to manage the health care benefits of 37 million seniors on a micromanagement basis, and you have all these self-referral laws and lots of things that have been appropriately in many cases put in the last 10 years.

But if you move to a system where the government is trying to pay for individual service and track it and make sure it does not get scammed on things to a system in which you are basically buying coverage like a private employer would be, the way to get savings in the system and encourage streamlining and the move to greater efficiency is to move to this kind of capitated payment system.

One of the problems you have is a lot of the existing laws that are set up in Medicare are for safeguards for fee-for-service systems. One of the things that concerns us is, as you move to a capitated privatized system, you are encouraging us to go and put together physician-hospital networks, to put together managed care networks. There are a lot of things in the Medicare law now that set up enormous barriers to that.

If you are fundamentally rescoping the program and moving away from a fee-for-service system to basically a capitated integrated service network system, you have got to turn the whole system around, because right now the incentives are all basically to make sure that people do self-referrals, that people do not set up coordinated care networks. And as you move toward that kind of system, you have got to really make sure that you look at the details in how you rescope it. That is a big concern of ours.

Mr. ENSIGN. One of the reasons that I raise the question is trying to convince people that this is one of the cost-saving areas. When you say that you are going to be saving money and providing better care, this is one of the ways I think is obvious, that this costs everybody. This is inefficiency and this costs the taxpayers. This costs the providers, as well. Everybody loses. This is the lose-lose-lose situation, instead of a win-win-win situation. So I would appreciate your getting me that part.

Mr. Scully, just one last quick question. Address Federal price controls, as you mention that in your testimony. That is something the seniors bring out an awful lot to me in townhall meetings. I know how I address that, but explain to the panel here why you think that Federal price controls would not work.

Mr. SCULLY. We have had this discussion for many years with people on the other side of the panel. Medicare is a single-payer, rate-set fee-for-service price system, that is what it is. And while it provides great service to the seniors, we think it is a model of inefficiency. It just creates a lot of perverse incentives.

If you are a hospital, and the reason we are so aggressively for reform is we are not exactly great lovers of managed care insur-

ance companies, but at least they provide rational market incentives. And if you are sitting there as a hospital administrator and you get 50 or 60 percent of your money from Medicare and Medicaid and 40 or 50 percent from private sector plans, the incentives are totally different. Because of the way Medicare works and you have got 15 different pots of reimbursement, you end up doing a lot of crazy things.

One example would be let us say you have a 64-year-old who breaks their hip and a 66-year-old that breaks their hip. The 64-year-old, if they are in a private health plan, he may not like Prudential or CIGNA or whoever it is, but you sit down and you work out what is the most rational way in different settings of care—inpatient, outpatient, skilled nursing facility, home health, whatever—to find the cheapest, most efficient way to get them healthy.

In Medicare, you get all these crazy incentives for pots. We get paid under DRG's 3-day rule. You follow where the money goes in Medicare and the hospital side, and we do a lot of nutty things, and we know and we have just gotten to the point of frustration. We have basically decided that we would rather deal—as much as we do not love insurance companies—we would rather deal with somebody who has rational economic incentives than deal with a very fragmented crazy reimbursement fee-for-service system with price setting.

Again, you asked if we could meet the capitated rates in 2002. We are not happy about that being put in the system, but our view is that the more efficient and more cost-effective providers will win, and we are willing to go out and compete to do that. Right now, everybody gets paid the same amount, whether you are efficient or inefficient. They basically have one Federal set of prices and that is it. So two hospitals in the same town get paid the same thing, regardless of how good they are.

Mr. ENSIGN. I want to thank you both. We have about 3 minutes left before we have a vote. I want to than you very much for your testimony. I would just make this prediction on the record that 7 years from now hospitals will still be open.

Thank you.

[Recess.]

Chairman THOMAS [presiding]. The Subcommittee will reconvene.

Reading from my left to my right, Mr. Bringewatt, Mr. Jasper, Mr. Strand, and Mr. Burman. I want to thank you all for coming. Your written testimony will be made a part of the record, without objection, and we look forward to hearing from you in the oral portion in any way you may see fit to inform the Subcommittee.

As we move forward, Mr. Bringewatt, you might well start, and then we will move to Mr. Jasper, Mr. Strand, and Mr. Burman.

Thank you.

STATEMENT OF RICHARD J. BRINGEWATT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL CHRONIC CARE CONSORTIUM, BLOOMINGTON, MINNESOTA

Mr. BRINGEWATT. Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify on behalf of the National Chronic Care Consortium, and to offer recommendations on restructuring the Medicare Program.

The National Chronic Care Consortium is a national organization representing 24 of the Nation's leading health networks. Our mission is to establish new methods of integrating care for people with serious and disabling chronic conditions, such as heart disease, Alzheimer's, and strokes.

The major premise of my testimony is that meaningful control over health care spending only can be achieved by fundamentally restructuring provider operations. We must shift our current legislative orientation from one which micromanages care settings and staff, piece by piece, to one which provides incentives for groups of providers who serve a common high-risk population, in order to work together in doing whatever is most cost effective across settings and over time. Establishing separate copays and deductibles, reducing payment rates or increasing care restrictions by hospital, nursing home, or home care providers may produce short-term cost savings for the affected program, but may not produce long-term cost savings, since these practices ignore the cuts in one part of the system and how they affect the total care costs.

Long-term cost savings will require several actions. First, we must shift our focus from an acute care orientation to a chronic care orientation. Chronic disease represents the highest cost, fastest growing segment in health care accounting for 80 percent of all deaths and 90 percent of all morbidity. Since the lion's share of health care resources are consumed by chronic diseases and disabilities, it does not make sense to maintain a system designed to respond primarily to acute care conditions.

Second, Congress must eliminate Medicare policies that reinforce high-cost care. Most Medicare policy is organized around health care settings, such as hospitals, nursing homes, and home health providers. These policies foster duplication of activity across settings, prevent providers from collaborating on care for the same patient, and prevent us from understanding the cost of treating the most costly problem in health care today.

For example, over the course of a single episode of care, a hip fracture patient needing surgery and postrehabilitation may require as many as 8 different assessments and 8 different care plans developed by multiple-care managers, each with their own approach to care.

Why can we not have a single assessment for an episode of care? Because Medicare requires separate workups for each care setting and specialists working in each setting. Why can we not have a single-care plan or patient record which follows the patient across settings? Because Medicare requires each place and profession to collect different data using different measures and documentation in different ways. Why can't I tell you what it would cost on average to treat a patient with a hip fracture, Alzheimer's disease, arthritis, or other major chronic diseases or disabilities throughout their evolution of such conditions? Because Medicare policies do not enable us to aggregate utilization, cost, and quality data in a way that produces cost information that crosses time, place, and profession.

What we can say is that where organizations have integrated health services under pool fixed-dollar financing, there have been demonstrated cost savings. For example, staff model HMOs versus other HMOs, and several demonstrations including PACE and

Evercare have demonstrated cost savings of between 10 and 30 percent.

Third, Medicare and Medicaid policies are intricately related and must be standardized. Both Medicare and Medicaid finance care for people with chronic conditions. Virtually all health care providers must respond to Medicare and Medicaid policies. Where these policies are inconsistent with one another, the providers must establish duplicate records and procedures. This has serious cost implications for both programs. Moreover, different care approaches under each program also has significant cost implications.

For example, failure to finance and manage medical care for people in nursing homes has a direct cost implication for controlling hospital expenditures under Medicare. Failure to manage chronic diseases and disabilities by physicians and hospitals has direct implications for controlling long-term care costs and associated Medicaid expenditures.

What is the answer? Congress must establish a new consolidated provider category for Medicare and Medicaid. Providers functioning under this category would specialize in care of people with chronic conditions; provide whatever combination of care is most cost effective; use integrated methods of administration, financing, and delivery; function under a single set of rules and regulations; and receive fixed-dollar or capitated payments at or below prevailing rates.

Mr. Chairman, a transportation engineer can make a train run faster by designing a new wheel, but the company paying the freight may find greater savings with a different mode of transportation. It is time for Medicare to stop reengineering payment rates for hospitals, nursing homes, and clinics and reassess its future cargo. The future cargo for Medicare and Medicaid is chronic care. Congress may find that a whole new approach to care is more cost effective than our current fragmented system.

I would be happy to answer any questions, and I look forward to opportunities of working with you and seeking ways to contain cost through better care.

Thank you.

[The prepared statement follows:]

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NATIONAL CHRONIC CARE CONSORTIUM
STATEMENT ON MEDICARE MANAGED CARE PROGRAMS
HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee on Health, I'm Richard Bringewatt, President and CEO of the National Chronic Care Consortium (NCCC). NCCC is a national organization representing 24 of the nation's leading health care networks with services provided in 16 states and every region of the country. The mission of NCCC is to fundamentally transform the way health care services are administered, financed and delivered. Our members are working toward the achievement of these goals through the establishment of delivery models that integrate the full range of services required by the chronically-ill from primary and acute care through long-term care.

NCCC appreciates the opportunity to offer our recommendations on restructuring the Medicare program. Clearly, Medicare cost containment is central to achieving Congress' balanced budget objective. We strongly support Congressional efforts to restructure Medicare through the application of integrated delivery system and managed care principles for several reasons. First, Medicare is one of the fastest growing entitlement programs in the Federal budget. Congress cannot meet its balanced budget objectives without reducing the growth rate of Medicare expenditures in future years.

Second, since our current health care system was formed several decades ago, the nature of illness in our country has shifted from a preponderance of acute care illnesses to a preponderance of chronic conditions. Chronic disease like heart disease, Alzheimer's and strokes now accounts for 80% of all deaths and 90% of morbidity and the rate of increase in chronic disease continues to surpass the growth of acute care illnesses. If we are to effectively contain health care costs we must shift our health care structures from an acute care orientation which responds to crisis events and focuses on isolated segments of the health care system such as hospitals and nursing homes to a disability prevention orientation which employs a multidisciplinary, systems approach to care. We need to change our approach from organizing financing and care around providers to organizing financing and care around the problems of people that cross provider settings and extend over a long period of time.

Third, we must streamline our regulatory systems to allow providers, purchasers and payors to make health care treatment decisions based on the most cost-effective approach to caring for specific chronic illnesses, regardless of what combination of care achieves those results. The private sector already has received this wake up call and has begun to modify administrative and delivery systems to accommodate this new paradigm in health care. Most of our nation's major health care systems and many free-standing providers have begun to affiliate with other providers in establishing integrated delivery systems. Increasingly, the focus is not just on consolidation of assets and strengthening of market position, but extends to fundamentally changing the nature of how we do business. Sufficient evidence from private sector initiatives and public demonstrations exits regarding the cost-savings potential of integrated care to warrant streamlining regulations to expedite the movement from segregated care to integrated care.

Public programs such as Medicare and Medicaid, however, remain entrenched in old rules which lock providers and payors into a system which fosters duplication and fragmentation across the spectrum of health care services and actually encourages providers to maximize billing opportunities for their individual segments of care instead of working collectively with other providers to meet common clinical, cost and quality goals. Until we simplify and standardize rules and regulations governing the administration, financing and delivery of Medicare and Medicaid services, we will be helpless even to document and understand, much less contain, health care system costs. Further, we must recognize the interdependence between the Medicare and Medicaid programs to prevent cost-shifting between these two programs, improve continuity of care for the dually eligible and contain the growth of the two largest health care entitlement programs. Most providers and an increasingly greater number of care recipients are affected by both programs with inconsistencies between these programs adding to the cost and confusion of serving people with chronic conditions.

Mr. Chairman, the NCCC has developed a legislative proposal for restructuring the Medicare and Medicaid programs which we believe can effectively address these problems. Our proposal focuses on both programs based on the interdependence between the two. The Chronic Care Act of 1995 would establish a single, consolidated provider category called a chronic care network (CCN) for delivering Medicare and Medicaid services to the chronically-ill. All Medicare and Medicaid services provided by

a CCN would be subject to a single set of administrative requirements, payment policies, reporting requirements and methods for evaluating performance. To receive certification as a CCN, provider networks would be required to demonstrate their ability to integrate the full range of primary, acute and long-term care services as well as the administrative and clinical systems necessary to support these services. The focus of this Act is on containing costs through better care.

CCNs services would be paid for under a pooled financing mechanism to reduce duplication of services and increase provider flexibility in resource allocation, fixed dollar or capitated financing to limit aggregate costs, and shared-risk methods to create incentives for collaboration toward common clinical outcomes and cost targets. Initially, the Secretary would establish payment rates for different categories of chronic illness such as End-Stage Renal Disease and acute episodes of chronic conditions like stroke and hip fractures. These rates would be set at or below 95% of the average community costs in caring for a defined population under the fee-for-service sector. While NCCC is very much aware of the disadvantages of using the fee-for-service sector as the basis for establishing payment rates, there simply is no viable alternative at this time for establishing fixed payment levels for chronic conditions. To date, no public or private programs have systematically collected data on individual chronic conditions across time, place and profession. In fact, one of the goals of the Chronic Care Act is to establish an integrated information system which will enable us to accurately document the cost of chronic care over time within defined populations.

We also understand the concerns raised by HCFA and Congress regarding Medicare HMO risk contracts which have had questionable success in producing savings due to the bias of Medicare HMOs toward the well-elderly, the cost-shifting that can result between Medicare HMOs and fee-for-service programs and payment link to the fee-for-service sector. Each of these factors has contributed, in some cases, to "overpayment" of providers, even under the 95% rule. We believe CCNs would be isolated from these effects, however, since these networks would only serve those persons already diagnosed with a chronic condition and payments would be established by the Secretary on the basis known costs directly associated with specific care needs.

In the interim, our Act includes several strategies that we believe will effectively contain costs. Cost-savings will be produced by improved care and outcomes; elimination of duplication and fragmentation among services; streamlining of regulations and standardization of oversight criteria and functions; spending caps and related incentives for further cost reductions. In cases where providers can deliver services for less than the negotiated rate, they will be permitted to keep half of these savings. The other half will be returned to the Federal government for deficit reduction and reinvestment in restructuring of the health care system.

Mr. Chairman, we cannot promise that the Chronic Care Act alone will produce major short-term cost savings for achieving the Congressional targets of $270 billion dollars in Medicare savings and $182 billion in Medicaid savings needed to achieve a balanced budget by 2002. Long-term cost savings requires a primary focus on producing better car through reengineering of our entire approach to how we administer, finance and deliver care to people with chronic conditions. It will require a phased-in approach to allow sufficient time for remodeling our health care infrastructure. Further, the type of health care initiatives being considered by the Federal government will require an initial investment in restructuring the administration, financing and delivery of Medicare and Medicaid services. NCCC is convinced, however, that if an appropriate investment in Medicare restructuring is undertaken today, some short-term savings can be attained. More importantly, significant long-term savings can be achieved *with better care results*. Ignoring the details of system transformation through simple but major reductions in allocations may fail to achieve both quality and cost-containment objectives.

II. STRATEGIC ASSUMPTIONS REGARDING HEALTH CARE SYSTEMS TRANSFORMATION

Effective reform of Medicare, Medicaid and other health care programs will require a fundamental transformation of the way care is administered, delivered and financed. Solutions must focus on underlying causes of health care inflation such as the fragmentation and duplication characterizing our administrative, financing and delivery systems in serving people with chronic conditions. Solutions must include strong incentives for consumers, providers, payors and regulators to approach the health care system in a cost-conscious manner.

Advances in medical care and technology are moving our society from a predominance of short-term, cure-oriented conditions to a predominance of conditions that require ongoing, multidimensional, high-cost care. Hospitals, nursing homes, physicians and community-based long-term care providers are

becoming increasing interdependent in serving a common chronically-impaired population. Cumulative costs and quality of life for persons with serious and persistent chronic conditions are both significantly dependent upon the full array of primary, acute, transitional and long-term care providers working together to prevent, delay or minimize disability progression and its associated costs.

To date, the health care system has not adequately responded to these changing demands. We continue to use heroic means to ward off death, while we largely ignore the benefits of disability prevention and primary care. We continue to finance and manage care through isolated care segments which increases administrative costs without improving the coordination of care. While major attention has been given to controlling short-term costs and maximizing profit margins within existing provider structures, little attention has been given to the accumulation of costs across time and setting. To effectively address the needs of the chronically-ill and reduce overall systems costs, we must modify our approach to the delivery, administration and financing of long-term care based on the strategic assumptions outlined below.

A. ***STRATEGIC ASSUMPTION:*** ***Our approach to service delivery must shift from an acute care orientation to a chronic care orientation.***

Chronic disease represents the highest-cost, fastest-growing segment of the health care system. To contain health care costs, we must recognize the need to shift our fundamental orientation to health care delivery from an acute care model to a chronic care model. The acute care model is designed to respond to crisis events and episodes of illness rather than the prevention of disability progression. An acute care approach focuses on isolated care planning and referral rather than management of patient care across the multiple disciplines providing primary, acute and long-term care services. Administrative, financing and delivery rules are based on the phase of illness being treated (acute vs rehabilitation vs long-term care), the treatment setting (hospital vs nursing home vs home care), and the health care professional delivering services (doctor vs nurse vs rehabilitation therapist).

Effective integration of chronic care services requires a "trinocular" view of health care delivery where the perspectives of acute, long-term care and managed care providers are taken into account. Acute care professions view chronic care in terms of illness and cure. They are very "high-tech" in service orientation and organize care in short-term, episodic approaches. Long-term care professionals view chronic care problems in terms of function and are "high-touch" in service orientation. They organize care over an extended period of time. Managed care professionals think of chronic care problems in terms of optimizing health outcomes and reducing costs. They approach health care solutions in terms of primary, secondary and tertiary prevention. Effective cost-containment will require the incorporation of all three perspectives into an integrated system of care.

The current system *must* be restructured to allow providers the flexibility and financial incentives to more effectively respond to the needs of the chronically-ill; manage care across time, place and profession; and to use whatever combination of care is most cost-effective. Providers must have the ability to make patient care decisions based on clinical judgements about the most effective treatments and settings, not based on which programs and services are reimbursed by a particular payor.

INTERVENTION: ***System Integration.***

We must move from a micro approach to managing isolated health care episodes to a macro or systems approach to managing particular patient conditions. System integration strategies must emanate from a clear vision and definition of a new service delivery reality. This new vision must be grounded in the following integrated health network concepts:

- full continuum of care, integrated across discipline and setting;
- multidimensional care planning and implementation;
- emphasis on preventing, delaying or minimizing the progression of disability;
- capitated, shared-risk financing across providers;
- longitudinal focus, not episodic focus, with emphasis on cumulative cost and results.

B. ***STRATEGIC ASSUMPTION:*** ***We must standardize our approach to the administration and management of health care services.***

Health care administrative policies and procedures are based on the acute care model with its episodic orientation. Separate policy authorities exist for major segments of chronic care financing and separate administrative authorities exist for each Federal program. Regulations governing eligibility criteria,

coverage rules, payment policies and evaluation methods differ across program categories such as Medicare and Medicaid. Requirements regarding patient assessments, care planning, data collection and record keeping are separately defined by clinics, hospitals, nursing homes and community-based service settings resulting in high costs and care fragmentation. Separate program administration locks in a major duplication of effort at the local level and makes it virtually impossible to measure, let alone manage, the unintended cost escalation.

For example, Medicare provides primary and acute care-related services to the elderly and disabled regardless of income. It is federally directed, administered through fiscal intermediaries, and reimburses acute care on a prospective basis and skilled care on a cost basis. Medicaid provides acute and long-term care coverage to the low-income, is federally defined, and administered by the state. Benefits vary from state to state as do income and asset eligibility criteria and reimbursement formulas. Differences in program authority and administrative requirements for the dually eligible who require acute and long-term care services create tremendous fragmentation in service delivery and needlessly increases system costs.

An example of the fragmented delivery created by different program directions is most evident in a dually eligible patient. Since Medicaid is oriented toward long-term care, payment for acute and primary care services is limited. For example, in many cases, a physician can only be paid for visiting a nursing home patient every 30 days unless a new problem arises. Selected acute care services which, theoretically, could be provided in a nursing home or at home are not provided in these lower-cost settings due to reimbursement and clinical restrictions. Therefore, patients experiencing recurring medical problems frequently must be hospitalized to receive payment for medical care since they become eligible for Medicare acute care benefits once transferred to the hospital. However, the incentive under Medicare's PPS system is to discharge patients to lower care settings as quickly as possible to maximize DRG payments. Frequently patients move back to a nursing home setting at a higher care level, often resulting in cost-shifting, cumulative cost increases and dissatisfied consumers.

Conflicting incentives in the Medicare and Medicaid payment systems leads to a continuous cycle of transfers among health care settings to meet patients' medical and long-term care needs. In addition, since each system has separate clinical requirements, costs are multiplied needlessly by duplication. For example, an elderly patient receiving services under Medicare, Medicaid, Social Service Block Grant and Older American Act programs, could have *four different case managers and four different care plans* – none of which routinely are coordinated with one another. Such conflicts must be eliminated if health care cost inflation is to be brought under control.

INTERVENTION: Consistent Public Policy.

To date, policymakers have focused on almost exclusively on financing reform as the solution to containing health care costs. Even if we move to a health care system which operates within a global budget and fully capitates all primary, acute and long-term care services, however, we won't be able to maximize cost-savings opportunities. Health care cost containment also is dependent on a restructuring of health care administrative and delivery systems. Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the chronically-ill.

The administration of health care financing must be standardized across providers and payors. Administration should be shifted from cost accounting systems focused on different payors and providers to a system which integrates financing administration for the network of providers providing services to common patients. All network providers should be required to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes. While different providers and payors require information that is unique to their own setting, it is critical that integrated delivery systems define information the same between providers where information is common to all. For example, assessment protocols for measuring functional and cognitive status should be the same whether collected by a nurse or social worker in a nursing home or home care setting.

Administrative policies also should be modified to allow provider networks to use a single budget cycle; compatible bookkeeping, accounting and reporting structures; and compatible claims processing and other fiscal management methods across settings. In addition, financial management systems must begin linking cost data with outcomes data across providers and payors for purposes of assessing the cost-effectiveness of various treatment protocols and establishing outcome measures for evaluating performance.

C. ***STRATEGIC ASSUMPTION:*** ***We must move from a fee-for-service payment system to risk-based, fixed-dollar financing which pools financing across programs and health care settings.***

Our current health care financing system is replete with disincentives to cost-effective service delivery. Whether a public or private agency, payors are writing increasingly stringent contract or grant specifications for service delivery and monitoring care for specific services on a case-by-case basis. Control is organized around issues of service amount, frequency, and duration for specific care segments, rather than based on outcomes. It is difficult for program integration to occur in the absence of outcomes-based management and global budget targets that allow for provider flexibility and innovation.

Most cost-containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk-arrangements. There is little or no incentive for providers to collaborate in cost-savings across the continuum of care. Even managed care organizations engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service basis. The result is risk management on an episodic basis by negotiating the lowest-priced contract for each provider or service. The result is a high cost administrative structure and ineffective delivery model for chronic care. Cumulative costs increase and quality diminishes.

INTERVENTION: Replace Micromanagment of Behavior with Outcome Orientation

Policies governing provider practices must be less prescriptive of process and procedures used by individual providers and staff, and more focused on outcomes of care and the cumulative effects on the client. Structures for finance and administration must shift from containing costs within narrow health segments to giving providers incentives to collectively contain costs, prevent disability progression and emphasize customer satisfaction across time, place and profession. Provider-based systems should be established where provider networks are paid under shared-risk arrangements for achieving cumulative cost and outcome targets.

III. RESTRUCTURING HEALTH CARE THROUGH INTEGRATED DELIVERY SYSTEMS

A. Private Sector Entry into Integrated Delivery Systems and Managed Care

NCCC believes that one of the most important outcomes of the health care reform debate of 1993-1994 was to increase awareness among consumers, providers and policymakers about the cost-savings potential of integrated delivery systems. While the private health care industry had been moving toward integrated delivery systems and managed care approaches prior to 1993, the prospect of health care reform legislation mandating health care delivery around "accountable health plans" and risk-based financing dramatically escalated the movement toward the integration of primary and acute care services. NCCC is convinced that, with or without legislative mandates, the private sector will continue the movement toward health systems integration. But it needs the support of Federal leadership to maximize its potential.

Today, many of our leading health care providers are merging their resources under new health care alliances covering the spectrum of primary, acute and long-term care services. Integration efforts have focused on the merger of hospitals, physicians and managed care plans operate. To fully realize the potential of integrated delivery systems to improve care and reduce costs, long-term care providers must become an integral part of the system. Efforts of the private sector need the stimulus of federal policy that is supportive of these emerging trends.

B. Integrated Delivery Systems as an Alternative Savings Device

NCCC believes that the integrated delivery system model represents a far more rationale approach to cost-containment than simply ratcheting down provider payments. Experiments with price controls beginning in the Nixon Administration have shown that this approach simply does not work. Results are short-term at best since price controls address the product of inefficient health care delivery, not the underlying causes.

The cost-savings potential of integrated delivery systems and managed care plans has evidenced

substantially lower utilization rates in areas such as hospital admissions and lengths of stay. In addition, health care systems, providers and insurers have become much more sophisticated and "bottom-line" oriented. Many private systems practice aggressive case management, capitated financing and information management and are increasingly characterized by an outcome orientation. As we move to new structures of operation under a single payment with which to manage a patient's total health care needs, there is a strong incentive to avoid high-cost, event-based care and significantly reduce the cumulative cost of primary, acute and long-term care.

Despite this progress, however, NCCC believes that it is important to note a missing link in the proliferation of integrated delivery systems. While the medical sector is moving forward quickly to establish cost-savings joint ventures, the long-term care industry has not been integral to the movement. Congress could play an important role in expanding opportunities for LTC provider participation by eliminating current barriers to using managed care principles in the delivery of LTC services and bridging the gaps among primary, acute and long-term care.

The integration of primary, acute and long-term care services is critical to maximizing cost-savings and efficiencies across the health care system. Pooling financing that rewards outcomes over process can free the long-term care industry from excessive use of institutional services. Long-term care services and settings such as home care, adult day care and skilled nursing care offer lower-cost alternatives to traditional acute care. Chronically-ill patients who represent the highest-cost and fastest-growing health care segment must have access to the full range of health care services with assurance of care continuity from primary through long-term care and commitment to minimizing disability progression if the system is to achieve optimal savings.

C. Integrated Delivery Systems vs Managed Care Plans

NCCC believes that it is important to distinguish between managed care arrangements and fully integrated health care delivery systems. While managed care contains an important ingredient that can facilitate integration, the concepts of managed care and integration are not necessarily the same. Managed care typically refers to an arrangement in which an HMO or other entity is given a prepaid, capitated payment for each enrollee in exchange for providing a defined set of services. Such risk contracts provide HMOs the incentive to effectively manage the cost and quality of care for all enrollees. Managed care techniques can include pre-authorization for the use of services, the assignment of a primary care physician to coordinate care, specialized case management for high risk cases, an emphasis on prevention, and the use of a more flexible benefit package than is normally permitted in fee-for-service arrangements. These techniques, however, do not automatically translate into an integrated health system.

Fully integrated service networks manage care across all settings in the service of a common care plan which seeks to optimize patient outcomes through collective action. Administrative, financial and information systems must be integrated to support a common approach to care. For integration to occur under managed care plans, all providers serving the same patients must share in the financial risks and rewards associated with providing care, with all providers working toward common cost and quality goals across the network. In contrast, under managed care plans, all too often individual providers work under separate, often non-risk contracts, and work within their own settings to maximize billing opportunities. Incentives among providers within a given network must be aligned for a network to be integrated.

Providers alone, however, cannot be blamed for their failure to employ an integrated systems approach to health care delivery. Current laws and regulation often prevent them from doing so. Congress could play an important role in eliminating a micro-management approach to health care delivery and promoting a systems approach by streamlining existing regulations and standardizing regulations governing the administration, financing and delivery of health care services. NCCC believes that the establishment of a consolidated provider category, such as the Chronic Care Network model described below, offers a viable strategy for moving toward an integrated delivery system approach.

D. Cost-Savings Potential of Integrated Delivery Systems and Managed Care

No one knows the actual costs of caring for any chronic condition because we don't collect information about the cost of care for complex chronic conditions across time, place, profession and funding source. For example, we know that there is a direct relationship between stokes and hip fractures and the use of long-term care services. We know that hypertension, diabetes and osteoporosis are all precursors to chronic conditions. We know that the chronically-ill use a significant amount of drugs

and medical equipment. But we cannot document the actual costs of these conditions across settings and over time. Only by coordinating information over time regarding cost, quality and outcomes for the same patients and populations across the continuum of care will it be possible to accurately assess the true cost savings potential of integrated delivery models.

The collective experience of NCCC members, however, suggests that integrated delivery system and managed care approaches have the potential to effectively address three primary and compatible goals of a health systems transformation. These goals include reducing aggregate health care costs, decreasing health care inflation rates and improving quality of care. Many of the NCCC members have been providing Medicare and Medicaid managed care services since the early to mid-80s under integrated/managed care models such as the Social HMO and PACE demonstrations and the hospice program. Other providers have had the opportunity to observe the cost savings potential of managed care through programs such as the End-Stage Renal Disease and Evercare Programs. Below are highlights of both the limitations and cost-savings potential of some of these programs.

Social HMO: The Social HMO (SHMO) model offers Medicare beneficiaries an enhanced package of Medicare acute care services and limited coverage of long-term care services. Services are financed on a capitated basis using Medicare, Medicaid and private premiums. SHMO is primarily an insurance model that manages risk across a representative population of well and disabled elderly. SHMOs have been effective in reducing acute care costs through fewer hospitalizations and shorter lengths of stay. Since SHMOs bear limited risk for long-term care services, however, they do not have the incentive to manage risk across the full array of chronic care services once an individual becomes nursing home eligible. Instead, these organizations have placed greater emphasis on issues related to the progression of disability during the earlier phases of a chronic condition, such as rehabilitation. While the SHMO represents an important financing demonstration on integrated care, and an important foundation for further reform, the evaluation of this demonstration to date indicates relatively little impact on the integration of acute and long-term care under this model.

PACE: The Program of All-Inclusive Care for the Elderly (PACE) provides the full range of primary, acute and long-term care services required by the nursing home certifiable population through an adult day care model which discourages institutionalization. Services are financed through Medicare, Medicaid and private resources and about 90% of PACE residents are dually eligible for Medicare and Medicaid. Providers receive a capitated payment from Medicare and/or Medicaid to provide the full range of services. PACE represents a risk management model focusing on the opposite end of the care spectrum from SHMOs. Since PACE enrolls only the frail, nursing home certifiable population, the program has a more fully integrated orientation toward patient care than the SHMO model. PACE programs have been forced to focus more extensively on restructuring of service delivery since they are financially at risk for any services needed that exceed the combined monthly capitation payment for a very high cost service group. Unlike the SHMOs, however, PACE programs have not focused on primary prevention strategies since enrollees are severely disabled when they enter the program. Although no formal evaluation of PACE programs have been conducted to date, the PACE Program indicates that sites have been effective in providing services at an average savings of 15% below what it would have cost to care for the same population in a nursing home setting.

End-Stage Renal Disease Program (ESRD): About 80% of ESRD program costs are financed through the Medicare program. Annual costs for 1995 are projected at $10 billion for dialysis patients alone, or about $48,000 per patient for the estimated 200,000 beneficiaries. Medicare costs for dialysis patients can be decreased as much as 20% from the fee-for-service system when patients are cared for within an integrated financing and delivery system such as proposed in the Chronic Care Act. Projected savings of $2 billion would come from reduction in per patient cost increases, reductions in hospitalizations achieved through early referral, aggressive care management and adherence to practice guidelines, and a reduction in outpatient ancillary costs.

Hospice: Hospice care is a special way of caring for terminally ill patients and is available under Part A of Medicare. Services primarily are delivered in a patient's home, including reasonable and necessary medical and support services furnished by an interdisciplinary team. Four studies conducted to date have projected cost savings for the hospice program when compared to the Medicare fee-for-service system. These savings ranged from 3% to 32%, depending on length of stay among other factors.

Evercare: Evercare is a managed care program for nursing home residents which coordinates all acute care services for residents. The cost savings results of this program have been impressive. Total costs have been reduced by 30% compared to fee for service arrangements. Savings have been achieved by

reducing hospital admissions by approximately one-third, decreasing average lengths of stay in a hospital by almost 50% and increasing preventive, skilled and subacute care services for nursing home residents.

Public sector approaches to health care cost containment have focused disproportionally on restructuring the way care is financed without simultaneously addressing the structural problems in health care delivery and administration. Further, demonstrations such as the Social HMO and PACE have focused on a segment of the total problem. Such limitations prevent us from being able to accurately access the cumulative cost-savings possible through continuous interventions at various stages of chronic disease. A second drawback to the demonstration model is that demonstrations are implemented in a artificial environment, freezing in place certain research designs and prohibiting modifications as learning occurs. Frequently, they operate under waivers that uncouple operations from the realities of mainstream providers. The changing dynamics in health care require a reengineering approach to change implemented in mainstream environments through a phased-in approach under flexible but carefully monitored arrangements rather than a research and demonstration strategy. The Chronic Care Act represents such as opportunity.

IV. COST CONTAINMENT THROUGH SYSTEMS TRANSFORMATION

NCCC has developed a legislative proposal which would restructure the financing, delivery and administration of Medicare and Medicaid benefits, streamline duplicative and conflicting regulations, and increase provider flexibility in the way care is delivered. The central vehicle for achieving these goals would be the establishment of chronic care networks, a consolidated provider category under the Medicare and Medicaid programs.

Chronic Care Networks (CCNs) represent alliances among the major providers of chronic care services, including primary and acute care, transitional care, and residential and community-based long-term care providers who function under integrated administrative, financing and delivery arrangements. CCNs would have the discretion to serve a predefined program serving the chronically-ill or a set of program categories. For example, some may choose to specialize in ESRD or acute episodes of chronic illness such as strokes and hip fractures. Others may treat many types of chronic conditions such as all primary, acute and long-term care problems for persons dually eligible for Medicare and Medicaid or all persons certified as nursing home eligible. All Medicare and Medicaid services provided by a designated CCN would be subject to a single set of regulatory requirements, performance standards, payment methods and administrative procedures for monitoring and reporting. CCNs would be certified by a national nonprofit organization with special skills in assessing network integration capabilities in serving the chronically-ill.

To become certified as a CCN, provider networks would need to meet the following requirements:

* **Integrated Continuum** of preventive, primary, acute, transitional and long-term care services with providers following a common set of care protocols and quality measures;

* **Integrated Care Management** coordinated by an interdisciplinary team of health care professionals with the authority to manage utilization, cost and care across the spectrum of CCN services;

* **Provider Network Contracting** under pooled financing to reduce duplication of services and increase provider flexibility, fixed-dollar or capitated payments to limit aggregate costs and shared risk financing to create incentives for collaboration toward common clinical, quality and cost targets;

* **Integrated Information Systems** that allow providers to track utilization, cost, quality and outcomes data across time, place and profession;

* **Integrated Quality Assurance Systems** for monitoring system performance and for changing practice patterns in response to network performance trends.

* **Disability prevention guidelines** consisting of standardized methods for managing care across time and setting to prevent, delay or minimize the effects of disability progression.

CCNs also would be required to employ self-help information, assistance and applied technology and

chronic care expertise. Consumers receiving services from CCNs would have the right to participate in care decisions and choose providers outside of the CCN by paying additional charges for out-of-plan utilization.

Services would be financed through the Medicare and Medicaid programs based on the payment method established for each chronic illness category eligible for reimbursement such as ESRD, hospice, etc. Different rate structures and payment methods would be established for each program category and for conditions within each program category. Some programs would offer a capitated payment while others would offer a fixed dollar or per case payment based on expected service utilization or duration of episode. The Secretary of HHS would have the authority to establish a single payment for all Medicare and Medicaid benefits provided by a CCN for a defined service group or population with all payment equal to or less than 95% of the fee-for-service costs in a defined community. CCNs initially would receive payments through a Medicare HMO, Competitive Medical Plan or other method until the entities establish the risk-financing capabilities to administer payments. At that time, HCFA or state administering agencies could make direct payment to the CCN.

The Chronic Care Act would produce savings in several ways: (1) improved care and outcomes; (2) by eliminating duplication and fragmentation among services; (3) by streamlining regulatory requirements; (4) through spending caps; and (5) through the development of technological strategies which could reduce labor, transportation and other costs. In addition, no CCN would be paid at a rate that exceeds 95% of costs under a fee-for-service arrangement in a given community. The costs will never be more and there will be incentives for further cost reductions. Any savings over traditional costs would be divided equally between the provider network and the Federal government. Federal savings would be divided equally between deficit reduction and reinvestment in restructuring the health care system. In cases where Medicare and Medicaid funds are pooled, HCFA would determine how to allocate these savings between the Medicare and Medicaid programs.

To assure quality under CCNs, the Secretary would designate a national certification and review organization to develop and implement a continuous quality assurance program for persons with serious chronic conditions with the support of emerging information systems technology. Certification methods would be established in accordance with CCN criteria identified in this Act. The Secretary also would establish a quality assurance program for persons with serious chronic conditions to identify:

- risk factors and interventions associated with progression of chronic conditions;
- interrelationships among medical, functional, cognitive, social and environmental conditions;
- the clinical and financial efficacy of different treatment protocols for specific chronic conditions;
- indicators of client satisfaction;
- a core data set (e.g., utilization, costs, quality, outcomes, etc.) and methods for moving towards outcome-based accountability;
- other factors affecting clinical outcomes and costs.

The Act also calls for the establishment of a public-private partnership among Federal and state governments, foundations, corporations and providers to help finance health systems reengineering. Initiatives would be developed in the following areas:

- **consolidated public administration:** streamline and integrate public administration for financing, monitoring and evaluating chronic care services

- **new payment methodologies:** provide financial incentives for integrating care across providers and settings to improve quality and reduce costs

- **integrated care management:** establish protocols for managing the multidimensional dimensions of care across episodes of illness as well as duration of condition

- **integrated information systems:** establish an integrated information management enabling all purchasers, payors and providers serving a single client to track service utilization, costs and outcomes over life of disabled individuals

- **health professions education:** establish interdisciplinary education and training programs focused on chronic illness

- **applied research:** identify new technologies and delivery methods that increase quality and client satisfaction and reduce aggregate health care costs

Technical assistance would be required to implement the new health care infrastructure. The resource centers on chronic care integration would be established to assist purchasers, providers and payors in the following areas:

- assist the Secretary and states in identifying and eliminating Federal and state regulatory barriers;
- assist organizations in implementation of chronic care networks;
- establish health care education programs, including primary care in geriatrics;
- develop new technologies for serving chronically impaired;
- conduct basic research on preventing the three highest cost chronic conditions.

V. CONCLUSION

In closing, I would like to underscore the need to alter several strategic assumptions regarding the restructuring of our health care delivery system. First, we must shift our focus from an acute care orientation which micro-manages individual components of the health care system to a chronic care orientation which manages the needs of specific populations across time, place and profession. Second, we must streamline legislative and regulatory requirements governing health care administration, financing and service delivery and adopt standardized policies and procedures. Such actions will give providers the flexibility to make treatment decisions based on patient care needs and the most cost-effective combination of services and allow payors to collect uniform information on cost, quality and outcomes for specific health care conditions. Integrated information systems will be critical to the development of standard outcome measures and payment methods which reward quality care.

Third, we must establish new payment systems characterized by pooled, fixed-dollar, shared risk financing which aligns provider incentives to work collaboratively toward common clinical outcome and cost targets. Fourth, we must recognize the interdependence between Medicare and Medicaid and the need for more consistent policies to ensure continuity of care, prevent cost-shifting and reduce overall system costs. Fifth, successful cost containment strategies must not be limited to financing reform alone, but must embrace a fundamental restructuring of our administrative and delivery systems.

The Chronic Care Act is intended to achieve each of these goals through the establishment of a consolidated provider category which would be subject to a single set of payment policies, reporting requirements and evaluation procedures. Chronic care networks would function as fully integrated delivery system for Medicare, Medicaid and dually eligible beneficiaries. We are not suggesting that the Chronic Care Act is a panacea. It is not a "full-blown" proposal which addresses all of the problems in our health care delivery system from insurance to fraud and abuse reforms. And as currently designed, the approach is limited to the Medicare and Medicaid populations. However, the Act is consistent with the goals of the 104th Congress in the areas of deficit reduction, regulatory reform and Medicare and Medicaid restructuring. It represents one approach for applying principles of integrated delivery and managed care to the Medicare program. Furthermore, we believe that our approach can easily be translated to private sector programs and that private insurers and employers will use this model in the future.

On behalf of the National Chronic Care Consortium, I appreciate the opportunity to weigh in at this critical junction when the Ways & Means Health Subcommittee is considering alternative for restructuring the Medicare program. The NCCC stands ready to assist you in any way we can as you move forward with the development of a legislative proposal.

Chairman THOMAS. Thank you very much, Mr. Bringewatt.
Mr. Jasper.

STATEMENT OF W. MARK JASPER, CHAIRMAN, AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS

Mr. JASPER. I would like to thank you for inviting AAPO, the American Association of Preferred Provider Organizations, to participate in this important hearing. The AAPO is the national trade association for preferred provider organizations or PPOs for short.

Since the eighties, PPOs have been available to the under-65 population. PPOs were a marketplace response to the health plan sponsors who are seeking to reduce the rate of medical cost inflation without reducing benefits, and while retaining free choice of physicians.

In the private sector now, there are 79 million people in PPO plans, 802 PPO plans. That compares with 55 million in 564 HMO plans. Clearly, there has been a rapid growth of PPOs, and this reflects their acceptance by patients, by providers, as well as the purchasers of health care.

Indeed, a recent major employer health benefits study reported that PPO plan typed had the lowest medical cost increase in 1994 over 1993, the lowest including HMOs. So PPOs had the lowest increase in that study nationwide.

As we look at Medicare today, we see that there are less than 10 percent of the beneficiaries in HMO plans, and the remaining 90 percent does not have access to a PPO type plan, which is so prevalent in the private sector. We believe the absence of PPOs as a choice and option for Medicare in part explains why the Medicare cost increases have exceeded the private sector's cost increases in recent years.

It is our strong recommendation that Congress legislatively enable PPOs to become direct contractors with HCFA, so that PPOs may be offered as a choice to beneficiaries to achieve the dual goals of slowing the rate of cost increase and maintaining beneficiary satisfaction.

If you are not familiar with PPOs, they are corporate entities that contract with networks of health care providers and in turn contract with the purchasers or plan sponsors of health benefits who then offer those networks as an option. PPO entities have a variety of ownership forms, but it is important to note that most PPO entities are not insurance companies. Some are owned by insurance companies.

PPOs use cost control methods that are not now employed by HCFA. By agreement with contracting physicians, PPOs manage the necessity, appropriateness, and level of health care services. This utilization management results in tangible savings and cost efficiencies in the health care system. PPOs also utilize different rate methods with providers than HCFA does.

For part A hospital services, PPOs pay typically on a daily basis rather than a per admission basis. As length of stays are shortening, this can often result in less cost than the current Medicare method. For part B diagnostic services, PPOs often pay a fixed rate well below the discounted rate that Medicare currently pays for

such diagnostic services in part B. PPOs are available now as a means to introduce to Medicare beneficiaries managed care.

AAPPO has the following recommendations for the congressional legislation that we believe would build upon successful innovations in the marketplace. First, enable direct contracts between HCFA and PPOs. This is similar to what is currently done between PPOs and self-funded employer health plans. Second, modify current Federal law and regulations to permit PPOs to assume full or partial risk arrangements. Third, require accountability of all managed care plan types to protect the interests of beneficiaries.

The AAPPO's board and staff stand ready to assist with the implementation of these recommendations. With your permission, Mr. Chairman, we would like to submit the official PPO definition of our organization to be appended to our testimony for the record.

Thank you.

Chairman THOMAS. Without objection.

[The prepared statement and attachment follow:]

STATEMENT on
PREFERRED PROVIDER ORGANIZATIONS' PART IN SAVING MEDICARE
before the
SUBCOMMITTEE ON HEALTH
of the
COMMITTEE ON WAYS AND MEANS
by
W. Mark Jasper
for the
AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS
July 19, 1995

Good morning, Mr. Chairman and members of the Subcommittee. I am Mark Jasper, Chairman of the American Association of Preferred Provider Organizations (AAPPO). I am also CEO of PROHEALTH, Inc., a PPO management firm in San Marino, California. On behalf of AAPPO, I am very pleased to take part in this important hearing, and to share with you our ideas for strengthening and improving the Medicare program.

AAPPO is the national trade association representing a large segment of the PPO industry and its partners in managed care, such as employers, insurers, and providers. Since its founding in 1983, the rapid growth of the association's membership has paralleled the dramatic expansion of network-based managed care. The more than 1,000 members include comprehensive medical/surgical networks, as well as specialty networks offering benefits for mental health, dental and opthalmic services, workers' compensation, and the like. Through its members, AAPPO represents a significant portion of both the delivery systems and recipients of health care in the United States. Data just in from AAPPO's about-to-be published 1995 *Directory of Operational PPOs* documents 802 active PPO networks in the United States, extending coverage to approximately 79 million eligible employees.

AAPPO believes strongly that Medicare needs to come into step with the private sector in delivering and paying for health care services. The public program's need to contain cost while maintaining accessibility and quality is the very same need that motivated the employers who are the primary private-sector purchasers to develop new health care strategies. Among the successes has been developing a means of managing fee-for-service medicine: the PPO.

The private health care market today is immensely competitive. It is no coincidence that runaway cost trends -- the annual double-digit increases that marked the last decade -- have moderated. This is the way the marketplace is supposed to work. Robust competition encourages product improvement and brings down costs, benefiting investors and consumers alike. In this case, both the federal government and Medicare beneficiaries have much to gain.

We agree with many members of Congress that Medicare beneficiaries should have the same choices available to their privately-insured fellow citizens. The success that PPOs have achieved in delivering choice and quality while substantially reducing costs offers a model that Congress can turn to in meeting the twin challenges of reducing the growth in Medicare expenditure while expanding choice to older Americans.

The PPO: Another Managed Care Option

A PPO is an entity through which employer health benefits plans and health insurance carriers (collectively, payers) contract to purchase health care services for covered beneficiaries from a selected group of "preferred" participating providers, including hospitals, physicians, and diagnostic facilities. Benefit plans offer a PPO network to eligible participants as an effective means of furnishing access to an array of qualified providers. The PPO is a separate, identifiable legal entity that can have various types of owners, including entrepreneurs, insurers, and providers. PPOs contract directly with their payer customers -- as we would envision them contracting directly with HCFA in the Medicare context.

A PPO's preferred providers generally are selected on the basis of their cost efficiency, community reputation, and scope of services. Payers offer financial incentives to the covered beneficiaries to encourage them to obtain needed health care services from the preferred

providers. In return, the participating providers agree to conform to certain utilization management and quality management requirements established by the PPO and to accept contractually set reimbursement levels for their services.

Unlike HMOs, PPOs do not require their members to use only PPO providers. Individuals with PPO coverage are permitted to use non-PPO providers if they are willing to pay higher levels of coinsurance or deductibles. As a result, the PPO offers more consumer choice of provider.

In 1994, PPOs were offered by 40 percent of employers with 10 or more employees, according to a survey of employer-sponsored health plans by the firm Foster Higgins. The average per-employee cost for PPO coverage for large employers actually dropped from 1993 to 1994, and four-fifths of plan sponsors characterized their PPO as effective in controlling costs.

Benefits of a Medicare PPO Option

Since the early 1980s, the federal government has sought ways to reduce spending for Medicare-covered health services. Notwithstanding efforts focused on price-setting, costs have continued to rise because of utilization increases. It has become abundantly clear that cost containment cannot be achieved merely by cutting back on payment rates without addressing utilization as well. For more than 90% of current beneficiaries, Medicare is merely an unmanaged fee-for-service entitlement program. By contrast, the private sector has controlled its fee-for-service expenditure through reliance on PPOs to manage both rates and utilization.

Even where the government has attempted to address utilization through a capitated payment, it has met with limited success in controlling Medicare expenditures. The Department of Health and Human Services moved into managed care in the 1980s, contracting on a risk basis with HMOs for the provision of comprehensive health services to Medicare beneficiaries. However, enrollment in HMOs by Medicare beneficiaries has been quite limited over the years, and HMOs have not achieved significant penetration of the Medicare market.

The private insurance market in the early 1980s also had just two options -- indemnity plans based on fee-for-service and the HMO with its lock-in requirement of enrollment. The market demanded more, and PPOs were the response. As described above, payers with a PPO option use financial incentives to encourage the consumer's use of the managed care features of the PPO. I have found in my own PPO management experience -- and my AAPPO colleagues will bear me out -- that 60-70% of health care services obtained by PPO-eligible persons are provided by network providers. Because of the flexibility inherent in a PPO, these arrangements are popular with consumers and providers alike.

PPOs are successful in reducing unnecessary utilization while allowing consumers to choose their own health care providers from a select panel of quality, low-cost providers. By adding a PPO option to Medicare, increased savings and controlled utilization can be achieved while offering an attractive managed care alternative to beneficiaries. Indeed, those who have been reluctant to venture into managed care because of the "lock-in" nature of provider panels should find PPOs particularly appealing.

PPOs have contractual agreements that physicians, hospitals, and other providers accept voluntarily, pledging to help develop and to participate in utilization review and quality assurance programs. A collaborative, non-adversarial relationship is fostered between the PPO and its physicians, based on a mutual commitment to cost-effective, high-quality health care and reinforced by the dramatic success their partnerships have enjoyed.

As PPOs have proliferated across the nation, they have developed tremendous aggregate capacity for the enrollment of new beneficiaries. More so than other managed care models, PPOs tend to be characterized by a broad array of providers, both physicians and hospitals.

PPOs offer Medicare savings in several areas:

- **Utilization review**: Prospective and concurrent reviews reduce unnecessary admissions and surgeries.
- **Part A:** PPOs may negotiate hospital rates at levels lower than DRG payments. DRGs were based on length-of-stay assumptions that have been reduced in practice. Medicare has not participated in the savings generated by this reduction. Most PPOs pay a per diem rate and manage length-of-stay with their physicians. A cost-per-admission based on a PPO per diem may easily be less than the corresponding DRG level.
- **Part B**: PPOs make extensive use of freestanding facilities with lower overhead costs than hospitals for outpatient diagnostic and treatment services. Payment typically is at negotiated fixed rates, less than the cost-based discount rates currently payable under Medicare.

PPOs and Risk

Most PPOs are not licensed as insurers and do not bear insurance risk. They typically are compensated on the basis of a per-member-per-month administrative fee. Capitated arrangements, characteristic of HMOs, are not common among PPOs. While some PPOs are exploring the process of becoming legally qualified as risk-bearing entities, and some indeed have done so, others are not prepared to recast themselves, in effect, as insurance carriers or HMOs.

AAPPO proposes that both standard and risk-bearing PPOs be recognized by Medicare. In the standard arrangement, a PPO would qualify as an eligible Medicare contractor through meeting federal standards related to the functions it performs (e.g., provider credentialing and contracting, utilization and quality management, review and complaint procedures). A qualified PPO would receive a per-beneficiary-per-month fee in return for making available its network, its negotiated rates, and its utilization and quality management services. HCFA would thus stand in the same relation to the PPO as self-insured employers do now. Such employers enjoy a cost/benefit trade-off in the neighborhood of 10 to one, savings achieved through PPO management compared to the monthly administrative fee paid.

In a variation on the standard arrangement, the PPO's administrative fees could be augmented or reduced based upon its success or failure to meet performance targets negotiated between the PPO and HCFA.

Finally, as noted, some PPOs are interested in pursuing risk contracts with HCFA. AAPPO's proposed risk option would establish by law a means whereby PPOs could become federally qualified, irrespective of their status under state licensure, by demonstrating compliance with federal standards similar to those now established for HMOs.

Conclusion

AAPPO has been pleased to receive favorable comments from members of this Subcommittee about adding a PPO option to Medicare. PPOs have been a boon to the private sector, and will prove a boon to Medicare as well. AAPPO understands that PPO participation would be in the context of a menu of choices for Medicare beneficiaries -- a prospect that we applaud, having every confidence that PPOs can hold their own in healthy competition. We ask you, though, to keep in mind the importance of real as opposed to apparent variety. There always exists a temptation to minimize complication by putting everyone through the same regulatory slicer. PPOs want to compete as PPOs, not as some quasi-HMO hybrid cut to fit the confines of the existing risk-contracting statute.

I thank you for this opportunity to represent AAPPO before you today, and look forward to working with you as the budget reconciliation bill takes shape. AAPPO will be happy at any time to discuss our option proposal with you in greater detail.

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THE PPO: PREFERRED MANAGED CARE

The Preferred Provider Organization (PPO) is the fastest-growing form of managed care organization, offering more choice than any other managed care model. A PPO promotes appropriate high-quality health care services and controls the growth of health care costs. Benefit plans offer a PPO network to eligible participants as an effective means of providing access to an array of qualified providers. The PPO integrates the financing and delivery of health care and adds value to all key parties through services such as:

To **patients:**	carefully selected credentialed providers, lower out-of-pocket costs, grievance procedures
To **payers:**	cost control, quality review, broad geographic service areas
To **providers:**	source of new patients

In order to fulfill these commitments, a PPO has the following functional characteristics:

A PPO tracks the numbers and geographic locations of its patients and providers in order to monitor **adequate patient access to a full range of contracted and fully credentialed providers** as required by the product (e.g., general medical/surgical, specialty services, workers' compensation, etc.) being offered. A stable network is maintained through management of provider turnover and a formal program to discourage inappropriate out-of-network referrals. The PPO encourages its eligible patient population, through education and benefit plan design (i.e., cost-sharing incentives), to use network providers, and facilitates the provider's ability to identify eligible patients.

A PPO has a **formal written program for credentialing and recredentialing providers** that includes specific criteria, an application process, primary source verification of key credentials, and a decision process with physician input. The program applies, with appropriate tailoring, to all provider types represented in the network. Recredentialing includes evaluation of quality and utilization data, patient satisfaction measures, and grievances.

Reasonable payment methodologies allow a PPO to achieve measurable savings for its patients and its payer partners. A PPO offers competitive and equitable compensation to provider members, controls payment-level adjustments by contract and formal monitoring, and uses the reimbursement mechanism to create incentives for efficient provider practices.

Where permitted by law, PPOs may assume financial risk and enter into risk-sharing arrangements with providers.

Formal programs for **utilization management** and **quality assessment** are essential to an effective PPO. Both programs share the aim of optimal utilization of health care services to avoid both over- and under-utilization. A utilization management program manages care prospectively, concurrently, and retrospectively. The needs of individual patients are addressed on a a case-by-case basis. The quality assessment program examines opportunities for improvement in all care settings and by all provider types. It uses mechanisms such as practice guidelines, preventive health measures, outcomes studies, access measurement, and patient satisfaction assessment. Under both the utilization and quality programs, providers have access to performance-specific feedback and a formal written appeals process.

A PPO is **financially viable**. This entails diversified revenue sources, such as payer fees for network access, utilization review/quality assessment, and other services (e.g., bill audits, retrospective review). Such fees are paid on an administrative-fee and/or percentage-of-savings basis. A PPO also may receive revenues from services to providers. Risk arrangements with payers involve a variety of payment methodologies. A PPO observes standard business and financial practices, e.g., budgeting, accounting, auditing, and insurance.

A PPO **establishes contractual relationships** with the payers and providers of health care and the appropriate intermediaries, binding these parties to the respective duties and responsibilities necessary to satisfy the PPO purpose, role, and functions described in this definition.

The legal definition of PPOs varies based on state law. Most PPOs are not licensed as insurers.

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Chairman THOMAS. Thank you very much, Mr. Jasper, for your testimony.

Mr. JASPER. Thank you.

Chairman THOMAS. Mr. Strand.

STATEMENT OF DAVID STRAND, PRESIDENT, HEALTH PLANS GROUP, ALLINA HEALTH SYSTEM, MINNEAPOLIS, MINNESOTA; ON BEHALF OF MEDICARE FAIRNESS COALITION

Mr. STRAND. Thank you, Mr. Chairman and Members of the Subcommittee.

My name is David Strand, and I am president of the Health Plans Group of Allina Health System, which is a Minneapolis based integrated system of hospitals, clinics, nursing homes, and managed care plans. We own and operate an HMO called Medica, which is a nonprofit health maintenance organization serving over 700,000 members in Minnesota and western Wisconsin. We also serve approximately 80,000 Medicare beneficiaries through a variety of arrangements with the Federal Government. We have been contracting with HCFA for this purpose for the last 15 years.

We are here today to talk to you about some of the experiences we have had as an organization, as well as other similar HMOs who make up the organization we call the Medicare Fairness Coalition. This coalition is a multi-State group of managed care organizations who support reform of the Medicare Program, supporting the need to control spending in Medicare and to increase the choices of Medicare beneficiaries. We include health plans offering services in Washington, Minnesota, Oregon, and Idaho. While we are a new organization that is fairly newly formed, we serve at present approximately 250,000 Medicare beneficiaries.

The message I would like to leave with you today is very simple and straightforward. The success of any of the reform proposals you are considering depends in part upon addressing dramatic regional variation in Medicare capitated payments that presently exist across the country today. Regional variations that cannot be explained by differences in costs that penalize rural areas and especially rural States, that penalize efficient markets, and that creates significant inequities for the elderly based solely on the accident of where they happen to retire. The geographic disparity that exists today is very significant.

In 1995, the Medicare payment rates to HMOs varied geographically from a low of $176 per month in the lowest county to a high of $647 per month in the highest county, a difference of 367 percent. Included with my written testimony and on the charts that I have here today are some illustrations of these regional disparities that you will see are rather significant and which I would be pleased to answer questions about on a specific basis during the question and answer session.

When you go about designing ways to control spending growth, across-the-board cuts will intensify the disparity that exists today and will increase the unfairness. So we believe that any market-based solution that you address should fix this underlying problem with regional disparity in order for the reform to be successful.

It would be natural for you to ask whether or not this variation can be explained on the basis of cost-of-living differences. The an-

swer to that question is no, that is not an explanation. In order to determine what a real difference in cost from region to region and what differences can only be explained by utilization of services, we have analyzed DRG rates as a basis for comparison.

HCFA allows the DRG rate to vary from region to region based on a hospital price index that computes legitimate differences in measurable labor and price inputs. Currently, the variation based on cost of living is plus or minus 7 percent. HMO reimbursement, on the other hand, as I mentioned before, varies by over 350 percent, far in excess of the 14-percent difference in variation in the DRG range. Clearly, regional variations in cost account for the sizable variation in reimbursement under HCFA's current methodology.

Now, this is not just a problem for health maintenance organizations receiving reimbursement from the Federal Government. Rather, it is a significant problem for the elderly who happen to live in counties served by these health maintenance organizations. The geographic disparity has the greatest negative impact on Medicare beneficiaries who live in these types of counties.

If I could leave a specific example with you, let us take the case of two Medicare beneficiaries, one who chooses a managed care plan in Seattle and one who chooses a managed care plan in Los Angeles, Ms. X, who lives in Seattle, and Ms. Y living in Los Angeles. Remember that both have paid the same amount into the Medicare system over the course of their working lives, 2.9 percent of payroll.

Despite the similarity in their contributions, they will receive vastly different benefits in their HMO options due to the accident of where they happen to retire. Ms. Y's HMO in Los Angeles County is paid a rate of $558 per member per month. Ms. X's HMO in Kings County receives $377 per month.

The inequitable payment rate means that a Seattle senior may pay between $600 and $1,800 more per year to choose managed care, while the Los Angeles senior will receive all the Medicare benefits plus supplemental benefits that the HMO can afford to provide, without any additional contribution of premium. In other words, in areas with high payments from Medicare, beneficiaries get more and pay less out of pocket than those in lower payment areas.

The health plans like ours who have done business in efficient markets have struggled with this problem for years. We have had to reduce our benefits, raise our premiums, while trying to provide high-quality care to the elderly. In short, the present system penalizes rural areas, it penalizes efficient markets, but, most importantly, it penalizes the Medicare beneficiaries.

We urge Congress to address this problem as part of your efforts to reform the Medicare system as part of your effort to preserve choice within a managed care system.

Thank you, Mr. Chairman.

[The prepared statement and attachment follow:]

SAVING MEDICARE AND BUDGET RECONCILIATION ISSUES

"FAIRNESS IS ESSENTIAL TO MEDICARE REFORM"

Statement of David Strand, President
Health Plans Group, Allina Health System
Minneapolis, Minnesota

on behalf of the Medicare Fairness Coalition

Before
The Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, D.C.

July 19, 1995

Mr. Chairman and members of the Subcommittee on Health, my name is David Strand. I am President of the Health Plans Group of Allina Health System. Allina is composed of hospitals, nursing homes, clinics and managed care health plans. Allina's HMO, which is called Medica, is a non-profit health plan in Minnesota. Medica currently serves over 700,000 HMO members, including 80,000 Medicare beneficiaries enrolled in TEFRA risk, cost or HCPP arrangements. Medica has been contracting with HCFA to serve Medicare beneficiaries for nearly 15 years.

I appreciate the opportunity to appear before you today to share with you some of the experiences of my company and other HMOs who make up the organization we call the Medicare Fairness Coalition.

Who Are We?

The Medicare Fairness Coalition is a multi-state group of managed care organizations who support modernization of the Medicare program. We recognize the need to control spending in Medicare and to increase the choices of Medicare beneficiaries.

We include health plans offering services in Washington, Minnesota, Oregon, and Idaho. We are a fledgling organization, but we have attracted the interest of hospitals systems, rural health organizations, state hospital organizations, and other health plans across the country who share our concerns. At present, our health plans serve approximately a quarter of a million Medicare enrollees.

Why We Have Formed The Medicare Fairness Coalition

Our message to members of Congress can be simply stated:

By now you have heard many different proposals for fixing the Medicare system, for saving the Trust Fund and offering more choices for beneficiaries. We are here to suggest based on real experience all over this country that the success of any of these reform proposals depends upon addressing the dramatic regional variation in Medicare capitated payments.

We cannot control growth in the Medicare program and offer beneficiaries greater choices among competing health plans without addressing the wide geographic inequities in Medicare HMO payments.

The good news is that if we do work toward eliminating unfair disparities, we can achieve the savings goals in the Budget Agreement and open up markets all over the nation to a wider variety of health plans. The result will be greater equity for all Medicare beneficiaries regardless of where they live.

Our goal today is to explain the causes of geographic disparity in Medicare payment and the consequences of that inequity for beneficiaries. In brief, every American pays 2.9% in payroll taxes to be assured access to hospital care when they retire. Many beneficiaries also choose to pay a premium in addition to receive physician services.

But, in 1995, the Medicare payment rates to HMOs varied geographically from a low of $176.00 per month in the lowest county to a high of $647 per month in the highest– a difference of 367%!

In nearly half of all counties in America, health plans rarely offer a comprehensive benefit package because the payment rate is too low to break even.

The result– some beneficiaries in high payment areas get more benefits, more choices, and pay less out-of-pocket than similarly situated elderly who happen to live in low payment areas. When Congress designs ways to control spending growth, across-the-board cuts will intensify the disparity and the unfairness will increase. This will deter a variety of health plans from offering choices to beneficiaries and will effectively close many markets to managed care options.

Background of Medicare Managed Care

In 1965, Congress guaranteed health insurance coverage for retirees and the disabled. Medicare was modeled on the prevailing fee-for-service insurance programs, reflecting the way health care was delivered at the time. Medicare paid hospitals and providers for each service–hospitals under Part A and physicians under Part B.

In the mid-1970s, HMOs began to thrive in some communities as an alternative to fee-for-service. HMOs offer a comprehensive set of benefits through an organized network for providers for a single prepaid premium. In 1982, Congress gave seniors the opportunity to choose either traditional fee-for-service Medicare or a new HMO package. Under the HMO option, called TEFRA risk contracts, Medicare HMO members could receive comprehensive integrated health coverage with little paperwork, more benefits, no deductible and low copayments.

A payment formula was developed that was tied to the fee-for-service spending. Starting with historical fee-for-service costs, HCFA calculates an average rate annually called the USPCC (United States Per Capita Cost), and then calculates separate rates for each county in the nation.

Through a series of subsequent steps, HCFA derives what is known as the AAPCC (Average Adjusted Per Capita Cost). The AAPCC reflects various demographic adjusters, and includes Part A which reflects hospital spending and Part B for physician and outpatient services in the fee-for-service side. Part A and Part B dollars are combined and health plans are paid 95% of that rate.

Congress Did Not Intend To Create Wide Regional Variation

—Efficient and Inefficient Markets

What no one anticipated was the dramatic change in how medicine was practiced in a growing number of markets. Recently, HMO growth has flourished in the private sector. There was a 10-12% growth in 1994, with a total of more than 50 million members nationwide.

An important effect of HMO growth in some markets has been a slowing of medical cost increases in these markets. To compete, fee-for-service plans try to emulate the efficiencies in the managed care sector, and wasteful practice patterns and unnecessary capacity decline. This reduces overall medical costs which are reflected in the AAPCCs.

Let me give you an example from our state. HMOs, PPOs and integrated care systems have quantifiably reduced costs for both the public and private sectors. According to national surveys, costs for Minnesota employers are 15-20% below the national average and their employees enjoy more comprehensive coverage. (Milliman and Robertson, 1993). Based on the 1995 rates published by HCFA, Medicare's per-beneficiary costs are 25% less in the Twin Cities than the national average for urban areas. We are proud to say that the quality of our care and the satisfaction of our members is extremely high.

As markets become more efficient, growth in the AAPCC has declined in some areas. In other counties, because of overcapacity, patient demand, and lack of concern about costs in fee-for-service, volume of care has increased per capita, with AAPCCs climbing each year often in the double digits.

—The Special Case in Rural Areas

Another aspect of the variation is played out in rural areas. Because of low numbers of physicians, less Medigap coverage, and fewer high specialty facilities, per capita spending in rural areas lags behind most urban areas. While the per capita spending in high volume markets grew, rural areas have been left way behind.

Medicare HMOs must guarantee easy access to a wide range of comprehensive services. At the payment rates now available, it is economically impossible to offer choices to beneficiaries in many rural areas. In the 1980s, many Minnesota HMOs enthusiastically offered HMO choices in rural Minnesota. However, the low payment rate soon discouraged them all and now there is no Medicare managed care available in rural Minnesota.

State by State Comparisons

The Fairness Coalition has developed charts to illustrate graphically the unfair nature of the current payment methodology. A selection of maps showing state variation in rates is attached. The Fairness Coalition will be pleased to provide additional maps to the committee on request.

Note that rural states suffer the lowest AAPCC payment rates, essentially foreclosing any alternatives to fee-for-service in those areas. States like Nebraska, South Dakota, North Dakota, New Mexico and Maine illustrate this point. All counties in these states receive less than the average AAPCC, and for many counties the payment is well below 30% of the average. Our research indicates that Nebraska appears to have the largest percentage of counties falling in the lowest range.

Efficient markets that have reduced overutilization, closed empty hospital beds, and aim for the highest quality at the lowest price are also penalized. Efficient urban areas, such as Seattle, Portland, Rochester N.Y., Minneapolis, Honolulu are all well below the national average. As fee-for-service utilization decreases, the AAPCCs fall, and plans struggle to continue to offer the extra benefits that are offered in the high payment areas.

Here are some examples of urban area variations in AAPCC:

Hennepin County (Minneapolis)	$362	(per beneficiary per month)
Kings County (Seattle)	$377	
Monroe County (Rochester NY)	$399	
Los Angeles County (L.A.)	$558	
Dade County (Miami)	$615	
Philadelphia County (Phil)	$625	
Kings County (NYC)	$646	

Cost of Living Differences Do Not Justify The Existing Variations

This variation cannot be explained on the basis of cost of living differences. In order to determine what are real differences in costs from region to region, and what differences can only be explained by utilization of services, our actuary looked to the DRG (diagnostic related groups) program as a model. Medicare pays hospitals on the basis of DRGs for bundles of services performed. HCFA allows the DRG rate to vary from region to region, based on a hospital price index that computes legitimate differences in measurable labor and price inputs. Currently, the variation based on cost of living is plus or minus 7%.

The AAPCC far exceeds the 14% DRG range by orders of magnitude! We believe that moving toward a similar variation for capitated payments is a laudable goal.

AAPCCs are Irrational and Unpredictable

According to ProPAC, between 1994 and 1995 in the top 50 counties in terms of risk contract enrollment, the increase in the AAPCC ranged from 2.1 percent to 9.5 percent. For the most part, growth rates are higher in the inefficient markets and lower in highly competitive ones.

Left unaddressed, the variation will get worse. Using documented growth trends, the variations will increase over the next 7 years. Graph I illustrates how the disparity will expand if growth continues as predicted on such a widely variable base.

The inequity is exacerbated by irrational variations across neighboring counties. For example, Mr. Thomas represents District 21 in California which includes parts of both Kern County and Tulare County. The 1995 AAPCC for Kern County was $438, well above the average, and Tulare payment was $334, a full $104 difference per enrollee per month. Do beneficiaries in Tulare deserve less than their neighbors to the south?

Similar irrationalities exist in northern Louisiana, which Mr. McCrery represents. Ouachita county receives $418 per member per month while neighboring Union receives only $318. Are medical costs that much different across rural county lines?

Unstable rates are a particular problem in rural areas. Because of small Medicare populations in some rural counties, variations in use of services can occur from year to year quite randomly. Thus, it is not uncommon to see major fluctuations on rates of increase from year to year.

Variation occurs in urban areas as well. The 1995 monthly capitated rate in the Washington D.C. area varied from $361 in Fairfax County to $543 in Prince George's County. It is difficult for health plans to care for individuals in a region when the government payment varies so much. It costs the same to deliver the care in a Washington hospital whether or not the patient resides in Fairfax County or Prince George's County.

The instability and unpredictability are additional factors that discourage health plans from entering and staying in markets subject to these swings.

Beneficiaries Pay the Highest Price

The geographic disparity has the greatest negative impact on the Medicare beneficiaries, although this problem is not widely known or understood.

Let's take the case of two Medicare beneficiaries who choose a managed care plan in their respective communities. Ms. X lives in Seattle. Ms. Y lives in Los Angeles.

Recall that both have paid in the same amount in Medicare taxes (2.9% of payroll) throughout their working lives. Despite the similarity in their contributions, they will receive vastly different benefits in their HMO options due to the "accident" of where they live.

Ms. Y's HMO in Los Angeles County is paid an AAPCC of $558 per member per month. Ms. X's HMO in Kings County receives $377 per month. Since rebates are not allowed, the Los Angeles health plan can load on additional benefits, such as prescription drugs, eye glasses and dental coverage. It may charge no member premium, can reduce copays and deductibles and still make a nice profit.

The Seattle HMO cannot afford to add additional benefits and must charge a monthly member premium to cover costs. Those premiums vary from $50 to $150 dollars per month.

The inequitable payment rate means that a Seattle senior may pay between $600 and $1,800 more per year to choose managed care, while the Los Angeles senior receives all the Medicare benefits plus lots of extras free of charge. In other words, in areas with high payments from Medicare, beneficiaries get more and pay less out of pocket than those in low payment areas.

Health plans who have done business in efficient markets have struggled with this problem for years. We have had to reduce our benefits and raise our premiums while trying to compete. Recent GAO testimony before the Commerce Committee, Subcommittee on Health and the Environment, reported that the number of risk contracts with zero premium is increasing. Zero premium plans are only growing in the high pay markets. It is not the case in efficient markets. There are NO zero premium options in the Portland market, for example. Plans simply can't afford to offer them and survive.

Chart 1 shows the impact of the differences in two additional markets--Minneapolis and Miami.

Managed Care Growth is Discouraged, Particularly in Rural Areas

Managed care has the potential to save dollars for beneficiaries and for the federal budget. However, the current inequitable payment means that growth in Medicare managed care is taking place primarily in the high payment areas.

The counties in the top 10% of payment rates have approximately 30 percent of the Medicare population. These areas account for 50% of all the Medicare managed care. By contrast, the counties in the bottom 50% of AAPCCs, also have 30 percent of Medicare enrollees, but only 15% of the Medicare managed care.

Let me again use our experience in Minnesota to illustrate this point. In the mid-1980s, more than 50% of Medicare eligibles in the Twin Cities of Minneapolis-St. Paul enrolled in the new risk contracts--a full two-thirds of whom had not previously been enrolled in HMOs. Now, a little over 10 years later, only 9% of Minnesota's Medicare beneficiaries are in risk contracts and this percent has not increased since 1990. This is in a market in which managed care for the employed population has been booming.

Why? The AAPCC increases have been minimal and in several years we experienced actual cuts in payment. Plans have had to reduce the extra benefits that attracted many to the programs in the first place, and also increase premiums, co-pays etc. Although we are anxious to serve this portion of the population, it is becoming economically more challenging every year.

The three remaining risk contractors in Minnesota (all of whom are members of this coalition), offer plans only in the Twin Cities metro area. Beneficiaries in rural areas have virtually no managed care options. This is true for all of the coalition member states and many states across the country.

Across-the-Board Growth Limits in AAPCC s Will Make this Problem Worse

It has been suggested that, in order to make savings targets, Congress should allow Medicare to grow at an average rate of 5% per year until 2002. This would permit the average annual per capita expenditure to increase from $4800 to $6300 (the number in the original House proposal) or $6700 (the number in the Budget Agreement).

Clearly, it is necessary to control the growth in expenditures in the program. However, if the rate of growth in the federal payment is imposed across the board the inequities will increase, inefficient markets will continue to be rewarded, and fewer and fewer areas will offer the choices that are anticipated in a reformed program.

Some health plans already receive sums in excess of what would be the average in 2002. Plans in Dade County, for example, already receive $7380 per year in 1995! Plans in Oregon receive $4476 in 1995. Allowing similar growth with this disparity as a base is patently unfair to the seniors in those markets and to the health plans seeking to provide quality care to them.

The attached graphs illustrate how much growth would be permissible based on assumptions underlying the Congressional reform goals. Whether the goal is an average of $6300 or $6500, or $6700, it is clear that holding the line on the 10 percent of the counties in the top AAPCCs to smaller growth rates will allow rural areas and efficient markets, which account for the vast majority of counties in the nation, to reach some level of equity by 2002.

A transition to equity is often referred to as "normalization" of rates. Normalization was achieved in the DRG transition and is also part of the RBRVs (resource based relative value scale) for physician fees. The government will have to determine what level of contribution it will make to beneficiaries, whether it be in the form of a voucher, defined contribution, or other arrangement. We believe that fairness requires that the federal payment be equitably distributed, taking into account on the legitimate and measurable variation in input prices from market area to market area.

The Opportunity

Congress has an opportunity to modernize the Medicare program. It can accomplish its budgetary goals in the process of offering more choices in a competitive environment.

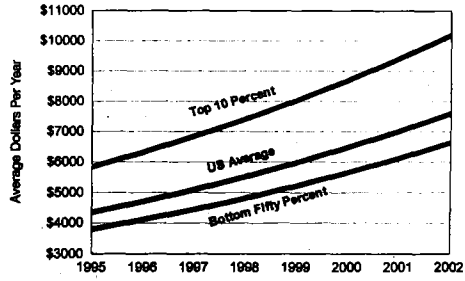
Provider groups have insisted that simplistic cuts to provider payments will not be adequate to solve the long-term challenge and could cripple the health care infrastructure, particularly in rural areas. We hope we have convinced you that across-the-board cuts in fee-for-service payments to providers or capitation payments to risk contracting health plans would ignore the wide variation that presently exists in Medicare spending and would penalize efficient markets and many rural communities.

There are a growing number of thoughtful proposals on the table that will introduce competitive market forces to modernize the program by changing both provider and consumer behavior to reward wiser choices. We applaud the work of the Physician Payment Review Commission, the Prospective Payment Review Commission, the Group Health Association of America, the American Hospital Association and others who have called for solutions rooted in the marketplace to improve the Medicare program in the long run.

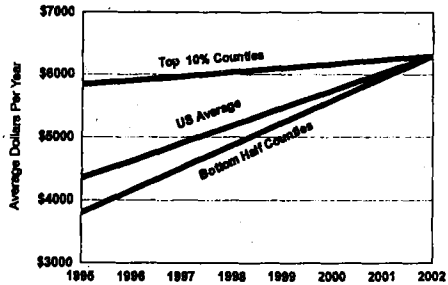
We are pleased to provide the committee with copies of our Fairness Coalition Concept Paper which describes in greater detail our principles for Medicare reform. (Appendix 1).

Today, however, our contribution is to illustrate the magnitude and the negative impact of the geographic disparity in payment on the present Medicare system. We hope you can see that failure to address the disparity problem will prevent the Congress from achieving its very laudable goals – savings to the federal budget to preserve the program and expansion of choices for Medicare beneficiaries in all communities across the nation.

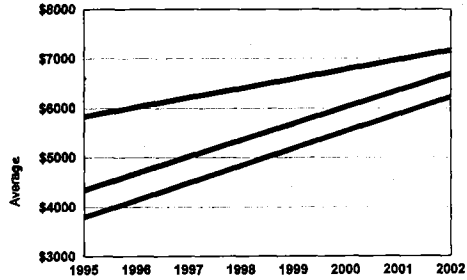
Graph 1: If Nothing Is Done, The Disparity Between TheTop Ten Percent Of AAPCC Counties And The Bottom Half Of AAPCC Counties Will Increase



Graph 2: Eliminate The Disparity Between The Top And Bottom Half Of AAPCC Counties To A US Average of $6300 In 2002 And Save $270 Billion



Graph3: Eliminate The Disparity Between The Top And Bottom Half Of AAPCC Counties To A US Average Of $6700 in 2002 And Save $270 Billion*



*Note: Assumes that by 2002, the Medicare Care Package this proposal is In has encouraged 50% of beneficiaries into managed care plans.

Medicare Payment Formula Unfair to Taxpaying Seniors

Medicare Beneficiary Identical Earned Income and Paid Medicare Taxes	HCFA Payment to HMO for Medicare Services	HMO Monthly Senior Premium for Non-Medicare Covered Services	Benefit Variances
Minnesota (Hennepin)	$362	$58	- no prescription drug coverage - $10 office visit copayment
Florida (Dade)	$615	$0	- prescription drug coverage - no office visit copayment

Chairman THOMAS. Thank you, Mr. Strand.

Before we get to questions, could you just give us an idea of the key in terms of those colors, so if there is a question we can——

Mr. STRAND. Mr. Chairman, I am sorry that the key is not on there. It is in the maps that we hopefully provided to the Subcommittee Members. The key is provided, but basically the colors that are purple and shades of blue would be colors that are at or below the national average reimbursement. Those that are shaded red and green and yellow are above the national average.

Chairman THOMAS [continuing]. For example, if you look at deep blue through light blue to green, to orange, to red, in terms of the price structure?

Mr. STRAND. That is correct. A good example of that, Mr. Chairman, would be a couple of counties in your district, Tulare and Kern, which as I understand it are similar counties from a perspective of cost, but yet the reimbursement for those two counties is nearly in excess of $100 per month, a good example of a regional variation that makes very little sense, that penalizes the senior who happens to retire in one of those two counties.

Chairman THOMAS. You did a good job on the charts. You hit two out of the three Members who are currently in——

Mr. STRAND. We tried to guess.

Chairman THOMAS. Jerry wonders what Wisconsin looks like.

Mr. KLECZKA. They got me before the hearing.

Chairman THOMAS. I want to thank the panel very much.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Mr. Jasper, you commented that you would like to see the PPO system have a direct relationship with HCFA and work directly with them. In my reading and my understanding of this whole dilemma, HCFA is the problem.

I do not know that you would want to have a direct relationship with HCFA. I think we ought to look to more of an idea that would allow you to have a direct relationship with the patient. In your comments of the direct relationship with HCFA, what do you see as the scenario, or what would even be a better scenario, if we were to streamline HCFA?

Mr. JASPER. Our objective is to afford the beneficiaries with a PPO option, and these would be plans that would be qualified according to standards and criteria that need to be developed. In fact, we have submitted some outlines to HCFA. We see this as an enrollment option where it is the beneficiary who is directly enrolling into those qualified plans. I guess it was our assumption that, in order to be offered for enrollment, that a PPO would need a contract with HCFA as it now does for the HMO options.

Mr. CHRISTENSEN. Mr. Strand, on your chart over there, I represent the little white part on the east side of that little spot of Omaha. The rest of it is covered by two other individuals. The white spot means that we are at 10 percent or at the average, is that correct?

Mr. STRAND. 10 percent or less below the national average.

Mr. CHRISTENSEN. It looks like we are OK, but the rest of the State is not quite up to par. But I will say that Nebraska, from what you said earlier, is not quite the cost it is of California, and relatively we are doing pretty good as a State, quite well.

You have in your own managed care you said about 80,000 senior citizens involved in your HMO?

Mr. STRAND. That is correct.

Mr. CHRISTENSEN. How is that working? What has been your experience? We had a lot of testimony about 1 month ago from some Arizona HMOs that have been addressing this issue and have seniors. How have you seen your satisfaction with the seniors, and tell us about your own program?

Mr. STRAND. Thank you for asking. Our program has been we think very successful. The satisfaction surveys that we received—we are always receiving ratings on service and quality that are in excess of 95 percent—seniors are either satisfied or very satisfied with the plan. In fact, in two of our products last year, the seniors on a random basis done by the Gallup Poll came in with a 100-percent rating, satisfied or very satisfied with both the quality and the type of service they were receiving.

The thing that is concerning the seniors that are enrolled in our plan today is cost, because as in the State of Minnesota, like Nebraska, which receives far less than the national average in most of our counties, we were having to pass along to the seniors a fairly significant premium to help supplement the reimbursement we get from the Federal Government. That means that each year the seniors are having to pay more out of pocket in our State in order to receive the same type of benefits that than have in the past.

Now, in Minnesota, as I heard the testimony this morning, some of the questions about the rate of increases that we have around the country, we are holding the line on costs today. We are expecting premium increases this year and next year to be under the rate of inflation. I have renewed 25 percent of my business for January 1 at less than 2 percent premium increase in 1995, and that includes a 1-percent increase in premium taxes that the State has levied on it.

In short, they are very satisfied with the quality, the service, the access they receive through our plan, but they are very concerned about increasing costs.

Mr. CHRISTENSEN. Thank you for your testimony, all three of you.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank you.

The gentleman from Wisconsin.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Jasper, I have handed to you a chart which shows growth of private insurance and Medicare.

Mr. JASPER. Yes, sir.

Mr. KLECZKA. Your statement was that private insurance over the years has done much better than Medicare. This chart that I have given you seems to contradict that. Do you want to respond?

Mr. JASPER. Certainly. This chart ends in 1993. The statistic I quoted is a statistic of the change from 1993 to 1994. Interestingly, 1993 is where the lines converge in that the Medicare and private rates of growth are almost identical at that point. So it is indeed a fairly——

Mr. KLECZKA. Give me the percentages for 1994.

Mr. JASPER. Do I have them?

Mr. KLECZKA. Yes.

Mr. JASPER. I have the ones that are cited in the study that I made reference to and I have my own experience. They are typically in the 5-percent level.

Mr. KLECZKA. So Medicare is 5 percent higher for the 1 year than the private insurance? But for the last 10 years, that has not been the case?

Mr. JAPSER. No, I am comparing the 5 percent that I think is the approximate PPO level with what is shown here for Medicare at approximately 8 percent in 1993, so I believe the private sector is lower.

Mr. KLECZKA. Would not PPOs be part of the private calculation there?

Mr. JASPER. I do not know what is in the calculation here. In the study that I was referring to for 1994 was a nationwide stratified sampling of organizations including PPOs.

Mr. KLECZKA. I will check my figures, if you go back and check yours, but I think if you look from 1990 to 1993 to 1983 and 1993, which you have indicated is not accurate, if in fact a change in 1994—I do not have that figure, so I would have to concede that.

Mr. Strand, looking at Wisconsin, which is not on the chart, I am still trying to figure out what you are trying to tell us here. Are you saying that the providers are getting less reimbursement from the program, thus the Medicare consumer is getting less health care or not quality health care? What are we trying to say here?

Mr. STRAND. What is happening is a result of the disparities in payment, two things. One is that because the payment levels are so low, there is a limitation on the number of new entrants in the market. HMOs who are willing to go into a market where reimbursement will be less than their costs that they——

Mr. KLECZKA. Well, what is the effect on the health consumer?

Mr. STRAND. On the consumer, what happens is that—let us just use the comparison again. Somebody who lives in one of the rural counties in Wisconsin versus someone who lives in Dade County, Florida, in Dade County, Florida, that senior would receive a benefit package from the HMO that had basic benefit coverage plus a variety of supplemental coverage, and because the reimbursement is so high, likely there would be no premium to the senior and their copayments and deductibles would be completely covered.

Mr. KLECZKA. Are you talking of a supplemental plan or——

Mr. STRAND. In an HMO risk contract, what happens is the HMO agrees to provide all services that Medicare otherwise provides plus some additional services for the same dollar amount less 5 percent the Federal Government would otherwise pay for those services. So we are talking about those services plus supplemental services and in the premium level.

That same senior who might live in the rural Wisconsin county would likely not receive those supplemental benefits, would likely not have full coverage for copayments and deductibles, and would likely pay a premium to supplement the contribution from the Federal Government to the HMO.

What I am saying is the result of these inequities in payment, someone who happens to live in rural Wisconsin is likely going to pay far more than the senior who happens to live in Dade County,

Florida, or other counties that have that type of reimbursement. It attacks the equity question, Representative. Everyone has paid into the system the same amount, they pay the same amount of contribution for part B services, and it is a question of what they are receiving back.

Mr. KLECZKA. What would happen to this fairness scheme here under a per capita fixed voucher-type system?

Mr.STRAND. We might want to look at the second chart. On the left-hand side here, the red line will show where the top 10 percent of the——

Mr. KLECZKA. I cannot see that.

Mr. STRAND. I am sorry, I think it is in the packet. It is in the written testimony. I can explain this. On the left-hand side is the current payment level, the top 10 percent AAPCC counties. The bottom line is the bottom 50 percent of the counties, and you can see the difference between the two.

If you capitate now going forward a fix your contribution level without addressing this disparity, what this chart tried to show is that the disparity will grow, and by the time you get out several years, by the year 2002, that disparity will have grown significantly. So the counties that are presently under the national average will fall further and further behind those counties that today are significantly above the national average. In a sense, the inequity to seniors will grow.

Mr. KLECZKA. Which would equate to more out-of-pocket and less——

Mr. STRAND. More costs that a senior will pay, a Medicare beneficiary will pay as a result of just where they live and nothing else considered.

Mr. KLECZKA. Thank you.

Chairman THOMAS. Or less of a program. One of the things that we have to—it is a minor consideration, but frankly people who tend to live in rural areas or other areas of the country on a regional basis in part define adequate or appropriate health care differently oftentimes than people in other regions of the country or in urban areas. So I can understand a degree of differences reflected in the cost, not just because there are low-cost areas from a labor market point of view, but also from what is considered an appropriate package for marketing.

What concerns me and I think reinforces your point, Mr. Strand, is when you take—and I just went through here quickly to try to find those portions of States that had the maximum number of color differential up against each other. Because whenever you create an artificial pricing mechanism like the AAPCC, and they use some kind of existing geographical or political lines, you wind up getting gross distortions where you will have the high-price red area next to the low blue or purple area—Louisiana, Texas, and California—in some areas that I am familiar with. And the formula completely fails to understand that these are rapidly growing suburban areas that carry virtually all of the labor costs from that urban area and the expectations for health care from that urban area, but fall bureaucratically into an area that is financed at $100 to $200 to even $300 to $400 less, really underscoring the inequity of kind of an arbitrary pricing formula as we have discussed.

We fought it when we did the DRGs and the various factors that were built into it. I have no desire to go down this road again in terms of trying to get HCFA to more adequately reflect reality. And you have some suggestions as to how we might be able to do it. To me, the best way would be to try to get the private sector pricing structure as a comparison for HCFA and basically create a linkage on a choice structure between the two to get some degree of reality into the system.

But I do appreciate the material that you have given that graphically illustrates the problem.

Mr. Bringewatt, you talked about the whole question of chronic care being something that we have not focused on from the structure, and you are right. As needs evolve, you would hope that support bureaucracies and industry evolves, obviously the private sector has to respond relatively quickly. The bureaucracy does not.

From your assessments of the change, I want to understand exactly where you are coming from. Are you saying that the structure should recognize or the bureaucracy—let me use that term—the bureaucracy should recognize that there is a need, in fact there is an occurring structural integration in the delivery of services along chronic illness lines, or that the bureaucracy ought to be more of an open system that allows innovative billing techniques to allow restructuring or grouping that may come together in one instance, but does not have to be integrated from the structural point of view to be able to get the financing from HCFA? Am I making sense to you?

Are you talking about a combination of those or structural integration that would be recognized and paid for by virtue of this new way of treating, delivering, and understanding chronic illness, or a flexible system open to the sense that you can mix and match and combine relatively freely for funding purposes of new and novel ways?

Mr. BRINGEWATT. Integrated care is critical to providing quality, cost-effective care, but the structure of integration may vary from one community to another—in fact, from one person to another. A gentleman by the name of Jeff Goldsmith has coined the term "virtual integration." What we are proposing here is an organizational strategy that enables providers to function as an integrated system in addressing problems that require multiple providers to work together. Currently, we tend to finance, regulate, and oversee care around microunits—different pieces of care that are needed by a given individual over time. This locks in place fragmentation, high costs, and poor outcomes.

Take for example someone who has a hip fracture or a stroke. When a person enters a hospital, there is a separate set of rules and regulations that relate to his or her hospital stay, a separate one for his or her subsequent nursing home stay. Procedures are duplicated, the case is disrupted, and costs are excessive. If the Federal Government recognizes the full episode of care that a person may need that cuts across those settings, takes a look at a total dollar amount in relation to that care episode and finances, regulates, and oversees the care as a total care episode, it enables providers who may serve that single person to work together in a collaborative arrangement and do whatever is most cost effective,

given that episode of care. How care is integrated may vary from one person to another but each person served would have his or her unique problem more effectively addressed. And, the cost of the infrastructure would be less, because each provider would not be required to duplicate procedures imposed by Medicare law and related regulations, and would not have the incentive simply to optimize its own reimbursement without regard for the cumulative cost effects.

What we are suggesting is this: The more problems of chronic care become significant on the Medicare side, the more critical it is to free up the financing and the oversight policies to match that broader problem, rather than lock in place existing health care structures when we know that the problems being addressed require a new and different approach to care.

Chairman THOMAS. But I am also not interested in locking into place a new integrated structure that at that time and that moment reflects the current thinking. The gentleman from Nebraska and I are not naive. We know there has to be some bureaucratic structure, but the last thing we want to do is to have government pick new winners just like the old structure has perpetuated certain folk who are winning by maximizing on a cost-plus basis.

Our job is basically I think in part to turn HCFA inside out, so that you have a freer structure to allow for innovation, but funding in a way that maximizes the saving and hopefully then technology is focused toward saving money, because perhaps of a fixed price available to deal with it, rather than an open-ended cost-plus structure.

There is great tendency, though, to lock in structure to reflect current practices and in essence to pick winners. Anything that you can do to help us with an understanding of how we might be innovative in recognizing more of a fluid payment structure under a dollar amount, it seems to me that one of the first steps would be to cap the dollar amount and then let folks figure out how they relate under that, because no one wants to, one, leave money on the table, or, two, leave it in someone else's pocket. Is that not a way in which we might be able to maximize those relationships to maximize the services given for a fixed amount of money?

Mr. BRINGEWATT. Yes. Just to be clear, we don't want to predefine a new structure of operation or to predefine a new set of winners and losers. Our proposal would consolidate and simplify the financing and regulations of care for chronic diseases and disabilities and provide incentives for providers to become more innovative in establishing new and varied systems of integrated care. The nature of the structure can and will vary from one setting to another. Our National Chronic Care Consortium is made up of a very diverse group of health care organizations, with diversity particularly in how they manage care. It includes a staff model HMO, Group Health Cooperative of Puget Sound, it includes vertically integrated health systems like Johns Hopkins and Henry Ford, it includes provider networks where providers are legally independent of one another, but agree to work together.

Our assumption here is that Medicare should organize its approach to financing and regulating care around problems of chronic disease and disability rather than around predefined provider

structures. One problem category might be an acute episode of a chronic condition like hip fracture and stroke. The problem category might be viewed as an extended DRG. Other problem categories for funding might include problems like ESRG or AIDS. Where we have an ability to identify a chronic care problem with known costs that cut across settings, it is possible then to establish a rate of financing or a fixed ceiling for addressing that particular problem. Then if we offer financing to primary care providers under a fixed-dollar amount, dollars can flow to whatever combination of care is most cost effective, so that you do not lock yourself into a specific structure and can in fact free up the system to function in new and more cost-effective ways.

I know the Subcommittee is considering the concept of bundling as one alternative for Medicare restructuring. This involves establishing a fixed-dollar amount starting at the point of hospitalization and ending approximately 90 days after hospitalization. Our members would be most comfortable if the concept of bundling allowed dollars to flow, regardless of where the care setting may be. Bundling should not have a bias toward any particular setting such as a hospital. One provider setting should not be in control of another.

For example, if you could take care of the person through a combination of home and nursing home settings without hospitalization, that should be allowed with preference for whatever is most cost effective. So we wholeheartedly concur with your flexibility interests and agree that the starting point is both the problem and the cost relating to serving that problem, rather than viewing the starting point as a place or a profession and regulating the cost of providing care in that place.

Chairman THOMAS. I appreciate that, because frankly it makes no sense at all to me, because each of you have indicated that your problem in part could be solved by a waystation in terms of change relative to a minor judgment recognition by HCFA of PPOs for contracting a little better formula for distribution of money and the rest.

The gentleman from Nevada's comments were especially insightful earlier in that we could solve all of your problems and more by being a little bit bolder conceptually in terms of moving beyond simply incremental adjustment and reconceptualizing the relationship. Some of my colleagues who are not here perhaps are not as appreciative, given the confines in which they now have to argue the debate. They are not able to voice perhaps some attitudes that would show more agreement than disagreement by being relatively bold at this time and fixing problems on an open-ended basis by getting away from a bureaucracy picking winners and therefore creating losers and allowing this relatively now synergistic and novel mixing to continue to go on, but to maximize taxpayer dollars in terms of health benefits.

We look forward to continuing to work with you so that we fully understand the problems we need to deal with, so that when we provide a solution to our current problem in Medicare, that it indeed preserves and strengthens Medicare, but that we do not fall into any traps that we are not aware of by locking in winners and losers.

We appreciate your testimony very much.

At this point of our hearing, without objection, the statement of Jeff Burman, president, Council for Affordable Health Insurance, will be made a part of the record.

[Mr. Burman's prepared statement appears on page 389.]

Chairman THOMAS. The Subcommittee is adjourned. The Chair is reminded that instead of adjourning, we will recess because this hearing will be in at least three parts.

[Whereupon, at 2:50 p.m., the hearing was adjourned, to reconvene on Thursday, July 20, 1995, at 10 a.m.]

SAVING MEDICARE AND BUDGET RECONCILIATION ISSUES

THURSDAY, JULY 20, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

Mrs. JOHNSON [presiding]. Good morning. The hearing will come to order.

We have a number of our colleagues prepared to testify, and I would like to start right in with them. But I will yield to Mr. Stark if he would like to make any opening comment.

Mr. STARK. Madam Chairman, yesterday the Chair and the distinguished gentleman from Louisiana, who is before us this morning, both told us that the Republicans were not planning to cut Medicare in the "old-fashioned way." But somehow you Republicans have been unwilling to tell us how you intend to cut the $270 billion needed to finance the tax giveaways for the wealthy.

Now, given this uncertainty, I know that the representatives of the seniors—the doctors, the hospitals, and other providers in the audience—were relieved to hear that none of the old-fashioned cuts would be proposed. So I would assume that these same people are comforted by the gentleman from Louisiana and the Chair's assertion that none of the following old-fashioned cuts would be included in the Chair's mark, because they were all included in previous bills. Of course, some were in last year's health bill, which the Republicans, every one of them, vehemently attacked and opposed. But I am sure, therefore, you will not include them in this reconciliation given their old and tired nature. Those would include increases in the part B premium, increases in the part B deductible, or changes in other copayments such as home health, reductions in the hospital update, reductions in the indirect medical education adjustment, reductions in capital payments to hospitals, and reductions in the default volume performance standard for physicians.

Given the assertion and the statements by my good friend from Louisiana yesterday and the Chair of the Subcommittee, I know everyone here would be relieved if the Chairman or the gentleman from Louisiana would again assure all of us that none of these types of old-fashioned cuts will be included in the Republican bill.

I want to know if Newt would allow any of you even to suggest such assurance, Madam Chairman.

Thank you.

Mrs. JOHNSON. Thank you, and I welcome the Members to this hearing. The challenge before us is great. Our job is to preserve Medicare as a strong health care system for seniors, providing the spectrum of services it has traditionally provided, but also to create the opportunity to strengthen Medicare so that seniors can have some of the benefits that the old system has not provided because it is an outmoded design and it enabled them to enjoy the quality and breadth of health services in the future that are so critical to security in your retirement years.

It is my pleasure to recognize Mr. Cardin of the Subcommittee. Then we will go in the order on the hearing agenda: Mr. McCrery next, Mr. McDermott, Mr. Stenholm, Mr. Gunderson, Mr. Roberts, and Mr. Poshard.

Mr. Cardin.

STATEMENT OF HON. BEN CARDIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. CARDIN. Thank you, Madam Chairman. May I ask that my full statement be made part of the record.

Mrs. JOHNSON. Without objection.

Mr. CARDIN. It is certainly a pleasure to testify before the Subcommittee.

I took this time in order to deal with one issue that will be talked about in Medicare reform, and that is how we treat our academic health centers. I will be filing legislation in this area and have worked with many Members of this Subcommittee since I have been on the Ways and Means Committee in order to deal with the appropriate funding of our academic health care centers.

I think it is an extremely important part of excellence in U.S. health. We are the leader in the world in medical education. We train the best in the world here in the United States. We have facilities, our academic centers, that lead in pioneering procedures and serve hard-to-serve areas around our Nation.

The academic health centers rely in great part on Medicare reimbursement, on direct and indirect medical education expenditures. It amounts to about $5.5 billion a year. We have the anomaly that Medicare overpays for the cost of medical education, and all other payers underpay for their responsibilities in medical education. All benefit from having well-trained professionals, yet Medicare pays more than its share, and the other payers pay less.

In Medicare reform, we may very well be looking at reducing the Federal Government's responsibility or the Federal Government's cost in medical education that has been recommended by ProPAC. The Shays document included significant cuts in medical education, $27 billion over 7 years. I think that would be disastrous if we do those types of cuts without offsetting recommendations that bring additional financial support to our academic centers.

The problem is compounded by managed care. Managed care looks for the least costly procedures in order to treat its patients. Academic centers, therefore, are finding it more and more difficult

to include in their rates cost of teaching if they wish to be competitive.

Last year, we were able to reach an agreement during the health care debate, and I really want to compliment both Mr. Stark, Mr. Thomas, and Mrs. Johnson on the works that we were doing last year on the academic centers. We reached an agreement that all should help pay for the cost of teaching. We developed an all-payer finance system by imposing a 0.5-percent premiums tax on all health care plans, including managed care and the self-insured. We may very well wish this year to look for alternative revenue sources other than premium taxes, but I would hope that we would look for an independent funding source in which all health care plans fairly contribute toward the cost of academic health.

We also dealt with the work force issue to provide for the appropriate number of health care professionals being trained in all fields, but primarily primary health care. So I invite the Subcommittee to join me in this effort to look for ways of adequately financing our academic centers to maintain excellence in training, to have a proper work force, particularly having adequate numbers trained in primary health care, to look for the viability of our academic centers, and to allow them to compete fairly in the current health care marketplace.

Thank you, Madam Chairman.

[The prepared statement follows:]

BENJAMIN L. CARDIN
3D DISTRICT, MARYLAND

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON OVERSIGHT

COMMITTEE ON STANDARDS OF OFFICIAL CONDUCT

COMMISSIONER
COMMISSION ON SECURITY AND COOPERATION IN EUROPE

DEMOCRATIC CAUCUS STEERING COMMITTEE

ASSISTANT DEMOCRATIC WHIP

Congress of the United States
House of Representatives
Washington, DC 20515–2003

Testimony of Congressman Ben Cardin
Ways and Means Health Subcommittee
July 20, 1995

Thank you for the opportunity to testify here today. I'd like to take a few moments today to discuss an issue of critical importance as we debate the future of the Medicare program: that issue is graduate medical education.

As we know, Medicare pays a large share of the cost of educating graduate medical students in our country. This year Medicare will spend approximately $5.5 billion dollars in direct and indirect medical education expenditures. These expenditures have ensured the U.S. position as the world leader in medical education and allow us to provide the highest quality health care to our citizens. These expenditures also ensure that our academic health centers are able to remain afloat -- to provide pioneering health care and in many cases to serve inner city populations with no where else to turn for their health care needs. These expenditures are vital to the viability of our nation's academic health centers -- especially at a time where managed care continues to consume more and more of the market. Generally speaking, managed care companies cut costs by looking for the lowest cost hospitals and other providers. An academic health center cannot compete if it is forced to cover part of its teaching costs through the rates that it charges for its services. Without a separate funding source for its full academic costs, an academic health center runs the risk of being non-competitive for managed care contracts through no fault of its own, potentially losing another major source of revenue.

There is much debate over whether Medicare should be paying the high costs it is paying for GME today. I don't dispute those arguments. The Prospective Payment Assessment Commission (ProPAC) has recommended that Medicare is significantly overpaying in the area of IME. However, while recommending that Medicare lower those payments, ProPAC recognizes the reliance of academic health centers on these funds. If an immediate reduction were to occur without offsetting recommendations, the affect would be devastating to many of these hospitals.

Today, we are here to discuss potential reforms for Medicare. We are confronted with a $270 billion cut put in place by the Republican Budget Resolution. GME is a likely target for some of those savings. In fact, in the Shays document which details a range of possibilities to achieve those savings, GME takes a huge hit. That proposal would save $27.2 from direct and

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indirect medical education costs over the next seven years and would further devastate academic health centers by eliminating disproportionate share payments.

My contention is that it makes no sense to devastate our graduate medical system in our country and endanger the continued existence of our academic health centers in the name of "Medicare reform." That is why I support restructuring the way we pay for graduate medical education in our country. Rather than having Medicare bear the brunt of the costs for graduate medical education, those costs should be spread across the population. We should create an "all-payer" system for financing GME so that all who benefit from graduate medical education are helping to pay the costs.

Last year during the health care reform debate, we were able to reach agreement on this issue. Under that plan, a new fund would have been created to supplement payments made by Medicare. That fund would have been financed through a premium assessment on insurers, managed care plans, and self-insured plans who would have been required to contribute .5% of premiums toward the costs of graduate medical education in our country. These are the very institutions which benefit from our country's superb medical education system -- they are hiring the health care providers we educate. But today, they are not contributing to the costs of that education. In return for spreading the cost of medical education across all payers and creating a stable funding source, we were also able to reach agreement on workforce issues: ensuring that we are training the appropriate health care providers to meet our health care needs. That meant moving toward a system that trains a preponderance of primary care rather than specialty care providers.

We should not squander that agreement from last year. Moving to an all-payer system for graduate medical education can simultaneously save money in Medicare while raising additional funds from new sources.

I am preparing legislation that would create an all-payer system for GME modeled after last year's agreement. In addition, I welcome the opportunity to work with my Ways and Means colleagues on both sides of the aisle to help fashion a graduate medical education proposal this year. Our goal should be to maintain the excellent training system that we have in this country, to guarantee its adequate funding, to ensure the appropriate training of primary care professionals, and at the same time allow academic health centers to compete fairly in today's health care marketplace.

Mrs. JOHNSON. I thank you, Mr. Cardin, and look forward to working with you on probably one of the most important aspects of assuring the quality of American health care in the future.

Mr. McCrery.

STATEMENT OF HON. JIM McCRERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. MCCRERY. Thank you, Madam Chair, and I congratulate the gentleman from Maryland on his remarks and look forward to working with him on that issue.

Madam Chair, in 1967, the combined cost for Medicare parts A and B was $4.7 billion. By 1995 we expect the cost of the program to be about $178 billion. According to the CBO, the program is projected to have annual growth rates above 10 percent for the next 5 years if nothing is done.

In 1995 Medicare will cover approximately 37.5 million people. While the program recipients certainly have a stake in this program, so does everyone else—taxpayers, families that must pay for the program in part now and in the future.

Medicare is governed by a board of trustees. Four of the six trustees are members of the Clinton administration. In April of this year, the Medicare trustees issued a report.

In their report, the trustees stated that,

> Under present law there is no authority to pay hospital insurance (HI) benefits if the assets of the HI Trust Fund are depleted. The fact that exhaustion would occur under a broad range of future economic conditions, and is expected to occur in the relatively near future, indicates the urgency of addressing the HI Trust Fund's financial imbalance.

And,

> . . . the present financing schedule for the HI Program is sufficient to ensure the payment of benefits only over the next 7 years. As a result, the HI Trust Fund does not meet the trustees' short-range test of financial adequacy.

And on page 14 of this summary, the two trustees who are not members of the Clinton administration, the so-called public trustees, summarized their findings as follows: "We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds"—that is A and B—"be urgently addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms."

Madam Chair, faced with this crisis, we have determined that we are going to abide by six principles as we go through our efforts to do what the trustees have asked the Congress to do.

Number one, we must act immediately to preserve Medicare for current retirees and to protect the system for the next generation of beneficiaries.

Number two, Medicare spending must increase, but it must increase at a slower rate than currently projected by CBO.

Number three, senior citizens deserve the same choices available to other Americans in the health care marketplace.

Number four, government must not interfere in the relationship between patients and their doctors.

Number five, senior citizens should be rewarded for helping root out waste, fraud, and abuse.

Number six, strengthening Medicare is too important to be left to "politics as usual."

Republicans are looking for ways to preserve what is right about the current Medicare system but fix what is wrong. We are soliciting broad participation from constituents and a variety of experts and organizations to determine how to achieve changes needed to protect Medicare from impending bankruptcy. While we are still in the crafting stage, I believe that when we present our product in September most people, including seniors, will be pleased at the options they will have.

While restoring the Medicare Program to solvency, Republicans have committed to the following:

Medicare spending will increase from about $178 billion this year to about $274 billion in the year 2002;

This represents an increase in spending per senior citizen of nearly $2,000, from about $4,800 per beneficiary this year to more than $6,700 per beneficiary by 2002;

Medicare spending will grow at an annual rate of about 6.4 percent. This is two times the rate of inflation and exceeds private health care spending.

I want to state very clearly today that it is too early to say what the specifics of the Medicare reform plan will look like. However, in structuring changes to the Medicare system, we are looking at opening up Medicare to offer seniors the same rights as others to choose the health plan that is best for them. Medicare does not offer today the degree of choice that seniors deserve. More choice for those who want it is a central goal of our efforts.

We are looking at proposals which would include the following four basic choices for seniors:

Number one, staying where you are within the current Medicare system;

Number two, choosing coordinated care, HMOs, PPOs, and the like;

Number three, continued care; that would be continuing the health care insurance that you have with your employer, your union, or your association;

Number four, medical savings accounts for those who would like to have incentives to use their own cash prudently for health care.

These options would open the way for the health care industry to create new choices for beneficiaries and empower the beneficiaries themselves to select health care that is tailored to their precise needs.

In conclusion, Madam Chair, the trustees' report is clear that Medicare is going broke. Republicans believe that it would be irresponsible to know that Medicare is going bankrupt and then do nothing about it. We are determined to act now to save this program.

Private sector growth in health care costs is significantly less than Medicare Program growth in costs. This is because employers and providers have introduced innovative and cost-effective changes to the private health care system. In our efforts to preserve and strengthen the Medicare system, we want to make Medicare more like the private sector, while at the same time give seniors the right to choose what type of health care system best fits their needs.

Anytime we talk about major changes to a program like Medicare, it is certainly risky politically. But we recognize from the trustees' report that this has got to be done. If we do nothing, the eventual day of reckoning will be even more catastrophic for seniors.

I thank the Subcommittee.

[The prepared statement follows:]

Testimony of the Honorable Jim McCrery
Before the Subcommittee on Health
House Ways and Means Committee
July 20, 1995

Medicare was enacted as Title XVIII of the Social Security Act in 1965 and was intended to pay for medical care for the aged and disabled. Today's Medicare program also covers those with end-stage renal disease who require kidney dialysis. The Medicare program consists of two parts--hospital insurance (Part A) and supplementary medical insurance (Part B). Part A was designed to be self-supporting, financed by a payroll tax shared equally by employers and employees. Part B was designed to be a voluntary program to help seniors pay for doctor visits and outpatient hospital services. The costs were to be equally divided between participating seniors and the federal government. Today, only 30% of the cost of the program is supported by premium payments. The remaining 70% is paid from general tax revenues.

In 1967, the combined cost for Medicare Parts A and B was $4.7 billion. By 1995, program costs have soared to $178 billion. According to the Congressional Budget Office (CBO), the program is projected to have annual growth rates above 10% over the next five years.

In 1995, Medicare will cover approximately 37.5 million persons. While the program recipients certainly have a stake in this program, so does everyone else--including taxpayers and families whose children must finance this program in the future.

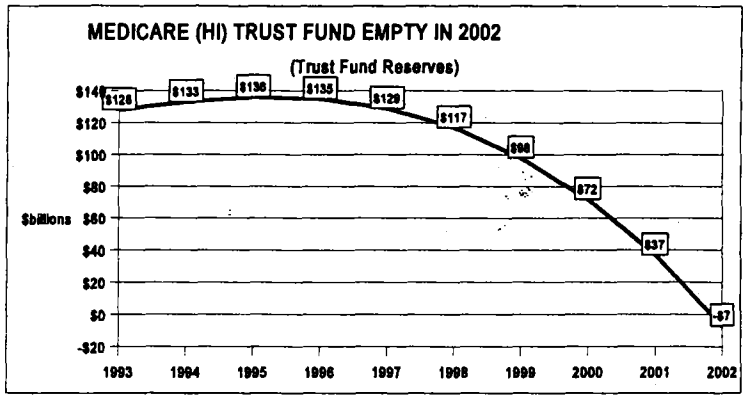
Medicare Trust Fund Report:

Medicare is governed by a Board of Trustees. Four of the six Trustees are members of the Clinton Administration. In April of this year, the Medicare Trustees reported that Medicare is projected to be insolvent by the year 2002. They stated:

"Under present law there is no authority to pay hospital insurance (HI) benefits if the assets of the HI trust fund are depleted. The fact that exhaustion would occur under a broad range of future economic conditions, and is expected to occur in the relatively near future, indicates the urgency of addressing the HI trust fund's financial imbalance."

And, "...the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. As a result, the HI trust fund does not meet the Trustees' short-range test of financial adequacy."

In plain English, this means that unless we strengthen the financial integrity of the Medicare system now, within seven years there will be no money in the trust fund to pay for the hospital and medical costs of Medicare beneficiaries.



Statement of Principles:

Faced with this crisis, House Republicans have determined six basic principles that will guide our efforts to preserve and protect Medicare.

1.) We must act immediately to preserve Medicare for current retirees and to protect the system for the next generation of beneficiaries. The President's Trustees have reported the Medicare Part A Trust Fund will be bankrupt in 7 years. Medicare must be preserved, and prompt, decisive action is imperative.

2.) Medicare spending must increase, but it must increase at a slower rate than currently projected. The budget agreement that was just passed calls for spending to increase from $4,800 per beneficiary this year to $6,700 per beneficiary in 7 years--an increase of nearly 40%.

3.) Senior citizens deserve the same choices available to other Americans. Medicare beneficiaries are given only one option when they enroll in the program--a bureaucratic, outdated, one-size-fits-all program that has not really changed since Congress passed it 30 years ago. Our seniors should have the same opportunities as other Americans in selecting health care options that best meet their needs.

4.) Government must not interfere in the relationship between patients and their doctors. Burdensome Medicare regulations on patients and providers must be eased. Medicare beneficiaries must be able to continue their existing coverage--including their choice of doctors and hospitals.

5.) Senior citizens should be rewarded for helping root out waste, fraud and abuse. We must fight waste, fraud and abuse in Washington's management of Medicare and we must reward seniors when they expose these shoddy practices.

6.) Strengthening Medicare is too important to be left to "politics-as-usual." Republicans stand ready to work with the President and House Democrats to strengthen the Medicare system.

Better choices for beneficiaries:

Republicans are looking for ways to preserve what is right about the current Medicare system but fix what is wrong. We are soliciting broad participation from constituents and a variety of experts and organizations to determine how to achieve changes needed to protect Medicare from impending bankruptcy. While we are still in the crafting stage, I believe that when we present our product in September, most people--including seniors--will be a bit surprised and pleased at the options they will have.

While restoring the Medicare program to solvency, Republicans have committed to the following:

- Medicare spending will increase from $178 billion this year to $274 billion by 2002;
- As mentioned above, this represents an increase in spending per senior citizen of nearly $2,000--from $4,800 per beneficiary this year to more than $6,700 per beneficiary by 2002; and
- Medicare spending will grow at an annual rate of 6.4%--this is two times the rate of inflation and exceeds private health care spending.

I want to state very clearly that it is too early to say what the specifics of the Medicare reform plan will look like; however, in structuring changes to the Medicare system, we are looking at opening up Medicare to offer seniors the same rights as others to choose the health plan that is best for them. Medicare does not offer the degree of choice seniors deserve; more choice for those who want it is a central goal of our efforts.

We are looking at proposals which would include the following four basic choices for seniors:

1. Staying where you are within the traditional Medicare system; or,

Choosing from three umbrella options, which include opting for:

2. Coordinated care (like a Health Maintenance Organization or a Preferred Provider Organization);

3. Continued care (from a former employer or a union plan); or

4. Medical Savings Accounts--with incentives to use cash accounts prudently.

These options would open the way for the health care industry to create new choices for beneficiaries and empower the beneficiaries themselves to select health care that is tailored to their precise needs.

Conclusion:

The Trustees report is clear that Medicare is going broke. Republicans believe that it would be irresponsible to know that Medicare is going bankrupt and do nothing about it; we are determined to act now to save this program.

Private sector growth in health care costs is significantly less than Medicare program growth in costs. This is because employers have introduced innovative and cost effective changes to the private health care sector. In our efforts to preserve and strengthen the Medicare system, we want to make Medicare more like the private sector, while at the same time give seniors the right to choose what type of health care system best fits their needs.

Anytime we talk about major changes to a program like Medicare it is risky politically. But we recognize, from the Trustees report, that this has to be done. If we do nothing, the eventual day of reckoning will be even more catastrophic for seniors.

Mrs. JOHNSON. Thank you, Mr. McCrery, for your excellent presentation of the necessity for change, the principles that should guide change, and the opportunities that this period of change offers us.

Mr. McDermott.

STATEMENT OF HON. JIM McDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. MCDERMOTT. Thank you, Madam Chair. I appreciate the opportunity to testify here today. I know that Waco, Whitewater, and the Packwood hearings have drawn away a lot of the attention, but this is probably one of the major issues of this Congress.

Mr. McCrery rightly has pointed out the trustees' report. It is clear that those same reports have been filed every year since 1965. You could probably lift the language. This problem has been adjusted in every Congress, so the question is: How do we do it?

The ability to testify today is all the more important since this hearing over the next 2 days may be the only opportunity the American people have to hear about the Majority's proposed cuts in the Medicare Program.

The irony is that there is no plan for them to see or debate in these hearings. The American people will probably not get a chance to even see the plan until just a few days before it gets jammed through the floor of the House of Representatives. They probably will not know that they have lost their most basic health care protection until after it has passed out of the House.

The real question is: Under the Republican plan, how much more are beneficiaries going to have to pay out of their own pockets to maintain the same level of access and quality of care they now get through Medicare?

The premise of much of the thinking here is that seniors do not pay enough to pay attention, and the fact is that they pay, on average, 18 percent of their income out of pocket for medical expenses. I do not know what level the Republicans think they ought to pay out of their pocket, but I think that is enough to keep the attention of seniors.

Now, you know Republicans love to talk about how Medicare will increase every year under their proposal. What the Republicans are not telling the American people is that under their plan, Medicare spending will not increase nearly as much as private health insurance costs. What that means is that the difference between what Medicare pays for and what health care will cost is going to be paid for by the beneficiary.

I brought a chart which shows the figures from the CBO and the Senate Budget Committee. The blue is what Medicare will pay; green is the same equivalent cost in the private sector. You can see in 1995 they are the same, so people will not feel anything the first year. But by the year 2002, there will be a marked difference between the blue—that is, what a voucher from the Congress will be worth to a senior—and the green, which is what it will cost in the private sector.

The difference between the blue and the green line will come out of the pockets either of the seniors or of their families.

It is clear that the Majority is not going to tell the American people what they have in mind, so I am going to make a few predictions. Before this debate is over, I predict that we will see the American Medical Association, the American Hospital Association, and the health insurance industry stand up with the Republicans and announce that they can support the proposal as drafted.

That means just one thing: That the lion's share of the cuts are going to be on the backs of beneficiaries and their families and that the hospitals and physicians have gotten off relatively lightly. Of course, the health insurance industry will only support it if they get huge profits out of the proposal, which will come, again, at the expense of the beneficiaries.

There are some basic facts about this that cannot be overlooked. The cuts will all come out of beneficiaries and their families because putting seniors in managed care—that is, HMOs—alone will not save Medicare money.

You cannot point to a single study—including our own CBO—which shows that putting seniors in HMOs will achieve anywhere near the savings that have been targeted by the Majority. In fact, all the studies by anyone outside the insurance industry indicate that any savings to be achieved in Medicare HMOs, to the extent they exist at all, are trivial.

I predict that the only way you are going to get savings in to give seniors a voucher—which you will claim will be voluntary—that will be ratcheted down over time. The Medicare family will have to pay the difference. The children of the Medicare beneficiary will pick up the difference between the cost of insurance and the value of the voucher. That difference will get bigger and bigger each year.

If you look on the next chart, you can see the difference in dollars between what the voucher actually is worth in blue, and the actual cost of insurance; and in red you can see the difference. By the year 2002, a family will have to pay $1,138 out of their pocket to buy the same insurance, and these are not figures I cooked up. They are out of the Senate Budget Committee's recommendations.

In the end, Americans will go from a system of guaranteed coverage for seniors to coverage for only those who can afford it.

I would remind you that 80 percent of senior citizens have incomes under $25,000 a year. The income of the average Medicare beneficiary is $17,000, and 11 million of those people are single women—mostly widows—who have incomes under $8,000 a year.

Now, the question I started this hearing with was: How much are seniors and their families going to have to pay under this proposal? The question I would end my testimony with is this: What will happen to the health care of seniors who are not able to pay the astronomical costs of health care on their own? Madam Chairman, the people who cannot afford to pay their health care costs on their own without adequate insurance.

Many seniors will not be able to come up with that additional money for insurance out of their own pocket. They are going to have to ask their kids for it. If their kids do not have it, the seniors will have an inadequate policy, and we are going to return to pre-1965.

[The prepared statement follows:]



News from Congressman

Jim McDermott

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STATEMENT BY
U.S. REP. JIM MCDERMOTT (D-WA)
BEFORE THE
WAYS AND MEANS HEALTH SUBCOMMITTEE
JULY 20, 1995

Thank you, Mr. Chairman. I appreciate the opportunity to testify here today. The ability to testify today is all the more important since this hearing over the next three days may be the only opportunity the American people have to hear about the Majority's proposed cuts in the Medicare program.

The irony is that there is no plan for them to see or debate in these hearings. The American people probably won't get a chance to even see the plan until just a few days before it gets jammed through the floor of the House. They probably won't really know that they have lost their most basic protection to health care until after it has passed out of this House.

The real question is: under the Republican plan, how much more are beneficiaries going to have to pay out of their own pockets to maintain the same level of access and quality of care they now get through Medicare?

You know, Republicans love to talk about how Medicare will increase every year under their proposal. What the Republican Majority is not telling the American people is that under the Republican budget, Medicare will not increase nearly as much as private health care costs and health insurance costs will rise. What that means is that the difference between what Medicare pays for and what health care will cost is going to be paid for by the beneficiary.

It is clear the Majority is not going to tell the American people what they have in mind so I am going to make a few predictions. Before this debate is over, I predict that we will see the American Medical Association and the American Hospital Association and the health insurance industry stand up with the Republicans and announce that they can support the proposal as drafted.

This will mean just one thing -- that the lion's share of the cuts are going to be on the backs of beneficiaries and their families and that the hospitals and physicians have gotten off relatively lightly. Of course, the health insurance industry will only support it if they get huge profits out of the proposal, which again will all come at the expense of beneficiaries.

There are some basic facts here that cannot be overlooked. The cuts will all come out of beneficiaries and their families because putting seniors in managed care (HMOs) alone WILL NOT SAVE MEDICARE MONEY.

You cannot point to a single study -- including your own CBO -- which shows that putting seniors in HMOs will achieve anywhere NEAR the savings you have targeted. In fact, all the studies by anyone outside the insurance industry indicate that any savings to be achieved in Medicare HMOs -- to the extent they exist at all -- are trivial.

I predict that the only way you are going to get savings is to give seniors a voucher -- which you will claim to be voluntary -- the value of which will be ratcheted down over time. The Medicare family will have to pay the difference between the cost of insurance and the value of the voucher. THAT DIFFERENCE WILL GET BIGGER AND BIGGER EACH YEAR. In the end, Americans will go from a system of guaranteed coverage for seniors under Medicare to coverage only for those who can afford it.

I would remind you that 80% of senior citizens have incomes under $25,000 per year. The income of the average Medicare beneficiary is $17,000, and 11 million Medicare beneficiaries are single women -- mostly widows -- who have incomes under $8,000 per year.

The question I started this hearing with was, "How much are seniors and their families going to have to pay under your proposal?" The question I end my testimony with is "What will happen to the health care of seniors who will not be able to pay the astronomical costs of health care on their own?" And Mr. Chairman, the people who cannot afford to pay their health care costs on their own without adequate insurance is just about all of us.

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Mrs. JOHNSON. Thank you, Mr. McDermott. Certainly the challenge we face is to preserve and protect Medicare, and there will be a lot of analysis of all the ideas that come forth. We have had 14 public hearings on the issue of saving Medicare. What we will be interested in during the weeks ahead, this Subcommittee, the Full Committee, and all Members of Congress, is: What are the ideas that will work for seniors and for the citizens of this country? We certainly welcome your contribution to the solutions, as well as your contribution to the dialog evaluating some of the ideas that are afloat at this time.

I understand that Mr. Gunderson wishes to precede or Mr. Stenholm wishes for Mr. Gunderson to precede him.

Mr. Gunderson.

STATEMENT OF HON. STEVE GUNDERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. GUNDERSON. Madam Chair, I have spent all my life doing what Pat Roberts and Charlie Stenholm told me to do, and I guess I am continuing that this morning.

As the current and former co-chairs of the House Rural Health Care Coalition, the four of us are here to share with you the unique needs of rural America, the unique role Medicare plays in these communities, and some recommendations about how best to reform Medicare in ways which will not disproportionately impact the 25 percent of our population living in rural areas. I am reminded as I sit here that once a week, Mr. Stark and Mrs. Johnson come up to me and remind me of all the dairy farmers they have in their districts. I want to start once a week coming up and reminding her that dairy farmers are rural constituents who need to be taken care of in this whole Medicare reform. So we are going to get even on this one.

To many, rural America brings to mind hearty farmers with well-manicured fields and Norman Rockwell lifestyles and families. Although this can be the case, it is not necessarily the rule in the rural United States.

Almost 18 percent of rural high school students are substance abusers, compared to 10 percent in urban areas.

More than 26 percent of rural households are among the poorest fifth of the U.S. households. By contrast, only 18 percent of urban households.

More than 20 percent of rural elderly have incomes below poverty compared to 12.4 percent in the urban areas.

Given these kinds of demographics, rural areas face great challenges in the accessibility and quality of health care services. The great distances, the lack of health care professionals and health care facilities, and the nature of the work force all contribute to the health conditions in rural areas.

Rural residents are more than twice as likely to have to travel more than 30 minutes to reach their usual source of care.

There are 5,424 primary care practitioners needed just to meet the demand in the underserved rural areas.

Over 17 percent of rural residents have no health insurance, many because they are self-employed farmers who simply cannot

afford the high-cost premiums and deductibles associated with what the insurers classify as high-risk professions.

Now, when we look at managed care in rural America, I think we need to understand that the movement of our health care system toward HMOs and other forms of managed care have gone a long way in keeping down costs and expanding access to the general population. In some areas, managed care is actually stimulating the development of even rural integrated health care networks.

However, if you have no hospital, if you have no providers, managed care does not do you much good. The lack of a health care infrastructure in rural areas makes the viability of managed care questionable for many rural networks.

Managed care for Medicare must also provide criteria and standards for determining the appropriate financial risks that can be assumed by smaller providers and networks. Without these standards, smaller providers face excessive risks.

In order for managed care to be effective in rural areas, systems must:

First and foremost, change the definition of literally what a hospital is in rural areas, according to the Social Security definition;

Second, provide adequate levels of reimbursement and the flexibility in delivering those services;

Third, ensure access for all populations, particularly as it relates to high-risk professions such as farming. If they are not included in a managed care plan, managed care is not going to give them any protection and coverage;

Fourth, make providers subject to certification to ensure that they have the systems necessary to provide the levels and quality of care needed in rural areas;

Fifth, require that all accredited, certified providers are included in such a plan. A big problem we are facing in rural America is that a few urban plans reach out and cover one or two facilities, and all of a sudden, unless you are a part of that HMO in that urban area, you do not have any coverage.

I have a small rural hospital in my hometown. We are desperately trying to keep it alive. I cannot tell you the number of people in Osseo, Wisconsin, who cannot use the local clinic and hospital because they are covered by an HMO that will not include that in their overall coverage and reimbursement processes.

Now, when we look at the role of Medicare in rural health, issues specific to rural health cannot be considered without discussing Medicare. The reality is there are few facts that illustrate the importance and problems that Medicare must be considered more than these:

First, rural providers can receive as much as 80 percent of their revenue from Medicare, while the average is between 50 and 70 percent. Most are certainly about 70;

Second, right now, with the current reimbursement rate, hospitals in my home State of Wisconsin receive only 88 percent of their costs. Nationwide, rural hospitals with fewer than 100 beds—which make up 36 percent of all hospitals—receive only 6 percent of Medicare prospective payment system type of payments.

Medicare casts a long shadow over rural health care while rural health is largely ignored by Medicare.

As leaders of the Rural Health Care Coalition, we accept that we will all play a role in making Medicare solvent. While we recognize that some levels of cuts are inevitable, it is critical that the Ways and Means Committee address specific areas of Medicare reimbursement that could make or break rural health care for both the elderly and the general populations.

My colleagues on this panel and the Rural Health Care Coalition will elaborate on the reforms which will make the difference in rural areas. These reforms will include: Creating single Medicare payment areas, restructuring of the Medicare wage index, and adjusting data to more accurately reflect the occupational mix of rural hospitals.

Obviously, as you go through this, Madam Chair and members of this panel, I hope you will come to recognize that for rural America there is clearly need for concern as you begin to make your determinations on Medicare. For us, what you do in Medicare will determine literally whether we have access to health care at all.

Thank you very much.

[The prepared statement follows:]

Testimony for the Ways and Means Subcommittee on Health

Congressman Steve Gunderson Member, U.S. House of Representatives

Regarding the Impact of Medicare Reforms on Rural Health July 20, 1995

Mr. Chairman, thank you for this opportunity to speak before the Ways and Means Subcommittee on Health. I am not going to take this time to restate the numbers on Medicare and the importance of the decisions we will make in the coming months. We all know we have an obligation to preserve, protect and attempt to improve the care of the 31 million seniors currently enrolled in Medicare.

As the current and former co-chairmen of the House Rural Health Care Coalition, we are here to share with you the unique needs of rural America, the unique role Medicare plays in these communities, and some recommendations about how best to reform Medicare in ways which will not disproportionately impact the 25 percent of our population living in rural areas. It is not enough to trim the increase in Medicare expenditures, we must also make the policy and program changes that will not only insure its solvency, but will also provide the best care possible for all populations.

Conditions in Rural America

To many, rural America brings to mind hearty farmers with well-manicured fields and Norman Rockwell lifestyles and families. Although this can be the case, it is not necessarily the rule in the rural United States.

* Almost 18 percent of rural high school students are substance abusers, compared to 10 percent of urban areas;

* More than 26 percent of rural households are among the poorest fifth of U.S. households. By contrast, only about 18 percent of urban households have incomes this low; and

* More than 20 percent of rural elderly have incomes

below poverty, whereas only about 12.4 percent of elderly in urban areas have incomes below poverty.

The poverty rate, the unemployment rate, and the percentage of the population that is elderly are all comparable or greater for rural areas than for any other geographic group.

Given these demographics, rural areas face great challenges in the accessibility and quality of health care services. The great distances, lack of health care professionals, and the nature of the workforce in also contribute to the health conditions in rural areas.

* Rural residents are more than twice as likely to have to travel more than 30 minutes to reach their usual source of care;

* There are 5,424 primary care practioners needed just to meet the demand in rural underserved areas;

* Over 17 percent of rural residents have no health insurance, many because they are self-employed farmers who face high premiums and deductibles.

Managed Care in Rural America

The movement of our health care system toward HMOs and other forms of managed care have gone a long way in keeping down costs and expanding access. In some areas, managed care is actually stimulating the development of rural integrated care networks.

However, if you have no hospitals and no providers, managed care doesn't do you much good. The lack of infrastructure in rural areas make the viability of managed care questionable for many rural networks.

Managed care for Medicare must also provide criteria and standards for determining the appropriate financial risk that can be assumed by smaller providers and networks. Without these standards, small providers face excessive risk.

In order for managed care to be effective in rural areas, systems must:

* provide adequate levels of reimbursement;
* ensure access for all populations, particularly as it relates to high risk professions such as farming; and
* make providers subject to strict certification, to ensure that they have the systems necessary to provide the levels and quality of care needed in rural areas.

Managed care has potential in rural America, but it is clearly not a panacea.

The Role of Medicare in Rural Health

Issues specific to rural health cannot be considered without discussing Medicare, because Medicare is integral to the quality and accessibility of health care in non-metropolitan areas.

There are a few facts that illustrate the importance and problems in Medicare that must be considered. First, rural providers can receive as much as 80 percent of their revenues from Medicare, with the average being between 50 and 70 percent. Second, right now, with the current reimbursement rates, hospitals in my home state of Wisconsin only receive about 88 percent of costs. Nationwide, rural hospitals with fewer than 100 beds -- which make up 36 percent of all hospitals -- receive only 6 percent of Medicare Prospective Payment System payments.

These facts make clear that while an overwhelming share of the patients seen by rural providers are Medicare enrollees, rural health receives a very minor portion of Medicare program expenditures. **Medicare casts a long shadow over rural health while rural health is largely ignored by Medicare.** Changes must be made which address this disparity, especially in light of projected cuts.

Changes to Medicare Policy

As the leaders of the Rural Health Care Coalition, we accept that we will all play a role in making Medicare solvent. While we recognize that some levels of cuts are inevitable, it is critical that the Ways and Means committee address specific areas of Medicare reimbursement that could make or break rural health care, for both the elderly and the general population.

My colleagues on the panel, and the rural health panel you will see later today, will elaborate on the reforms which will make the difference in rural areas. These reforms include:

* **Creating Single Medicare Payment Areas**

* **Restructuring of Medicare Wage Index**

* **Adjusting data to more accurately reflect the occupational mix of rural hositals**

Both panel will also touch on current policies which are essential to rural health, including Sole Community Hospitals and bonus payments to rural providers.

Close

For rural America, there is clearly need for concern as you begin to make your determinations on Medicare. However, there is no need for panic. Through a conscientious dialogue, I am confident the Ways and Means committee can make the difficult decisions which will ensure rural health care is not impacted disproportionately. I appreciate the opportunity to represent our concerns and I hope the Rural Health Care Coalition can continue to act as a resource as you perform the difficult task of reforming Medicare.

Mrs. JOHNSON. Thank you very much, Mr. Gunderson. We certainly will depend on the guidance and input of this group of rural health care experts as we move forward.

Mr. Stenholm.

Mr. STENHOLM. Mr. Poshard will be next, Madam Chair. I yield to Mr. Poshard to be next, and then Mr. Roberts, and then I will be the last.

Mrs. JOHNSON. Mr. Poshard.

STATEMENT OF HON. GLENN POSHARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. POSHARD. Thank you, Madam Chairman, for giving us the opportunity to appear today before your Subcommittee.

Let me first of all say that our Rural Health Care Coalition is a broad bipartisan group, and we have differing views, of course, among the membership as to what we should or should not do with respect to Medicare. We are talking here today about Medicare cuts. I personally feel that we do have to go through downsizing the program somewhat. I supported Mr. Stenholm's budget when it came through the House because I thought it was a reasonable level of dealing with these things. But within our coalition, we all have different views on this. But I want to talk about the effects that I believe will occur in rural America if substantial cuts are made to the Medicare system.

Along with many of you here today, I agree it is time to address the problems that have continued to plague this system that has been responsible for providing health care services to our Nation's elderly for 30 years. I also believe that changes in the delivery of rural health care have to be made to become more cost effective. However, I believe the proposed level of cuts to Medicare will have the reverse effect. Perhaps these cuts will remedy a faltering Medicare system, but I sincerely believe that they will also put into jeopardy the ability of Americans living in rural areas to have quality and accessible health care.

Beyond the issue of accessibility of quality health care services, we put into jeopardy many of our rural hospitals which often rely on Medicare reimbursements as their major source of income. The fact is without these reimbursements, many of our rural hospitals will close, our physicians and nurses will relocate, unemployment will rise, and rural economies will become further distressed. In my district, over 75 percent of the patient load in our rural hospitals is Medicare and Medicaid patients.

I come here today because it is important for those of us in Washington to know the broad implications drastic cuts to the Medicare system will have on rural Americans. As cochairman of the Rural Health Care Coalition, I believe our first concern during this debate has to be that every American has access to quality and affordable health care. I am afraid with these types of cuts to the program, many seniors living in rural regions of this country will no longer be able to afford or even find health care services.

Already our rural hospitals are fighting to survive urban competition and declining levels of patients who can afford their services. I believe by cutting back too drastically on Medicare reim-

bursement to these hospitals, we will simply be pushing away many of the hospitals and pushing them out of business.

In my central and southeastern Illinois congressional district, which is comprised of 27 rural and economically distressed counties, many families have to travel 50 or more miles, and in some cases to a neighboring county, to see a doctor. If just one of these hospitals closes, hundreds of people, both young and old, will not have available to them the services of a hospital or an emergency room. If these hospitals that rely so heavily on Medicare reimbursement are forced to close because of cuts, not only will our seniors be without services, but so will our children, our parents, our neighbors.

Today, rural America has the highest percentage of poverty, the highest rate of unemployment, and the highest percentage of elderly in our society. In many rural communities, hospitals drive the local economy. The effect of closing many rural hospitals would be devastating to a rural economy that is already faced with high unemployment and economic slowdown. Many of our small businesses rely on local hospitals to purchase their goods and services. Without the hospital acting out the role of consumer, these businesses would no longer be able to stay open, further distressing the local rural economy.

As a Member of the House Small Business Committee, I have on many occasions heard the testimony of small business owners whose business is tied to the success of the rural health care system.

Along with small business owners and operators, many residents of rural communities look to their local hospitals for jobs. We often only remember the physicians and nurses during our debates on health care, forgetting about the important and large support staff that provides many of our people with a stable job and income. From the cafeteria worker to the bookkeeper, these are important and necessary jobs, and without them I am afraid many of our communities could not survive. And I believe drastic cuts to the Medicare Program will result in dramatic reductions in the number of these jobs.

In fact, I have several small communities in my district where the hospital and the nursing home and the ambulance service are the major employers in the county. Let me emphasize, the major employer in the county.

Here in Washington, we too often forget to look at the broad implications of our actions. When we think about Medicare cuts, it is simply not just a case of providing health care services to our seniors. It is about facing the threat of many of our rural hospitals closing and our physicians and nurses, who all of us so greatly rely upon, relocating to urban areas. It is about people losing their jobs, small businesses closing, and economies faltering. That is what this Medicare debate is all about, a fact none of us can afford to forget.

In closing, Mr. Chairman, I urge this Subcommittee during its consideration of Medicare reforms and reductions to consider all of the effects that Medicare cuts will have on rural health care and rural communities. Rural America is an important part of life in this country, and those that live and work there deserve the same opportunity for affordable and accessible health care services as

those living in our Nation's cities and suburbs. I believe we can make Medicare work better for those it serves, but we have to do it responsibly and not on the backs of our rural health care system and our rural communities.

I thank the Chairman for allowing the Rural Health Care Coalition to be represented at these hearings focusing on Medicare. If I or any member of the coalition can be of further assistance in making your recommendations, feel free to contact us.

Thank you.

Mr. CHRISTENSEN [presiding]. Thank you, Congressman Poshard.

Congressman Roberts.

STATEMENT OF HON. PAT ROBERTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. ROBERTS. Thank you, Mr. Chairman.

As a past cochairman of the Rural Health Care Coalition, I am very happy and pleased to be here with the group I would describe as the four horsemen of rural health care.

Mr. Gunderson has given an overview of rural health care, and Glenn has just given a very good statement in regards to the impact in relation to the entire community. I am going to be riding shotgun with the hospitals, Mr. Chairman, and then batting clean-up we have Mr. Stenholm, who is the sheriff who tries to round up as many doctors as we can for the rural areas.

This has not been an "Easy Rider" trip if we are the four horsemen of rural health care. It has been more like "Lonesome Dove," and I hope we get there from here.

We are bipartisan in our effort, and as I have indicated, it is my duty to talk about the future of rural hospitals under the Medicare Program.

As it has been indicated, rural hospitals do provide health care services to a higher Medicare population and a lower level of insured patients. This unique patient base provides a very limited opportunity for our hospitals to shift costs on to private-pay patients. How much? We are talking about the fact if a patient goes into a rural hospital they have to pay 10 to 20 percent more because of the cost shifting and the fact the hospital does not get reimbursed properly in regards to Medicare.

In addition, the Medicare payment updates have not always been fairly distributed between the rural and the urban hospitals. So the combination of these factors, combined with $270 billion we intend to save in Medicare over the next 7 years means we have a very difficult challenge for our rural hospitals.

I recently met with the Kansas Hospital Association, along with the rest of the Kansas delegation, and I would like to submit a copy of their report to the Subcommittee for your review. I am very impressed with their study not only because it provides the facts about the impacts of the Medicare reductions, but it also includes some very constructive and positive recommendations to Congress to help us fix this very difficult system.

[The following was received:]

Congress of the United States

Washington, DC 20515

July 20, 1995

Chairman Bill Thomas
House Ways and Means Health Subcommittee
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Bill:

As Members of the Kansas Congressional delegation, we support the efforts of the Health Subcommittee to save and strengthen the beleaguered Medicare system. However, we feel it is vitally important to consider the impact that Medicare reforms will have on every aspect of our health care system including access and delivery of health services in rural areas of the country. As you and the Ways and Means Health Subcommittee members are well aware, the issues concerning rural health care are unique and must be examined closely.

During a recent meeting with the Kansas delegation, the Kansas Hospital Association presented the enclosed report. This report provides an excellent summation of the concerns that face patients, providers and administrators not only in Kansas, but across the nation. We are particularly impressed by the constructive recommendations made in this report, and urge the Subcommittee to take them into consideration.

The effort to reform Medicare, led by House Republicans, will indeed save and strengthen this essential program for future generations. We appreciate your consideration of this report, and look forward to working with you in the future on this critical issue.

Sincerely,

Sam Brownback M.C.

Pat Roberts M.C.

Jan Meyers M.C.

Todd Tiahrt M.C.

[Kansas Hospital Association Report retained in Committee Files]

PRINTED ON RECYCLED PAPER

In fiscal year 1993, over 60 percent of the hospitals in Kansas lost a total of $43 million treating Medicare patients. These hospitals are predicting now that under fiscal year 1996 budget guidelines—we do not have the specifics yet, but under the guidelines they are going to lose $905.80 on each Medicare patient that must be admitted to the hospital. Now, these are very serious predictions because they represent a real threat to the delivery of health care services in many Kansas communities, and I would imagine in every rural area. If these hospitals are forced to close, everybody, not just the Medicare beneficiaries, will lose access to even basic health care services. In many rural communities, these hospitals have nowhere to turn. So we have a situation in rural America where bond issue after bond issue has been passed by the local community simply to keep the doors open.

Now, I want to make it very clear that I do not believe in simply throwing Federal dollars at our rural hospitals, and I do not think we should pour money into facilities that can never really operate on an efficient basis. We should, however, give rural hospitals the proper tools to make the changes to fit into a new Medicare system. The challenge before us today is to achieve the significant Medicare savings that we have to while at the same time maintaining the very critical access to high-quality health care services in our rural areas.

Now, we have heard a lot about the new managed care world, incentives to establish managed care plans and encourage the Medicare recipient to choose. These plans are especially important in the rural areas.

Under the current structure, however, the Medicare risk contractor simply does not have the incentive to establish managed care plans in our rural areas. It is simply more difficult for managed care plans to make money in rural areas because the smaller population base generally leads to lower utilization rates. The Medicare payment system to HMOs will have to be restructured to take into account geographic factors, health and age status of local populations, and utilization of services in the local areas. We should then consider changes to make it easier for the Medicare beneficiaries to choose these plans.

We also need to preserve the networking arrangements, Mr. Chairman, that are already in place in many of our rural areas. The Hays Medical Center, located in western Kansas, is an excellent example of how the Essential Access Community Hospital Program—that is called EACH and RPCH. If there was ever an amazing acronym, it is the "each" and "peach" program. But these programs can strengthen, expand, and deliver the services in our rural areas. The Hays Medical Center has established an interactive telemedicine home health care program to link our elderly patients and their physicians. This technology has really reduced the cost of the program for home health care by one-sixth. Unless we take steps to preserve these kinds of network arrangements, severe reductions in Medicare provider payments will limit the effectiveness and the efficiency of the rural health care system.

Mr. Chairman, I support you in your efforts to preserve, protect, and strengthen Medicare. Your entire panel's challenge in this regard is very difficult. Your Subcommittee faces an especially dif-

ficult challenge. As you continue in your efforts to restructure this ailing program, I encourage you to rely on the experience and the advice of the members of the Rural Health Care Coalition. We are eager to work with you and try to help you develop a new system that will take care of our elderly now and in the future.

I thank you, Mr. Chairman. I thank the panel.

Mr. CHRISTENSEN. Thank you, Congressman Roberts.

Congressman Stenholm, we would be honored to hear your testimony.

STATEMENT OF HON. CHARLES STENHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. STENHOLM. Thank you, Mr. Chairman.

As you have heard, the four of us from the Rural Health Care Coalition are unified in our understanding that reforms to the Medicare Program must occur for both budgetary and programmatic reasons, that changes in the delivery of health care in rural areas are inevitable, and that a status quo attitude toward Medicare would be devastating to all Americans. We want to make it clear from the beginning that we are not here before you to argue against change.

We also want to state as clearly as possible, however, that the rural areas which we represent, as well as those district of the 100-plus members of the coalition, will be impacted in a major way by the decisions this Subcommittee makes regarding Medicare. These impacts will go beyond a simple marketplace "survival of the fittest" result which might be considered in many urban and suburban areas. The decisions you make will determine not only if managed care is encouraged but if any hospital care at all is available in some large counties; not only whether the right physicians are being trained but whether any physician at all will serve dispersed populations; not only if clinics survive but whether entire communities survive.

To summarize what you have already heard from my colleagues, we believe that there are certain rural reimbursement issues which are absolutely critical and should be protected, such as sole community provider status—or some other way of indicating those essential community providers without whom care would be greatly diminished or eliminated—and Medicare bonus payments for physicians practicing in shortage areas. We also think there are new ideas, such as incentives to make managed care work in rural areas, or allowing hospitals to downsize while retaining eligibility for Medicare reimbursement, which could be extremely productive.

But in the process of making these requests, we understand political and fiscal realities demand that we also be willing to offer up areas of lower priority. We understand that not every item for which the coalition has advocated in the past can necessarily be continued. Special Medicare treatment for every existing rural referral center and every current rural health clinic may not be possible. Again, we know that we must focus on those providers which are absolutely critical to an area. We accept that disproportionate share should truly become what its name ostensibly implies, meaning that only hospitals which actually treat a disproportionate

share of low-income, uncompensated cases should receive the extra payment.

Those are fair tradeoffs for this Subcommittee to make. Not every nonmetropolitan hospital needs to keep its doors open. Not every physician deserves a higher payment for living in a nonurban area. But for us in the coalition, the bottom line is that we must protect those providers whose loss would mean a profound loss of health care for rural populations; that is, those who genuinely are essential community providers. We must ensure that a basic level of health care is available to rural communities, encouraging networks for higher levels of care but spreading a health safety net for our rural residents.

My colleague, Mr. Roberts, has mentioned how these protections relate to hospitals. I would like briefly to extend that discussion to physicians. Although this Subcommittee does not have primary jurisdiction over Medicare reimbursement for physicians or medical education, I know that the issues become entwined, and so I would like to offer a few comments.

Physician attraction and retention is a persistent and chronic battle for many rural areas. There are a host of reasons for this difficulty, including professional isolation, low and inconsistent revenues, and technological deficiencies. Obviously, the Federal Government cannot counteract or compensate for all of these disincentives, but to the degree that we can assist rural areas in meeting their basic physician needs, we should do so.

I fear that, just as a decade or more ago when everyone started talking about a "physician glut," today there may be a false sense of optimism about the primary care physician supply. According to 1994 AMA data, the percentage of physicians choosing primary care as a career is down from 10.6 percent in 1980 to 8.9 percent in 1993. Even those who choose the field of primary care continue to practice in traditionally well-served markets such as suburban communities, not in either remote rural areas or inner-city neighborhoods. Small and rural counties have had a decline in the primary care physician-to-population ration since 1988.

As this Subcommittee knows well, HPSA, the Health Professional Shortage Area, designation was created to help us focus nationally on the areas of greatest need in our country. The number of primary care HPSAs has more than doubled from 1978 to 1994. Currently it is estimated that the total number of providers needed to eliminate primary care HPSAs is 5,341.

Increasing the supply of health providers and attracting them to an underserved practice requires action at several stages of their professional education and professional development. Reaching out to rural students with a potential interest in medicine has proved somewhat effective. Next, Medicare reimbursement of direct medical education costs should, in general, give preference to the primary care specialties and should target funding to rural-oriented programs.

Part of the answer to this problem is not within the boundaries of Medicare. For example, the coalition strongly endorses the National Health Service Corps, the Area Health Education Center program, deferral of repayment of medical loans for individuals who conduct their internships and residencies in rural areas.

But there are ideas which clearly are Medicare reimbursement issues. For example, previous rural health medical education demonstration programs experienced only minimal success because the Medicare reimbursement for moving the resident and the family to the rural area was inadequate. This idea of encouraging residencies in rural areas, especially when the experience could involve a consortia of training sites, holds great promise with simply a small influx of Medicare dollars.

We also strongly encourage significant Medicare bonus payments for physicians who agree to practice in underserved areas. You will hear later today about a new urban-rural Medicare differential, with rural practitioners once again coming out on the short side. If there is to be a differential, shouldn't it be weighted in the direction of incentivizing movement toward underserved areas, not vice versa?

Clearly, this problem of training, attraction, and retention of providers in underserved rural areas is not a uniquely Federal issue. I have been amazed by the creativity and investment States and individual communities have made in this effort. But they need our help as well, and I hope as this Subcommittee explores Medicare reforms, it will be sensitive to the tremendous return there can be on limited Medicare dollars sent to rural areas.

Let me close by expressing our appreciation for your hearing not only this panel but also for granting time for the panel of rural experts which you will hear later today. We in the coalition depend on the good advice we receive from folks like those here representing RUPRI and NRHA. These are the people who are rolling up their sleeves and attempting to solve the real world challenges before us, and I believe you will find their comments extremely helpful, as we have.

Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Thank you, Congressman.

Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman.

I want to welcome my friends from the rural caucus and remind them of a couple of incidents of which this Ranking Member is very proud. This Subcommittee, under the Minority's direction, equalized the rural reimbursement rate to equal the urban rate so the rural was brought up. We extended the sole community hospital program. We created and extended the Medicare-dependent small rural hospital program. It is a fact that when small rural hospitals close, generally the last patient in that hospital before they turn out the lights is a Medicare patient. The smaller the hospitals get, the higher the percentage of Medicare reimbursement, and the more important it becomes to those.

We created the Essential Community Hospital, the EACH Program, which I am proud to say I authored, along with Mr. Gradison. We increased the number of hospitals eligible for the designation of rural referral centers.

I would like to think that under the new leadership, this creative attempt to help provide rural assistance would continue, but I remind my friends from dairy States, for instance, that cheddar cheese and cow chips come from the same place, and there is a bit of a difference between them. So as you look upon this Subcommit-

tee, please keep up your information. We need to have our noses held to the grindstone.

Further, I would point out as to HMO enrollment that Indiana, Montana, Wyoming, North and South Dakota, Nebraska, Kansas, Oklahoma, Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, South and North Carolina, Tennessee, Kentucky, Indiana, West Virginia, Virginia, Maine and Iowa have less than 10 percent of their population in HMOs, and that has not shown much growth. So as we talk about these marvelous new plans, recognize that many of these rural States—Alaska, by the way, has none; Wyoming has none. They have no HMOs. So to say let Medicare beneficiaries go into an HMO, you might as well tell them to jump off the edge of a cliff.

But I do want to pledge that the Minority on the Subcommittee will continue to work to see that Medicare is fairly distributed to all citizens and recognize the limits living a great distance from centers of excellence puts on the medical delivery system and the special requirements that are needed by rural folks.

I would like to ask Mr. McCrery a question. It was just 1 year and 1 month ago, about June 25, Jim, that you said this—and this was in regard to $168 billion in Medicare cuts, all of which were being reinvested in hospitals and doctors. Today we are faced with $270 billion in Medicare cuts, all of which go to rich taxpayers. But you said in our Subcommittee then that you "would love to believe that we could achieve the level of cuts"—that is, $168 billion—"you have in this bill." I think that was directed to me.

But history tells it that this is not possible, and I think we are just playing games here. We are just making the numbers match. That is all Democrats have done in your bill to make it revenue neutral. You have just estimated the number needed from Medicare to make the numbers match, and I think the public understands that.

Now, what is different today except that you want to cut $270 billion out, match the numbers to the tax cut, which is $245 billion. I am not sure what is different, and a follow-on question would be: How many years does your bill extend the Medicare solvency? Or if you are not sure, how many years do you think it should? That really is a major case, and then maybe you could tell us that. How many years will we have breathing room under the Republican plan? And what is different?

Mr. MCCRERY. Well, the red light is about to come on, but thank you for your very good question. The answer to the first question is, as I said yesterday, Republicans are in control now and not Democrats. So I have more faith that we will come up with innovative ways to address the Medicare Program than I did when the Minority was in control, because the history of the Minority, frankly, was cranking down reimbursement rates, making jiggles here and jiggles there on a yearly basis to try to shore up the fund.

I am confident that we are going to come up with a plan that makes much more fundamental changes just as recommended by the trustees when they say a review of the program's financing methods, benefit provisions, and delivery mechanisms are all necessary in order to avert this crisis. I am confident that we are going to do that.

Last year, when I spoke of the historical basis for this Subcommittee's action—of course, since 1965 it has all been controlled by the Democrats, and the history was that you went right after the providers to try to squeeze out those savings to address the problems. Now I am confident that we are going to do better. We are going to make those fundamental changes that most experts agree are necessary.

Mr. STARK. How many years?

Mr. MCCRERY. Well, it is hard to say, and nobody knows for sure. CBO, though, looking at what we proposed, can say that it will be solvent through 2005, which is as far out as they will go. But asking independent sources outside of government, they think if we are able to do what the numbers that we have set down say we will do, then it should remain solvent for as far as the eye can see, at least until the latter stages of the baby boom development, when, of course, nobody knows what is going to happen. But at least as far as the latter stages of that baby boom development we think, and other outside experts agree, that the changes we intend to make will make it solvent for that period of time. So I would say they are saying maybe to 2020, 2025 it should be solvent. Then, of course, we have to see what the baby boom retirement does.

Mr. STARK. Somewhere between 2005 and 2020?

Mr. MCCRERY. Yes. Well, CBO will only say to 2005. They will not go further than that.

Mr. STARK. I thank the gentleman.

Mr. MCCRERY. Thank you.

Mr. STARK. Except to remind him that in those budgets where we cut out of the providers, in every one of those 8 years, save last, the ranking Republican Member cosponsored. It was never passed along partisan lines. It always had votes from both sides of the aisle.

Mr. MCCRERY. Thank you for that notation.

Chairman THOMAS. The gentleman's time has expired.

Does the gentleman from Nebraska wish to inquire of the Members?

Mr. CHRISTENSEN. Yes, please. Thank you, Mr. Chairman.

As a new Member on this Subcommittee, it still continues to amaze me when I hear a $4,800 in Medicare spending this year per senior citizen to $6,700, $6,800 per Medicare recipient spending in the year 2002 still referred to as "a cut." And I guess only in Washington, DC, is a $1,900 increase a "cut." I guarantee you in Nebraska, where I am from, that is an increase.

What would be, Mr. Poshard, in your opinion, an acceptable growth in Medicare percentagewise?

Mr. POSHARD. Thank you for the question. Both parties, in my judgment, are politicizing this terminology of cuts or decrease in the increase. But the fact remains that the Federal Government pays a certain percentage of health care costs for the Medicare recipient today, and they pay a certain percentage out of pocket. That is roughly 75:25.

At the end of the budget that just passed the House, that percentage will increase out of pocket for the Medicare recipient by 5 to 10 percent. So in terms of the percentage of health care costs

at the end of that budget, it will be greater for the individual. That is what Democrats mean when they say it is a cut.

We can argue about that all day. The fact is we do need to save the system, and we do not disagree that the system has to be downsized somewhat. I supported the budget that was put forward by the coalition of moderate Democrats in the House on which Mr. Stenholm worked for a number of years. I believe the coalition budget will downsize Medicare by about $170 billion, if I am correct, over the life of the budget; whereas, the budget that passed out of the House downsizes Medicare by about $270 billion.

So if I had to give you a direct answer, that would be somewhere in the vicinity of where I would say would be a reasonable alternative.

Mr. CHRISTENSEN. One of the things that we are doing in Nebraska, even though I represent Omaha, Nebraska, I grew up in a small town of 2,000 people. My folks farm and feed cattle for a living. The large metropolitan area of Omaha, Nebraska, is my district, but a lot of the other parts are mostly rural. We are putting together alliances of hospitals in the greater Nebraska area, small towns, to hook up with some of the larger hospitals in the Lincoln and Omaha area. And it seems to be working pretty well.

I think they are forming alliances for two reasons: One, out of threat of incoming competition from a major for-profit hospital; and two, to secure themselves for the future and for the oncoming Medicare streamlining and downsizing. I think it is something that rural America must do to survive.

Yes, the hospital in St. Paul, Nebraska, where my family lives, serves a need. But 30 miles away is a metropolitan area of 40,000 people that has a number of hospitals where I think that a lot of the people from our area could go. Anytime you are downsizing, you have to make some changes, and you have to be willing to make those changes to make the system survive.

I appreciate your position that the Rural Coalition has brought here before, and I know you are willing to work with us. And that is, I guess, the best thing I like about what you have offered today, is that you are not saying that there is not a problem out there and you are not willing to address it. You are willing to address it, and you are willing to give us your thoughts. That is the best thing that I have heard yet today, and I just want to thank you for your input.

Thank you, Mr. McDermott and Mr. McCrery, also.

Mr. POSHARD. Thank you.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire of the Members?

Mr. KLECZKA. I think the gentleman from California has a short announcement.

Mr. STARK. I just wanted to pass on to my friends in the Rural Coalition that the Subcommittee on Labor, HHS, just zeroed out the EACH Program in the Subcommittee. I hope you will get over before that appropriation goes to Full Committee and see if we can put that back in.

Mr. KLECZKA. Let me just respond very quickly to the gentleman from Nebraska. If, in fact, we are looking at Medicare and we are downsizing everything—we are going to downsize what the Federal

Government gives to Medicare patients to pay for their health care. If we also downsize physician payments and hospital reimbursement and control the health care costs, then all that will equal out and we are not going to disadvantage those people on Medicare. But know full well, the only thing that is being downsized is the government reimbursement to purchase the health care.

AMA had a proposal here yesterday which took all limits off docs; the docs could charge whatever they wanted. OK? In fact, in their plan, in their calculation, Medicare would pay the doctors $14 billion more over the 7-year period.

Well, if all the providers start getting increases and increases and the person who you represent getting that Medicare voucher has to go buy a policy out on the private market, know full well that every one of those increases, every nickel of the increase is going to come out of their pocket. Or they are going to buy the cheapest plan available which affords them nothing, and at that point they are going to go without.

So if you are going to downsize, we have to downsize things other than the voucher. In fact, what is planned by the Majority party is that voucher will be raised by a fixed dollar and not by a percentage, the same percentage increase that we as Federal employees get in our reimbursement for our health care plan. So they use the Federal health care system as a model, but they do not make it identical in all aspects. So we are looking at a real crisis.

I have three points I would like to quickly cover in my short time. To my colleague and seat mate, Mr. McDermott, you indicate in your statement that over the next 3 days this may be the only opportunity for the American people to hear about the Majority's proposed cuts in the Medicare Program. But as you can recall in your years on the Subcommittee, anytime we had an issue of such magnitude affecting 30-plus million people in the country, a cut of some $270 billion, this place would be flooded with cameras. And on the evening news, those who are affected by what we are doing and talking about today would hear about it.

As you can recall from yesterday and you can see today, there is no press here. There is no television press. In the Washington Post, there was not even an article on yesterday's hearing.

And so what I would say to you is happening, we are having a Medicare news blackout, and it is not an accident that this happened. And I can see some of my Republican colleagues smiling. I can just see the Speaker of the House going to the Republican consultant, getting big, big money, saying, OK, we are forced to have some Medicare hearings on this cut. What would you suggest we do? And the consultant, after he gets paid, is forthcoming with his recommendation, and he says, I will tell you what you do, Newt; you schedule Waco hearings and the Senate schedules Whitewater hearings, and then you guys come back and do the Medicare hearings, and it is going to be lost in the shuffle.

I think it is clever. I applaud the Majority party for that strategy. But know full well it is not going to work because the news of what is happening in this room will still leak out because the hearing is open to the public and there are some folks who represent seniors and others around the room who are going to go and get the word out.

So I think it is clever. I have to applaud you—not too loudly, but the strategy worked well. And if, in fact—you know, we were guaranteed that once a proposal is written, that will come before this Subcommittee for public hearings, as was our health care bill which we had hearings and markup on for over a period of 3½ months. I would not worry about the blackout of the news that we are going through today. But I am told that that is not going to occur, and I will let my colleague from Washington respond.

Mr. MCDERMOTT. I think one of the things that you are bringing up is something that troubles me. The Chairwoman has suggested that there have been 18 hearings on Medicare. There have been 18 hearings on the problem, but it is on the solution that we need 18 hearings. If we are going to try and change the program, simply taking it and throwing it away in a 2-day session or so in the midst of September during reconciliation will be a disservice to all the American people because nobody, not even the Members who vote for it, will really understand what is happening in it. And I think that is the real danger here, is that without a program on the table for us to look at for the next month, we are forced to come in here on September 5, have something dropped in our lap that must pass by October 1. That is too short a period of time to have adequate hearings on this issue.

Mr. KLECZKA. I have two more points. Maybe I will get some more time after we go through the round. The other point I think should be made is that the savior for the Medicare Program under what we think might be the plan is managed care, HMOs. In today's national journal, Congress Daily—and let me just quote from it:

> Meanwhile, as Congress rushes to add more managed care to the Medicare and Medicaid Programs, a new survey released Wednesday shows that managed care consumers in the private sector are not entirely enthusiastic about their own managed care plans. The survey, conducted by Lewis Harris and associates for the Commonwealth Fund, a health and social policy foundation, found that managed care enrollees were more likely to rate their health care plans as fair or poor than those in traditional fee-for-service plans. Not surprisingly, the survey also found that choice of health care plans and of physician is a key issue.

I state that because I think we should look at managed care as one of the options, but I feel that what is going on is we are looking at managed care as the only option. And we will all recall when the President presented his health care plan sometime ago, even though it was changed radically by this Health Subcommittee, Harry and Louise ran to the air waves, and one of their main focuses and messages to the American people was: Do you know what they are doing in Washington? They are going to take away your choice of your doctor. You cannot go to your doctor who you went to for the last 20, 30, whatever years.

Mr. CHRISTENSEN. Would the gentleman yield?

Mr. KLECZKA. After I finish my comment.

Chairman THOMAS. The gentleman's time has expired.

Mr. KLECZKA. I know, but I have to finish this point if the Chair will permit me.

Chairman THOMAS. Certainly.

Mr. KLECZKA. And so to put all our eggs in a basket on managed care, know full well that there will be a reaction from the American public, because they still want that choice of physician, and we just

saw it. The roles are reversed, and we are not in the majority. But we saw that happen before our eyes. I think if we push ahead and make the mainstay of Medicare reform not mandatory, but a major push for managed care, that is going to blow up in our faces just like catastrophic care did. And I recall after we passed that, we thumped our chests, went home, and we stumbled over each other to repeal the thing, because there was an adverse reaction by the public.

So I think there is some part for managed care to play here, but to bet the farm on it, I think we could be back, shortly after we do the dastardly deed, tripping over ourselves to undo it.

Let me thank the Chairman for the extra time.

Chairman THOMAS. I thank the gentleman. This is not directed specifically at him, but as you know, over the last several days the Chair has been extremely lenient with the red light. And to the degree people take advantage of the Chairman's leniency, we will simply go back to the lights and play the game according to the rules very strictly.

I would also just briefly——

Mr. KLECZKA. Well, would the Chairman yield?

Chairman THOMAS. No, the Chairman will not yield.

Mr. KLECZKA. Could we have a second round, then, since not many Members are attending the hearing?

Chairman THOMAS. I thought you had your second round on your time. If you want a second round, we certainly will have a second round. But we will control it if Members are unable to control themselves.

I will also tell the gentleman that we have had hearings on Medicare in the month of January, in the month of February, in the month of March, in the month of April, in the month of May, in the month of June. We are holding hearings in the month of July.

The gentleman from Washington just indicated these are not about the finished product. They are about bringing people in who are practitioners, who are beneficiaries, who are people who are concerned in academia and other areas about the fact that the trustees said that the Medicare Trust Fund is going bankrupt. And we are actually listening to these people, and we are attempting to move forward. We are looking at possible alternatives in trying to solve the problem.

It would be a pleasure to work with the Democrats in sharing alternatives. I think the gentleman from Wisconsin is complaining that there are not a lot of media here. It is because since January they have heard the same old song from the Democrats, and that is a resounding negativism of simply attacking, of protesting, of complaining. And, frankly, if there was some positive work product generated by the Democrats, I think that would really be news.

So if the gentleman seeks to try to attract the news media, maybe he ought to try a slightly different tack than the one that you folks have been on——

Mr. KLECZKA. Will the Chairman yield?

Chairman THOMAS [continuing]. For the last 6 months.

Mr. KLECZKA. Will the Chairman yield?

Chairman THOMAS. The Chair is not going to——

Mr. KLECZKA. Are we going to have markup on an alternative when the Republicans produce one?

Chairman THOMAS. You know we are going to, and I have assured Members of this Subcommittee over and over again that when the finished product is done, you will receive it way ahead of the usual 48 hours that, when we were the Minority, was the usual time that we got a work product. I will assure you we will not conduct this Subcommittee the way you folks conducted it when you were in the Majority. Believe me. When we create a work product, you will share in the operation and the examination of that work product. But what we want to do is hear from people before we write the work product.

Now, I know that is new and novel for you folks as well. But what we want to do is have a number of hearings to understand what the problem is while at the same time analyzing and examining suggestions over and over again. It is called growth; it is called learning; it is called being educated about the problem. And that is what this process is, and we are going to continue.

The Chair thanks the audience for their indulgence.

Mr. KLECZKA. So do I. Thank you very much, audience.

Chairman THOMAS. Does any other Member on the Majority side wish to inquire of the Members?

Do you want to get back in, then? No one over here wants to.

Mr. KLECZKA. One last point, and I thank the Chairman for yielding additional time.

The gentleman from Louisiana, Mr. McCrery, you indicated that if we do nothing, Medicare growth over the next bunch of years will be 10 percent, and I think that is in the ballpark, 9.5 to 10 percent. Could you break out for me what those increased centers are? We know that utilization, people turning 65, is a piece; an aging population living longer than anyone anticipated. Do you know what that breakdown of that 9.5 or 10 percent is?

Mr. MCCRERY. Not specifically, but you have enumerated a couple of them, and utilization certainly is, I would say, the key factor there. But there are all sorts of drivers, as you well know: Technology, the increased demographics, in other words, the increased universe of those qualifying for Medicare. So there are a number of things that are driving that. But I would say the big one is utilization.

Mr. KLECZKA. Well, I do not have the breakdown, and I have tried to get it, and I will work with you to try to get the specifics of it. The actual utilization is only 1.4 percent, and then if you add in the increased health care costs because of the more aging population, that is 0.4. So we are only at 1.8, and I cannot get to the 10 percent. I know a couple of the other ones.

Nevertheless, what I am trying to do is figure out, at least in my own mind, if, in fact, we are going to limit growth to 4.6 percent, there are some of these factors we have no control over, like the utilization, like more people coming on to the system. And so it is like punching a balloon. Once you take that 10 percent and you restrict it to a small portion of that and try to take out the entire 4.6 or the cuts to that, it is going to really be a hard hitter or exacerbate the problem. And I just do not know what the other ones are. I will share with you the ones I do have: 1.4 for increased utili-

zation; that is, people turning 65; 0.4 for an increased aging population, which equates to more health care usage; and health care inflation of 3.4. That totals 5.2 and I need another 4 percent, and I just do not have a good understanding.

But if we take the things we cannot control off the table, then what is left is going to get a real hit, and I thought you might know that. But we will have to get those figures.

Mr. MCCRERY. There is no question that this is going to be difficult to do—and, trust me, we are still exploring all these things. We are not there yet. But as a general concept, we think the only way to get there is to allow innovations in the private sector to take place rather than have the government micromanage the health care system as we have done for the last 30 years.

Mr. KLECZKA. Well, if, in fact, we are going to micromanage the actual voucher amount, then we are going to have to do some look-see at the other portions. Otherwise, we are going to do disaster to those out-of-pocket expenses, or in lieu of that, people are just going to go without. And I think no one wants that outcome.

Mr. MCCRERY. No.

Mr. KLECZKA. But if you look at the private health care costs and plans around the country, we have not seen them doing much better in Medicare over the years.

Mr. MCCRERY. Over the years, but in the recent couple of years, you certainly have seen much better performance, much better efficiency in the private sector.

Mr. KLECZKA. Well, the chart I had yesterday up to 1993 showed that Medicare was increasing at a lower rate than the private plans.

Mr. MCCRERY. But you saw also those lines converging and going in opposite directions.

Mr. KLECZKA. In 1993, and so we only had really 1-year experience. Thank you very much.

Mr. Thomas, thank you very much.

Chairman THOMAS. I thank the gentleman.

I want to thank the panel very much, and I look forward to your continued input as we try to completely understand the problem and work toward solutions.

The Chair welcomes the next panel of one: The Administrator of the Health Care Financing Administration, Dr. Bruce Vladeck. Nice to have you with us, Bruce. Thank you for being here.

I will tell the gentleman from Wisconsin I had sent a letter asking if the Secretary of Health and Human Services might be with us, might have generated some additional press. And my understanding is she is not able to be with us, and Dr. Vladeck is here.

The gentleman from California informs me that Dr. Vladeck writes her speeches anyway, and so we have eliminated the middle woman, and it is a pleasure to have you with us, Dr. Vladeck. Any written testimony, as usual, will be made a part of the record, and you can inform us in any way you see fit about what you folks are doing.

STATEMENT OF BRUCE C. VLADECK, PH.D, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman. I appreciate the opportunity to testify before you today on approaches to restructuring Medicare, and I appreciate the sympathy and cooperation of your staff in dealing with some scheduling exigencies that affected the schedule for today. I do appreciate that.

I do need to note for the record that I feel we are all poorer for the inability of the Secretary to appear here today rather than me, although, as you know, it has not been the custom for executive branch Cabinet Members to appear at Subcommittee hearings. But it is always my pleasure to be with the Subcommittee.

As the 30th anniversary of the enormously successful and popular Medicare Program approaches, we believe we should approach any Medicare reform agenda with a healthy respect for the program's strengths and a determination to preserve the fundamental health security it offers to Americans.

Medicare is universal. All Americans count on health security in their retirement years.

Medicare is always available. No Americans are barred because of preexisting conditions, nor are they charged more because of their age or health status.

Medicare is portable. Coverage continues even if beneficiaries move or their circumstances change.

Medicare provides choice, which is especially important to elderly and disabled beneficiaries, many of whom have multiple and complex health problems and have long-established relationships with particular physicians.

This administration is committed to preserving these essential strengths even while we pursue reforms to make the program even stronger and work even better for beneficiaries.

I would like to testify today on our strategies for strengthening Medicare by expanding beneficiary choices, enhancing the quality of care, and improving customer services. I will also, Mr. Chairman, testify on the administration's strategy for containing Medicare costs, extending the life of the Medicare Trust Fund, and moving toward a balanced Federal budget in a way that is consistent with our goal of protecting beneficiaries and respecting the fundamental social contract between government and the American people that Medicare represents.

Finally, I will distinguish our reform strategies from those embodied in the discussions of Republican alternatives to the extent we know what they contain, where we are concerned that some of the proposals being discussed would fundamentally undermine Medicare's protections and harm its beneficiaries.

We believe in reforming Medicare in order to make it work better for beneficiaries, not as a way of financing tax cuts or meeting other nonhealth care objectives.

Very briefly, in our strategy for reform of the program, we think it is critical to give beneficiaries a wide range of choices about which they have good information in a fair and noncoercive marketplace. Just a few weeks ago, we announced Medicare choices, a demonstration program designed to expand the types of managed

care available to Medicare beneficiaries and to test different payment methods.

We are hopeful that Congress this year will enact an expansion in the range of managed care choices for Medicare beneficiaries. But, of course, one can never take the outcome of congressional action for granted. And the fact is that from Medicare's perspective, we do not have very much experience with non-HMO managed care and we need to gain that as quickly as possible.

It is also critical that we learn better ways to pay for managed care, and we are currently undertaking a number of steps to explore alternate payment methodologies, as well as improving our current systems. We are planning to test competitive pricing as an alternative to the fixed-rate AAPCC arrangement. The best evidence available indicates that using our existing payment method, we have paid more for comparable populations of beneficiaries than we would have had they remained in the fee-for-service program. We think that competitive pricing is a promising idea. We would like to test several variants of it in different geographic areas, and we very much look forward to working with Members of the Subcommittee on structuring demonstrations, since we do believe we need specific legislation to implement such a demonstration.

As we have discussed in the past, we also want to work with you to make available a PPO option to beneficiaries. PPOs have proven to be very popular in the commercial market. As we envision a PPO, beneficiaries would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time if they were willing to pay additional cost sharing. That would also require a change in statute.

We are currently developing guidelines under existing statutory authority for our current risk contractors to offer a point-of-service option which will be implemented next year. The option would be similar to the point-of-service plans that HMOs are increasingly offering in the commercial marketplace and that are receiving increasing acceptance and support.

We are committed to ensuring that beneficiaries, whether they are served by our traditional arrangements, by HMOs, or by new managed care arrangements, receive high-quality care. We are moving on a number of fronts, as described in the written testimony, to develop better quality measures and better consumer information. We are also working increasingly in collaboration with leaders in the private sector on new mechanisms for ensuring the accountability of all health plans.

Finally, we are committed to improving customer service and have set standards of service that meet or exceed the best practices in the public and private sectors. We are increasingly in dialog with beneficiaries to educate them about the programs and services available under Medicare and to disseminate reliable data to foster informed choices about their health care needs and the providers who furnish care.

We are also working very closely with our contractors to better fulfill our responsibility of fiscal stewardship. We have recently sent the Congress draft legislation to establish a Benefit Quality Assurance Program to ensure a stable level of funding for critical payment safeguard activities. Operation Restore Trust, the health

care antifraud demonstration announced by the President in May, represents a major effort to develop better methods to protect the fiscal integrity of both Medicare and Medicaid.

Many of the operational reforms I have described will produce significant long-term savings, but the President is also committed to reducing the growth of Medicare outlays in the shorter term as part of his plan to achieve a balanced Federal budget. The administration has offered a responsible deficit reduction plan that balances the budget and strengthens the Medicare Trust Fund while protecting beneficiaries.

It is based on three fundamental principles: First, we must protect beneficiaries. Beneficiaries come first. We do not believe that Medicare beneficiaries, the overwhelming majority of whom have incomes of $25,000 a year or less, should be forced to pay thousands of dollars more to keep their current health care arrangements or to finance tax cuts for the wealthy. We believe that out-of-pocket costs are already too high for those age 65 and older, currently accounting for as much as 21 percent of their disposable income. Massive reductions in Medicare spending of the magnitude in the budget resolution achieved by shifting costs to beneficiaries would increase the financial burden precisely on the Nation's most vulnerable elderly. Furthermore, almost 60 percent of senior citizens rely on Social Security for 50 percent or more of their income. We believe that shifting costs to beneficiaries is the logical and functional equivalent of reducing their disposable Social Security income, something Members of all parties pledged not to do this past spring.

We propose a plan to balance the Federal budget that we believe represents a reasonable approach to ensure Medicare's financial solvency into the 21st century. We propose $124 billion in net spending reductions over the next 7 years which will extend the life of the Federal Hospital Insurance Trust Fund at least through the year 2005.

We propose no new increases in out-of-pocket costs for beneficiaries, and we propose enhancing Medicare benefits by providing respite care for beneficiaries with Alzheimer's disease and by eliminating the copayment for mammography services.

A major aspect of our strategy is to take advantage of some of the changes now occurring in the health care marketplace. Historically, Medicare was the leader in health care cost containment. However, the statutory constraints on our payment rates have precluded us from taking advantage of some of the changes in the market as rapidly as the private sector has done.

For example, as competition for services has increased in the private sector, employers and insurance companies are increasingly demanding large discounts on charges in return for an agreement to send patients to particular providers. Given our market share, we should be able to extract discounts, at least as large as the private sector does, in a wide variety of setting.

We would also like to work with the Subcommittee to establish competitive bidding for certain part B services, such as clinical laboratory services and certain types of durable medical equipment, where we are now statutorily forbidden from undertaken such competitive bidding.

We believe this approach represents the right way to reform Medicare. In contrast, $270 billion in Medicare reductions over the next 7 years is the wrong way. It will do irreparable damage to beneficiaries and the entire health care system.

Obviously, we are working with only very limited details as to how these savings would be accomplished. Looking at some of the paper that has been associated with the Majority, reported in the press, and circulated to various people in town suggests that Medicare beneficiaries would be required to pay substantially more just to keep their current coverage and access to dollars. For example, in variants of budget-related documents, anywhere from $400 to $600 more a year in part B premiums would be necessary for Medicare beneficiaries by the year 2002, plus coinsurance on home health and skilled nursing care that would cost those using those services who are disproportionately poorer and older than other beneficiaries more than $1,000 apiece in 2002.

Finally, I would like to comment on the notion that has received a lot of attention these days to convert Medicare into a so-called defined contribution or voucher program. Instead of secure Medicare coverage of all medically necessary care from the providers of their choice, beneficiaries would be given a voucher to purchase medical insurance on the open market. Advocates of voucher-like approaches often suggest that Medicare emulate the private sector and, therefore, benefit from private sector growth rates.

CBO estimates the private sector will grow by about 7 percent per capita over the next 7 years. The Republican budget resolution would require a growth rate of less than 5 percent per year per capita over that period.

Under those circumstances, the value of a voucher would very quickly erode. All the risk of increased medical care costs would be borne by beneficiaries. A voucher would have the effect of coercing seniors into buying less coverage. As one of my colleagues described it, you pay more and get less. We do not believe this is real choice for Medicare beneficiaries.

Even if vouchers were adequately indexed, however—and there is no way to do that under the numbers in the budget resolution—our experience to date on how insurers behave relative to the Medicare population raises questions about what would happen under a voucher system. Indeed, Medicare exists in the first place because in the past insurers did not make coverage available to the most vulnerable elderly, except at prohibitively high premiums.

In principle, one could establish a set of market rules that would prevent risk selection, cherrypicking, and discriminatory practices. In fact, the draft working document that has circulated seems to acknowledge this, with enormous mandates on the Secretary to regulate this type of behavior. It is hard for us to square the mechanisms that would be necessary to make a real voucher market work with the current antiregulatory agenda being pursued by much of this Congress.

Even more basically, there is a very strong correlation among Medicare beneficiaries, as there is in most populations, between income and health status. Our poorest beneficiaries are also our sickest. A poorly designed voucher system could systematically disadvantage the most vulnerable.

There is a right way and a wrong way to reform Medicare. The right way is to protect beneficiaries' access to care and to strengthen the part A trust fund while pursuing the broader goal of balancing the Federal budget in a reasonable timeframe. The wrong way, the way contained in the budget resolution, would demolish the basis protections embodied in the Medicare Program in order to finance tax cuts. We believe the right way is more consistent with rational health policy, fiscal prudence, and the overwhelming preferences of the American people.

I thank you again for the opportunity to testify. I'm happy to answer any questions you might have.

[The prepared statement follows:]

STATEMENT OF BRUCE C. VLADECK, PH.D.
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Thank you for the opportunity to testify today on approaches to restructuring Medicare. As the 30th anniversary of this enormously successful and enormously popular program approaches, we should approach any Medicare reform agenda with a healthy respect for the Medicare program's strengths and a determination to preserve the fundamental health security it offers Americans.

Medicare is universal. Because of the contract this nation made with its citizens in 1965, all Americans -- no matter how rich or poor, no matter how important or humble -- can count on health security in their retirement years or in the event of a severe disability.

Medicare is always available. Americans are not barred from Medicare due to preexisting conditions, nor are they charged more for Medicare because of their age or health status.

Medicare is portable. It costs beneficiaries the same amount and covers the same services, no matter where they live or how their personal circumstances might change.

And, Medicare provides choice. It is especially important to elderly and disabled beneficiaries, many of whom have multiple and complex health problems, to be able to select their own doctors.

This Administration is committed to preserving these essential strengths of the Medicare program, even while we pursue reforms to make the program even stronger and more beneficial to the 37 million Americans it serves today. In particular, I would like to testify today on our strategies for strengthening Medicare by expanding beneficiary choices, enhancing the quality of care and consumer information, and improving customer service.

In addition, I will testify on the Administration's strategy for containing Medicare costs, extending the life of the Medicare trust fund, and moving toward a balanced federal budget -- a strategy that is consistent with our goal of protecting beneficiaries and respecting Medicare's social contract.

Finally, I will distinguish our reform strategies from those of Congressional Republicans which we believe would fundamentally undermine Medicare's protections and harm its beneficiaries.

I. THE ADMINISTRATION'S STRATEGY FOR REFORM

Since we came into office 30 months ago, the Clinton Administration has pursued a multi-faceted approach to reforming Medicare in the context of our efforts toward broader health care reform. We are increasing the number of beneficiaries and plans participating in Medicare managed care and are testing new managed care options. To make possible well-informed decisions by our beneficiaries, we are developing improved consumer information and quality measures. Finally, we are continuing our efforts to improve customer service.

A. Giving Beneficiaries More Choices

Over the past two years, Medicare managed care enrollment has increased dramatically. In the first six months of 1995 we have already seen a nine percent increase in managed care enrollment, an acceleration over last year's annual rate of 16 percent growth. Currently, 9.5 percent of all Medicare beneficiaries -- over 3.5 million people -- have chosen to enroll in managed care plans. Seventy-four percent of Medicare beneficiaries have access to a managed care plan, and 57 percent have a choice between two or more plans.

More than 250 managed care organizations currently contract with the Health Care Financing Administration (HCFA) to serve Medicare beneficiaries, including 165 that do so on a risk basis. Interest in the Medicare managed care program continues to increase. In the last three weeks alone, we received 17 new applications. Much of the recent growth in new contracts has

been in regions that have not had a strong Medicare managed care presence in the past.

As you know, however, most of the growth in managed care in the private sector in recent years has involved plans other than traditional closed HMOs. The centerpiece of our reform strategy is making such choices available to Medicare beneficiaries. We believe beneficiaries should have a wide range of choices and good information in a fair and non-coercive marketplace.

"Medicare Choices"

Just a few weeks ago, we announced "Medicare Choices," a demonstration program designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methodologies. HCFA has invited a wide variety of managed care organizations to participate in this demonstration, including preferred provider organizations (PPOs), HMOs, and integrated delivery systems.

Nine geographic areas have been targeted for the demonstration: Jacksonville, Florida; Sacramento, California; Hartford, Connecticut; Philadelphia, Pennsylvania; Atlanta, Georgia; New Orleans, Louisiana; Columbus, Ohio; Louisville, Kentucky; and Houston, Texas. We chose these markets to build on the strong base of private sector plans currently available in these communities. We will, however, accept applications from innovative plans in other areas, and we are particularly interested in those that offer to extend coverage to rural areas and those that emphasize primary care case management.

Pre-application forms have already been distributed to over a thousand interested organizations. Based on the response to these initial forms, selected plans will be invited to submit more detailed final applications in the Fall, and we anticipate enrollments will begin early next year.

New Pricing Approaches

We are also exploring alternative payment methodologies and improvements to our current payment systems for managed care.

For example, we are planning to test competitive pricing as an alternative to the Adjusted Average Per Capita Cost (AAPCC) payment methodology, which is now used to establish Medicare's payment to entities that accept full risk for paying for patient care. The AAPCC payment methodology, required by statute, has long been a source of discontent. Plans have been concerned with the AAPCC's adequacy, stability, and equity. The best evidence available indicates that Medicare, using this methodology, has paid more than it would pay for comparable populations of beneficiaries who remain in the fee-for-service program.

We think that competitive pricing is a promising idea, and we would like to test variants of it in a number of geographic areas. We would be interested in working with the Subcommittee on the structure of a competitive pricing demonstration since specific legislation will be necessary to implement this demonstration.

HCFA has entered into discussions with Kaiser Permanente to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees.

For the past decade, HCFA has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should soon produce health status adjusters that can be used on a pilot or demonstration basis. HCFA has also undertaken a demonstration project in which we are working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.

Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology. For example, the industry has expressed interest in using Metropolitan Statistical Areas (MSAs) rather than counties for

geographically adjusting Medicare's payment rate to HMOs.

New Options

As I previously explained to the Subcommittee, we also want to make available to beneficiaries a PPO option. This option has proven to be very popular in the commercial market. Under the PPO option, beneficiaries would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time, if they were willing to pay the additional cost-sharing. Implementing such a change would require a change in statute.

HCFA is also currently developing guidelines, under existing statutory authority, for current risk contractors to offer a "point-of-service" (POS) option, with implementation anticipated for the 1996 contract year. The option would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace.

B. Quality Measures and Consumer Information

HCFA is committed to ensuring that beneficiaries -- whether they are served by traditional Medicare, HMOs, or one of the new managed care options described above -- receive high quality care. A major facet of our strategy for Medicare reform involves the development of quality measures and enhanced consumer information.

As I mentioned to this Subcommittee in March, HCFA has reinvented and modernized its Medicare fee-for-service quality assurance and improvement activities under our Health Care Quality Improvement Program (HCQIP). HCQIP gives providers the tools to achieve continuous quality improvement, allows for the external monitoring of how well providers are improving quality, and supports the development of quality improvement projects throughout the country.

We are equally interested in assuring that as Medicare managed care options evolve, we have adequate measures in place to assure quality of care. As Medicare beneficiaries' options expand, beneficiaries will require reliable information to make well-informed choices about their health care. We are working on a number of fronts simultaneously to achieve this goal.

For example, HCFA, together with the Department of Defense and the Federal Employees Health Benefits Program, has joined private sector health purchasers, including GTE, AT&T, and PepsiCo, to explore the formation of a new organization for quality improvement and managed care accountability. This group represents more than 80 million insured individuals. The group will leverage the collective buying power of the participating organizations to ensure that our beneficiaries' needs are met and to eliminate unnecessary duplication of individual quality improvement and accountability efforts. We expect our efforts to complement the initiatives of existing quality assurance and accrediting organizations, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and have received their support.

HCFA also plans to collaborate with the NCQA, with the support of the Kaiser Family Foundation, to modify the Health Plan Employers Data and Information Set (HEDIS) to incorporate measures more germane to the Medicare population.

In May 1995, we launched a pilot test of the three core performance measures, developed by the Delmarva Foundation and Harvard University, to be used by Peer Review Organizations (PROs) in their external review of HMOs. The Delmarva contract was intended to help HCFA and the PROs shift from the current retrospective case review method of HMO oversight to one based on outcomes measurement and continuous quality improvement.

At this stage in the evolution of measures of plan quality, there is no single best approach. We intend to continue to work with a broad range of private sector organizations, as well as pursuing our own developmental work, to move forward as quickly as possible.

C. Improve Customer Service.

In everything HCFA does, we are focused on our strong commitment to improve customer service. To meet the President's call for increased customer satisfaction, we have set standards of service that meet or exceed the best practices in the public and private sectors. Today's HCFA is a significantly different organization from that of just two years ago. As we have embraced an ethic of customer service and beneficiary outreach, we have reinvented our agency to cultivate a consumer-focused workforce and partnership, responsive to the changing needs of our beneficiaries.

Under our consumer information strategy, we are improving opportunities to develop a dialogue with beneficiaries, to educate them about the programs and services available under Medicare, and to disseminate reliable data to foster informed beneficiary choices about their health care needs and the providers who furnish care.

With the assistance of our contractors, we are redesigning our Explanation of Medicare Benefits (EOMB) form to consolidate Part A and Part B notices into a single, standardized, easy to understand benefits summary.

We have already totally revised the way in which we evaluate Medicare contractors to encourage better customer service, and we will also be proposing legislation to change the way we contract with fiscal intermediaries and carriers to make them more service oriented -- to both better adapt to changing program needs and improve the cost-effectiveness of the Medicare contractor budget.

We are also collaborating with contractors to fulfill our responsibility of fiscal stewardship. The Secretary has recently sent to Congress draft legislation to establish a Benefit Quality Assurance Program (BQAP) to ensure a stable level of funding for our critical payment safeguard activities. The legislation would enhance our ability: (1) to educate providers regarding payment integrity and benefit quality assurance; (2) to determine those situations in which Medicare should have been a secondary payer and recover payments that should not have been made; (3) to target our cost report auditing priorities toward focused field reviews which provide a high return on investment; and (4) to develop clear medical and utilization review policies and communicate those policies to providers.

Operation Restore Trust, the health care anti-fraud demonstration announced by the President in May, is a major effort to develop better methods to protect the fiscal integrity of the Medicare and Medicaid programs. An interdisciplinary team from HCFA, the Office of the Secretary, the HHS Inspector General, the Department of Justice, State governments, and the private sector will test the most effective approaches to combat fraud, waste, and abuse associated with certain Medicare and Medicaid providers and suppliers. The demonstration will target five States (New York, Florida, Illinois, Texas, and California) that account for more than a third of all Medicare beneficiaries in the country and nearly 40 percent of all Medicaid recipients.

II. THE ADMINISTRATION'S STRATEGY FOR COST CONTAINMENT

Many of the operational reforms I have described will produce significant long-term savings, but the President is also committed to reducing the growth of Medicare outlays in the shorter term as part of his plan to achieve a balanced federal budget. The Administration has offered a responsible deficit reduction plan that balances the budget and strengthens the Medicare trust fund while protecting beneficiaries.

The Administration has a three-pronged strategy for controlling costs in Medicare. First, we need to protect beneficiaries' access to affordable, quality health care. Second, necessary reductions in Medicare should serve to extend the solvency of the Hospital Insurance (HI) Trust Fund. Third, we want to take advantage of changes in the health care marketplace.

A. Protect Beneficiaries

Beneficiaries come first. We do not believe that Medicare beneficiaries, the majority of whom have incomes of $25,000 or less, should be forced to pay thousands of dollars more to keep Medicare in order to finance the tax cuts for the wealthy.

Out-of-pocket costs are already too high for those aged 65 and older, currently accounting for 21 percent of their income. Massive reductions in Medicare spending of the magnitude in the Republican budget resolution achieved by shifting costs to beneficiaries would increase the financial burden on the nation's most vulnerable elderly. Furthermore, almost 60 percent of senior citizens rely on Social Security for 50 percent or more of their income. Shifting costs to these beneficiaries is the equivalent of reducing their Social Security checks.

Medicare has made significant contributions to improving the health status of the nation's elderly and disabled. Significant increases in beneficiaries' out-of-pocket costs could cause them to forgo needed health care services and might result in erasing some of the gains in health status that have been achieved since the implementation of Medicare.

B. Focus Deficit Reduction Efforts on Preserving Medicare

The President has proposed a plan to balance the Federal budget that presents a reasonable approach to ensure Medicare's financial solvency into the 21st century. The proposal includes $124 billion in net spending reductions over the next seven years and extends the life of the HI trust fund through at least the year 2005.

The plan contains no new increases in out-of-pocket costs for beneficiaries, but does revise the Medicare benefit package by providing respite care for beneficiaries with Alzheimer's disease and by eliminating the copayment for mammography services.

C. Take Advantage of Private Sector Innovations

A major aspect of our cost-containment strategy will be to take advantage of some of the changes now occurring in the health care marketplace. Medicare has historically been a leader in cost containment. The prospective payment system for hospitals and the physician fee schedule for physicians were groundbreaking payment systems that have become the basis for many payment systems in the private sector. However, the statutory constraints on Medicare's payment rates preclude us from taking advantage of changes in the market as rapidly as the private sector has done.

For example, competition for services has increased substantially in the private sector, with employers and insurance companies demanding large discounts on charges in return for an agreement to send patients to those providers. Given Medicare's large market share, we should be able to extract discounts, as the private sector does, in a wide variety of settings.

We also would like to work with the Subcommittee to establish competitive bidding for certain Part B services, such as clinical laboratory and certain types of durable medical equipment (DME). HCFA is now statutorily prohibited from engaging is such competition.

III. ALTERNATIVE PROPOSALS FOR MEDICARE REFORM

We believe our plan for Medicare represents the right way to balance beneficiary needs, program modernization and deficit reduction. In contrast, the Republican plan to cut $270 billion from Medicare over the next seven years is the wrong way. It will do damage to beneficiaries and the entire health care system.

The $270 billion in Medicare cuts that the Republicans have proposed is three times anything previously enacted. A quick review of the Republican Medicare reform working document suggests that Medicare beneficiaries would be required to pay

substantially more just to keep their current coverage and access to their doctors. Specifically, preliminary HCFA estimates show that such beneficiaries would need to pay $403 more in Part B premiums than they would under the President's plan in 2002. Additionally, they would face new coinsurance on home health and skilled nursing care that would cost the average person using these services in excess of $1,000 for each benefit in 2002.

American Medical Association Proposal

Another wrong way to reduce Medicare spending is contained in the proposal by the American Medical Association (AMA) to end the current safeguards on beneficiary liability for charges for physician services. Extra billing limits give beneficiaries financial protection against unlimited charges by physicians. Under the AMA proposal, physicians would be allowed to charge beneficiaries an unlimited amount over and above what Medicare pays for a service. A preliminary estimate is that removal of the extra billing limits could cost beneficiaries more than $900 in out-of-pocket costs in the year 2002 alone.

Medicare has had limits on what physicians can charge since 1984. The current extra billing limits were an essential part of the physician payment reform package established in 1989, which consisted of (1) a fee schedule, (2) extra billing limits, and (3) the Medicare volume performance system. The AMA strongly supported the fee schedule, which was explicitly designed to rearrange Medicare physician payments across procedures and geographic areas while remaining budget neutral. The extra billing limits were an integral companion of the fee schedule, providing essential protection for beneficiaries in these circumstances -- otherwise any losing physician could simply shift the cost to the beneficiary.

We believe that the AMA's new proposal to repeal the limits on how much physicians can charge beneficiaries calls into question the entire political compromise represented by the Medicare physician payment reform and is nothing short of outrageous.

Voucher Proposals

Finally, I would like to comment specifically on the Republican proposals to convert Medicare into a "defined contribution" or "voucher" program. Instead of secure Medicare coverage for all medically necessary care from the provider of their choice, beneficiaries would be given a voucher to purchase medical insurance on the open market.

Advocates of voucher-like approaches frequently suggest that Medicare should emulate the private sector and therefore benefit from private-sector-like growth rates. CBO data indicate that the private sector per capita growth rate would be 7.1 percent from 1996-2002. However, the Republican Budget Resolution would require an incredibly tight 4.9 percent per capita growth rate for Medicare.

Constraining the costs of providing care for a much more vulnerable Medicare population to a rate of increase so much smaller than that of the private sector is, at best, unrealistic. The resulting impact would be that the value of the voucher would very quickly erode. Beneficiaries would be forced to pay a substantial new "premium" for exercising the choice to buy a policy that covers what Medicare covers today. Such an approach would put all the risk of increased medical care costs on the beneficiaries.

In view of the fact that 75 percent of Medicare beneficiaries have incomes below $25,000, most seniors will find it extremely difficult to pay these additional amounts to keep their current Medicare benefits. The Republican voucher proposal would likely coerce many seniors into buying less coverage -- for example a medical savings account-like policy with a $10,000 deductible that Republicans also are advocating.

If beneficiaries wanted not only to retain their current level of Medicare benefits, but also to remain in traditional fee-for-service Medicare so that they could continue to see their own doctors, their out-of-pocket costs could be much, much

greater. Especially if adverse selection meant that sicker people were more likely to want fee-for-service coverage, the cost of traditional Medicare coverage could skyrocket.

In short, the choice beneficiaries would face under the Republican voucher plan would be to either pay significantly more or to get significantly less. We do not believe that this is the type of choice Medicare beneficiaries seek.

Even if the Republicans vouchers were adequately indexed, however, we have other concerns. First, for the Republican voucher system to work properly, there should be a wide range of plans available to Medicare beneficiaries, and beneficiaries would not be denied enrollment because of their medical conditions or subjected to pre-existing condition requirements. Our experience to date on how insurers behave vis-a-vis the Medicare population raises questions about how insurers might behave under a voucher system. Indeed, the Medicare program was created 30 years ago precisely because insurers did not make coverage available to the elderly except at prohibitively high premiums, and insured persons were at risk of losing their coverage after a serious illness.

The problems in the current "Medigap" market illustrate some of the problems that could be expected to arise if the health insurance market were not properly regulated. After the creation of Medicare, insurers began to offer Medigap policies to the elderly to fill in the "gaps" in Medicare. Medigap policies cover Medicare deductible and coinsurance costs, and some cover extra-billing by physicians and outpatient prescription drugs. The current market provides incentives to avoid risks by health screening or using medical underwriting criteria to offer coverage only at an unaffordable price. They also establish premiums that climb steadily as the beneficiary ages and becomes more likely to need expensive medical services, and hence to need Medigap insurance.

Of course, in principle, one could establish a set of market rules that would prevent such behavior. In fact, the Republican Medicare restructuring document seems to acknowledge this by directing the Secretary to regulate this type of behavior in numerous instances throughout the document. This is ironic in light of the anti-regulatory agenda currently pursued by many in Congress.

Even more basically, there is a strong correlation among Medicare beneficiaries -- as in most populations -- between income and health status. Our poorest beneficiaries are also our sickest. A poorly designed voucher system could systematically disadvantage the most vulnerable.

IV. CONCLUSION

There is right way and a wrong way to reform Medicare. The right way is to protect beneficiaries' access to quality care and strengthen the HI Trust Fund while pursuing the broader goal of balancing the Federal budget in a reasonable time frame. The wrong way -- the way the Republican budget resolution has turned -- would demolish the basic protections embodied in Medicare in order to finance tax cuts for the wealthy. We believe that the right way is more consistent with rational health policy, fiscal prudence, and the overwhelming preferences of the American people.

Thank you for the opportunity to testify on this important subject. I would be happy to answer any questions you may have.

Chairman THOMAS. Thank you very much, Doctor.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you, Mr. Chairman. And welcome, Dr. Vladeck. It is a pleasure to be getting to the point where we can be somewhat more specific about the changes that have to be adopted in order to protect Medicare for the seniors of America and to assure its presence for future retirees.

I was interested and I am very pleased that you really are going to get out there and work with competitive bidding and more realistic risk contracts and so on and so forth. I do want to clear up one fact in your testimony because I think it is an important one. It is one that I think we understand differently, but I am not sure from the way you have used it.

In your testimony, you mention that currently there are only 9.5 percent of Medicare beneficiaries enrolled in managed care plans. To be enrolled in a managed care plan, that managed care plan has to have completed a Medicare risk contract with the government. Isn't that so?

Mr. VLADECK. No, Mrs. Johnson. That includes our cost contractors and our so-called health care prepayment plans, which also have contracts with us but which are not paid on a risk basis.

Mrs. JOHNSON. But a senior cannot just join a managed care plan. It has to be one of the ones that has a contract with the government.

Mr. VLADECK. That is correct.

Mrs. JOHNSON. So not only 9.5 percent of Medicare beneficiaries are in a managed care plan. You follow that statement with a statement that 74 percent of Medicare beneficiaries have access. Now, they do live in areas of the country where there are managed care choices, but in many of those areas of the country, there are not Medicare risk contracts available.

Mr. VLADECK. In metropolitan areas accounting for 74 percent of the beneficiary population, we have contracts with managed care plans for Medicare. They are not risk contracts in every instance. Some are cost contracts. But in almost every one of those communities, there is the full HMO that is seeking to enroll Medicare beneficiaries.

Mrs. JOHNSON. I think this is important to get clear. What you are saying is that for 74 percent of the population, they live in a region where there is a Medicare risk contract or some other Medicare managed care contract. The problem is that there is often no more than one or two. There is not the capacity for everyone who lives in those areas to join these contracts because they are a relatively minor aspect of Medicare at this time. Isn't that correct?

Mr. VLADECK. Well, I think that is changing very rapidly.

Mrs. JOHNSON. It is changing rapidly, absolutely.

Mr. VLADECK. I think your point is that there is not capacity among our existing contractors to enroll a much larger fraction of Medicare beneficiaries.

Mrs. JOHNSON. Correct.

Mr. VLADECK. I think that is true. I think that is one reason we need to have a lot more contracts——

Mrs. JOHNSON. That is right. I just do not want the implication to stand that only 9.5 percent are choosing it when 74 percent

could. Seventy-four percent could not because the 9.5 percent are at the capacity level of our current contractors, roughly. It may be 12 percent or something. And so I commend you on really looking to a far more aggressive effort to change the way we contract with the private sector and to move toward competitive bidding. I think there is an enormous opportunity out there to make that happen. Furthermore, I think we have already the data an experience to show that if we do that, seniors can get more care for the same dollar. You described it as overpaying. Well, you can either describe it as overpaying and then we will cut what we pay, or you can say to seniors you can get more for that dollar. I would hope that we would take the latter course.

In your testimony, you talk about the fact that there are $124 billion in net spending reductions over the next 7 years that the administration has identified, and I assume that you do have a list of those that is fairly detailed.

Mr. VLADECK. We have a series of options that can be combined in a variety of ways to reach that amount.

Mrs. JOHNSON. Have you made any decision as to which of those options you prefer?

Mr. VLADECK. No. We are hopeful that at some point the congressional Majority will have specific proposals, at which point we can make ours public and begin the negotiations process.

Mrs. JOHNSON. I understand. So it is really a game of chicken. We are all out there on the road, and you do not want to put your cards on the table until we put our cards on the table. You are, after all, the administration. And, frankly, it is your team that has said this program is going bankrupt, and 2 years ago they said it, too, and we paid no attention. At least 1 year ago, they said it and Congress paid no attention.

I hope we can find a way to overcome the game of chicken, but roughly knowing what that list is, I would say that there is $124 billion we will be quite able to agree on that will not compromise the quality of the Medicare system or beneficiaries. But I would ask you, when you go on to say other cost savings, do you expect then to realize additional cost savings over and above the $124 billion over 7 years from competitive bidding for lab fees and durable medical equipment?

Mr. VLADECK. Actually, there are a number of things we are proposing to do which CBO will not score. They actually will score some savings from competitive bidding. Some of the other negotiating prices which we propose to do and which may save us money will not produce scorable savings at the moment.

Mrs. JOHNSON. My time has expired, and I will come back later.

Chairman THOMAS. I thank the gentlewoman.

The gentleman from California.

Mr. STARK. I would submit that we do have a number from the Republicans, that is, $270 billion. I believe the President came out with 120-something in cuts over 10 years. Is that——

Mr. VLADECK. Our proposed reductions are over 7 years.

Mr. STARK. And how much——

Mr. VLADECK. It is $127 billion gross. There are $3 billion in additional benefits, so that the net reduction is $124 billion.

Mr. STARK. And you did not have a specific wish list of exactly which cuts to make?

Mr. VLADECK. There are a number of ways, we believe, to——

Mr. STARK. Don't we have lists from previous years of many suggestions for savings?

Mr. VLADECK. I think there are literally hundreds of people in town who could produce such a list.

Mr. STARK. So I would stipulate that if the gentlewoman from Connecticut would like to go for the $124 billion that the President is suggesting and pick cuts out of the President's previous lists, I will sponsor the bill and put it in if that is what she is—then she could show us hers. There is no real secret. There is nothing new in this business. It is just a question of can you sustain $270 billion in cuts without destroying the Medicare system.

But one of the things that keeps coming up, in particular, out of some of these proxies for the Republicans, these new think tanks keep talking about the Federal Employee Health Benefit Plan. First of all, they say it is more efficient, which I hope you can explain why that is wrong. And then they are just saying, well, we all get a voucher; why can't we just give the same voucher to my Mom?

Can you explain some of the differences to my colleagues between the Federal Employee Health Benefit Plan and the Republican voucher plan and where it is different?

Mr. VLADECK. There are several differences given that there are a lot of variants of so-called voucher plans floating around, and it is hard to get your arms around any one in particular. But the most important difference is that historically the employer's contribution to the Federal Employees Benefit Plan has been pegged to a fixed proportion of the cost of a fixed benefit package as defined in a benchmark plan, which is, in effect, what we do with Medicare now.

Mr. STARK. So as the benefit package goes up in cost, the government's share goes up.

Mr. VLADECK. That is correct, and that is, in effect, in terms of our payment to managed care plans, what we do in the Medicare system at the moment. And what we would propose to do is the basis for expanding managed care choices.

Most of the voucher proposals that I have seen index the growth in the voucher to some external measure apart from what it actually costs to provide a defined set of benefits.

Mr. STARK. Would it be fair to say if you took the Federal Employee Benefit Plan and just gave it to the seniors with the government paying its increase it has in the past, that it would be far more expensive than the current Medicare system?

Mr. VLADECK. I have not looked at that. Looking at the general experience of private insurance, I would expect that Medicare has grown less quickly over the last 20 years.

Mr. STARK. There has also been a lot of discussion about the trust fund going broke and a lot of hand wringing. Can you give us some idea of how the trust fund's status is today relative to how it has been in the past and what you think the realities of its going broke and the urgencies that exist today?

Mr. VLADECK. The trust fund at the moment is in considerably better health than it was in the last 18 months of the Bush administration. It is in considerably better health than it was in the first 2 years of the current administration. The exhaustion date that is now projected by the actuaries and the trustees of around 2002 or so is 7 years away. That is the most breathing room we have had since the late eighties. I think that is the basic circumstance.

In the 30-year history of the trust fund, if you look at where it stood in terms of exhaustion date or ratio of assets to outlays, it has been in far worse circumstances in most years in the history of the fund than it is at the moment.

Chairman THOMAS. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Vladeck, how did CBO score the $124 billion from the President's Medicare decreases in rate of growth?

Mr. VLADECK. We have not put specific proposals to CBO because——

Mr. ENSIGN. Did they score those?

Mr. VLADECK. We have not put specific proposals in public, and so I cannot tell you exactly how CBO would score them. Many of them, as Mr. Stark has suggested, are similar to or in some instances identical to proposals that were scored by CBO in the past. We took a rough cut at this, which is purely an estimate, and we would expect that CBO would score the kinds of things we are talking about at a level very, very close to that of OMB.

Mr. ENSIGN. Does the administration think that we can continue the current fee-for-service without increasing copays, deductibles, or payroll taxes and have a viable system?

Mr. VLADECK. Yes.

Mr. ENSIGN. And what dollar amount does the administration think actually goes on on a yearly basis in fraud or abuse?

Mr. VLADECK. Well, again, we are asked that question many times, and I am afraid I have——

Mr. ENSIGN. Just a rough guess.

Mr. VLADECK. We do not know. The GAO some years ago estimated that roughly 10 percent of all health care expenditures, including those of Medicare and Medicaid, was lost to fraud and abuse. That would equate in the current year to between $17 and $18 billion in the Medicare Program.

Mr. ENSIGN. You think that that is an accurate number?

Mr. VLADECK. We do not know. If we knew exactly how much fraud and abuse out there, we would be able to catch it all better than we are currently able to do.

Mr. ENSIGN. And if we, through efficiencies and market forces, are able to slow the rate of growth of Medicare expenditures, would the administration classify those savings as a cut?

Mr. VLADECK. If one is purchasing the same benefits under the same marketplace conditions as a period of time——

Mr. ENSIGN. No, no. We may have to change the marketplace conditions. That is one of the efficiencies. I said market forces. If under market forces and efficiencies through the system we can provide the same or better quality care, if we are able to have savings when we do that, similar to what the private sector has

done—maybe we get prescription drug coverage out of it. May be we provide better quality care. If we are able to do that and save money, would the administration classify that as a cut?

Mr. VLADECK. It would be a cut in outlays. It would be defined as such by CBO. Since we have been criticized so much for not using CBO for all things, I would go along with CBO in that regard.

Mr. ENSIGN. So now the administration does go along with CBO.

Chairman THOMAS. In that regard.

Mr. ENSIGN. Yes, in that regard. OK.

Yesterday, Mr. Cardin did not feel that the government could design a system that could take advantage as the private sector has done and slow the rate of growth as well as the private sector has done. He asked that question time after time to the panels yesterday. Does the administration feel that either the administration is smart enough or that the Congress is smart enough to design a system to take advantage of what the private sector has done and at least slow the rate of growth down close to what the private sector has done?

Mr. VLADECK. I think the historical record of Medicare suggests, particularly when the administration and the Congress work together, that for each type of service Medicare purchases, it is possible to design a system in which our costs grow at a rate equal to or below that of the private sector. It has been our experience——

Mr. ENSIGN. So a 4- or 5-percent rate of growth would not be an unreasonable rate of growth, then, for Medicare over the next 7 years?

Mr. VLADECK. If it were obtained in that way and if the private sector can sustain that, which none of the bodies that are engaged in formal forecasting predict they will be able to do. If you gave us a target——

Mr. ENSIGN. But the private sector has been doing that over the last few years, and so if we are able to match what the private sector is doing in Medicare growth, we will have saved Medicare by the year 2002, but we also will have met and perhaps even exceeded $270 billion in savings through efficiencies improving the system.

Mr. VLADECK. Quite the contrary, sir. I believe the analysis we have done suggests that CBO projection is that private sector per capita health insurance costs in the budget window will grow at the rate of approximately 7 percent per year. They also believe that Medicare outlays on a per capita basis in the budget resolution grow at less than 5 percent per year. So that in order to preserve the same benefits under the budget resolution, you have to 30 percent better——

Mr. ENSIGN. The budget resolution you are talking about is——

Mr. VLADECK [continuing]. Than the private sector.

Mr. ENSIGN. Are you talking about the budget resolution after conference?

Mr. VLADECK. Yes, sir.

Mr. ENSIGN. I was under the impression that it was over 6 percent.

Mr. VLADECK. That is total. But, again, I have said it on a per capita basis, per enrollee, which is the most valid basis for comparison with the private sector, since there is about a 1.8-percent-per-year growth in beneficiaries over that period.

Mr. ENSIGN. Does the administration not put any stock in the fact that the private sector has already made a lot of these reforms and Medicare has not, and looking historically, the last 3 or 4 years at the private sector, the administration does not think that now if we put those same reforms into Medicare and carry those in the next 3 or 4 or 5 years that we are not going to get those savings?

Mr. VLADECK. I think you have to be very careful, sir. One of the things the private sector has done is reduce benefits in many instances. And if you read the Foster & Higgins survey that is often cited as showing have private sector costs went down——

Mr. ENSIGN. The private sector provides better coverage in most cases than Medicare does.

Chairman THOMAS. The gentleman's time has expired.

Mr. ENSIGN. Thank you, Mr. Chairman. Including, obviously, prescription drug coverage.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Washington.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Vladeck, can you imagine the practical problem of sending these two documents to 34 million Americans and asking them to go through page after page of lists and deciding which—we are talking senior citizens and disabled people now—going through and filling out an application and sending it back into you so you would know where to send the voucher? Have you begun to think about what that is going to be like if they put the Federal Employees Health Benefit Program out there as choices for senior citizens?

Mr. VLADECK. Mr. McDermott, I have been in Washington for 2½ years. I can imagine damn near anything by now. [Laughter.]

In fact, we need to get better information about plan choices to our beneficiaries. We believe that we can do a substantially better job than FEHBP does of putting that in comprehensible, accessible form.

We have also talked to a lot of employers, and they have invariably told us that, in order to get expanded choice of plans among their covered populations, they need to make an enormous investment not only in written material but also in human beings who can provide counseling, advice, and assistance to the employees in making these choices. And we believe that is a direction in which we should go. But we have no idea how it would be paid for, or whether in the long run the government would be prepared to continue to make the investment that private employers will tell you is necessary in order to really have a good, effective education of choice.

At the moment, our budget does not permit us to mail the Medicare handbook, which is the equivalent of an annual benefit summary statement, to every Medicare beneficiary. It costs us about $30 million a year. It costs about $30 million to do a one-time mailing to all 36 million beneficiaries.

And so we are very much troubled by and are giving a lot of thought to the question of how, in fact, we would pay for the mechanics of expanded choice and who would pay for it.

Mr. MCDERMOTT. I think you are raising the whole question of the personnel department of a big corporation like Boeing or Weyerhaeuser where they sit down and counsel their people. But when you have as many choices as we do, I hope that if you figure out how to make it simple, you will send it to Members of Congress, because most of us do not know what is covered in our own plan and do not understand what is the difference between the seven, eight, or nine choices each of us has.

I want to go one other question, though, and I really want this to be informational for the Subcommittee, because I think that one of the things that we sometimes—we sit up here and think Medicare is all by itself over here and Medicaid is all by itself over here. Because of my personal experience out in the field, I always think of them as interconnected and very interwoven. And I am trying to figure out what is going to happen to Medicare when you have block granted Medicaid and at least jeopardized the QIMB Program, if not a whole series of other things.

I would like you to talk a little bit about the interface between Medicare and Medicaid, because we have already made a major change in the health care system with the block granting of Medicaid. Now we are talking about Medicare. Would you please talk about that interface and what we have already done and what will happen?

Mr. VLADECK. We are very, very concerned about that. About one-half of all Medicaid expenditures are on behalf of Medicare beneficiaries. Medicaid is Medicare's safety net. For the 12 percent of Medicare beneficiaries who are also eligible for Medicaid, it is Medicaid that pays the out-of-pocket expenses, the part B premiums, the copayments, as well as providing the prescription drug benefit. And, of course, Medicaid is Medicare's long-term care system in a very basic sense as well, because the long-term care benefits in the Medicare Program are so limited.

We do not know what the States would do under a block grant, but it is very plausible to imagine that under the kinds of things that are being talked about for Medicare, the lowest income, roughly the lowest income, 15 percent of Medicare beneficiaries, would suffer a double whammy from reductions in their Medicare at the same time as reductions in Medicaid. And many of them in the absence of some compensatory mechanism would literally be left without access to health care.

Mr. MCDERMOTT. You are really saying that the 11 million single women, mostly widows, whose average income is about $8,000, who are almost certainly to be covered by that QIMB Program in Medicaid, will be without that benefit?

Mr. VLADECK. Well, the numbers are slightly smaller, sir. It is about 6 to 6.5 million people. But if Medicaid goes away, they are up a tree in terms of getting health care.

Mr. MCDERMOTT. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Earlier this year, Dr. Vladeck, you testified here you were looking at a prospective payment system for skilled nursing facilities. Where is the administration at this point in their study? Have you checked with the industry, and what is their thoughts on that?

Mr. VLADECK. We are continuing to work on that. We have met with the industry. The industry is very concerned that at the rate we have been going in the past it would be several years before we could put into place a fully articulated prospective payment system for skilled nursing facilities. The industry has proposed to us an interim system which we think holds very considerable promise.

Mr. CHRISTENSEN. An interim system being months or years?

Mr. VLADECK. Being something that we could put into effect in fiscal year 1996 if we were to do budget resolution legislation in the next few weeks, but that we could put into place in calendar 1996 if we get reconciliation by October.

Mr. CHRISTENSEN. Would you agree with me, the numbers I have looked at—and I do not know if your numbers reflect this as well, but the numbers I have looked at show skilled nursing facilities for subacute and postacute care being nearly one-half or 60 percent of what hospitals provide in terms of cost. What do the administration's numbers reflect?

Mr. VLADECK. We have an enormous variation in what we pay per day for skilled nursing facilities, some of tied to the level of sophistication of service for the illness of the patients. There are a number where we are paying as much as $500 a day under the current system.

Our average reimbursement for inpatient hospital care is not a heck of a lot higher than that.

Mr. CHRISTENSEN. On average, you would say that from the administration's point of view it is what percent of hospital care?

Mr. VLADECK. Well, again, I think the average per diem payment for skilled nursing facilities is very much less. So on a per day basis, we are probably paying somewhere about one-third as much for a nursing facility. But I could get you more exact information.

Mr. CHRISTENSEN. I would like that. If, as you say, it is one-third less—and I think that some reports have been even as much as one-half less—I would encourage the administration to move policy along the lines that it was able to save money for the American taxpayer through a reduced savings and increasing the use of skilled nursing facilities.

[The following was subsequently received:]

There is wide variation in per diem payments for skilled nursing facilities. The variation is due in part to the level of intensity of service. SNF, skilled nursing facility services, are reimbursed on a cost basis, subject to limits. The extent of the variation limits the usefulness of an average per diem estimate.

According to 1994 SNF data, the average cost per day for skilled nursing facilities is $317. This includes averages for free-standing, $275, and hospital-based facilities, $435. Some skilled nursing facilities receive per diem payments of $600 to $700.

HCFA pays for hospital care on the basis of the prospective payment system. Payment is made for a hospital stay, regardless of the length of stay. Research has indicated that the first few days of care are the most expensive. Thus, while on average HCFA pays $840 for each inpatient hospital day, the costs of the last few days of hospital care would be considerably less.

Source: BPD, 8/21/95.

Mr. CHRISTENSEN. You have been at HCFA now for a couple of years, you said.

Mr. VLADECK. Yes, sir.

Mr. CHRISTENSEN. Give me three examples of where HCFA can do a lot better in, in terms of efficiency, in terms of reducing bureaucratic redtape and bureaucracy? In your opinion, where can we make better strides at making your organization a better organization?

Mr. VLADECK. Well, I think we discussed one of them earlier, sir, which is how we pay for durable medical equipment or clinical laboratory services and certain other Medicare services is now specified in statute in incredible detail. It is a very cumbersome, time-consuming process.

If we had the authority to engage in something closer to a private sector model of negotiated prices or even open competitive bidding the way the government buys other things, it would save us a lot of work and effort. It would make us more responsive, and we believe we could save a lot of money.

Second, we are going to make a proposal to the Congress in the next few months to bring the law of our relationships with the Medicare contractors, the intermediaries and carriers who actually pay bills and are the front line part of the system. We propose to bring that law under general Federal procurement law rather than all of the special statutory requirements those contractors now have, which is also costly and inefficient.

Mr. CHRISTENSEN. In my last few seconds here, I want to also thank Congresswoman Johnson for bringing out some of the testimony, and talking about your numbers, I believe it was 74 percent of Medicare beneficiaries have access to managed care plans. I think one of the things that you did not include in your testimony that I think needs to be put in there is the fact that they may or may not have access to those plans, but the thing that I found in all our townhall meetings and talking to seniors is that they do not have the information. They do not know about the access, if they do indeed have access. You may have sent out information or provided information, but I have found that there is very little out there as far as actual knowledge of what is available to them. And I would concur wholeheartedly with Dr. McDermott in the complexity of our Federal employee's health care plan.

Thank you for your testimony today, and I appreciate your being here.

Mr. VLADECK. Thank you, sir.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Vladeck, you were in the room when I indicated some reservations I had about shifting vast numbers of the Medicare population to managed care, knowing full well the dialog we went through on the health care bill on not giving people the right to choose their own providers or their own doctor. We have had Medicare Select around for a while in some selective States. Now, there is a report coming out at the end of the year on that program?

Mr. VLADECK. I promised Mrs. Johnson and other Members of the Subcommittee that, plus or minus Labor Day, we will have some much more systematic data on the Medicare Select plan.

Mr. KLECZKA. Now, will we be able to ascertain from that report the acceptance level and the fact that this might be a viable option, or are we going to have to wait a while—and we do not have the luxury of time—to see how your Medicare choices program is accepted? Could you comment?

Mr. VLADECK. Well, I think, as we have discussed, the Medicare Select is a very limited hybrid of a true managed care plan and a traditional Medigap plan. And so while I will be in considerable trouble if we cannot give you lots of data early in the fall—and I expect we will be able to—I do not know how much that will tell us about managed care options more generally. And it will be a while before our choices demonstration yields us systematic data. We have been doing——

Mr. KLECZKA. Is that just going online now?

Mr. VLADECK. Pardon?

Mr. KLECZKA. Is that just going online now?

Mr. VLADECK. We have just sent out a solicitation for proposals. But we have supported and have worked with a number of others to support various kinds of survey research and other public opinion research among Medicare beneficiaries, caretakers of beneficiaries, and preretirees in their sixties, regarding their perceptions and feelings about managed care and managed care choices. We do have a growing body of data about people's preferences, about what is important to them, about what those who are in managed care like and dislike about managed care and so forth.

Mr. KLECZKA. Do you have any opinion on what that data is showing at this point?

Mr. VLADECK. I would say in general it shows the following, very quickly: First, with a voluntary election process among Medicare beneficiaries who are in managed care, the overwhelming proportion are highly satisfied. Among those who are not in managed care, the overwhelming proportion do not want to be in managed care.

The second thing I would say is that there is a maturation and life cycle phenomenon at the level of the metropolitan area. In those areas where HMOs have been established in the private sector for a longer period of time, like the Pacific Northwest or parts of California, beneficiaries know HMOs; they understand them. There is substantially less negative feeling toward them and substantially more interest, although it is still a minority of the beneficiaries. In communities where HMOs are much newer on the health care scene, there is much less interest.

What beneficiaries who enter HMOs like most are the elimination of paperwork and the reduction in out-of-pocket payments. They rate additional benefits third or fourth in priority.

Those who do not enroll or chose to disenroll from HMOs most dislike the restrictions on choice of physicians. This has more to do with the ability to self-refer or to negotiate referrals to specialists than with problems with choice of primary care physician.

Mr. KLECZKA. The other concern—and I must say that the administration and your testimony are very sensitive to this—is the

actual beneficiary liability. As I have indicated over the last 2 days, if, in fact, that voucher grows in a limited way over a period of years and there are no controls on every other factor, you know, starting from premium to out of pocket to reimbursement, we are going to have a really serious problem, especially knowing that the population that we are dealing with has fixed income, and I think in your figures, 75 percent of the population, their total annual income is less than $25,000.

Do you have any guesstimate as to what we could be seeing for total out of pocket using a $270 billion cut in the program?

Mr. VLADECK. Again, it really depends on how that is achieved.

Mr. KLECZKA. I know it is a guess because there is very——

Mr. VLADECK. Our estimate is that one-half of those savings fall on beneficiaries, on increased out-of-pocket payments for beneficiaries, that is about $600 or $700 a year in 2002. It is about $2,800 over the 7-year budget cycle in increased out-of-pocket liability for beneficiaries.

Mr. KLECZKA. Above and beyond what is out of pocket today?

Mr. VLADECK. That is correct.

Mr. KLECZKA. That is not total.

Mr. VLADECK. Above and beyond what is out of pocket in the baseline, which actually grows with inflation in part B.

Mr. KLECZKA. Thank you very much.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. Vladeck, in your testimony, you talk about voucher-like approaches. You cite two figures: The growth per capita in the private sector and the growth in the Republican budget resolution. I have just sort of a statement first and then a question afterward.

The 7.1 percent sounds awfully high. I do not know whether it is CBO—if you say it is, that is fine. But every sounding I make, it is a lot less than that. But even if it were that figure, aren't you really comparing apples and oranges? Isn't there a different base when you talk about the 7.1 percentage in the private sector versus the Medicare base, the ingredients that go into that figure?

Mr. VLADECK. Yes, sir, and the Urban Institute I think just yesterday released a study, which I trust will be available to all of you soon, that suggests the base works to Medicare's disadvantage. That is to say, most private health insurance covers very little in the way of skilled nursing facility or home health care, which have been the two fastest growing sources of Medicare outlays. Conversely, most private health insurance does cover prescription drugs, which Medicare does not, and over the last 2 or 3 years prescription drug prices have grown less quickly than other components of health care expense.

So, to the extent that the benefit packages are dissimilar and, therefore, the comparison is potentially misleading, then, in fact, Medicare's comparative performance looks better and the differentials between the budget resolution and the private sector would be even harder to achieve.

Mr. HOUGHTON. Sure, but is it fair to say that those two numbers should really not be compared or contrasted?

Mr. VLADECK. No, I think they are an appropriate basis. Certainly listening to speeches of Members of the Majority since January and to all the experts and pundits, the ostensible performance of the private sector is referred to constantly. We think, therefore, it is appropriate to talk about the comparison between Medicare and the private sector but to use the most reliable numbers that are available.

Mr. HOUGHTON. I have no more questions.

Chairman THOMAS. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Mr. Chairman, thank you for this opportunity. I think these hearings are very useful, and I do hope there will be a chance at the Subcommittee or the Committee level for hearings on the plans when they are unveiled.

I think Mr. Houghton——

Chairman THOMAS. If I might respond to the gentleman, if we could get some specifics from the administration rather than generalities, I would be more than willing to hold a hearing to examine those options as well. I think we need to look at all sources of options as we have been doing with the private groups, and I would look forward to that hearing.

Mr. LEVIN. OK. Well enough, as long as there are specifics under the budget resolution, there are some hearings.

I think Mr. Houghton, as usual, has put his finger on what is really the gist or the most important point in this debate. There are others that are significant, but I think, Dr. Vladeck, your statements on page 9 of your testimony are what much of the shooting and shouting are all about. And I think your answers to Mr. Houghton indicate the dilemma that the budget resolution has placed its advocates in. It is this syllogism on page 9, "CBO data indicate that the private sector per capita growth rate would be 7.1 percent . . . ." This is CBO data. You generally embrace CBO. That is their data.

The budget resolution—and I will leave out the adjectives for a moment—would require 4.9 percent, and I do not see how you escape the conclusion that

> Constraining the costs of providing care for a much more vulnerable Medicare population to a rate of increase so much smaller than that of the private sector is, at best, unrealistic . . . . Such an approach would put all the risk of increased medical care costs on the beneficiaries.

That last line would place all the risk of increased medical care costs on the beneficiaries. That is what the present approach or the suggested approach does, places the risk of increased medical care costs on the beneficiaries.

That is why the loud protests, including from this side and from seniors. Essentially, there is a gamble being suggested here. And the losers, I think there would also be hospitals who would lose. But the main losers would be the beneficiaries.

Someone needs to respond to that syllogism. I have heard no response that is at all persuasive except hopeful thinking. And, indeed, I want to ask Dr. Vladeck about the $124 billion, because I think we have got to be realistic and straight about all these figures.

Now, we do not have the details yet on the $124 billion. But isn't it true that there has been reference to what has been suggested in the last few years, but some of the proposed—I think it was $108 billion deficit reduction in the plan of a few years ago that came through this Subcommittee, was offset by increases, for example, for certain hospitals. So, I mean, is $124 billion going to be so easy? Is that a given? Weren't there some offsets there?

Mr. VLADECK. I do not think it is easy by any stretch of the imagination. I think we do take to heart the notion that since 1993 the bigger buyers in the private sector, not all private insurers but the bigger buyers, have been getting significant price reductions from certain providers. We would like to take advantage of that.

Mr. LEVIN. Reform is necessary, clearly.

Mr. VLADECK. Pardon?

Mr. LEVIN. We need to change, that is clear. But is this so easy, the——

Mr. VLADECK. No, I do not think reform is easy. If there ever are hearings on anyone's specific proposals, I think we will make it clear.

There are no painless ways to cut Medicare outlays at all. There are only two places the money can come from: One is payments to providers, and the other is out-of-pocket costs for beneficiaries. And you will not have a provider, I do not believe, come here today or in any of your hearings and tell you they think Medicare is overpaying them, and many of them have grounds for good sympathy.

So unless you believe in some alchemical processes of throwing numbers around, the fact is that whether it is $124 billion or $270 billion, either somebody is paying a lot more or somebody is receiving a lot less.

We believe that in a balanced, measured way, over a period of 7 years you could reduce payments to providers by $100 billion or so in a way that they will be able to respond to with productivity improvements. Because for the first time, the private sector is moving in the same direction. But that will not be easy, and it will not be painless. No one should have any illusions that any reduction in expended Medicare outlays is going to hurt somebody and that the amount of pain grows exponentially with the dollars involved.

Mr. LEVIN. Thank you.

Chairman THOMAS. Does the gentlewoman from Connecticut wish to inquire for a second round?

Mrs. JOHNSON. Yes, Mr. Chairman.

Dr. Vladeck, what is your per capita growth rate on your OMB baseline in your latest proposal?

Mr. VLADECK. In the President's proposal, I believe it is somewhere in the range of 6 percent, but I would have to get back to you on that because we were trying to figure that out last night and ran into some technical problems.

Mrs. JOHNSON. Well, you can get back to me on the specifics, but you are saying roughly 6 percent. Did you calculate the Republican increase using your baseline?

Mr. VLADECK. No. We calculated the Republican numbers using the CBO baseline. Using the CBO baseline, our growth rates with our reductions would be substantially higher.

[The following was subsequently received:]

Average Per Capita Growth Under the Administrations Proposal 1/

Fiscal Year	Annual Per Capita Growth
1997	4.7 %
1998	6.5
1999	5.5
2000	4.8
2001	6.5
2002	6.5
2003	7.2
2004	7.4
2005	7.5
Average (1997-2005)	6.3 %

1/ Per capita growths are based on savings from the Administrations proposals measured against the OMB Midsession Review baseline.

Office of the Actuary
November 12, 1996

Mrs. JOHNSON. I am interested that growth rates using your baseline are 6 percent, which is higher than CBO says ours will be, but in talking with CBO, they believe that when we rectify the baselines, the percentage growth will be roughly the same. So I think we do need to go through that exercise because I think a lot of what we are talking about here today is fundamentally irrelevant to what is going to happen in the end.

Mr. VLADECK. Mrs. Johnson, we believe that the difference between $270 billion and $124 billion is far more than a baseline estimation issue. We believe that even correcting for differences in baseline, we are talking about between a 50- and 100-percent difference in the magnitude in outlay reductions.

Mrs. JOHNSON. I believe that CBO does not agree with you, but we will go through that. Some difference is manageable. A lot of difference is a problem. And I think when we get the baselines rectified, we are going to find that there is a manageable difference.

In your section on vouchers, you are very negative about vouchers, but you make a lot of assumptions that, frankly, none of us is making. If the voucher is pegged to cover the Medicare service basket and it is indexed properly so it continues to be able to cover that and it is age-adjusted so that as people get older and their costs are higher that is taken into account, and we do not allow any exclusion on the basis of medical underwriting, which we know is possible because in the Medigap market in every single sector of their market, there are Medigap policies that do not exclude for preexisting conditions, and we maintain the subsidies of the current system for low-income seniors, I do not understand why that would not work.

You assume in your testimony that somehow we would not peg it at the right level to cover services. You assume it would not be indexed. You assume there would be no consideration of frailty and age. You assume that we would allow exclusion of people on the basis of health history. Of course, we are not going to do those things. We are guaranteeing to the seniors of America that the premium would buy them just exactly what they get under Medicare now, the service basket they get under Medicare now, the access they get under Medicare now. But it would allow them to buy those services in a managed care system.

So your assumptions are so wrong that of course your conclusion is hostile.

Mr. VLADECK. No, you cannot make that guarantee, Mrs. Johnson, under the terms of the budget resolution. The budget resolution would have the voucher growing at $270 billion less than is necessary to maintain the existing set of benefits.

Mrs. JOHNSON. Yes, but you see——

Mr. VLADECK. And unless we have a miracle——

Mrs. JOHNSON [continuing]. That is a different judgment to be made, Dr. Vladeck. I think we all have to start from the assumption that if we give seniors the right to buy a premium, we are giving them the buying power to buy a plan comparable to Medicare. The reason we want to do that is because we know—and you have acknowledged in your testimony this morning—they can buy more than the Medicare package for that premium.

Now, rather than make the savings of dropping the premium, as you are suggesting in your testimony, we are going to allow them to buy more for the same price. Now, we think that that is absolutely doable within the larger picture of growth that we put in Medicare because there are so many other areas where Medicare needs to be far more efficient.

For instance, if the government is paying for a voucher for a senior, they are just paying the insurance company. Now they are paying the insurance company of the senior's choice. Now they are paying every time that patient goes to the doctor. Think of the fiscal intermediary costs that are going to be cut if we move into a system where seniors have more choice, but government does not have the burden of procedure-by-procedure reimbursement, a visit-by-visit reimbursement. We certainly would not have that burden under a system that provided more choice and greater access to seniors.

Mr. VLADECK. Mrs. Johnson, I believe you are misinterpreting the data in two ways. The reason HMOs are providing additional benefits and no premium is because we are overpaying them. The Mathematic study shows that in Dade County, Florida, or Los Angeles County or Orange County, what we are actually paying the HMOs is more than we would be spending on the same beneficiaries in the fee-for-service system. That is where the extra benefits come from.

Mrs. JOHNSON. Of course, it depends on whether the benefit has high cost or low cost as to what you would be paying.

Mr. VLADECK. No, but that is why we say we are overpaying. Second, the fact is that all of that detailed administrative activity you talk about in the Medicare fee-for-service system costs the government 2 cents of the benefit dollar. There is no private plan, whether an HMO, a PPO, or a private indemnity plan, that can manage a plan at that level of overhead. In fact, the average medical loss ratio of Medicare HMOs is in the range of 80 percent. So, in fact, in order to provide the same benefits to Medicare beneficiaries as they receive now, assuming we pay them exactly the same amount as we would pay in fee-for-service, a private plan has to reduce utilization by 20 percent to break even in terms of the benefit.

Mrs. JOHNSON. The light is on, so I cannot continue, but there are answers to the charges you just made. I think to keep the record clear we do have to acknowledge that the Medicare reimbursement system through the fiscal intermediaries is now compromising access to seniors because the fiscal intermediaries will not reimburse the way Medicare directs because of budget concerns. So they are reimbursing for office visits at the lowest level regardless of how much care was given. In Connecticut, that is $19.19, and if you do not think that is not going to hurt, is not hurting Medicare beneficiaries now and is not later, I sure would not tout the efficiency of the Medicare administration capability now to provide access and quality to seniors when it is on the skids.

Thank you.

Chairman THOMAS. The gentlewoman's time has expired.

Does the gentleman from California wish a second round?

Mr. STARK. Thank you, Mr. Chairman.

Mr. Vladeck, did the President's plan put any financial burdenpaying for that $124 billion on the beneficiaries?

Mr. VLADECK. The President's plan continues the proposal that was in his budget in January and in the extenders of keeping the part B premium at 25 percent.

Mr. STARK. In other words, you did not add any financial burden——

Mr. VLADECK. But other than that, there is no additional cost to beneficiaries in the President's proposal.

Mr. STARK. And what do you suppose the Republican plan adds to the burden? About $1,000 a year by the year 2002, as we heard? Is that right?

Mr. VLADECK. Again, that would be on average of a range of possible proposals.

Mr. STARK. Let me ask you this: Do you know—you were an official in the New Jersey government and, before that, ran a large hospital charity operation in New York. Do you know of any private insurance, fee-for-service, that would provide Medicare-style benefits that is available to people over 65 if they do not qualify for Medicare? Is anybody selling that today in the whole United States?

Mr. VLADECK. Not that I am aware of.

Mr. STARK. In other words, you give these folks a voucher. Is there any law on the books of the United States or any State that you know of that requires an insurer to sell a policy to any particular individual?

Mr. VLADECK. Several States now have laws that if they sell health insurance at all, they have to sell in the individual market, to any individual.

Mr. STARK. If they sell it. But there is no law that requires an insurance company, that says you have got to sell this insurance or you go to jail?

Mr. VLADECK. That is correct.

Mr. STARK. They can pull out of the market. So, in effect, we could give all these vouchers to seniors, and as we sit here, there is no insurance company in the country that offers a policy that they could purchase. Is that not correct?

Mr. VLADECK. That is correct.

Mr. STARK. And there is no law of the land and never has been one that would require an insurance company to offer it.

Mr. VLADECK. That is correct.

Mr. STARK. Can you think of any circumstance under which you offer people a $5,000 voucher to purchase 6,000 or 7,000 dollars' worth of benefits—I know that we often hear from my colleagues in the Majority about free enterprise. None of them ever had a job in free enterprise, but they all talked about it a lot. But for those of us who have occasionally worked, how would you sell something to people for $5,000 that costs $7,000 and win one of the President's awards for entrepreneurship? How would you do that?

Mr. VLADECK. Mr. Stark, my particular concern is actually the opposite. I think at any price you set the voucher, there would be people in the marketplace who would exploit that price. Unless you had a very extensive regulatory system, there would be people who

would thrive in such a market by promising to provide 7,000 dollars' worth of benefits for $5,000—and, in fact, providing 3,000 dollars' worth of benefits. And we have a lot of history of that in the history of managed care in both Medicare and Medicaid.

Mr. STARK. We have that problem today, do we not, particularly in Florida——

Mr. VLADECK. Less in the past——

Mr. STARK. Less, but we have had it in California.

Mr. VLADECK. Yes, sir.

Mr. STARK. Pericles Celsus, $12 million they stole, and they are back in business. We have no Federal regulations that would prevent these scalawags from offering to take the $5,000 from my mother and only give her 3,000 dollars' worth of benefits. There is no law now that would prevent that, is there?

Mr. VLADECK. Well, once again, there is no actual voucher proposal, but we hear on the one hand that there would be all those sorts of consumer protections but that there would be no new bureaucracy or regulation. One of those two things cannot be so.

Mr. STARK. Thank you.

Chairman THOMAS. Does the gentleman from Washington want to do a followup?

Mr. MCDERMOTT. Were there any of those consumer protections in the Medicare Select bill that went out of this Subcommittee?

Mr. VLADECK. No, I do not believe so.

Mr. MCDERMOTT. So they are talking about some consumer protections they are going to cook up between now and the passage of the reconciliation bill, is what you are talking about?

Mr. VLADECK. Again, according to those who have seen the draft that was attributed to the Majority of the Subcommittee, it enumerates quite an extensive list of protections.

Mr. MCDERMOTT. You mean there is a draft floating around somewhere?

Mr. VLADECK. I only know what I read in the newspaper.

Mr. MCDERMOTT. Would you please send a copy to my office?

[Mr. Vladeck subsequently stated he had only seen the article and not any draft proposal. He stated this information did not originate with HCFA.]

Chairman THOMAS. Would the gentleman yield? Would the gentleman yield briefly?

Mr. MCDERMOTT. Yes.

Chairman THOMAS. The Chair has been relatively patient in some of the show going on here, and there may be somebody who walked in the room who now believes that Congress just passed a law for which there are no consumer protections. And, frankly, Dr. Vladeck, I think you just did a great disservice. Do we have any consumer protections in the basic Medigap law that is currently on the books?

Mr. VLADECK. We have some limited consumer protections, yes, sir.

Chairman THOMAS. Some limited ones. Are you advocating that they be improved? Do you have suggested legislation in front of us to improve them?

Mr. VLADECK. No, we have not suggested legislation.

Chairman THOMAS. No, you do not. And will the Medicare Select legislation that the President signed have that same basic protection that applies to all other Medigap programs applied to it?

Mr. VLADECK. That is correct.

Chairman THOMAS. Thank you.

Mr. MCDERMOTT. May I reclaim my time?

Chairman THOMAS. You certainly may.

Mr. MCDERMOTT. Thank you.

I wanted to ask you about another issue, and that is the interface between Medicare and Medicaid with respect to hospital reimbursement, particularly rural hospitals. Some of the Members, before you came in, were talking about the impacts. I would like the Subcommittee to understand what all these changes are going to do to rural hospitals, particularly, but also urban hospitals, as you see the machinations that are going on here.

Mr. VLADECK. In general—and, of course, it varies very substantially from community to community, but, in general, rural hospitals receive more than one-half of their total revenues from a combination of Medicare and Medicaid. The proportion of folks who are privately insured in rural communities is lower than it is in urban communities, and rural populations tend to be somewhat older than the metropolitan area populations. So, in general, rural hospital are more dependent on Medicare and Medicaid between them than are other hospitals. Therefore, significant reductions in the amount of money flowing through Medicare and Medicaid would have a particularly severe effect on them.

Mr. MCDERMOTT. If you figure that the Federal Government is going to spend 15 percent less in the Medicaid block grant to the States, where do you think a State—I mean, you operated in State government I think in New Jersey.

Mr. VLADECK. Right.

Mr. MCDERMOTT. What would be your guess about the segment of the Medicaid Program that would take the hit for the 15 percent?

Mr. VLADECK. I think both the politics and the economics are that to reduce Medicaid outlays by that level, you have to significantly reduce the number of people you are covering. And I think in order to do that, most States would start with the top of the income distribution of the low-income mothers and kids, but they are not that expensive. So you would have to end up significantly cutting back on coverage, the supplemental coverage for the noninstitutionalized elderly and for the non-State-responsibility disabled persons, the physically disabled and so forth. Those are expensive populations, and those are the ones you would have to cut to meet the targets in the block grant.

Mr. MCDERMOTT. You would cut those before you cut the nursing home program?

Mr. VLADECK. My impression of the politics of Medicaid in most States is that nursing homes tend to do relatively better in both cutting and adding scenarios than do other beneficiaries or providers of service.

Mr. MCDERMOTT. So you are really talking about the least able to defend themselves, the mother and the child, of the working poor or the poorer families in this country?

Mr. VLADECK. I think they would be most at risk from a Medicaid cut.

Mr. MCDERMOTT. I had the feeling that you might have had some response to Mrs. Johnson's last comments, and if you want to take 1 minute to respond to that, I would like to offer you that opportunity, because I think you ought to have your chance to say what your response was to that.

Mr. VLADECK. Well, again, I think it is important to get the facts straight and to get the record straight here. And the fact is that I am not familiar with the particular problem in Connecticut, and we may well be having one. The program does not always work perfectly. But, in fact, over the last several years, since the fee schedule was put into place, the proportion and number of physicians seeing Medicare patients has increased. The proportion of the income of primary care doctors that is attributable to Medicare has increased. And the proportion of all physicians accepting Medicare assignment has increased. So while we do have problems in some parts of the country, the aggregate data is very, very clear that Medicare beneficiaries' access to all physician services, including primary care services, has improved measurably over the last several years.

Chairman THOMAS. The gentleman's time has expired.

Mr. MCDERMOTT. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nevada wish to have a second round?

Mr. ENSIGN. Thank you, Mr. Chairman.

While I probably could go down and just play politics and say why does the administration feel that it needs to balance the budget in 10 years when during the campaign 5 years was necessary, we will not go down that road.

Let me turn to something concrete.

Mr. VLADECK. I thank you for not mentioning it.

Mr. ENSIGN. No problem. No, seriously——

Chairman THOMAS. What was it that the gentleman did not mention? [Laughter.]

Mr. ENSIGN. One of the problems that we have in the whole Medicare system is the way the incentives are put in for hospitals and doctors is to spend a lot of money at the end of a person's life. Now, granted, we know that the problem is that we are always looking retrospectively. We do not know that that is the last 60 days of a person's life, but a lot of times we do. A lot of times we have—especially physicians, you work in the field long enough, and you pretty much know when those last 60 days are.

What are your and the administration's ideas on changing the incentives prospectively toward hospices? Because a lot of times, the money is spent when people would not even want that money spent on them. A lot of times their living will is with them, but their family members are not around to enforce the living will. I am talking about care they would not want done on themselves in the first place.

Mr. VLADECK. I appreciate your raising that, sir, because it is an issue about which I feel very, very strongly. I frankly feel that these are kinds of issues that really transcend the economic considerations, whether they are public or private.

We have in the final stages a final regulation, implementing legislation that the Congress enacted about 4 or 5 years ago, I believe emanating from this Subcommittee, that is entitled "The Patient's Self-Determination Act." The legislation makes certain that all patients in Medicare-certified hospitals are advised in appropriate ways about their right to have a living will, to make decisions about terminal care. It makes certain that hospitals have appropriate procedures for educating patients and their families, and that there is community-wide education as well.

It is my belief, and from your question, if I can imply that it is your belief, that if we really gave patients and families more control over this decisionmaking process, they would make more rational, humane, and often less expensive determinations than physicians who, for a whole variety of legitimate reasons, tend to err on the side of too much service and too much technological intensiveness and so forth.

So we are very much committed to helping patients and their families be clearer about what they want, be more assertive about it, and have more control over terminal care.

Mr. ENSIGN. Let me toss this out for discussion, because it is one of the reasons that I think, and you mentioned in your testimony, the administration is committed to this as well as the Republican Congress; that is, giving people more choice. That is the reason I think some of the people have tossed out the Federal Employees Health Plan. Can it be devised in such a way that one of the things they are doing when they are choosing plans is they are choosing that type of health coverage; that they can decide if they want all these heroic measures being done at the end of their life, that is one part of the plan the private sector could offer that as one of the options so that that choice is built in that they have made, and it is obvious because they made those choices up front. And maybe the beneficiaries could share in the benefits because maybe that is what allows them to have prescription drug coverage.

Mr. VLADECK. In principle, the Medicare hospice benefit works that way. When someone has a diagnosis of being terminally ill with limited life expectancy, they choose palliative care and a different package of benefits than they would had they not entered Medicare hospice.

Now, some changes in the law and the program over the last several years have moved us away from that. But I would be concerned, sir, about people having the right to change their minds. We often tend to deny our own mortality. One may make an election at one point in life, and later find out that they are terminally ill and then be unsure they want to continue to live with their election. Morally or as a matter of public policy, I am not sure how prepared I would be to hold them to their decision and say, Look, you have been getting prescription benefits for 10 years, so you are out of luck in terms of heroic therapy. I am not sure I would be comfortable with setting up choices in that regard.

Mr. ENSIGN. Thank you for the extra time, Mr. Chairman, and it is just an issue that I think needs to be raised and we need to continue to work on, because it is such a large area of expenditures in the Medicare system.

Thank you.

Mr. VLADECK. I will put in a plug. I have an article in the Journal of the American Medical Association next month on this subject.

Chairman THOMAS. The issue needs to be raised, it needs to be pursued, and it needs to be resolved.

The gentleman from Michigan.

Mr. CARDIN. Maryland.

Chairman THOMAS. I apologize. I have been accustomed to Sandy down there. Sorry, Ben.

The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Vladeck, one of the options that is being looked at to open up Medicare more to private insurance is to continue those individuals who become qualified for Medicare in their employer-sponsored plan. I know that you have looked at that. You have done some work with some of the larger employers to see whether there is interest among the employers to take on the responsibility of all of their retirees with some contractual arrangements with HCFA. And I am wondering whether you have any observations as to your discussions with large employers as to whether there is a willingness to take on the total responsibility for their population over 65; how the Medicare beneficiaries are responding to the prospects of remaining in their employer-sponsored plans versus traditional Medicare; and whether there has been any indication as to potential savings to the Federal treasury as a result of these arrangements.

Mr. VLADECK. We have talked to a number of employers in a relatively preliminary way, and, frankly, their views are mixed. We have talked to two employers over the last 5 or 6 years very intensively in a process that got a lot of attention, I believe, in the late eighties. Both the Chrysler Corp. in conjunction with the UAW, and John Deere, also with the UAW, proposed the creation of a so-called Medicare-insured group in which we would treat their employee benefit plan for their retirees as though it were a capitated managed care plan.

We have been in negotiations with John Deere around such a plan to the present day and believe they are finally going to go forward on a very small and cautious basis.

Several years ago, Chrysler concluded that the risks to them from an actuarial point of view of such an arrangement would be too great to justify potential savings they had initially hoped for and, therefore, discontinued the discussions with us.

So I would say I think it depends. It depends on the nature of the retiree benefits now being offered. It depends on how the employer feels about what kind of deal they are getting from their health plan. It depends on the ratio of retirees to workers and where they are located—a set of issues. I think you will find some continuing interest from employers and the opportunity to provide some real benefit to beneficiaries in the process. But I do not think it will be anywhere near a universal response even from the largest and most sophisticated employers. And one of the things we would like to work with you on is to provide that option, again, as a voluntary one for both the employer and the retiree, and see how many takers we can get.

Mr. CARDIN. Well, if it is maintained as a voluntary option—I understand the political difficulty of anything other than a voluntary—don't you run the risk of the adverse selection problems or the risk that the employer will try to pawn off on the Federal Government their highest cost beneficiaries, therefore taking the best of both possible worlds from the private sector but the worst from the government sector?

Mr. VLADECK. You do run that risk, although I think there are ways to accommodate it. But, again, I think the ways in which you accommodate it may reduce the attractiveness to some of the employers.

I hate to respond in this way, sir, but the basic answer is that it is very complicated and different employers feel differently.

Mr. CARDIN. Do you think you will save money for the Federal Government?

Mr. VLADECK. Not in significant amounts.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman THOMAS. I would tell the gentleman that that line of questioning is an interesting one, and obviously it would be a voluntary one with complete protection on an all-or-nothing arrangement. But in pursuing that, we found, frankly, some very positive discussed with labor unions, especially the Taft-Hartley labor unions that already have the employer's dollars by which they structure their plans. They find this is a relatively attractive one for the union family, especially since many of the labor contracts have retirement at 55 now. And I think we can probably on a volunteer basis draft some programs that would be modest initially, but I think perhaps have some long-term benefits not only from employers but from union health plans as well.

Mr. VLADECK. And, if I may, Mr. Chairman, we, in fact, find more enthusiasm for these sorts of ideas among the unions, and we are in discussions both with Amalgamated Life Insurance, an affiliate of what used to be the Amalgamated Clothing Workers that also goes back many years, and more recent discussions initiated by the Joint States Welfare Plan of the Teamsters. So we do think there is some interest in the multiemployer union plans, and we are pursuing it and would be interested in continuing to explore it.

Chairman THOMAS. I thank the gentleman. And I guess people are through, so I can ask some questions.

Mr. CARDIN. Mr. Chairman, before you do that, could I just explain the reasons why several Members of our Subcommittee will not be here? Three of the Members of the Subcommittee serve also on the Ethics Committee, which will be meeting shortly, and we are required to be at the Ethics Committee. Mr. Thomas does not require us to be at this Subcommittee. I particularly want to apologize to Dr. Bennett, who will be on the next panel, from Johns Hopkins, and also Dr. Foreman, who was previously from Maryland, for why I cannot personally be here to listen to their testimony, but our staffs are present.

Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. The testimony is made a part of the record, and we do utilize the information as we move forward in trying to craft a strategy to preserve and strengthen Medicare.

Earlier, the gentleman from California made a statement: There is nothing new in this business. You spent some pages, Dr. Vladeck, explaining some of the things that you are doing. Is any of this new?

Mr. VLADECK. We believe it is, but none of it is scored for savings, sir.

Chairman THOMAS. Well, if we relied in terms of the scoring to define what we should be doing in terms of new, we would not do anything.

I am concerned that people do not believe and have a mental set going into the solution for Medicare that there is nothing new. Apparently, they are not paying attention to what is going on in the private sector, and I thought the dialog here, although you may have been pursuing employers for some time, based upon what we may do with incremental health reform in other areas, might, in fact, increase the comfort level of some employers. Because, frankly, what I have heard from them was that they were scared to death that we would get them into the retiree business and then walk away from them and then have them hold the bag in terms of risk. And I said, Well, based upon some of my experience, that may, in fact, be a real worry. And so to the degree that we can create a structure which alleviates some of those concerns, I think we have perhaps a greater opportunity to move forward.

Dr. Vladeck, in your busy schedule, did you get a chance to see the editorial page of the Washington Post this morning?

Mr. VLADECK. I did.

Chairman THOMAS. You did. And so you saw the editorial entitled "Medicare As We Know It." The last paragraph says,

> But Medicare as we know it is too costly to be sustained, and the problem will only grow worse as the baby boomers begin to retire in the next century. The Republicans are right that it has to be restructured. The questions are how drastically, at whose expense, and how. Vouchers will not magically solve the problem all by themselves. They can't. But they might be part of a tolerable solution. The idea deserves some thought.

It is focusing on the whole question of vouchers. Obviously, to a great extent, the discussion here was over the vouchers.

As a matter of fact, in your testimony you discuss—and this is the question I want to ask you, Mr. Vladeck. In your testimony, you used a phrase, "In short, the choice beneficiaries would face under the Republican voucher plan . . . ." That is in your written testimony. It was reviewed by the administration officials. It is your official testimony characterizing the Republican voucher plan. And yet just 1 minute ago, in your exchange with the gentleman from California, you admitted there is no actual voucher program.

Now, was that just a moment of candor on your part, or was your written statement a true reflection of your belief about whether or not there is a Republican voucher plan?

Mr. VLADECK. Well, I think without getting into semantics, sir, the reason for the phrasing of my statement earlier was my understanding of some of the dialog that occurred in one of your sister Committees on Tuesday with one of my colleagues. A document that has been widely circulated as a staff draft was disavowed by many of the Members of the Majority. And we both, based on press reports and other sources of information, had reason to believe it

was being still talked about by Majority staff. The Majority has since advised in other settings that this was not their plan. So to the extent that the timing of a written statement predates this and to the extent that, in fact, you and your colleagues are prepared to say that you do not, in fact, have a plan, then I would, in fact, correct the record.

Chairman THOMAS. If the gentleman had looked at any purloined materials, I think he would have realized—and he certainly could not have gotten it from reading Washington Post stories over it—that, in fact, that was salted constantly with phrases like "alternatives A, B, C," and "options 1, 2, 3, 4," and that an entire panoply—in fact, the universe of suggested topics were part of that program. The stories do not talk about options or alternatives. They invariably take the largest or the worst possible scenario and paint that as "a Republican plan." And yet at the same time a reporter is playing those kinds of games, the Washington Post is writing an editorial that says we ought to at least take a look at it.

Now, I will assure you there is no plan, notwithstanding your statement and then your attempt to trash it based upon assumptions which were not in the plan and options which were not contained in—and your certainly heard the response of the gentlewoman from Connecticut about her concerns in couching any structure and that it serves no useful purpose in trying to solve the problem that is in front of us by carrying on the kind of political dialog.

Are we looking at every possible option to make sure that Medicare does not go bankrupt? You bet we are. We would be irresponsible if we did not. Does that mean that that is what we are placing in front of the Congress tomorrow? Of course not. Have we ended the hearings in terms of trying to get ideas about how to solve this problem in front of us? No. And yet you folks decide to take the valuable time that we have here playing the kind of cute games that you play when you knew there were consumer protections in the law under the Medigap provision; the Medicare Select is in addition to the 10 Medigap proposals.

Now, that does not get us anywhere in trying to resolve the problem in front of us.

In your exchange with the gentleman from California about the condition that the trust fund is in vis-a-vis earlier periods, and your representation that the trust fund has been in trouble in previous periods much more so than currently, in those previous periods had the cap on payroll been removed? In fact, when was the cap on payroll deductions for the part A trust fund removed, Dr. Vladeck?

Mr. VLADECK. I believe it was removed in OBRA 1993, sir.

Chairman THOMAS. In OBRA 1993, the cap on payroll was removed. So in previous years, the way in which you partially resolved the trust fund dilemma was to up the dollar amounts that people had to pay on payroll deduction into the trust fund?

Mr. VLADECK. May I note for the record, sir, that every Republican in the House of Representatives voted against that change in OBRA 1993.

Chairman THOMAS. I appreciate that very much, because I think it is very important as we go along, and I really do appreciate your underscoring that.

Now, back to the question. Was one of the ways in which you saved the trust fund from impending bankruptcy increasing the amount of income that people were required to deduct for payroll deduction into the part A trust fund?

Mr. VLADECK. That was done on a number of occasions, yes, sir.

Chairman THOMAS. Can we do it any more?

Mr. VLADECK. No, we cannot.

Chairman THOMAS. No. And when was that done? In 1993. You have exhausted that option, which was available earlier to do these short-term increased-tax approaches to saving Medicare.

Anything else done in OBRA 1993 to make adjustments on the Medicare Trust Fund?

Mr. VLADECK. Yes, there were some reductions in increases in payment rates to part A providers.

Chairman THOMAS. About how much was that?

Mr. VLADECK. I honestly do not recall the number.

Chairman THOMAS. $55.8 billion, revisions——

Mr. VLADECK. That included the B providers.

Chairman THOMAS. $55.8 billion.

Now, the President submitted a 1996 budget. Were there adjustments on Medicare in the 1996 budget?

Mr. VLADECK. No, there were no further adjustments—other than extenders of current law.

Chairman THOMAS. There were $10.9 billion of doing what?

Mr. VLADECK. Of extensions of what would be expiring authorities.

Chairman THOMAS. You are going to have to explain that a little bit. You mean there were reductions already in place that were going to expire?

Mr. VLADECK. That is correct.

Chairman THOMAS. Suggested dates.

Mr. VLADECK. Pardon?

Chairman THOMAS. What were the suggested dates? When were they going to expire?

Mr. VLADECK. They will expire at the end of fiscal year 1995 unless Congress extends them.

Chairman THOMAS. And so instead of coming up with new reductions that were available, basically your arsenal was reduced to taking things that were going to stop and extending the date at which they continued. So we do not have the payroll-upping procedure anymore. That cap has completely been blown. You have now decided you think you can balance the budget. You do believe it is over 10 years, and you do believe there are changes that need to be made in Medicare. But in the 1996 budget, what you offered were simply extensions of decisions that had been made earlier.

Frankly, one of the reasons we are in the problem we are in is because all of the easy decisions have already been made. In the mideighties and in the early nineties, including OBRA 1993, you folks continued to do what used to save Medicare. That is whack, cut back, modify, squeeze providers. And in your 1996 budget you

pretty well admit you cannot keep doing that anymore. All you did was extend current law.

Now you have decided that maybe you can go back in and whack providers if you need some kind of a model to offset the apparently attractive position that the Republicans have advocated that maybe we ought to balance the budget and maybe we ought to save the trust fund. And one of the things that concerns me very much as we try to go forward to save this trust fund is to make the kinds of statements that you make out of context; that, Gee, this is no different than any other period in terms of the Medicare Trust Fund being threatened because we have had serious conditions in the past and we have always rectified them.

Isn't it true that we have far fewer weapons that have been used in the past in our arsenal to deal with the current crisis? Is that a fair statement?

Mr. VLADECK. I think it is fair to say we have one less weapon in our arsenal.

Chairman THOMAS. And what is that?

Mr. VLADECK. We can no longer raise the wage ceiling on the HI tax because we have removed the ceiling. Other than that, nothing that has been done in the past in principle, in general form, to strengthen the trust fund could not be done again.

Chairman THOMAS. Except that we have a number of current reductions in the law that all you can do is extent them. And that certainly is not, in my opinion, a substitute for a solid policy to rethink the system.

Mr. VLADECK. Mr. Chairman, the President has laid out the shape of a proposal that would extend the life of the trust fund several more years. Our concern about this argument is that, as far as we are given to understand, none of the options that have been talked about by the Majority in implementing the budget resolution dedicate all of the savings to the trust fund. In fact, we have heard numbers anywhere from one-third to two-thirds of the $270 billion outlay reduction is coming on the part B side or the premium side and doing the trust fund no good whatsoever.

So we think there is a long history that raises questions about whether anyone is prepared to have an apolitical discussion of the future of the trust fund. We do not envision ourselves at the moment of being in the circumstances where the Majority has had a straightforward discussion of these issues either because it is clear you do not need $270 billion in savings to keep the trust fund going through the next decade or through the budget window. And it is also clear that even $270 billion in savings will not put the trust fund on a long-term, sound actuarial basis.

Chairman THOMAS. If what we are doing will not put the trust fund on a sound actuarial basis long term, what is the President doing since his objective and the numbers that you stated are far less than ours?

So you would characterize it as what?

Mr. VLADECK. We believe that the prudent course of action is to adopt a set of measures that will keep the trust fund solvent for the next 10 years which ought to be enough time for cooler heads to prevail and for us to have some long-term, serious, scholarly discussion.

Chairman THOMAS. And that is why it is prudent, but ours is not?

Mr. VLADECK. Pardon?

Chairman THOMAS. You just characterized what we were trying to do as not enough money to save the trust fund for the long term. Everyone knows, who is trying to carry on a rational discussion about the Medicare Trust Fund, that by 2012, 2013, and certainly by 2015 because of the demographic problem of the baby boomers coming along, we have to make some fundamental changes. Somebody has to start looking at the long-term problems. That is the question of age and the question of trying to open up the Medicare Trust Fund.

What you have suggested the President is doing in a prudent way is to buy a few more months. And I think what that does is get you by November 1996. And, frankly, I think the American people are a little tired of Band-Aid approaches that buy a few more months that you say gets you out into the years when cooler heads will prevail.

All your plan does is buy a few months. And if you want to say it is a couple of years, you are certainly privileged to say that because 24 months is a couple of years and that we have not fundamentally addressed the problem.

It seems to me that we have an opportunity to lay the groundwork to fix Medicare through that next real crunch which is about 2012. Are you interested in really going to work to solve this first wave problem of Medicare to 2012, or are you interested in a few little gimmicks that gets you by the election which allow you to say that you can push Medicare along until 2004, 2005, depending?

Mr. VLADECK. Mr. Chairman, it is not the leader or my party or paid political advertising supported by my party that says that $270 billion in cuts are necessary to save the trust fund.

No Democrat of whom I am aware in the executive branch or in the legislative branch has claimed that any level of proposed savings this year are necessary to save the trust fund. That is an assertion the Majority has been making, sir.

Chairman THOMAS. Medicare is not just the part A trust fund. I have used the term, Medicare. Medicare is part A and part B. Currently what do beneficiaries pay per month for their premium?

Mr. VLADECK. Approximately $46.

Chairman THOMAS. That is $46.10 and everyone pays that same amount, correct?

Mr. VLADECK. Essentially, yes, sir.

Chairman THOMAS. And, in fact, you brag about that on the first page of your testimony, do you not, that it is available to all Americans no matter how rich or poor. So that there are millionaires today who are retired who are subsidized by young taxpayers trying to make a living to feed, clothe, and house their family, is that not correct?

Mr. VLADECK. It depends on what they are paying in income taxes, sir.

Chairman THOMAS. Who?

Mr. VLADECK. Those retired millionaires.

Chairman THOMAS. Regardless of what they pay in income taxes, are they being subsidized?

Mr. VLADECK. Their health care is being subsidized, yes, sir.

Chairman THOMAS. And, yet, you, in later pages, talk about the wealthy in a very derogatory way. You brag about the fact that you cover the rich, in one sense, and you criticize, in terms of the wealthy, in another. I think that is interesting.

In addition to that you use the term ironic. To try to get you to understand how frustrating it is as we are moving forward to deal with the problem that the previous Majority simply ignored, except by raising taxes, principally, at the bottom of the page you talk about, in fact, the Republican Medicare restructuring document seems to acknowledge this by directing the Secretary to regulate the type of behavior in numerous instances throughout the document.

This is ironic. Not hopeful. Not encouraging. Not reassuring in terms of us being responsible, understanding the inner workings of this operation and taking into consideration the need to deal with this, but you see it as ironic.

Do you believe if we move forward in some of these changes in a responsible way that we are, in fact, going to have to deal with those issues that you have indicated apparently were dealt with in a document that you characterize as a Republican one?

Mr. VLADECK. Absolutely.

Chairman THOMAS. Then why is that ironic?

Mr. VLADECK. Well, for those of us who sat here over the last 2 years being accused of creating all sorts of new bureaucratic interventions and regulations in the private market as a part of health care reform, we find it ironic. We believe that in order to make a real voucher system work fairly for the majority of beneficiaries, one would have to create many of the interventions in the insurance market precisely of the sort for which we were so roundly criticized when we suggested them as a part of health care reform.

Chairman THOMAS. So you do——

Mr. VLADECK. And that I find ironic.

Chairman THOMAS [continuing]. Believe that we can have a voucher system that works?

Mr. VLADECK. I believe that in order to have a voucher system that works, you would require a level of regulation and bureaucracy that is so extensive that folks who criticized the Health Security Act's alliances would find very ironic, because it would be even more expensive than what we laid out there.

Chairman THOMAS. Is it worth the effort to try to see if we can put something together that works?

Mr. VLADECK. I believe that the fundamental principle of putting the beneficiary at risk for growth in the cost of services and——

Chairman THOMAS. I guess you did not hear the gentlewoman from Connecticut in her response to you in which she got rather emotional because, frankly you did not listen to her then. She said we are not going to do that, but you choose not to hear the words.

Mr. VLADECK. Mr. Chairman, if you have to hit a target of $270 billion in savings, you have to do that. That is what the budget analyses, that is what the CBO numbers show. A voucher indexed to produce 270 billion dollars' worth of savings, with what CBO projects to be the increased costs of medical care, will not maintain

the same package of benefits at the same level of out-of-pocket liabilities. It just will not do it, sir.

Chairman THOMAS. I appreciate your attitude and willingness to move forward with the changes that are necessary in Medicare. It is really ironic to find out that even the Washington Post thinks that what we are doing is something that is worthwhile and ought to go forward because when you are down to looking for editorial support from the Washington Post you have gone a long way. But I think it is ironic and I really would like to have you folk work with us.

It is difficult when the administration leaks stuff, and it makes it even more difficult to try do to a job when, in fact, we have had assurances that that sort of thing was not going to go on.

My problem is that if you are down to going back to the old solution of raising taxes, now you have got to raise the basic deduction amount two to three times, CBO tells us, that is certainly unacceptable and this Majority is not going to do it.

If you keep the old fee-for-service and continue to repeat the mantra that you have got the fee-for-service and that if you extrapolate off a fee-for-service base you cannot do any of the things you are doing without getting into a new conceptual framework about taking what is outside, turning HCFA, in fact, inside out, and having some of these changes come in with a full understanding that the profile of the beneficiaries in the Medicare Program are different from the outside, that does not mean we cannot move forward with some changes.

I was pleased with the interchange between the gentleman from Maryland and the Administrator of HCFA about the ongoing pursuit for new and novel approaches like employers and unions. Frankly, I think we are going to have to look at all of these approaches and, of course, we have been criticized because we actually are circulating materials from outside organizations, from people within the Congress looking at a lot of different alternatives.

The goal is not to focus on those alternatives that, perhaps, best achieve solving the problem of Medicare. Apparently your job, Mr. Vladeck, I do not know if you relish it or not—Dr. Vladeck, excuse me—is to focus on what you indicate in your written statement as a Republican plan and then create a whole series of suggested nightmares which will lead to the inevitable result of a failed and collapsed system with seniors handed a voucher, shoved out into the cold and that this is, of course, an approach that is unacceptable.

That does not really help us solve the problem in front of us. I look forward to the time when either privately or otherwise we can sit down and carry on a little more of this conversation. Because Republicans want to change the program; they believe there is a need to change the program. Even the Washington Post thinks we need to restructure Medicare and I would very much like your help in restructuring.

And if you are not willing to do it in the brief time you have left in this administration, we will work with the new administration.

Mr. VLADECK. We look forward to seeing your plan and working on it, sir.

Chairman THOMAS. We look forward to having you come as the people who are currently charged fiduciarily with running Medicare to put something specific on the table if you do not like what we have offered. That is the American way of doing business.

Mr. VLADECK. We look forward to that.

Chairman THOMAS. Thank you, very much.

Mr. HOUGHTON [presiding]. We would like our next panel to come forward. Susan Zagame, Dr. Wood, Mr. Van Etten, and Dr. Bennett.

All right, we have a little shift in chairmanship here on a temporary basis. I am delighted you are here. I am going to refer to you all as doctors, because I am not sure of Mr. Van Etten or Ms. Zagame are.

So, Dr. Zagame, would you please commence your testimony.

STATEMENT OF SUSAN K. ZAGAME, VICE PRESIDENT FOR PAYMENT AND HEALTH CARE DELIVERY, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Ms. ZAGAME. Thank you, very much, Mr. Chairman.

My name is Susan Zagame. I am not a doctor, I am a lawyer, however. And I am also the vice president for Payment and Health Care Delivery at HIMA, the Health Industry Manufacturers Association. HIMA also will be submitting additional written comments for the record on Medicare restructuring issues.

What I would like to address in my testimony today is, however, the importance of restoring Medicare coverage for items and services provided as part of a medical device clinical trial and urge passage of H.R. 1744, the Advanced Medical Device Access Assurance Act of 1995.

This legislation addresses questions that have been raised about Medicare coverage for medical device clinical trials by making it clear that HCFA has the authority to pay for this treatment. If enacted, this bill would help to ensure that Medicare patients have the same access to new technologies as all other patients and it is budget neutral.

At a time when there are so many important and complex challenges surrounding Medicare, not the least of which is proper restructuring, we appreciate the focused leadership and foresight that you and Chairman Thomas have brought to this issue. Both H.R. 1744 and its Senate companion, S. 955, enjoy remarkably broad bipartisan support. HIMA supports their immediate consideration and enactment.

Let me say briefly a word about who we are and who we represent. We are a Washington, DC, based national trade association representing more than 700 manufacturers of medical devices, diagnostic products, and health information systems. Our members manufacture more than 90 percent of the nearly $50 billion in annual domestic sales of health care technology products.

I would like to take a moment to dispel one of the prevalent myths about our industry which is that device manufacturers are mainly large corporations. In fact, the opposite is true. Of the 11,000 firms in the medical device industry, nearly 80 percent are smaller firms with annual revenues of less than $20 million who generally have fewer than 50 employees.

Much of the early stage research and development of medical technologies is conducted at thousands of small companies scattered across the country. Medical device innovation is an incremental process, typically involving numerous successive generations of product development each requiring clinical trials.

The cost of the device, itself, as well as the associated health care services can be substantial for an individual patient. Recognizing the unique economies of an industry of mostly small companies the Food and Drug Administration, by regulation, allows device manufacturers to recover manufacturing, research, development, and handling costs for investigational devices with an approved investigational device exemption known as an IDE.

I think this current practice to deny Medicare reimbursement for all investigational technologies has caused some of the Nation's top research centers to terminate studies using medical devices and is doing serious damage to this industry's competitiveness.

A very important study, released last month, conducted by the Wilkerson Group indicated that patients over 65 years of age are currently being denied access to new products and therapies because of HCFA's restrictive payment policy. And 71 companies that were surveyed reported that clinical trials had been suspended by hospitals due to Medicare's refusal to reimburse providers for care when investigational devices are used.

Of these companies, 40 percent reacted by limiting clinical trials to non-Medicare patients, thereby, depriving the elderly of access to the latest technologies; 59 percent moved projects or clinical trials overseas; 57 percent said they planned to move future trials overseas; and 67 percent of the cardiovascular companies that have had clinical trials suspended as a result of Medicare practices said they are moving research projects or clinical trials overseas as a result of these practices.

Mr. Chairman, I do have some more data in my testimony with regard to all of the very rigorous requirements that FDA imposes upon manufacturers as part of the process. I would like to point out the Medicare statute already gives HCFA the authority to pay for these types of devices and says only that there shall not be a reimbursement for services that are not reasonable or necessary.

It is out understanding that HCFA is exploring ways in which it can modify its practices. We believe that H.R. 1744 and S. 955 must be enacted so that there be no doubt, at all, that Congress intends HCFA to exercise its broad authority to pay for clinical trials.

As Gail Wilensky, Chair of the Physician Payment Review Commission stated, "This policy question requires only a relatively minor modification to fix Medicare payment practices."

In conclusion, we enthusiastically urge the enactment of H.R. 1744 during this session. It would restore access to important new and improved technologies for Medicare patients, would remove a significant barrier to the American medical device industry's ability to remain competitive.

HIMA, Mr. Chairman, respectfully requests that the Subcommittee recommend approval of this legislation.

Thank you, and I would be happy to answer any questions.

[The prepared statement follows:]

TESTIMONY BEFORE
THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

by

Susan K. Zagame
Vice President
Payment and Health Care Delivery
Health Industry Manufacturers Association

July 20, 1995

Mr. Chairman, my name is Susan K. Zagame, and I am Vice President, Payment and Health Care Delivery of the Health Industry Manufacturers Association (HIMA).

I am grateful for the opportunity to testify here today to reinforce the importance of restoring Medicare coverage for items and services provided as part of a medical device clinical trial and urge passage of your bill, H.R. 1744, the "Advanced Medical Device Access Assurance Act of 1995."

Your legislation addresses questions that have been raised about Medicare coverage for medical device clinical trials by making it clear that the Health Care Financing Administration (HCFA) has the authority to pay for this treatment. If enacted, your bill would help to ensure that Medicare patients have the same access to new technologies as all other patients. And it is budget neutral.

At a time when there are so many important and complex challenges surrounding Medicare, not the least of which is proper restructuring, we appreciate the focus, leadership, and foresight you have brought to this issue. Both H.R. 1744 and its Senate companion, S. 955, enjoy remarkably broad bipartisan support. HIMA supports their immediate consideration and enactment.

The Medical Technology Industry

Let me say a word about who we are and who we represent. HIMA is a Washington, D.C.-based national trade association representing more than 700 manufacturers of medical devices, diagnostic products, and health information systems. HIMA's members manufacture more than 90 percent of the nearly $50 billion in annual domestic sales of health care technology products.

I would like to dispel one of the prevalent myths about our industry, which is that device manufacturers are mainly large corporations. In fact, the opposite is true. Of the 11,000 firms in the medical device industry, nearly 80 percent are smaller firms with annual revenues of less than $20 million who generally have fewer than 50 employees. Much of the early stage research and development of medical technologies

is conducted at thousands of small companies scattered across the country.

Medical device innovation is an incremental process typically involving numerous successive generations of product development, each requiring clinical trials. The cost of the investigational device itself, as well as the associated health care services, can be substantial for an individual patient. Recognizing the unique economies of an industry of mostly small companies, the Food and Drug Administration (FDA), by regulation, allows device manufacturers to "recover manufacturing, research, development, and handling costs."

HCFA's current practice to deny Medicare reimbursement for all investigational technologies (i.e. devices that have received an Investigational Device Exemption (IDE) from the FDA) has caused some of the nation's top research centers to terminate studies using medical devices, thereby denying patients' access, and is doing serious damage to this industry's competitiveness.

A study released last month, conducted by The Wilkerson Group, Inc., indicated that patients over 65 years of age are currently being denied access to new products and therapies because of HCFA's restrictive payment policy.

- Seventy-one companies surveyed reported that clinical trials had been suspended by hospitals due to Medicare's refusal to reimburse providers for care when investigational devices are used. Of these companies:
  - Forty percent had reacted by limiting clinical trials to non-Medicare patients, thereby depriving the elderly of access to the latest technology.
  - Fifty-nine percent had moved projects or clinical trials overseas.
  - Fifty-seven percent said they plan to move future trials overseas.
  - Sixty-seven percent of the cardiovascular companies that have had clinical trials suspended as a result of Medicare practices said they are moving research projects or clinical trials overseas as a result of these practices, since they effectively exclude people 65 and over—a necessary patient population—from companies' FDA data gathering.

Clinical Trials

Patients participating in clinical trials authorized under the Federal Food, Drug and Cosmetic Act receive a very high level of care because human testing protocols require that patients be monitored more carefully and more frequently than those patients not involved in clinical trials. During the entire process from medical device design through preclinical laboratory testing to clinical testing in humans, the medical

device manufacturer, the clinical investigators who oversee the clinical trials, and the Institutional Review Boards (IRBs) are subject to numerous regulations and procedures to assure patient safety, such as:

- *Pre-clinical testing* - Prior to receiving IDE approval from the FDA, products must be rigorously tested in the laboratory. This draws the distinction between what is investigational versus what is truly experimental.

- *Facility controls* - Approved IDE products must be authorized by the hospital's IRB, which oversees the way in which the device is being used, with special attention paid to controls on patient safety and welfare.

- *Physician qualifications* - Only certain physicians are authorized to use products subject to an approved IDE and then are limited to specified protocols.

- *Informed consent* - Patients chosen to be diagnosed or treated with the investigational device must give their full consent to participate in a clinical trial.

All of these protections are in addition to Medicare's requirements that ensure that services are reasonable and necessary.

Medicare Coverage

HCFA already has the authority to pay for services provided as part of a medical device clinical trial. The Medicare statute simply states that no payment may be made under Parts A or B for any expenses for items or services that are not "reasonable and necessary" for the diagnosis or treatment of illness or injury. There is no statutory or regulatory language that impels HCFA to deny coverage, on a wholesale basis, for any procedure performed in any setting solely because an investigational device is used. In fact, HCFA traditionally paid for such services until June of 1994 when an HHS Office of Inspector General (OIG) investigation drew attention to the unclear policy.

Today HCFA denies payment for all services solely on the grounds that a device under an IDE was involved. Even if the patient, his or her physician, and the medical institution seek treatment with a device in a clinical trial, and all the appropriate FDA guidelines are followed, Medicare now flatly denies coverage without exception. Several major research institutions decided to stop participating in device clinical trials for Medicare patients with a few stopping trials for all patients as a result of this strict interpretation.

It is our understanding that HCFA is exploring ways in which it can modify its practice. HIMA believes that H.R. 1744 and S. 955 must be enacted so that there is no doubt that Congress intends HCFA to exercise its broad authority to pay for clinical

trials. As Gail Wilensky, chair of the Physician Payment Review Commission stated during its June 14 meeting, this policy question requires only a "relatively minor modification" to fix Medicare payment practices.

"The Medical Device Access Assurance Act of 1995"

In conclusion, we enthusiastically urge the enactment of H.R. 1744 during this session. It would restore access to important new and improved technologies for Medicare patients. It would remove a significant barrier to the American medical device industry's ability to remain competitive. Provider, patient, and industry groups all support your bill. In its ***1995 Annual Report to Congress***, PPRC recommended that Medicare should pay for FDA-approved clinical trials. It has been scored budget neutral by the Congressional Budget Office (CBO). It enjoys bipartisan cosponsorship in both the House and Senate.

The Health Industry Manufacturers Association supports H.R. 1744, Mr. Chairman, and respectfully requests that the Subcommittee recommend its approval. Thank you. I would be happy to answer any questions.

Mr. HOUGHTON. Thank you, very much, Ms. Zagame.
Dr. Wood.

STATEMENT OF DOUGLAS L. WOOD, D.O., PH.D., CHAIRMAN-ELECT, BOARD OF GOVERNORS, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Mr. WOOD. Thank you, Mr. Chairman.

Mr. Chairman, I would like to very briefly summarize my remarks and submit my full written statement for the record.

Mr. Chairman, and Members of the House Ways and Means Subcommittee on Health, my name is Douglas L. Wood, D.O., Ph.D., and I am chairman-elect of the Board of Governors of the American Association of Colleges of Osteopathic Medicine, which I will refer to as AACOM. And for the past 5 years I have been dean of the College of Osteopathic Medicine at Michigan State University.

On behalf of the 16 colleges of osteopathic medicine which are members of AACOM, I appreciate the opportunity to present our views regarding Medicare funding of graduate medical education which I will refer to as GME.

AACOM supports all congressional initiatives that both assure the provision of the best health care in a cost-effective delivery system, and that maintain the capacity to educate outstanding practitioners to provide these cost-effective services at a level of quality that the American public expects and deserves.

We recognize the responsibility of the Subcommittee to examine the Medicare Program and GME with an eye toward increasing fiscal responsibility. However, Congress must also develop a reasonable health care work force policy while achieving dollar savings. We believe the recommendations of AACOM are entirely consistent with these objectives and with the recommendations of the Council on Graduate Medical Education in its recently released seventh report.

GME funding, through Medicare, can be modified to produce significant savings to the Federal Government while enhancing the physician work force's capacity to meet the primary care needs of our citizens. Primary care has always been the centerpiece of osteopathic medical education. Indeed, more than 60 percent of osteopathic physicians practice in the primary care fields.

Similarly, AACOM member schools have a long history of dedication to training primary care physicians to work in America's smaller communities. Accordingly, AACOM believes that this Subcommittee and the Congress should consider the following recommendations.

First, we urge that graduate medical education providers be paid direct medical education or DME and indirect medical education, IME payments, for all residents who are graduates of U.S. medical schools.

In addition, DME and IME payments for international medical graduates should be gradually reduced to 25 percent of the 1994 levels.

Second, AACOM recommends that funding criteria should be modified in order to consider the participation of programs in consortia of educational programs. Osteopathic teaching hospitals, the typically smaller community-oriented facilities frequently joined

with colleges of osteopathic medicine to form consortia which we feel serve to increase the availability of graduate medical education for training in family medicine, internal medicine, and other specialties within the profession.

Third, primary care training payments should be upweighted to 125 percent to provide incentives for physicians to train as generalists and to lower the increasing costs of primary care training. Correspondingly, we feel that DME and IME should be downweighted to 75 percent for nongeneralists positions.

Fourth, the DME and IME components of the average adjusted per capita costs should be removed from Medicare capitation rates and these GME funds used specifically for GME purposes. Currently, a Medicare GME funds are factored into these payments which go to HMO contractors whether they have teaching programs or not.

Fifth, we recommend that direct medical education payments be made without reference to a base year.

And finally, the trend in many cases is to make increasing use of ambulatory care settings for teaching purposes.

So we would like to encourage ambulatory care training, and we would recommend that GME payments should be made for primary care resident's time spent in walk-in clinics, physician's offices, group practices, community health centers, and managed care facilities.

Mr. Chairman, AACOM believes that these recommendations would generate significant savings while targeting taxpayer funds to train primary care physicians in both hospital and nonhospital settings.

I thank you for your time, Mr. Chairman, and Members of the Subcommittee, and would be glad to answer any questions.

[The prepared statement and attachment follow:]

STATEMENT OF DOUGLAS L. WOOD, PH.D.
CHAIRMAN-ELECT, BOARD OF GOVERNORS
AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Mr. Chairman and Members of the House Ways and Means Subcommittee on Health, my name is Douglas L. Wood, D.O., Ph.D. and I am Chairman-Elect of the Board of Governors of the American Association of Colleges of Osteopathic Medicine (AACOM) and for the past five years, I have been Dean at Michigan State University College of Osteopathic Medicine. On behalf of the sixteen Colleges of Osteopathic Medicine that are members of AACOM, I would like to take this opportunity to present our views regarding Medicare funding of graduate medical education (GME).

AACOM supports all Congressional initiatives that both assure the provision of the best health care in a cost-effective delivery system and that maintain the capacity to educate outstanding practitioners to provide these cost-effective services at a level of quality that the American public expects and deserves. We recognize the responsibility of the Subcommittee to examine the Medicare program and GME with an eye toward increasing fiscal responsibility while maintaining their effectiveness in meeting the health care needs of all Americans. Congress needs to be concerned about developing a reasonable health care workforce policy and at the same time achieving dollar savings. Mr. Chairman, policies affecting health care delivery and payment should reflect the unique characteristics of osteopathic teaching health care facilities and physicians so that their fundamental mission can be preserved. We believe that our recommendations are entirely consistent with these objectives, and with the recommendations of the Council on Graduate Medical Education (COGME) in its recently released Seventh Report.

GME funding through Medicare can be modified to produce significant savings to the federal government while enhancing the physician workforce's capacity to meet the primary care needs of our citizens. Primary care has always been the centerpiece of osteopathic medical education. Indeed more than 60% of osteopathic physicians practice in primary care fields. Similarly, AACOM member schools have a long history of dedication to training primary care physicians to work in America's smaller communities. Throughout the continuum of an osteopathic medical student's education, both undergraduate and graduate, the principles of osteopathic medical practice and primary care are imparted and reinforced. Accordingly, AACOM believes that this Subcommittee and the Congress should seriously consider the following recommendations:

First, consistent with the Council on Graduate Medical Education's (COGME) recommendation, we urge that graduate medical education providers be paid Direct Medical Education (DME) and Indirect Medical Education (IME) payments for all residents who are graduates of U.S. medical schools. In addition, DME and IME payments for International Medical Graduates should be gradually reduced to 25% of the 1994 levels. We are aware that the quality of American medicine is such to attract physicians from other countries to learn and disseminate our practices. However, public support for such training should be separated and distinctly recognized as part of our country's humanitarian commitment to other nations, and support for graduate medical positions for IMGs should not be at the expense of U.S. medical school graduates (D.O. or M.D.).

Second, AACOM recommends that funding criteria should be modified in order to consider the participation of programs in consortia of educational programs. Osteopathic teaching hospitals are typically smaller, community-oriented facilities frequently joined with colleges of osteopathic medicine to form consortia which serve to increase the availability of graduate medical education for training in family medicine, internal medicine and other specialties within the profession. We believe that the formula for reimbursement should be revised to recognize these consortia and fund them accordingly.

Third, primary care training payments should be upweighted to 125% to provide incentives for physicians to train as generalists and to lower the increased cost of primary care training. Correspondingly, DME and IME should be downweighted to 75% for non-generalist positions. Primary care physicians provide services that most effectively meet the public's needs generally and Medicare beneficiaries' needs specifically. Both generalist and non-generalist positions should be downweighted at 50% for DME and IME after the lesser of five years or initial board certification. The net effect of these changes should be significant savings in GME expenditures.

Fourth, the DME and IME components of the Average Adjusted Per Capita Cost (AAPCC) should be removed from Medicare capitation rates and these GME funds used specifically for GME purposes. Currently, Medicare GME funds are factored into AAPCC payments which go to HMO contractors whether they have teaching programs or not.

Fifth, we recommend that Direct Medical Education payments be made without reference to a base year. The DME base year of 1984 is becoming increasingly outdated and inappropriate especially for osteopathic graduate medical education programs. There is great variation of DME payments around the country. Osteopathic medicine has traditionally been at the lower end of that curve and allopathic medicine had been at the upper end. In 1984, osteopathic graduate medical training sites utilized large numbers of volunteer educators. That number has decreased significantly in the last eleven years with many volunteers being replaced by paid faculty. Accordingly, costs associated with osteopathic GME have risen. We, therefore, suggest that in place of the base year formula per resident amounts be based on an adjusted national average of per resident costs.

Finally, the trend in many cases is to make increasing use of ambulatory care settings for teaching purposes. While all specialities could benefit from education in ambulatory settings, it is critical for the primary care disciplines, namely, family medicine, general internal medicine and pediatrics that reimbursements for this training be increased to recognize the higher cost of ambulatory education. To encourage ambulatory care training, GME payments should be made for primary care physicians' resident time spent in walk-in clinics, physicians' offices, group practices, community health centers, and managed care facilities.

We also recommend that special reimbursement be provided to clinical settings which are used for the education of undergraduate medical students. Osteopathic medical schools have relied heavily on the use of volunteer primary care practitioners to provide community-based ambulatory training experiences for our students although, as indicated above, the numbers of these volunteers have dropped. This emphasis on community-based, ambulatory clinical education has played a major role in maintaining our students' interests and competencies in primary care. The dedication of our volunteer primary care faculty preceptors to the osteopathic medical education process will be in danger of contracting even further as health care reform encourages practitioners to enter the managed care sector.

Health maintenance organizations and similar managed care arrangements have not shown a great interest in undergraduate medical education because it would reduce the number of patients that a preceptor could see during a working day. Ironically, just as the nation has begun to recognize the value of community-based medical education (which has always been at the heart of osteopathic medical education), the economic forces generated by reform may be a barrier to community-based participation in undergraduate medical education. As more and more attention is paid to the "bottom line," colleges will be forced to utilize hospitals and tertiary care centers for almost all of their clinical education, losing the benefits of ambulatory training; or, the costs of that education would substantially increase as a significant number of primary care preceptors drop out of the volunteer faculty network.

With the above concerns in mind, AACOM recommends that special funding be established for undergraduate training in ambulatory care settings when the GME reimbursement formulas are restructured: For example, creation of an all-payor pool for training programs that foster primary care.

Mr. Chairman, AACOM believes that these recommendations will generate significant savings while targeting taxpayer funds to train primary care physicians in both hospital and non-hospital settings. Thank you for your consideration and AACOM looks forward to working with the Subcommittee to achieve these objectives.

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Chicago College of Osteopathic Medicine of Midwestern University
555 31st Street, Downers Grove, Illinois 60515-1235

College of Osteopathic Medicine of the Pacific
College Plaza, Pomona, California 91766-1889

Kirksville College of Osteopathic Medicine
800 West Jefferson Street, Kirksville, Missouri 63501

Lake Erie College of Osteopathic Medicine
1858 West Grandview Boulevard, Erie, Pennsylvania 16509

Michigan State University College of Osteopathic Medicine
East Fee Hall, East Lansing, Michigan 48824

New York College of Osteopathic Medicine of the New York Institute of Technology
Wheatley Road, Box 170, Old Westbury, New York 11568

Nova Southeastern University College of Osteopathic Medicine
1750 N.E. 167th Street, North Miami Beach, Florida 33162-3097

Ohio University College of Osteopathic Medicine
Grosvenor and Irvine Halls, Athens, Ohio 45701

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1111 West 17th Street, Tulsa, Oklahoma 74107

Philadelphia College of Osteopathic Medicine
4170 City Avenue, Philadelphia, Pennsylvania 19131

The University of Health Sciences College of Osteopathic Medicine
2105 Independence Boulevard, Kansas City, Missouri 64124

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One Medical Center Drive, Suite 312, Stratford, New Jersey 08084

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11 Hills Beach Road, Biddeford, Maine 04005

University of North Texas Health Science Center at Fort Worth
Texas College of Osteopathic Medicine
3500 Camp Bowie Boulevard, Fort Worth, Texas 76107

University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery
3200 Grand Avenue, Des Moines, Iowa 50312

West Virginia School of Osteopathic Medicine
400 North Lee Street, Lewisburg, West Virginia 24901

Mr. HOUGHTON. Thank you, very much, Dr. Wood.

We are going to have a vote here, so we are going to have Mr. Van Etten go ahead and we might even be able to squeeze Dr. Bennett in and then we will have the vote and come on back.

Go right ahead, Mr. Van Etten.

STATEMENT OF PETER W. VAN ETTEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, STANFORD HEALTH SERVICES, STANFORD, CALIFORNIA; ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. VAN ETTEN. Good morning, Mr. Chairman.

I am Peter Van Etten, president and chief executive officer of Stanford University Hospital. While I am here today representing all of the Nation's medical schools and their associated teaching hospitals, I would like to focus my initial remarks on the situation faced by Stanford in Northern California.

In the two counties adjacent to Stanford, nearly all of the employed population and 40 percent of Medicare recipients belong to managed care plans. The result has been beneficial to employers who pay for health insurance. However, it has been catastrophic for doctors and hospitals and, as a result, the jury is out as to what the long-term effect will be upon the general population.

Most hospitals in the bay area are losing money, including the two regional teaching hospitals, UCSF and Stanford. Stanford's annual profitability has declined by $40 million in the last few years, despite increased admissions and $80 million of cost reductions due to declining prices.

Now, I fear that the same economic forces that resulted in payment well below our cost for HMOs, for employed managed care patients, will be used to reduce Medicare patients. I have the following concerns regarding these proposals.

First, several recent studies have concluded that under present payment methodologies it costs the government around 5 percent more for the 9 percent of the Medicare population enrolled in HMOs than it would if these recipients were enrolled in traditional Medicare Programs. This problem is due to adverse selection. Five percent of the Medicare population uses 50 percent of the Medicare resources; 10 percent utilizes 70 percent. To put it another way, the 10-percent lowest cost Medicare recipients have average costs to Medicare of $1,300 a year. The 10-percent highest cost recipients have average costs of $28,000 a year.

Is it any wonder that HMOs have signed up healthy recipients rather than those with acute illnesses? Teaching hospitals are particularly exposed to adverse selection since they are the institutions of last resort. I believe that much more work needs to be done designing adequate risk adjustment mechanisms so that Medicare managed care can be implemented in the manner that results in savings to the government and fair payment to providers.

My second concern is that during the last few years, there has been a massive redistribution of money in California from doctors and hospitals to HMOs, most of which are for-profit, publicly traded, billion dollar corporations. Last December the Wall Street Journal ran an article entitled "HMOs Pile Up Billions in Cash, Try To Decide What To Do With It."

Whereas Medicare administrative costs are approximately 2 percent of total costs, the five largest publicly traded HMOs have administrative costs including profits of 22 percent. Would it be appropriate for public moneys now paid for nurses and other care givers to be directed to Wall Street investors?

My third concern is that I am particularly concerned with the present AAPCC methodology used to pay HMOs who enroll Medicare recipients. This rate includes all Medicare expenditures in the county, including DME, IME, and disproportionate share payments. However, there is no assurance that the teaching hospitals, which originally earned these payments will receive them. In fact, none of the HMOs which we deal with have offered to pay their share of DME, IME, or disproportionate share payments.

If all of Stanford's Medicare recipients sign up for a Medicare HMO tomorrow, under present methodologies, Stanford would lose $40 million of revenue.

We believe these payments should be excluded from the AAPCC and paid directly to teaching hospitals. Our written testimony explains how we would do this. This is an urgent matter for teaching hospitals. The longer we wait to correct this problem, the harder it will be to remove these dollars from the rate.

Compounding this problem are present discussions to reduce Medicare spending cuts in the level of payment for both the direct and indirect costs associated with graduate medical education. The particulars about how to do so involve issues that could undermine the viability of the Nation's health care. These decisions, including decisions about IME and DME payments, must be informed, fair, and should not be disproportionate.

Further, what I have discussed demonstrates the need to move to a system of shared responsibility for costs related to the unique missions of academic medicine. I would like to make one last point about the fragile nature of medical school financing. Revenue from clinical faculty practice plans accounts for one-third of total revenue school revenues. As the environment becomes more competitive, less money will be available from the faculty practice plan to support educational and research efforts.

You may have seen the July 21 issue of U.S. News and World Report which lists America's best hospitals. Of the 128 hospitals listed, virtually all are teaching hospitals. Academic medical centers are ready, willing, and able to do their fair share. However, changes in Medicare payments will substantially affect the ability of teaching hospitals to fulfill their traditional missions.

We urge caution as you consider Medicare reform and the program's level of spending.

I would be happy to answer your questions.

[The prepared statement and attachment follow:]

STATEMENT OF PETER W. VAN ETTEN
PRESIDENT AND CHIEF EXECUTIVE OFFICER
STANFORD HEALTH SERVICES

Mr. Chairman and members of the Committee, I am Peter W. Van Etten, President and CEO of Stanford Health Services in Stanford, California. The AAMC welcomes the opportunity to testify on the importance of Medicare payments to teaching hospitals and their associated medical schools and faculty in providing the best medical care in the world. The Association represents all of the nation's 125 accredited medical schools, approximately 300 major teaching hospitals that participate in the Medicare program, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents.

The health care delivery system is evolving as both public and private payers struggle to control health care expenditures, and academic medicine is prepared and willing to meet the delivery system's new imperatives. Teaching hospitals, medical schools and faculty practice plans have recognized the need for change within their own organizations and are actively engaged in reformulating the health delivery system, finding ways to reduce the rate of increase in health care costs, improving accountability, and enhancing the quality of care.

Academic medicine is adapting to a market-driven health care delivery system, but is concerned about proposals that would jeopardize its ability to fulfill its core missions. There are three fundamental principles which the AAMC believes should guide changes in the delivery system and the Medicare program:

1. The AAMC believes in a "shared responsibility" approach to financing the special missions of academic medicine. All payers should recognize and pay for the costs associated with these missions. Teaching hospitals and their associated medical schools and faculty are important components of the health care system because they:

- provide all levels of patient care--from preventive to tertiary services--often to the most disadvantaged members of our society;
- ensure the availability of trained health care providers, including physicians, nurses and allied health professionals, by serving as principal sites for clinical education; and
- provide the environment for the conduct of clinical and behavioral research and the introduction of new technologies.

The costs of these additional missions traditionally have been supported by patient care revenues from public and private payers. For example, patient service revenues have supported medical education and research, and payments from paying patients have supported charity care patients.

The AAMC believes that the ability of teaching hospitals and teaching physicians to fund their mission-related costs through charges to patients is eroding. In a price-conscious delivery system, private payers of patient care services increasingly limit their payments to only those specific services that their enrollees receive. Teaching hospitals cannot require or receive higher prices for their services. Additionally, some state Medicaid programs, which traditionally have recognized costs associated with the academic missions, are retreating from the inclusion of explicit payments for these missions in their financing structures.

At a time when it is most needed, the AAMC regrets that the possibility of establishing all-payer funds for the special missions of teaching hospitals and medical schools appears to have diminished. However, the Association continues to emphasize the fundamental importance of the principle that all payers of patient care services must support the training of the work force as well as providing an environment in which education and clinical research can flourish.

2. The AAMC believes that teaching hospitals and teaching physicians should not bear more than their "fair share" of reductions in the rate of projected Medicare spending. Teaching hospitals rely heavily on the two Medicare payments with an educational label: the direct graduate medical education (DGME) payment and the indirect medical education (IME) adjustment. In the absence of a marketplace where all insurers or sponsors of patient care programs share responsibility for supporting the academic missions, these historical, explicit payments to teaching hospitals take on added importance.

The AAMC recognizes that unrestrained growth in Medicare spending threatens the long-term solvency of the Federal Hospital Insurance (HI) Trust Fund, and supports reforms to align trust fund income and outlays. But any reductions proposed for DGME and IME payments are real cuts for teaching hospitals. These proposed reductions, coupled with private sector losses, reductions in Medicaid spending and other cuts in projected Medicare payments, will force teaching hospitals to bear an unfair burden of Medicare payment reductions, making it more difficult for them to sustain their additional missions.

3. Any changes in Medicare payment policy should be implemented gradually with an annual evaluation of their impact on the financial viability of different groups of hospitals. The AAMC believes that Congressional decisions on Medicare payment policies should be made in the context of their impact on the entire health care system. Nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) account for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges. For many COTH member hospitals, Medicare payments comprise from one-quarter to one-third of all their revenue. Clearly, changes in Medicare payments will have a profound impact on these institutions.

As the Congress turns its attention from the overall level of federal spending, the particulars about which programs and payments to reduce become difficult. These decisions, including those about Medicare support for graduate medical education and for the higher costs incurred by teaching hospitals in fulfillment of their special missions, must be informed and fair, and based on objective analyses of the impact of various options on Medicare beneficiaries and other patients and on the financial viability of health care providers.

I urge the members of this Committee to consider carefully its Medicare payment policy recommendations. Teaching hospitals and teaching physicians play critical roles in our health care delivery system. They could be damaged severely unless changes are crafted carefully and are based on an extensive understanding of the education and service missions of academic medicine. Massive reductions in Medicare payments for activities related to graduate medical education will negatively affect these institutions' continued excellence and touch every American's life.

Today, I would like to comment specifically on four issues of significance to academic medicine: 1) the role of Medicare payments for DGME costs in support of residency training; 2) the importance of the Medicare IME adjustment to the financial viability of teaching hospitals; 3) the methodology for calculating the adjusted average per capita cost (AAPCC), the rate that the Medicare program pays to risk contractors; and 4) the importance of clinical practice income as a source of financial support for the nation's medical schools.

While many understand the importance of DGME and IME payments to teaching hospitals, failure to address the way in which they and the disproportionate share (DSH) payment are incorporated in the AAPCC rate poses a threat to the financial viability of teaching hospitals. Finally, it should be understood how changes in the delivery system threaten the ability of the clinical faculty to make their traditional contribution to medical schools in support of the schools' education and research activities.

Direct Graduate Medical Education Payments

In addition to providing health care, teaching hospitals provide the resources for the clinical education of physicians, nurses, and allied health personnel. To provide this formal, experientially-based clinical training, hospitals incur costs beyond those necessary for patient care. These added direct costs include: salaries and fringe benefits for trainees and the faculty who supervise them; classroom space; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

The Purpose and History of the Medicare Direct Graduate Medical Education Payment

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (House Report, Number 213. 89th Congress. 1st Sess. 32 (1965) and Senate Report. Number 404. Pt. 1. 89th Congress. 1st Sess. 36 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals. If there was ever an assumption that the "community" would take responsibility for its share of these costs, it certainly is not occurring in the current competitive environment.

Until the mid 1980s, Medicare paid for its share of DGME costs based on the hospital's historical and reasonable costs as determined by an audit. Reimbursement was open-ended in that a portion of "reasonable and allowable" DGME costs incurred every year was "passed through" to the Medicare program. DGME payments also were open-ended because there was no restriction on the number of years that Medicare reimbursement would financially support a resident's training.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-72), which dramatically altered the DGME payment methodology from one based on annual historical DGME costs to a prospective per resident amount. The Medicare program now pays its proportionate share of a hospital-specific per resident amount based on audited costs from a base year and updated for inflation rather than on the basis of DGME costs actually incurred. Today, a hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital. Other legislative and regulatory changes have been made since COBRA, but the basic methodology for calculating the DGME payment remains the same.

In addition to changing the payment methodology, COBRA placed limits on the number of resident trainee years for which full Medicare payment would apply. In a subsequent change, Congress chose to restrict full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. Payments for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent. The five-year count is suspended, however, for a period of up to two years for training in a geriatric or preventive medicine residency or fellowship program.

The change in DGME payment methodology required by COBRA, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits DGME payments, it still acknowledges the historical scope of direct graduate medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Proposals to Change Medicare Payments for DGME Costs

Nearly ten years after COBRA's passage, policy makers again are examining proposals to reform Medicare DGME payments. Many of these proposals are intended to limit the growth in Medicare expenditures. Several seek to achieve a more appropriately configured physician work force by shifting the balance of generalist and nongeneralist physicians, or placing limits on the total number of physicians-in training. Among the more frequently mentioned proposals that seem to have captured the attention of some policy makers are:

- facilitating the development of non-hospital-based ambulatory training by allowing entities other than hospitals to receive Medicare DGME payments and by encouraging the formation of graduate medical education consortia;
- limiting payments to the period required for initial board certification;
- limiting payments only to graduates of U.S. medical and osteopathic schools;
- weighting Medicare payments by specialty to encourage training in the generalist specialties; and
- constructing a national average per resident payment methodology to reduce the variation in hospital-specific per resident

payments.

Each of these proposals and its potential impact on graduate medical education is discussed below:

Facilitating the development of non-hospital-based ambulatory training sites. The AAMC supports changes in Medicare DGME funding to encourage residency training in non-hospital, ambulatory sites, such as private physicians' offices, freestanding clinics, or nursing homes.

Entities Eligible for Medicare DGME Payments. Training sites chosen by residency program directors should be selected because they offer appropriate educational experiences, not because they are more easily funded. However, the law regarding Medicare DGME payments explicitly states that DGME payments may be made only to hospitals. On the other hand, the law and implementing regulations allow hospitals to receive DGME payments for the training of residents in non-hospital, ambulatory settings (subject to certain requirements). Although an ambulatory site may not at present receive a Medicare payment directly for any DGME costs it might incur, nothing in the law prevents it from negotiating for a payment from a hospital for the residents that the non-hospital site accepts.

The Association believes that Medicare DGME payments should be made to the entity that incurs the cost. Recipients of payments could be teaching hospitals, medical schools, multi-specialty group practices or organizations, such as graduate medical education (GME) consortia, that incur training costs. Funding for graduate medical education should support residents and programs in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the residents. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization in which the program functions must determine the institutional commitment to graduate medical education.

Formation of GME Consortia. The AAMC strongly encourages the formation of GME consortia. Local or regional educational consortia have been advanced as mechanisms for enhancing the quality of medical education, especially graduate medical education, while at the same time better aligning the physician work force with the needs of the newly emerging health care system. GME consortia are defined as formal partnerships, involving two or more separate institutions involved in graduate medical education, formed to reorganize or strengthen medical education and characterized by shared and joint decision making.

In 1993, the AAMC and the Maine Medical Center jointly conducted a national survey to determine the number, composition and accomplishments of existing GME consortia. These findings were subsequently published, and led to another research effort. At present, the AAMC, in conjunction with the Center for the Health Professions at the University of California, San Francisco, is conducting an in-depth study of GME consortia.

The AAMC urges Congress to consider modifying the statutory requirement that only hospitals may receive Medicare DGME payments and to permit other entities to receive payments if they incur the cost of training. A payment methodology would have to be developed based on the costs of training at those sites. To explore the issues inherent in such a change, the AAMC supports the interest of the Health Care Financing Administration (HCFA) in designing a research and demonstration project to encourage the development of new integrated training sites and/or GME consortia. Under such a project, HCFA could experiment and monitor the impact of allowing non-hospital sites to receive DGME payments if they run the training programs and incur the costs.

Limiting Payments to the Period Required for Initial Board Certification. Currently the Medicare program restricts full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. The five year count is suspended, however, for a period of up to two years for training in a geriatric or preventive medicine residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent. The Medicare program then continues to support residents at the 50 percent level indefinitely, as long as they remain in a training program approved by the ACGME, the AOA, or in a specialty for which a member organization of the American Board of Medical Specialties (ABMS) issues a certificate.

Several policy makers have proposed imposing additional limits on the length of time for which the Medicare program should provide its support. Some have suggested that Medicare should pay only through the period required for initial board certification in a specialty or pay only for a three-year period, regardless of the specialty.

The AAMC believes that support through initial board eligibility is an essential minimum training period that every patient service payer should help finance. Medicine involves a number of different specialties, and each specialty area has developed its own residency training period. The initial skills and techniques needed by different specialties require different lengths of training. The AAMC believes that the variable length of training for each specialty area is appropriate and in the national interest, but recognizes that Medicare payment policies must be balanced.

Table A, derived from the AAMC's DGME microsimulation payment model, shows the financial impact of limiting Medicare support to the period required for initial board certification on all teaching hospitals. The financial impact would reduce significantly the viability of many training programs. If this policy were implemented for Federal FY 1996, DGME payments would decrease $342 million, or 19 percent, compared to what Medicare would expect to pay next year under current policy. Those groups experiencing the greatest average losses would be integrated academic medical center hospitals, hospitals with intern and resident-to-bed ratios greater than 0.40, and major teaching hospitals that receive DSH payments. (An integrated academic medical center hospital is either under common ownership with a college of medicine, or has the department chairmen at the school also serving as the chiefs of service at the hospital.)

Another often-discussed policy option would limit Medicare support for graduate medical education to three years. The AAMC believes that limits on support should not be arbitrary or inconsistent with adequate minimal residency training. In its March 1993 report to the Congress, the Physician Payment Review Commission (PPRC) also "rejected as unwise the options of paying only for primary care positions or only for the first three years of training" (page 66). The commission concluded that the nation would continue to require well-trained physicians in all specialties, and that such a policy would not be "sufficiently flexible" if changes in the health needs of the population called for physicians in specialties that required more than three years of training.

Limiting Payments Only to Graduates of U.S. Medical and Osteopathic Schools. The Medicare program currently sets no limit on the number of residents it will support. Additionally, Medicare provides support for medical school graduates regardless of whether they are graduates of U.S. or foreign medical schools. International medical graduates (IMGs), or those U.S. citizens or nationals of other countries who have graduated from overseas medical schools must, however, pass Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) and be in an approved training program.

Some policy makers have called for an examination of national policy on IMGs in light of a growing consensus that U.S. medical and osteopathic schools have sufficient capacity to train an adequate number of physicians for the nation. They also have questioned whether it is appropriate to use public funds, including Medicare payments, to support the large number of foreign-trained physicians entering residency programs in the U.S. when many agree that there is an oversupply of physicians. These policy makers point out that the majority of IMGs who participate in graduate medical education ultimately enter practice in the U.S., adding to the projected oversupply of physicians and aggregate health care costs.

Data show that in the past few years, the number of physicians-in-training has continued to increase. While the number of graduates of U.S. allopathic medical schools has remained relatively stable for several years, the number of international medical graduates (IMGs) receiving training in this country has increased substantially. Between 1988 and 1993, the number of IMGs in graduate medical education nearly doubled from approximately 12,000 to nearly 23,000. In 1993-94, nearly 27 percent of all first-year residency training slots in allopathic and osteopathic programs were filled by IMGs.

In response to concerns regarding overall physician supply, on June 22, 1995, the AAMC Executive Council adopted a policy position on the physician work force and the participation of IMGs in graduate medical education:

> That the Association of American Medical Colleges, in recognition of the growing oversupply of physicians in the United States, pursue and undertake initiatives to address the future supply of physicians consonant with legal restrictions and requirements. While the Association should consider all available options for addressing this oversupply, it should--first and foremost--pursue options to diminish the number of international medical graduates pursuing graduate medical education in the United States and remaining in the United States following the completion of their graduate training. Any options supported by the Association that would result in constraints on the number of international medical graduates receiving training must include mechanisms to mitigate the impact on hospitals that currently train IMGs and those hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for IMGs would cause substantial access and service problems for Medicare beneficiaries. One of the issues that policy makers would need to address in enacting such a change would be the implementation of a process and a time table so that patient access to services would not be reduced precipitously. Additionally, mechanisms would be needed to mitigate the impact on hospitals that currently train IMGs and on hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

Table B demonstrates the significant financial impact on teaching hospitals in FY 1996 if Medicare payments were limited only to graduates of U.S. allopathic and osteopathic medical schools. Medicare DGME payments would decrease $374 million, or 21 percent, compared to what the Medicare program would expect to pay in 1996 under current payment rules. The greatest average losses would be for hospitals with 50 to 100 residents; resident-to-bed ratios between .10 and .40; major teaching hospitals with no DSH payments; other teaching hospitals that receive DSH payments; and hospitals in the Middle Atlantic states.

A variation of this proposal offered by some policy makers would limit Medicare DGME payments to a defined number of residents. One option could be to freeze the number of full-time equivalent (FTE) residents that the Medicare program would support at the current number of residents in the training system. A more aggressive option that has been suggested might be to impose an aggregate limit on the total number of positions, e.g., the number of U.S. graduates plus some add-on percentage for IMGs. It should be understood that these proposals could require the establishment of control or regulatory mechanisms.

Weighting Payments by Specialty. For several years, some policy makers have proposed changes in Medicare payments for DGME costs to provide incentives for training generalist physicians and to eliminate the variation in hospital-specific per resident amounts. Additionally, these proposals could reduce the Medicare program's role in GME funding.

Weighting proposals would attempt to accomplish these policy goals by paying relatively favorable amounts for generalist residencies, and substantially less favorable payment amounts for all other residencies. For example, Medicare DGME payments could be based on a per resident amount that would then be weighted based on the specialty area that a resident is pursuing. The Medicare program would make a higher payment for a resident in a generalist specialty than for a non-generalist resident. Thus, a hospital's total DGME payment would be based not on its costs, but on the specialty mix of its trainees.

Current Medicare payment policy includes modest differential payments for residents in generalist specialties. OBRA 1993 (P.L. 103-66) created separate hospital-specific payment rates for generalist and nongeneralist residents. In FY 1994 and 1995, only hospitals' per resident payments for residents in generalist disciplines were updated by the annual inflation factor. Per resident payment levels for all other residents were frozen.

The Association did not oppose the change adopted in OBRA 1993 and strongly supports more individuals entering generalist practice. However, the AAMC does not believe that more intensive weighting of DGME payments by specialty would achieve its intended objective.

The Association recognizes that the present system has not produced the number of generalist physicians that society may need in a reconfigured health care system. An Association policy adopted three years ago calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The AAMC's policy rests on the implementation of voluntary, private sector initiatives. Personal incentives such as loan forgiveness, tax benefits, and other inducements to narrow the income gap between generalist and non-generalist physicians, are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. There are already a variety of federally-sponsored student loan repayment programs that could be bolstered. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs.

The nation's medical schools have implemented programs to increase the awareness and attractiveness of generalist medicine. More schools are adding required clerkships in one of the generalist disciplines during the third- and fourth-year of the curriculum. Schools have convened primary care task forces, appointed new Associate Deans for Primary Care, and developed new departments of family medicine and divisions of general internal medicine and general pediatrics.

The AAMC is pleased that medical schools' efforts are bearing fruit as medical students' interest in generalist practice continues to increase. Although data on medical students' career choice from as recently as the graduating class of 1989 showed a declining selection of the generalist specialties, more recent data signal that medical school graduates continue to respond to changes in the health care environment. In 1994, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased again. Of graduating medical students, 22.8 percent indicated an intent to choose a generalist career in 1994 compared to 14.6 percent in 1992 and 19.3 percent in 1993. In addition, results from the National Residency Matching Program (NRMP), released on March 15, 1995, showed that medical students "matched" into family medicine residency programs at the highest rate in the NRMP's 43-year history. Over 2,000 graduating seniors from U.S. medical schools, or 15.4 percent of those seeking first-year residency positions, matched into a family medicine residency. This compares to 14.0 percent of all U.S. seniors in 1994.

Additionally, data on career choices of medical school graduates indicate that medical students' selection of residency training programs is affected not by Medicare payments to hospitals, but by market conditions and personal suitability to a particular specialty. At present, there are more generalist training positions offered than there are interested students to fill them. In March 1993, the PPRC concluded that weighting DGME payments to hospitals is undesirable. The commission indicated that there was already a sufficient number of existing generalist training slots, and weighting would have little influence on hospital management's and residency program directors' decision making.

While proponents of preferential weighting proposals indicate that a higher payment differential would be enacted only for generalist disciplines, it is likely that many clinical specialties would argue that they also deserve a "special weighting factor." It is unclear what criteria would be used to define a "primary care" program. The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal in 1991, and that physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

The AAMC supports strategies to develop the generalist physician work force. Strong residency programs require continuity of effort and stable support, but proposals to weight Medicare DGME payments based on specialty, if enacted, would only contribute to the instability of GME funding.

Constructing a National Average Payment Amount for DGME Costs. Last year, during the debate over comprehensive health care reform, some policy makers recommended the development of a national average per resident payment methodology with payment adjustments for regional differences in wages and/or wage-related costs. In some instances, the proposals excluded certain types of costs, such as direct overhead costs or allocated institutional overhead costs. These changes were suggested in the context of a package of proposals for graduate medical education reform, including an all-payer funding mechanism that was to be separate from payments for patient care services.

The AAMC supports the continuation of the current Medicare hospital-specific per resident payment method because it recognizes structural factors that legitimately affect a hospital's per resident costs. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne variably by the medical school or teaching hospital. The diversity of support for the costs of faculty who supervise residents is probably the most important reason for the variation in Medicare per resident amounts. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Wide variation in per resident amounts exists among hospitals in the availability and amount of support from non-hospital sources, including public subsidies and faculty practice earnings. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While some proposals would adjust the Medicare national average per resident payment for differences in wages and other wage-related costs, these other structural factors would not be reflected in the national average payment methodology, creating inappropriate winners and losers.

Last year, at its January 1994 meeting, the Prospective Payment Assessment Commission (ProPAC) discussed recommendations on graduate medical education financing for its March 1994 report. Reviewing a staff analysis of graduate medical education costs and payments, the Commissioners noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Altman, Ph.D., cautioned those who would prefer a national average payment methodology for DGME costs without incorporating a number of payment adjustments. Citing the commission's eleven-year experience with the prospective payment system (PPS)--the first attempt by the federal government to standardize payments based on national averages--Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's analysis of graduate medical education costs found significant relationships between per resident costs and hospital size; its share of full-time equivalent residents in the outpatient setting; its share of costs related to faculty physicians' salaries; geographic region; location in a metropolitan statistical area; and area wages.

The AAMC also supports the current methodology because it recognizes all types of costs, including salaries and fringe benefits of the faculty who supervise the residents; direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for maintenance and utilities. The AAMC opposes proposals to exclude certain types of DGME costs, such as faculty supervision costs or direct or allocated institutional overhead costs, from the calculation of the Medicare per resident amount. The current method recognizes the diversity in how graduate medical education is organized and financed. Further, ample faculty supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing patterns of practice. Graduate medical

education in all specialties is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

The AAMC believes that, within certain policy parameters, the Congress should consider changes that would ensure equitable, economically justified Medicare DGME payments among training sites, including non-hospital and ambulatory settings. The AAMC believes that the payment system should recognize the significant diversity across institutions that participate in graduate medical education. Graduate medical education rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and are based on an extensive understanding of both the nature of the teaching hospitals and other settings in which it is conducted and the nature of graduate medical education itself.

Indirect Medical Education (IME) Adjustment

Since the inception of the Medicare PPS in 1983, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment. The IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals.

The Purpose of the IME Adjustment

While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the Senate Finance and the House Ways and Means Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The IME adjustment is not to be confused with the Medicare payment for DGME costs. Payments for Medicare's share of the direct costs of graduate medical education programs are separate from the PPS and serve a different purpose.

The Importance of IME Payments to Teaching Hospitals

As the Congress contemplates adjustments in the annual growth rate of the Medicare program, payments for hospital services are principal targets and changes in payment policy naturally affect not only the total amount but the distribution of payments. PPS operating costs represent the largest single source of payment for the Medicare program. In FY 1995, Medicare payments for hospital services are expected to total $105.7 billion, with the largest portion of the total, $66.5 billion or 63 percent, attributable to PPS operating payments. PPS operating payments include the basic Diagnosis-Related Group (DRG) payment, and, if warranted, payments for outliers, IME and DSH. IME payments, expected to be about $3.9 billion in 1995, represent 3.7 percent of all Medicare payments to hospitals and 5.9 percent of all PPS operating payments. DSH payments are expected to account for 3.6 percent of all Medicare payments to hospitals, and 5.7 percent of total PPS operating payments, or about $3.8 billion.

Proposals to slow the growth in PPS operating payments have centered on three specific elements: the annual increase in the basic PPS price for all hospitals, called the update factor, and two add-on payments, the IME and DSH adjustments. All hospitals' Medicare payments are affected by changes in the update factor, but only certain types of hospitals experience the effect of changes in IME and DSH payment policy. While teaching hospitals recognize the need to control Medicare expenditures to protect the long-term solvency of the program, these institutions would be affected not only by IME reductions, but also by reductions in the update factor and DSH payments. At the levels being proposed by some policy makers, these would be real cuts in payments that would endanger the ability of teaching hospitals to fulfill their core missions of patient care, education and research.

The Financial Viability of Teaching Hospitals. Since the inception of the PPS, the IME adjustment has been reduced twice from its original level of 11.59 percent. In recent years, however, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care for all Americans.

Historically, teaching hospitals have had higher PPS inpatient operating margins--the excess or loss of revenue attributable to PPS patients expressed as a percentage--on average than non-teaching hospitals, but teaching hospitals' total margins--the financial margins from all patients--have remained consistently lower than other hospitals' total margins. As analyzed by ProPAC in its June 1995 report and shown in Table C below, data from the tenth-year of PPS (1993-94), the most recent information publicly available, show that average PPS margins for non-teaching hospitals were minus 4.0 percent, but total margins were plus 4.8 percent. Major teaching hospitals, however, posted PPS operating margins of 11.7 percent, but their average total margins were substantially lower at 2.7 percent. The average total margin for all hospitals was 4.3 percent.

Table C
PPS Operating Margins and Total Margins, by Hospital Group, PPS 10

Hospital Group	PPS Margin	Total Margin
Major Teaching	11.7%	2.7%
Other Teaching	0.5	4.6
Non-teaching	-4.0	4.8

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

An analysis of FY 1994 financial data supplied by 91 hospitals belonging to AAMC's COTH shows that a precipitous reduction in the IME adjustment would substantially harm teaching hospitals, destroying the relative equity that has been achieved with the current level of the IME adjustment. If the IME adjustment were reduced from 7.7 to 3.0 percent, as proposed in one of the three Medicare restructuring options by Congressmen Christopher Shays (R-CT), Dave Hobson (R-OH), Dan Miller (R-FL), and Steve Largent (R-OK), the average PPS margin in 1994 would fall from a positive 11.75 to a negative 1.49 percent, a reduction of 13.24 percentage points. The impact on average total margins would be substantial. The average total margin in 1994 would fall from 5.1 percent to 2.8 percent, a decrease of 2.3 percentage points.

PPS Improvements that Would Distribute Payments More Equitably. Now in its twelfth year, the prospective payment system continues to be based on national average rates that do not by themselves recognize important differences in hospital costs. Originally developed to create a "level playing field" for teaching and non-teaching hospitals, the IME adjustment serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;
- non-recognition of the teaching hospital's costs of maintaining a broader and more specialized scope of services, often at the regional level, and the capacity for introducing new technology;
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- unavoidable decreases in productivity stemming from the presence of trainees; and
- additional ancillary services ordered by trainees as they learn how to diagnose and treat patients.

The AAMC supports efforts to improve payment accuracy and the equitable distribution of PPS payments. The Association believes that improvements could be made in the PPS, such as the introduction of better measures of severity of illness, that would distribute payments more equitably across hospitals. The overall payment impact of changes in the DRG patient classification system must be budget neutral. Therefore, more accurate measurement of severity of illness would not increase Medicare expenditures. The primary payment impact would be a different allocation of PPS payments across hospitals, all other things being equal.

The inability of the DRG system to distinguish severity of illness within diagnostic groups, or account for other characteristics that are likely to affect a patient's costs, such as whether the patient was transferred from another facility, has led to research on improved measures of severity. For example, HCFA has developed a new patient classification system that incorporates severity refinements, called the Refined DRGs. This new set of DRGs, if implemented, would result in more accurate patient classification and payment for PPS cases.

The AAMC understands that the use of better severity measures likely would result in a reduction in the empirical level of the IME adjustment. However, teaching hospitals may experience less uncertainty from year to year if severity of illness were captured in the DRGs and were paid through the case mix index. The AAMC believes that a complete analysis of the integration of a new DRG system would be required, including the impact of the new system on outlier policy and the interaction of the IME and DSH adjustments.

Similarly, research efforts also could focus on improvements in the Area Wage Index (AWI), which accounts for variation in hospital wage rates across geographic areas. As with the DRG classification system, the overall payment impact of changes in the AWI must be budget neutral. The current labor market areas used to determine the AWI, which are based on fixed county and state boundaries, fail to account for the higher labor costs faced by hospitals located in central, inner city areas compared to hospitals in suburban areas. To some unknown degree, these central city/suburban ring cost differences are incorporated in the level of the IME adjustment.

Finally, the AAMC supports a more equitable approach to outlier policy that targets outlier payments to the highest cost cases. Adjustments to outlier payment policy should be considered to protect hospitals from the risk of large losses on some cases. Teaching hospitals, because of their special missions, treat groups of patients who are more likely to become unusually costly cases, resulting in costs that are much greater than the DRG payment. Under current policy, costly cases treated in teaching and/or DSH hospitals are less likely to qualify for cost outlier payments and when these cases do, the outlier payment is smaller than one in a non-teaching, non-DSH hospital.

The AAMC urges the Congress to consider carefully the impact of a reduction in the IME adjustment on all teaching hospitals. Teaching hospitals understand that to protect the solvency of the HI Trust Fund, Congress must moderate the projected growth in Medicare spending. However, teaching hospitals also are concerned that they will be asked to bear a disproportionate burden of the proposed payment reductions. For these institutions, the proposed levels of Medicare spending growth would mean real cuts in their payment levels. Adjustments can be made to the PPS to improve payment equity, but the financial position of teaching hospitals, as measured by total margins, is tenuous. Teaching hospitals are concerned about their ability to fulfill their missions, including the provision of high technology care, costly services for referred patients, and community services such as burn and trauma units.

Adjusted Average Per Capita Cost (AAPCC)

As the delivery system moves toward capitated payments for patients, separating the payment for DGME costs and for patient care costs attributable to the special roles of teaching hospitals (IME and DSH) from patient care revenue becomes necessary. The AAMC believes that the current method of calculating the Medicare AAPCC, the rate that the program pays to a risk contractor, results in a payment system that creates an uneven playing field between teaching and non-teaching hospitals.

The AAPCC calculation incorporates all Medicare expenditures, including the DGME, IME and DSH payments. These payments are intended respectively to compensate hospitals for specific missions (graduate medical education), or for providing services to atypical patients who are severely ill or are of low-income socioeconomic status. Once these payments have been included in the AAPCC and paid to a risk contractor, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with risk contractors because the risk

contractors receive the same AAPCC amount regardless of with whom the risk contractor has a contract.

ProPAC recently noted this problem in its March 1995 report to the Congress:

> Medicare's capitated payment under its managed care risk contracting program does not appropriately distribute payments for the costs of teaching programs or of caring for a disproportionate share of low-income patients. The capitated rate reflects the extra Medicare payments provided to teaching and disproportionate share hospitals in the fee-for-service sector, regardless of whether Medicare enrollees receive care in those hospitals. The relationship between HMOs and the teaching and disproportionate share hospitals in their service area warrants further evaluation (pages 7-8).

On May 24, 1995, Gail R. Wilensky, Ph.D., Chair of the PPRC, noted that changes are needed in how the Medicare program pays HMOs. In testimony before the Subcommittee on Health of the House Ways and Means Committee, Dr. Wilensky explained that "Medicare's current payment methodology for risk-contracting HMOs has a flaw that results in overpaying many HMOs for expenses related to graduate medical education." As part of its work plan, the PPRC will assess the impact of this policy in the coming months and analyze the implications of moving towards alternative financing approaches.

In recent months, the AAMC has been working to develop a methodology for removing these costs and distributing these payments to the appropriate hospitals for the special costs they incur. The AAMC believes that both near-term actions to address the immediate issue at hand, as well as longer-term actions to resolve issues surrounding the current Medicare payment methodologies (DGME, IME, DSH, and AAPCC) should be pursued. Based on an analysis for the AAMC by Deloitte and Touche and discussions with hospital groups about the results, the AAMC recommends the following near-term and long-term actions.

Near-Term Actions. The AAMC believes that DGME, IME, and DSH payments should be removed prior to the calculation of the AAPCC rates and paid directly as intended by Congress to teaching and non-teaching DSH hospitals that incur the costs of these activities. These "carved-out" mission-related payments should be made to teaching institutions when Medicare risk contractor enrollees utilize their services. The AAMC recommends that separate payment methodologies, which mirror the current Medicare regulations and are administratively feasible, be applied to each component of the DGME, IME and DSH payments. This approach could be accomplished through direct payments to the providers by continuing to use the current Medicare payment methodologies and settlement process with some relatively minor changes:

- Direct Graduate Medical Education. Using the current methodology for DGME, identify the number of inpatient days that are incurred by Medicare risk plan enrollees. Allow the teaching institution to count these days as part of the formula for calculating Medicare's share of DGME costs.
- Indirect Medical Education. Because care for Medicare risk plan patients is paid for at a rate negotiated between the hospital and the risk contractor, there is no longer a DRG payment against which to apply the IME adjustment. However, when a teaching hospital cares for Medicare risk plan enrollees, it would compute what the DRG payments would have been for these patients. This amount would then be combined with the actual DRG payments for remaining Medicare fee-for-service patients, and the IME formula would be applied.
- Disproportionate Share. The DSH formula would be used in the same "shadow bill" manner. In the cases of risk contract Medicare inpatients, the teaching hospital would calculate what the DRG payments would have been under the prospective payment system. This amount would then be added to the actual DRG payments of the fee-for-service patients, and the DSH formula would be applied.

Long-Term Actions. Initiatives should be undertaken to identify and study potential alternative contracting mechanisms to the AAPCC methodology, and to reform payments for the education-related missions and the care of low-income patients.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk-based contracts grow. Additionally, the same issues will arise under proposals to give vouchers to beneficiaries so that they may purchase other types of insurance. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding risk-based contracts among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Medical School Financing in an Emerging Price Competitive Environment

Thus far, this testimony has addressed the impact of potential changes in Medicare on teaching hospital payments. Finally, I would like to make members of the Committee aware of how the emerging competitive delivery system threatens the fragile nature of medical school financing and the importance of clinical income to the financial viability of the nation's medical schools. The competitive environment is beginning to unravel medical schools' entire financing system at a time when medical schools and teaching physicians are being called on to transform the medical education system from one that focuses on specialist training in hospital inpatient settings to a more expensive system of small group education and generalist curricula carried out in ambulatory sites.

Like teaching hospitals, medical schools finance education and research activities through a complex system of cross-subsidization. Education, research and patient care exist as joint products. Undergraduate medical education in the clinical setting, directed by the medical school, is not recognized explicitly by any payment system. Like other academic costs, it has been financed indirectly through patient care dollars. Even at public schools, undergraduate medical education derives minimal support from tuition, fees and state appropriations. Tuition accounted for 4.1 percent and state appropriations for 11.5 percent of total medical school revenues in 1991-92. Education and research programs rely in large part on revenues from the delivery of medical services by the faculty of the school. Clinical faculty practice plans represented 32.4 percent of total medical school revenue in 1991-92; by contrast, in 1980-81, medical service revenue contributed only 15.7 percent of the total. Hospitals also support medical schools for activities conducted in the hospital. Payments from hospitals have increased from 6.2 percent in 1980-81 to 11.4 percent of total medical school revenue in 1991-1992. Research is supported partly by federal and local grants

and contracts. Grants and contracts represented about one-third of total medical school revenue in 1991-92. Philanthropic support supplements these sources, but by themselves these funds remain insufficient. Education also benefits from an elaborate system of nonpaid voluntary faculty drawn from the community.

For several reasons, medical schools are having difficulty sustaining this complex financial system undergirding the education and research missions. Federal support for research is increasingly constrained, with medical schools expected to accept a greater share of the costs. Pressures brought to bear on medical service costs will likely lead to declining income from the faculty clinical practice, and less money available to support educational and research efforts. To preserve the patient base critical for medical education and research, faculty physicians are being drawn into developing networks with affiliated teaching hospitals and are being asked to accept capitated or discounted payments from private payers. As community physicians are forced to align with various health plans in integrated networks, their willingness to "contribute" teaching services may even be threatened. The shift to a more explicit financing system threatens the ability of medical schools and teaching hospitals to fund education and research.

Conclusion

The AAMC regrets that the possibility of establishing all-payer funds for the special missions of teaching hospitals and medical schools apparently has diminished. This "shared responsibility" approach to financing the special missions of academic medicine is an issue that deserves the Committee's attention. All evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals and teaching physicians so that their fundamental missions can be preserved. Reductions in Medicare payments to teaching hospitals and teaching physicians will undermine the ability of these institutions to fulfill their multiple responsibilities at the same time they are struggling to adapt to a new delivery environment. Academic medicine supports those changes that assure the provision of high quality health care in a cost effective delivery system, a vibrant research capability and the capacity to educate outstanding practitioners. Academic institutions need the understanding and support of society to fulfill their obligations. The AAMC looks forward to working with the members of the Committee and their staff to meet these common goals.

TABLE A

Distributional Impact of Limiting Payments to Residents Within Initial Residency Period, FY96

	Number of Hospitals	Total Medicare DGME Payments		Change	
		Baseline ($Mill.)	Policy Option ($Mill.)	$Mill.	%
DGME Payments	1,138	$1,795	$1,454	($342)	(19)
COTH Membership					
Integrated AMC's	114	666	516	(150)	(23)
Independent AMC's	180	590	479	(111)	(19)
Non-COTH Teaching	844	539	459	(80)	(15)
Intern Resident Bed Ratio					
<0.10	608	213	183	(30)	(14)
0.10 - 0.25	280	497	421	(76)	(15)
0.25 - 0.40	108	314	253	(61)	(20)
>0.40	142	771	598	(174)	(23)
Medicare Share 1/					
<25 Percent	195	154	124	(30)	(20)
25 - 40 Percent	269	676	531	(144)	(21)
40 - 55 Percent	453	773	631	(141)	(18)
>55 Percent	221	193	167	(26)	(13)
Medicaid Share 1/					
<10 Percent	435	455	375	(80)	(18)
10 - 25 Percent	458	901	735	(166)	(18)
25 - 35 Percent	114	253	196	(57)	(23)
>35 Percent	131	185	147	(38)	(20)
No. of FTE Residents					
<50 Residents	769	338	290	(47)	(14)
50 - 100 Residents	148	284	240	(44)	(16)
100 - 250 Residents	145	550	442	(108)	(20)
>250 Residents	78	624	482	(142)	(23)
Type of Hospital Ownership					
Voluntary Nonprofit, Church	243	317	264	(53)	(17)
Voluntary Nonprofit, Other	886	1,222	984	(238)	(19)
Proprietary	81	34	28	(6)	(18)
Government	128	222	177	(45)	(20)
DSH Payments by Teaching Status 2/					
Major Teaching / No DSH	74	195	153	(42)	(21)
Major Teaching / DSH	176	890	697	(193)	(22)
Other Teaching / No DSH	449	291	248	(42)	(15)
Other Teaching / DSH	439	419	355	(64)	(15)
Region of Country					
New England	88	171	134	(38)	(22)
Middle Atlantic	246	639	511	(128)	(20)
South Atlantic	140	220	175	(45)	(21)
East North Central	244	378	309	(69)	(18)
East South Central	52	52	43	(9)	(16)
West North Central	97	116	100	(16)	(14)
West South Central	93	71	60	(12)	(16)
Mountain	42	36	32	(5)	(13)
Pacific	136	110	91	(19)	(18)

1/ Based on inpatient days
2/ Major teaching hospitals are those with IRB ratio greater than 0.25
Source: Calculated for AAMC by Health Policy Economics Group, Price Waterhouse Graduate Medical Education Model.

TABLE B

Distributional Impact of Limiting Payments to U.S. Residents, FY96

	Number of Hospitals	Total Medicare DGME Payments		Change	
		Baseline ($Mill.)	Policy Option ($Mill.)	$Mill.	%
DGME Payments 1/	1,138	$1,795	$1,421	($374)	(21)
COTH Membership					
Integrated AMC's	114	666	566	(100)	(15)
Independent AMC's	180	590	452	(138)	(23)
Non-COTH Teaching	844	539	404	(136)	(25)
Intern Resident Bed Ratio					
<0.10	608	213	173	(40)	(19)
0.10 - 0.25	280	497	369	(128)	(26)
0.25 - 0.40	108	314	231	(84)	(27)
>0.40	142	771	649	(123)	(16)
Medicare Share					
<25 Percent	195	154	128	(27)	(17)
25 - 40 Percent	269	676	559	(117)	(17)
40 - 55 Percent	453	773	601	(172)	(22)
>55 Percent	221	193	134	(58)	(30)
Medicaid Share					
<10 Percent	435	455	356	(100)	(22)
10 - 25 Percent	458	901	723	(178)	(20)
25 - 35 Percent	114	253	207	(46)	(18)
>35 Percent	131	185	135	(50)	(27)
No. of FTE Residents					
<50 Residents	769	338	266	(72)	(21)
50 - 100 Residents	148	284	206	(78)	(27)
100 - 250 Residents	145	550	439	(112)	(20)
>250 Residents	78	624	511	(112)	(18)
Type of Hospital Ownership					
Voluntary Nonprofit, Church	243	317	253	(64)	(20)
Voluntary Nonprofit, Other	886	1,222	942	(280)	(23)
Proprietary	81	34	29	(6)	(16)
Government	128	222	197	(25)	(11)
DSH Payments by Teaching Status 2/					
Major Teaching / No DSH	74	195	144	(51)	(26)
Major Teaching / DSH	176	890	735	(155)	(17)
Other Teaching / No DSH	449	291	229	(61)	(21)
Other Teaching / DSH	439	419	312	(106)	(25)
Region of Country					
New England	88	171	143	(28)	(17)
Middle Atlantic	246	639	455	(184)	(29)
South Atlantic	140	220	189	(31)	(14)
East North Central	244	378	300	(78)	(21)
East South Central	52	52	48	(4)	(8)
West North Central	97	116	88	(28)	(24)
West South Central	93	71	64	(7)	(10)
Mountain	42	36	33	(3)	(9)
Pacific	136	110	101	(9)	(8)

1/ Based on inpatient days.
2/ Major teaching hospitals are those with IRB ratio greater than 0.25
Source: Calculated for AAMC by Health Policy Economics Group, Price Waterhouse Graduate Medical Education Model.

Mr. HOUGHTON. Thank you, very much.

Dr. Bennett, please give us sort of a quick summary within 5 minutes and then I will have to duck out and then I will come back.

STATEMENT OF RICHARD G. BENNETT, M.D., ASSOCIATE PROFESSOR OF MEDICINE, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, BALTIMORE, MARYLAND; ON BEHALF OF AMERICAN GERIATRICS SOCIETY

Dr. BENNETT. I am Richard Bennett. I am a physician and a geriatrician. I am an associate professor of medicine at Johns Hopkins and the Johns Hopkins Geriatric Center. I would like to thank the Subcommittee for the opportunity to testify here today on behalf of the American Geriatrics Society.

The American Geriatrics Society is an organization of over 6,000 geriatricians. Geriatricians are physicians who are specially trained in the health and illnesses of older persons. Geriatricians specifically focus on the care of the chronically ill Medicare beneficiaries. Today, I would like to specifically focus my comments on proposals to revise Medicare support for graduate medical education for geriatricians.

As you know, current Medicare rules provide full support for the direct cost of training residents for first board certification up to 5 years. Payment for all other residents are reduced by 50 percent. Current law includes a special rule for geriatric medicine. This exception provides full support for the additional 2 years of training in a geriatric fellowship program.

We understand that the Subcommittee is considering various options to revise Medicare payments for GME. Some of these options would limit Medicare payments to training required for the first board certification only. We urge the Subcommittee to maintain the special rules that now apply to geriatrics. Unless special provisions are authorized, geriatric medicine will not be eligible for funding since training occurs after initial certification for family practice or internal medicine.

We believe that full funding for training is justified for the following four reasons. First, geriatrics is the only discipline to focus solely on Medicare patients. If Medicare is to provide training support for any medical discipline, we believe geriatrics must be a priority. Geriatrics is, by definition, the study and delivery of care to the most frail and most vulnerable of Medicare beneficiaries.

Second, geriatrics is not a subspecialty. Training in geriatrics occurs after the completion of a 3-year residency in family practice or internal medicine. Rather than a subspecialty board certification, both the American Board of Internal Medicine and the American Board of Family Practice jointly offer a certificate of added qualification in geriatric medicine. These fellowships expand the primary care training of physicians rather than diverting them to specialized or procedural care. In our own practice, over 98 percent of our clinical billings are for primary care, not for subspecialty care.

Third, there is a significant shortage of geriatricians to meet the growing needs of the elderly. This has been recognized by several major institutions, including the Institute of Medicine, the NIA,

and the Council on Graduate Medical Education. During the last decade there has been a growing recognition that there is a significant need for physicians who are better trained to care for older persons. Because of advances in aging research, there is a growing body of knowledge that this needs to be done.

Fourth, we believe that training in geriatric medicine represents an investment paid back in savings of future Medicare dollars. Geriatricians are taught to provide rational, goal-directed, cost-effective primary care.

In conclusion, geriatrics is a relatively new field in this country. If geriatrics training is not supported by Medicare, it will not be possible to train the numbers of geriatricians needed to care for the growing numbers of older Americans. This could destroy a young field that must continue to mature and expand to provide cost-effective care for the increasing number of older adults in the United States.

Thank you.

[The prepared statement follows:]

STATEMENT OF RICHARD BENNETT, M.D.
ASSOCIATE PROFESSOR OF MEDICINE
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
ON BEHALF OF AMERICAN GERIATRICS SOCIETY

Mr. Chairman, I am Dr. Richard Bennett, Associate Professor of Medicine at the Johns Hopkins University School of Medicine. Thank you for the opportunity to appear today on behalf of the American Geriatrics Society. The American Geriatrics Society is an organization of over 6,000 geriatricians -- physicians who focus on the care of chronically ill, frail Medicare beneficiaries.

Today, we would like to focus our comments on proposals to reduce Medicare reimbursement for graduate medical education. Specifically, we urge the Committee to maintain the special reimbursement rules that currently apply to geriatric training. Funding for geriatrics education is critical to train an adequate number of physicians needed to care for the growing population of older patients.

Current Medicare Rules for Direct Medical Education

Current Medicare rules provide full funding for geriatric education. Training in geriatric medicine takes place after the completion of a three year residency program in family practice or internal medicine followed by a two year program. The Medicare program fully supports the direct costs of residents for the number of years of training necessary for initial board certification, up to a maximum of 5 years. Payment for all other residents (beyond the initial five years and beyond first board certification) are reduced by 50 percent. Support for geriatric medicine would be so reduced but for a special exception which provides full support for the additional two years of training in a geriatric fellowship program.

Current Geriatric Medicine Training Requirements

During the last 10 years, there has been a growing recognition that there is a significant need for physicians who are better trained to care for older patients. As medical advances through aging research have been made over the past two decades, there is a growing body of knowledge about the health of older persons that has led to therapies that can improve the quality of life. Disease manifests itself differently in older persons. They are affected by prescription drugs differently than younger persons. When drugs are not prescribed appropriately, they can actually cause illness in older patients, increasing health care costs and needless suffering. Multiple chronic illnesses are quite common in older persons particularly those over age 75. Geriatricians focus on these areas and teach primary care physicians how to address the special needs of older persons.

Geriatrics is not a subspecialty. Rather than a subspecialty board certification, the American Board of Internal Medicine and the American Board of Family Practice jointly offer a "Certificate of Added Qualifications in Geriatric Medicine." This certification process began in 1988 and provides a means by which internists and family physicians can obtain formal recognition of their expertise in geriatric medicine. Certification requires both attaining clinical skills and the passing of a certifying examination.

Up until 1994, physicians were eligible to sit for the exam based on substantial clinical practice experience with older patients. This pathway has now expired, such that all physicians who wish to attain this certification of additional qualifications must complete formal geriatrics training.

Training in geriatrics emphasizes the unique aspects of the health and illnesses of older persons; functional assessment; and treatment/management of multiple chronic conditions. Training supports an interdisciplinary approach to meeting the patient's needs and involves coordination of care among the various health care providers, e.g., physician specialists, nurses, speech/physical therapists, home health agencies, nursing homes, etc.

Positions offered in geriatric fellowship programs have increased significantly in recent years. There were 341 positions offered in 1993, compared to 201 positions in 1990.

Shortage of Geriatricians

Today there are over 8000 certified geriatricians in the United States. Most of these geriatricians who were not trained in fellowships and received needed training some years ago will soon retire. Therefore, the actual number of geriatricians is expected to fall by the year 2000. Moreover, the number of geriatrics faculty is also expected to drop in the next decade.

Various expert panels have recommended a substantial expansion in the number of trained geriatrics faculty and practitioners, including the Council on Graduate Medical Education, the National Institute on Aging, the Institute of Medicine Committee on Leadership for Academic Geriatric Medicine, and a special committee of the United States Department of Health and Human Services.

There are currently more than 3.3 million Americans over the age of 85. That number is expected to nearly double over the next 15 years. Federal policies must encourage and support training in geriatric medicine for physicians who will care for these individuals.

Proposed Graduate Medical Education Reforms

We understand the Committee is considering a proposal to eliminate Medicare reimbursement for training beyond first board certification. Unless special provisions are authorized, geriatric medicine will not be eligible for funding since training occurs after initial certification for family practice or internal medicine. We strongly urge the Committee to continue the special geriatric provision now included under current law.

We believe this special treatment is justified because:

- Geriatrics is the only discipline to focus solely on Medicare patients. If Medicare is to provide training support for any medical discipline, we believe geriatrics must be a priority. Geriatrics by definition is the study and delivery of care to the most frail and vulnerable Medicare beneficiaries.

- Geriatrics is not a subspecialty. Rather, as stated above, the Boards offer a "Certificate of Added Qualifications" for geriatrics education. These fellowships expand the primary care training of physicians rather than diverting them to specialized or procedural care.

- There is a significant shortage of geriatricians to meet the growing needs of the elderly.

The American Medical Association (AMA) has recognized the special needs of geriatric medicine in its graduate medical education proposal. In the proposal, "Transforming Medicare," the AMA proposes to decrease the number of funded residency positions. AMA would provide full funding only to the years leading to initial board certification plus funding for the full length of geriatric training programs. **Geriatrics is the only exception recommended by the AMA.**

Conclusion

In closing, the country is capable of making much greater strides in improving care for older Americans. To achieve this goal, the nation needs to train an adequate number of physicians with formal geriatrics education to provide direct care to frail, chronically ill patients and to teach other primary care physicians the skills necessary to care for older people and their special problems. If geriatrics training is not supported by Medicare, it will not be possible to train the numbers of geriatricians needed to care for the growing numbers of older patients.

Mr. HOUGHTON. Thank you, Doctor, thank you very much. This obviously is an area of tremendous concern to us. We do not quite know how we are going to maneuver the shoals but we appreciate your being here. I am going to have to duck out for a vote, I will be back, and maybe some of my associates will also.

Thanks very much. If you could just hold here.

[Recess.]

Mr. HOUGHTON. OK. If we can begin again. Thank you very much for your patience. We will not try to keep you too long. As you can see, I am surrounded by hordes of people here in this Subcommittee. I apologize. It is sort of a scattered day. We are all over the place.

Obviously, I would like to continue the whole concept of paying for medical education. And if I understand it—and maybe I am saying things that you will disagree with—that you feel that there is no way, under the HMO system, that they are going to give up part of their profits and pay for the type of medication which we ought to have. Is that right? Does anybody disagree?

[No response.]

Dr. BENNETT. No one has offered us any money at John Hopkins yet. From HMOs there has been no offer of money in that regard. One anticipates that you will not see that kind of money from HMOs.

Mr. HOUGHTON. Right. So you do not think there is even any possibility of levying sort of a surtax, just assuming their responsibility as citizens of this country, that they somehow divvy up?

Mr. VAN ETTEN. Well, Mr. Chairman, what the AAMC would like to see is some form of sharing of the cost of teaching spread across all payers. Absent that, some way to carve out these costs and to have reimbursement outside of the AAPCC system seems to us to make the most sense.

Mr. HOUGHTON. OK. Now, just to continue on with you, Mr. Van Etten, I think you have indicated the possibility of eliminating graduate medical education for international medical graduates.

Mr. VAN ETTEN. No, that was not my testimony.

Mr. HOUGHTON. How do you propose to take care of the international doctors or doctors to be?

Mr. VAN ETTEN. The position of the AAMC is that there should be strong consideration of options to diminish the number of international medical graduates. However, that should only be done with very careful consideration of what the effects would be in many of the communities that do depend upon international graduates.

So we recognize that there does need to be strong review of manpower needs of physicians. On the other hand, we are very concerned about what the implications would be of an abrupt reduction in the payment for international medical graduates.

Mr. HOUGHTON. Now, let me ask all of you a question. Obviously, we are wrestling with this issue. And I, particularly, am representing a district in New York State and recognize the importance of medical education in New York State, not only to the Nation but to the State.

But the question is, what are the options that we have? We would like to throw this thing back, more into the system, rather

than holding back and having a special category of payments to the medical institutions.

Is there any way that we can work this so that the accounting is a little more simple and that the responsibility is on the shoulders of everybody rather than just saying, x percent will be for the graduate medical education program?

Maybe you have got some comments on that, anybody?

Mr. WOOD. Well, Mr. Chair, as you have already recognized, this is a complex issue. It is not a simple issue whatsoever. There are probably payment methods simpler than we have right now with the IME and the DME allocation. However, I do not think that I can offer, from my perspective, anything that would replace where we are right now without causing significant upheaval in the system.

Mr. HOUGHTON. Well, should Medicare pay entities other than the hospital for graduate medical education?

Mr. WOOD. Should they pay other?

Mr. HOUGHTON. Yes.

Mr. WOOD. I believe, as has already been stated, and I think the organization I represent believes that all payers should be involved in some way or another in bearing the costs of graduate medical education.

Mr. HOUGHTON. Would anybody like to elaborate on that?

Mr. VAN ETTEN. We would agree, as well, that the payment for graduate medical education should relate to who bears the cost of providing those services. We have, in AAMC, been very active in pursuing consortia.

Mr. HOUGHTON. Well, everybody bears the cost. It is just the accounting procedure you set up.

Mr. VAN ETTEN. Well, the question would be, who bears the direct cost of providing support for the graduate medical education? And we would, indeed, support spreading that beyond hospitals, particularly to ambulatory facilities or to consortia that are established.

We would also in AAMC be happy to provide suggestions as to how one might spread the cost of graduate medical education to a broader population and, indeed, feel that is the most effective way in which to pay for these costs.

Mr. HOUGHTON. Another question. Mr. Van Etten, you suggested the freezing of the number of residents, if I am not mistaken.

Mr. VAN ETTEN. No.

Mr. HOUGHTON. You did not. All right, so, do you think freezing the number should be possible? Is that a good idea that we somehow cut down on the number of people flowing through the system?

Mr. VAN ETTEN. I think that it needs a great deal more attention. We need to better understand what our manpower needs will be in the future. We have seen, in the past, that arbitrary freezes in the past have had untoward effects. There needs to be, again, just a better, broader understanding of what the manpower needs will be over the next 10 to 15 years.

These are decisions that have such long-range implications that there needs to be a great deal more thought before a freeze is implemented.

Mr. HOUGHTON. Sure. OK, now let me just step back 1 minute. For anybody on this panel, we have a system for paying for graduate medical education now. We are in a cross-crunch for a variety of different reasons. We are trying to keep the graduate medical education, while at the same time, find other ways of paying for this thing and having a more moderate approach as we move into uncharted territory.

Have you got other suggestions that we ought to specifically remember as we go here, other than what you propose in your testimony? Anybody?

Mr. VAN ETTEN. We do not have other suggestions. I would note, however, that as the update factor is reduced and is less than inflation, that will result in reductions in supporting graduate medical education. So that there is an automatic racheting down of graduate medical education expenses as the update factor is removed. So that there would be some diminution over time.

Mr. HOUGHTON. I think the worry that I have is that we have an accounting procedure that has gone along a particular path and then that may not be sufficient as we look over the next hill into the future.

And other people ought to maybe help us in assuming the cost of training our doctors. And it now falls on, many times, those big city hospitals who have the double responsibility of taking care of Medicaid patients, and it is an overwhelming cost burden on them.

Are there other approaches which you can think of which have a broader sense of cost responsibility throughout this society of ours?

Mr. VAN ETTEN. Well, again, I think that taking the payments and spreading them across a broader payer, across many payers would be the most effective way of doing so, of not requiring it to be borne strictly by Medicare.

Mr. HOUGHTON. Fine. And at the end of the day, if you looked at 100 percent of the costs, how would those costs be allocated amongst taxpayers and directly or indirectly to hospitals? What would that chart look like?

Mr. VAN ETTEN. Well, it might be—if it were charged to various health care, to, let us say to HMOs and to others providing health insurance—it would be indirectly paid through higher prices ultimately, or in the case of HMOs, perhaps by smaller profits and smaller administrative costs than presently are earned.

Mr. HOUGHTON. OK fine, thank you.

I am going to turn you over to my associate here who would like to ask a question.

Mr. ENSIGN. Thank you, Mr. Chairman.

I just would like to address the whole concept of residents and try to understand a little better why residents cost hospitals or the places where residents are, teaching hospitals, why is the cost to the teaching hospital? In my experience, residents usually are, you know, 70-, 80-, 90-, 100-hour-a-week people and their salaries are $25,000 to $35,000 usually. It seems a lot of the work that residents do, they do in lieu of a normal clinician, chief of staff, or the senior team person.

And, because they are being paid a lot less, doing it for less cost to the hospital. And I have not been able to have it explained to

me effectively, at least, or maybe I am not bright enough to understand, why they cost money?

In other words, why are not these profit centers?

Dr. BENNETT. Let me give you an example.

You go into the hospital with chest pain. You go to a teaching hospital. The first person that is going to see you may be an intern. The intern may spend 1 hour with you evaluating you, maybe he will spend 15 minutes if he thinks you are really sick.

The next person that comes in may be the attending physician that decides you need to be admitted to the CCU. There is an interaction between those two folks that you do not see outside your room, where teaching occurs. That intern, with you the first time, is really going through a learning process understanding how to take care of someone. So, in fact, it is not clear that that person is really providing much service to the hospital at that stage.

Mr. ENSIGN. By the way, just for your background, I am a veterinarian who went through an internship. I understand the process.

Dr. BENNETT. OK, fine, but in the next process, as well, the person is admitted to the medical service. An intern does an evaluation. A resident does an evaluation. The attending physician does an evaluation. Those kinds of interactions really are very expensive interactions and they do cost extremely.

Mr. ENSIGN. OK. The intern is obviously the lowest, the first year resident, whatever you want to call him now. Third-year resident, maybe tops, $35,000, in most places?

Dr. BENNETT. That is ballpark.

Mr. ENSIGN. If you look at an 80-hour week, most of these people work about 80 hours a week, and multiply that down on an hourly wage, we are looking in the $4 or $5 an hour type of a reach. My internship paid $14,000 a year and we were the lowest paid people, including kennel workers, and we averaged, I think, $2.75 an hour that year.

And it still, even taking that into account, because your hourly wage is so low, you still save the senior clinicians work. Because residents do a lot of things on their own that the senior person never has to do. The senior person that is making $250,000 a year never has to do these things. Only $35,000 up to, maybe, the $35,000 a year person, but even the first and second year people still do a lot of that work.

I still do not understand how—because in veterinary medicine, a lot of times you have residents and you have internships because it is a profit center. The transfer is that, yes, you are teaching, that is the tradeoff that you do. That you say to do this internship or to do this residency I know that I am going to get paid slave wages but my tradeoff is that I am going to learn something for the next three or 4 years and I am going to have a specialty afterward. The teaching hospital makes money off of you doing those 4 years in exchange for teaching.

Now, that is purely a free market situation. I realize that you are not truly in a free market because you have government subsidies. But I do not understand why it does not work the same in human medicine, when medicine is medicine.

Mr. VAN ETTEN. Congressman, I would not argue that residents are not a bargain and that is that they provide very significant

services. What is important to recognize in a teaching hospital is that the resident plays an absolutely critical role in treating acutely ill patients. Most of the patients at Stanford or Johns Hopkins could not be treated in a community hospital with a normal treatment of an attending physician who comes in once or twice a day and——

Mr. ENSIGN. Oh, I totally agree with residents being valuable, internships being valuable. The training, the whole way we do all of that is incredibly important to our future medical system. What I do not understand is why the government needs to subsidize it in the first place, why did they ever need to subsidize it because these people are profit centers.

Mr. VAN ETTEN. I do not think we are asking to subsidize. We are asking simply for the government——

Mr. ENSIGN. What is graduate medical education for if that is not a subsidy?

Mr. VAN ETTEN. To pay its cost, to pay the cost. The government, through the Medicare Program reimburses the providers for the cost of providing services. These are legitimate costs of providing services, the direct medical education costs associated with residents.

So it is another form, it is like paying for the nursing costs. The problem was it was not included within the DRG because the DRG payments only were related to all hospitals. So the DME, the direct medical education costs, were excluded and paid through a separate formula.

So in many ways it is not dissimilar from the other forms of Medicare reimbursement.

Mr. ENSIGN. Correct this if I am wrong, it sounds like to me from a logic standpoint, that the government has created a problem by not including, that now it cannot get out of.

Mr. VAN ETTEN. But the dilemma was, that the government, there was no way, it was very difficult to come up with a technical way to include the cost of education within the DRG payment. And so it was determined it was better to pay it, externally, paying the direct medical education costs explicitly and the indirect medical education costs, which are the indirect costs associated with the severity of patients treated, separately from the DRG payment. It is not a subsidy.

Mr. ENSIGN. And as most cost-plus systems, though, it ends up skyrocketing the——

Mr. VAN ETTEN. Well, hopefully not cost-plus because there is a base at which, of 1984, at which the costs are established.

Mr. ENSIGN. OK, thank you, Mr. Chairman.

Mr. HOUGHTON. Thank you, very much.

Let me just get back to the international medical graduates. There have been a variety of different suggestions that you could put freezes on them and we were talking about this thing earlier. And the one suggestion I think, Mr. Van Etten, you had is to have some sort of a ratio.

I do not know whether that makes any sense at all. I know that it will probably hurt the smaller hospitals in areas that I represent because they have had a tremendous impact up there. And I won-

der whether we do want to put some sort of a hold back on the international medical graduate. Anybody can answer?

Mr. VAN ETTEN. Again, it seems to me it is an issue that needs a great deal more study. I would suggest in the next panel, Dr. Foreman, from Montefiore Hospital, is extremely knowledgeable about this issue and I think could well explain to you the role of international medical graduates and the critical role that they play in an urban hospital setting.

Mr. HOUGHTON. Fine. But how do you feel?

Mr. VAN ETTEN. I think, well, again, the AAMC position is that there does need to be consideration of manpower needs. We need to look at international medical graduates and their role. There does need to be some change in the present form, but it needs more study before a final decision is made.

Mr. HOUGHTON. Ms. Zagame, Dr. Wood, Dr. Bennett, are there any particular things you would like to drive home as you leave here because there is so much information, we are jamming so much into these 2 days, any special ending comments that you have?

Ms. ZAGAME. Well, I would certainly reiterate the plea for reporting out of this Subcommittee, as soon as possible, the Chairman's bill on investigational devices. Medicare reimbursement for those investigational devices is a very important issue for Americans.

Mr. WOOD. Mr. Chair, we would ask that the Subcommittee would take a careful look at our recommendations. We feel they are valid recommendations and would result in cost savings, and I agree strongly with Dr. Bennett that we need to take a very careful look at work force needs in this country.

Dr. BENNETT. I would like to just urge the Subcommittee to extend and continue the narrow exception for geriatricians and their training to be funded beyond first certification.

Mr. HOUGHTON. Thank you, very much.

Mr. Laughlin, would you like to inquire?

Mr. LAUGHLIN. No questions, Mr. Chairman.

Mr. HOUGHTON. All right, fine. Ladies and gentlemen, thank you, very much. We certainly appreciate your being with us.

Now, we have Dr. Foreman and Mr. Hall. If you would come up, we would appreciate that.

Gentlemen, welcome and thank you very much for being with us today. Dr. Foreman, Mr. Hall, we are delighted to have you here and to have you share your wisdom with us. Maybe after you have had that glass of water, Dr. Foreman, you would like to start.

STATEMENT OF SPENCER FOREMAN, M.D., PRESIDENT, MONTEFIORE MEDICAL CENTER, NEW YORK, NEW YORK; ON BEHALF OF GREATER NEW YORK HOSPITAL ASSOCIATION

Dr. FOREMAN. Thank you very much, Mr. Chairman, gentlemen of the Subcommittee. I am Dr. Spencer Foreman and I am the recent chairman of the Greater New York Hospital Association, which represents 170 voluntary, not-for-profit private and public hospitals and nursing homes in New York. In addition, I have had the privilege of appearing before this Subcommittee in the past as the chairman of the Association of American Medical Colleges.

At the risk of turning this hearing into an echo chamber, I would like to say some things that you have heard before and some things, perhaps, that you have not heard said quite the way I hope to say them.

I will primarily focus on the preservation and protection of two critical aspects of the Medicare Program, its historic commitment to graduate medical education, which has been crucial in the preservation of America's preeminence in medicine; and the disproportionate share hospital program which has enabled institutions serving low-income patients to fulfill their missions.

The Greater New York Hospital Association urges the Subcommittee to recommend the maintenance of Medicare's historic commitment to these programs. In addition, we ask the Subcommittee to make crucial changes in the Medicare managed care payment methodologies in order to make Medicare restructuring comprehensive and effective, and finally I will offer some comments regarding Medicare payment for international medical graduates.

Direct medical education payments recognize the costs incurred by hospitals to employ resident physicians and to pay for supervising physicians and related overhead costs. Medicare has paid its share of these costs in one form or another since the inception of the program.

The indirect medical education adjustment serves a wholly different function. It was developed to pay for observed extra costs incurred by teaching hospitals which are in addition to those represented by the direct medical education costs.

The disproportionate share adjustments were designed to assist hospitals that treat large numbers of low-income patients in meeting the costs these institutions incur due to their need to provide extra services to these populations.

Moreover and, importantly, there is a very significant overlap between hospitals that receive graduate medical education payments and those that receive disproportionate payments. Teaching hospitals account for 66 percent of all disproportionate share payments.

The vast majority of all teaching hospitals, in Greater New York's membership, are eligible for payments under the disproportionate share program, and most of them, including my own, qualify as high disproportionate share institutions.

Each of these payments is extremely important to sustaining the variety of activities that these teaching hospitals conduct. We believe that reductions in both of these programs would be devastating.

I would like to make a comment about New York's unique environment. New York's teaching hospitals are essential to the public health of the city and the Nation because the problems that plague American society are particularly pronounced in urban areas like ours. For example, 20 percent of all AIDS cases, nationwide, are in New York City and New York's hospitals see more cases of tuberculosis than all of the hospitals in the cities of Atlanta, Boston, Chicago, Houston, Los Angeles, Miami, and San Francisco combined.

As you know, New York's hospitals have operated for the past 12 years under one of the most regulated systems in the country. Our

State established a social contract which sought to achieve prospectivity in hospital reimbursement, contain hospital costs, and assure the universal access through its public and private hospital system for those unable to pay.

That contract largely succeeded. With respect to cost containment, New York had the lowest hospital inflation rate in the country throughout the decade of the eighties and those low prices continued into the nineties. Moreover, it has created a system which provides high-quality care to New Yorkers, no matter what their ability to pay. But an unfortunate outcome of the regulatory system was its effect on the hospitals' financial condition.

Thus, while total margins have hovered around 4.4 percent for hospitals nationally, with somewhat lower margins for teaching hospitals, New York's hospitals' margins have consistently ranked last in the Nation. Overall, the hospitals in New York lose money on an annual basis at a rate of nearly minus 2 percent. Even the private voluntary hospitals have not been able to produce a significant or consistent margin and have an average margin rate of zero.

I recite this profile because it is crucial for the Subcommittee to understand the fragility of the institutions that comprise the New York biomedical system. All teaching and disproportionate share hospitals face the same threats from the Medicare reductions now under discussion, but New York's hospitals will reach the last stop sooner due to their poorer financial condition.

Like the Association of American Medical Colleges, we believe that it is extremely important that our Nation's teaching hospitals do not bear more than their fair share of the sacrifices necessary to balance the budget. Severe cuts in Medicare reimbursements for graduate medical education and for the institutions that serve a large proportion of poor are not merely reductions in the growth of costs, they are really cuts in the actual funding of these institutions and would have a devastating effect on our community.

Reducing prospective payments through cuts in the update factor will naturally ripple through and reduce IME and disproportionate share payments, as well. Separately reducing IME and disproportionate share factors would impose an additional and actual cut targeted at a group of hospitals least able to withstand them.

In addition to those changes, I would like to take a moment to make a few comments about Medicare managed care. The Congress is looking at many ways to restructure the Medicare Program. All of these restructuring proposals share a common goal to enroll a much greater proportion of Medicare beneficiaries in managed care plans. Even without statutory changes, Medicare managed care enrollment is rapidly increasing. The move to Medicare managed care makes a great deal of sense, but a fundamental flaw now exists in the way that Medicare HMOs are paid and it has been mentioned by previous speakers. Basically, it is that the graduate medical education payments and disproportionate share payments get rolled up into the average per capita cost payments that are given to HMOs, but those educational and disproportionate share payments never find their way back to the teaching hospitals for which they were intended.

Until now my testimony has supported positions espoused by the Association of American Medical Colleges. The Greater New York

Hospital Association disagrees with the position AMC has taken with respect to graduate medical education for graduates of schools not in the United States or Canada. The AMC has recommended that we reduce or eliminate payment to support such positions.

The contention that there is an excess of physicians in the United States which has been described as the principal justification behind proposals to deny support to programs that use foreign-educated doctors, is part of a very complicated debate. Much of the concern over a physician surplus has been grounded in the economics of medical care on a fee-for-service basis. And market changes have now dramatically changed the incentives and competitive forces and any analysis of physician excess must, likewise, be changed. Even using fee-for-service assumptions, many policymakers and researchers have disagreed as to whether there is a physician oversupply.

The principle reasons for continuing to fund graduate medical education for international medical graduates are these. The majority of international medical graduates are either American citizens or permanent U.S. residents. They are concentrated in programs serving poorer communities and provide essential care for those communities. And they have made a historic contribution upon graduation to the care of Americans across the Nation. Our association urges the Subcommittee to reject any proposals that will restrict graduate medical education funding to positions filled by international medical graduates.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF

SPENCER FOREMAN, M.D., PRESIDENT

MONTEFIORE MEDICAL CENTER

PAST CHAIRMAN, GREATER NEW YORK HOSPITAL ASSOCIATION

HEARING ON MEDICARE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

UNITED STATES HOUSE OF REPRESENTATIVES

JULY 20, 1995

Thank you Mr. Chairman and members of the Subcommittee for inviting me to testify before you today on efforts to restructure the Medicare program. I welcome the opportunity to share my views on this challenging endeavor.

My name is Dr. Spencer Foreman. I am the President of the Montefiore Medical Center in the Bronx, the principal academic affiliate of the Albert Einstein College of Medicine and the largest Medicare provider in the United States. I am a past Chairman of the Greater New York Hospital Association (GNYHA), which represents 170 voluntary, not-for-profit private and public hospitals and nursing homes in the metropolitan New York area, the largest physician training ground in the nation. I am also a past Chairman of the Association of American Medical Colleges (AAMC).

You have called this hearing today to discuss ways to "preserve, protect, and improve" the Medicare program. While there is certainly much to improve in order to place the Medicare program on a more secure financial footing and to bring the program more in line with the changes taking place in the health care marketplace, I will primarily focus on the preservation and protection of two critical aspects of the Medicare program. These include the program's historic commitment to (1) graduate medical education (GME), which has been a crucial component of America's preeminence in medical science and has improved the health outcomes of the Medicare population; and (2) the Disproportionate Share Hospital (DSH) program, which has enabled institutions serving low income patients to fulfill their missions to deliver services to medically underserved communities.

We urge the Subcommittee to maintain Medicare's historic commitment to these programs, at a minimum, by refraining from imposing a greater share of any Medicare reductions on teaching and DSH institutions than on hospitals not carrying out these missions.

In addition, we ask the Subcommittee to make crucial changes in Medicare managed care payment methodologies to make Medicare restructuring comprehensive and effective.

Finally, I will offer some comments regarding Medicare payment for International Medical Graduates (IMGs), i.e., physician residents who received their medical college degrees abroad.

Brief Overview of the Medicare GME and DSH Programs

Medicare pays for GME through two mechanisms. The first, direct medical education (DME), recognizes the costs incurred by hospitals to employ resident physicians and pay for supervising physician services and related overhead costs. DME payments are currently calculated from audited costs in a 1984 base year, translated into an amount per resident, and updated by an inflation factor to the current rate year. Medicare pays for its share of this cost based upon the proportion of Medicare inpatient days to total inpatient days delivered by a hospital. In addition,

Medicare restricts payments for the later years of residency training, favoring instead those necessary for initial board certification, up to five years. The program has also paid slightly more for generalist residency positions than for nongeneralists through application of a trend factor for the former but not the latter. Medicare has paid for DME in one form or another since the inception of the program.

The indirect medical education (IME) adjustment is very different from DME reimbursement and serves a wholly different function. The IME adjustment was developed with the creation of the Prospective Payment System (PPS). The rationale behind it was expressed by the Senate Finance and House Ways and Means Committees as follows:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Finance Committee Report, Number 98-23, March 11, 1983; House Ways and Means Committee Report, Number 98-25, March 4, 1983).

Thus, the IME adjustment was developed to pay for observed extra costs incurred by teaching hospitals in addition to those represented by DME costs.

The DSH adjustment was also developed as a component of PPS because rural and urban hospitals that treat large numbers of low-income patients have higher costs than otherwise similar institutions due to the provision of extra services such as translation, increased security, social support, and other factors. The formula used to calculate a hospital's eligibility for DSH payments is based upon the proportion of inpatient days it provides to Medicaid and low income Medicare beneficiaries. This calculation produces a disproportionate patient percentage for each hospital. Hospitals with a percentage of 15% or greater qualify for DSH payments. Hospitals with percentages of 20.2% or higher are considered by the Medicare program to be "high DSH" institutions, a designation relevant to calculation of the add-on.

Overlap between GME and DSH

There is a significant overlap between hospitals that receive GME and DSH payments nationally. Thus, teaching hospitals account for 66% of all DSH payments, while DSH hospitals account for 76% of all IME payments. The overlap is even greater in some states than others. The vast majority of all teaching hospitals in GNYHA's membership are eligible for payments under the DSH program, and most of them, including Montefiore, qualify as "high DSH" institutions. Each program is extremely important to sustaining the varied activities of major teaching hospitals today such that reductions in either GME or DSH would have a major negative effect our entire membership. Reductions in both would be devastating.

New York's Teaching Hospitals

GNYHA's more than 80 teaching hospital members are quite diverse. They include academic medical centers affiliated with the region's eight medical schools; large, free-standing teaching hospitals; and the 11 hospitals comprising the City's Health and Hospitals Corporation (HHC). Collectively, these institutions train more than 12,000 physician residents per year, or more than 12% of the nation's total.

The medical schools with which these institutions are affiliated, and the hospitals themselves, comprise New York City's biomedical research complex. Montefiore Medical Center, for example, conducts substantial undergraduate, graduate medical education, and biomedical research programs. New York State itself is home to 13 medical schools and trains almost 15% of the nation's residents -- 60% more than California, the next largest state. Applying methodologies developed by the Council on Graduate Medical Education (COGME) to estimate primary versus specialty care mix, in 1993, 41% of the residents in training in GNYHA member hospitals were in primary care and obstetrics/gynecology specialties (37% without ob/gyn) and 59% were being trained in nongeneralist fields. These proportions are at or slightly better than the national average for generalist training.

New York's teaching hospitals are also essential to the public health of the City and nation because the problems that plague American society are particularly pronounced in urban areas like ours -- violence, substance abuse, homelessness and public health epidemics. Twenty percent of all AIDS cases nationwide are treated in New York City. New York hospitals also see more cases of tuberculosis than all the hospitals in the cities of Atlanta, Boston, Chicago, Houston, Los Angeles, Miami, and San Francisco combined. The biomedical complex thus has been essential to providing care to many of our nation's most vulnerable citizens and would be hard pressed to continue in similar fashion if either Medicare GME or DSH funding were cut.

From these statistics it is clear that New York's teaching complex is the center of advanced science, medicine, and education for the world. Patients come from all over the country -- indeed, from throughout the world -- to receive care in our institutions. The New York biomedical industry is a national treasure that enriches our lives, America's status in the world, our national economy, and the health care of all Americans. As such, it is in the interest of all Americans to preserve this vital resource.

The importance of our biomedical institutions to the community can be better appreciated by describing the activities of a specific hospital center. I am particularly proud of the track record that Montefiore Medical Center has established as an academic medical center that has purposefully oriented itself to meeting community needs.

Montefiore has accomplished this in the Bronx, where 1.2 million people live, among them some of our nation's most impoverished. We provide institutional care through two hospitals and three skilled nursing facilities. We offer related health care services through a large network, including the nation's oldest and largest hospital-based home health agency, nine community-based, primary care centers with many more in development, a nine-site multispecialty group practice, seven school-based clinics, an 850-physician faculty practice plan providing the full spectrum of primary and specialty care, an affiliated Medicaid managed care organization, and a range of other community based health services including drug treatment and renal dialysis. We provide services to North Central Bronx Hospital under an affiliation contract with HHC, and, under contract with New York City's Department of Health, we provide health and mental health services to 105,000 inmates a year at the Riker's Island Detention Center. Montefiore, HHC, and AECOM collaborate to provide medical and related services at the Bronx Municipal Hospital Center. Finally, our orientation to community needs is reflected in a range of services that surpass medical treatments and include, for example, a Child Protection Center for abused children, a Lead Poisoning Prevention Program, and Homeless Health Teams.

We have established this record of service as part of our mission to serve the community, and the residents and undergraduate medical students we train are an integral part of it. We provide training to more than 300 undergraduate medical students and 1,000 house staff annually. These programs include training for 60 primary care residents in community settings, 75% of whom choose medically underserved inner city practice sites for their first jobs upon graduation from the program, and 60% of whom are still working in such sites.

The New York Environment

As you know, New York's hospitals have operated for the past 12 years under one of the most regulated systems in the country. The issues presented by current budget discussions are the same for all teaching and DSH institutions across the country, in New York, however, regulation gives them a harder edge and sharper bite.

Since 1983, New York has strictly regulated hospital inpatient rates for all payers and, since 1985, for all payers except Medicare. We have operated under a stringent Certificate of Need (CON) process for the approval of capital expenditures and major modernization projects which continues in force today, as well as under the New York Prospective Hospital Reimbursement System (NYPHRM), which is set to expire in the middle of next year.

Under NYPHRM, our State essentially established a social contract that, through State-established inpatient rates for all non-Medicare payers, sought to achieve prospectivity in hospital reimbursement, contain hospital costs, and assure universal access through its public and private hospital system for those unable to pay. NYPHRM did this by tying commercial payer rates to rates paid by Medicaid, thus restricting cost shifting from public to private payers to the lowest

rate of any state in the country, and by creating innovative payment mechanisms for uncompensated hospital care.

With respect to cost containment, NYPHRM appears to have done its job, as studies of health care inflation in the 1980s show that New York had the lowest inflation rate of any state in that decade. Low prices for hospital prices persisted in the 1990s. In 1993, New York's institutions had the sixth lowest price per inpatient discharge adjusted for regional wage and illness severity factors, and the second lowest wage-adjusted price per outpatient visit of any state.

Another NYPHRM goal, to create one system of care for all, also succeeded. New York's hospitals provide a greater proportion of their services to indigent populations than the national average. Thus, while Medicaid inpatient discharges comprised 33% of New York City's voluntary hospital discharges in 1993 and 69% of public hospital cases, less than 14% of the country's hospital inpatient services were rendered to Medicaid beneficiaries, with 19% at major teaching hospitals nationally.

An unfortunate outcome of NYPHRM is the effect it has had on hospital financial conditions. Thus, while total margins have hovered around 4.4% nationally, with lower margins for major teaching hospitals, New York's hospital margins rank last in the nation. According to the New York State Department of Health, statewide in 1993, the weighted average total hospital margin was -.05%. In New York City, public and private hospitals combined had total margins of -1.9%. Private, voluntary hospitals had no margins, at 0.0%.

New York's hospitals also labor under severe cash flow constraints. A recent study by the United Hospital Fund found that while New York City academic medical centers are efficient at collecting receivables when compared to their national counterparts, they had only 5.5 days cash on hand in 1993. This compared to a national average of 40 days for U.S. teaching hospitals. And, in all other significant economic indicators, New York's hospitals rank at the bottom.

I recite this profile because it is crucial for the Committee to understand the fragility of the institutions that comprise the New York biomedical system when contemplating reforms in Medicare. As stated earlier, all teaching and DSH hospitals face the same threats from the Medicare cuts under discussion. New York's hospitals will reach the last stop sooner due to their poor financial conditions.

Hospitals Will Bear Their Fair Share of Sacrifice

The 104th Congress has embarked on a historic mission: to balance the Federal budget by 2002. This is a laudable, though daunting, undertaking. As a part of this challenging effort, the Joint Budget Resolution calls for reductions in projected Medicare spending of $270 billion over seven years.

Congress has indicated its intent to reduce the rate of growth in all Medicare expenditures, and we in New York do not expect to be exempted from any such actions. Given the financial picture of New York's hospitals, and the fact that they have already engaged in massive cost reduction programs, however, Medicare reductions will be difficult to bear. Cuts will mean dislocation, downsizing, loss of services to the community.

Teaching and DSH Hospitals Cannot Survive More Than Their Fair Share of Sacrifice

Having said this, it is extremely important that our nation's teaching hospitals do not bear more than their fair share of the sacrifices necessary to balance the budget or, quite simply, we will lose them. Severe cuts in Medicare reimbursements for graduate medical education and for institutions that serve a large proportion of poor patients, over and above reductions in the rate of growth in Medicare expenditures, are real cuts and will have a devastating -- and perhaps, deadly -- impact upon our biomedical infrastructure and upon quality of care for everyone.

In testimony before the House Ways and Means Subcommittee on Health, the Prospective Payment Assessment Commission made just this point on March 23, 1995:

> Teaching hospitals are an important source of care for Medicare enrollees... These

> hospitals are responsible for over 40 percent of all PPS discharges and half of PPS payments...[D]irect and indirect graduate medical education payments [and] disproportionate share payments...have helped many major teaching hospitals to avoid severe financial stress and to continue to provide access to care for Medicare enrollees, while maintaining their teaching mission. Accelerating price competition in the private sector is reducing the ability of teaching hospitals to obtain the higher patient care rates from other payers that traditionally have contributed to financing the costs of medical education. In addition, as Medicare's risk contracting program grows, teaching hospitals may not be benefitting as intended from the medical education payments included in the capitated payment.

Add to this statement the pressures of rate regulation under which New York hospitals have labored for decades, and it becomes readily apparent that Medicare reimbursement cuts to teaching hospitals, beyond cuts to hospitals generally, are a prescription for disaster.

The reason teaching hospitals are at risk of bearing more than their fair share of reductions is because of the focus, to date, on three elements to reduce Medicare hospital payments: cuts in the annual inflation adjustment, or update factor, to all PPS rates; cuts specifically in the IME factor; and cuts specifically to DSH payments. If Congress were to achieve Medicare savings in this way, it would impose a multiple blow to all teaching hospitals with even greater harm inflicted on teaching hospitals that also rely upon DSH payments.

This is because the IME and DSH add-ons are calculated upon the base of PPS payments. Reducing PPS payments through cuts in the update factor is intended to reduce the rate of growth in Medicare hospital payments, and will naturally ripple through to reduce IME and DSH add-ons. Separately reducing the IME or the DSH factors would impose an actual cut, not just a reduction in growth, targeted at a group of hospitals least able to withstand them, and which constitute the core of our nation's commitment to medicine.

Given these facts, it is our position that, in that teaching hospitals will see reductions in GME and DSH payments simply as a result of cuts in the update factors, further reductions are unwarranted and dangerous. We believe Medicare should continue to pay for GME and disproportionate share using the current Medicare payment methodologies in order to avoid severe damage to our nation's GME and biomedical infrastructures.

I should also note that significant reductions in support for teaching and DSH hospitals would counteract to the efforts to engage in fundamental restructuring of the Medicare program through increased managed care. As noted by ProPAC and the Association of American Medical Colleges (AAMC) in its testimony today, teaching hospitals provide a disproportionately large degree of services to the Medicare population, and do so with assurances to their patients of the highest quality and access to the latest medical advances that science has to offer. Teaching hospitals thus are a key part of the delivery system infrastructure to be relied upon in delivering Medicare managed care and assuring quality in the process. Maintaining the ability of teaching hospitals to help create superior alternatives in the Medicare program will be a crucial component of any strategy to implement Medicare managed care.

Medicare Restructuring Must Recognize Teaching and DSH Hospital Costs

The Congress is looking at many ways to restructure the Medicare program and to bring it more into line with private sector innovations. While restructuring proposals are diverse -- from providing vouchers to Medicare beneficiaries to enable them to buy private insurance products to encouraging more beneficiaries to enroll in Medicare risk programs -- all restructuring proposals share a common goal: to enroll a much greater proportion of Medicare beneficiaries in managed care plans.

Even without statutory changes, Medicare managed care enrollment is rapidly increasing. In some states, most notably California, Medicare managed care enrollment is approaching 30%. In New York, Medicare managed care enrollment has reached 7% Statewide and is close to 10% in New York City. Marketing efforts by Medicare HMOs in our area are exploding, with some plans reporting enrollments of more than 4000 new members per month.

The move to Medicare managed care makes sense, particularly given private sector trends. We

urge that, as Congress engages in this restructuring, it do so in a thorough manner that converts all elements of the system to one that is compatible with a more market-oriented environment.

In this regard, a fundamental flaw now exists in the way that Medicare HMOs are paid. The GME and DSH payments discussed above were developed to support public benefits delivered by teaching and other hospitals, and payment mechanisms were formulated in the context of the regulated fee-for-service environment. When Medicare managed care premiums, or the Adjusted Average Per Capita Cost (AAPCC), are developed, however, these payments are rolled into the premiums paid to Medicare HMOs and lose their special distinction as teaching and DSH payments. Thus, there is no requirement that HMOs contract with, much less pay the costs of, teaching and DSH institutions. Ironically, the costs of these programs are the source of higher Medicare premiums to HMOs, particularly in teaching intensive areas like New York City.

Because of the inherent competitive disadvantage of teaching hospitals in the managed care market, action is urgently needed to transfer GME and DSH payments out of the premium and pay them to the institutions and programs they are intended to fund. This proposal would not affect the total amount Medicare would spend under managed care, but would change the payment mechanics to ensure the support for GME and other public benefits is maintained. GNYHA therefore strongly supports the AAMC's proposal outlined today to address these concerns. I cannot overstate the importance of this issue to hospitals, and the very real threat that lack of swift action will pose to the very existence of our nation's most preeminent medical centers.

We believe Medicare managed care can offer many of the benefits that managed care has bestowed upon commercial populations and payers. However, not all hospitals are alike, a fact reflected in the programs they sponsor and related cost structures. If we are to preserve the best in our system, we need to recognize those differences in the way we pay premiums to HMOs.

Specific Proposals to Reduce or Restructure GME Payments

In its testimony today, the AAMC has cogently and comprehensively explained the importance of DME and IME payments to support the teaching hospital mission, as well as analyzed the pros and cons of specific proposals. As noted above, GNYHA similarly does not believe that reductions in the IME or DSH factors would be equitable or sensible as they would force teaching hospitals to bear a greater share of the burden of reductions than hospitals that do not perform these missions, and because teaching hospitals are crucial components of the American health care system and any restructuring that might occur within it.

With respect specifically to DME, various proposals that have been made over time, and are discussed in the AAMC's testimony, include facilitating the development of ambulatory training sites, limiting payments based on the period required for initial board certification, weighting DME payments by specialty, and creating a national average per resident amount. GNYHA supports the AAMC's analysis and positions on these issues.

On one issue, however, we would like to offer a different perspective. This concerns proposals to limit Medicare payments to residency positions only when they are filled by graduates of American medical colleges, and denying such payment in years when they are filled by International Medical Graduates (IMGs).

IMGs are U.S. citizens and persons of foreign citizenship who attend foreign medical schools. Medicare does not currently discriminate in its support of residency programs on the basis of whether the resident is an IMG or a graduate of a U.S. medical college so long as the IMG resident is in a qualified residency program and has passed Parts I and II of the National Board of Medical Examiners test. This test is equally applicable to both American and foreign IMGs.

The contention that there is an excess of physicians -- the principle justification behind proposals to deny support to programs that use foreign educated doctors -- is part of a complicated debate. Much of the concern over a physician surplus has been grounded in the economics of medical care in a fee-for-service system, where physicians are autonomous drivers of health care utilization through the tests, procedures, medications, and treatments they prescribe. However, market trends have changed this dynamic by introducing new incentives and competitive forces, and analyses of physician excess must likewise change.

Even using fee-for-service assumptions, many policy makers and researchers have disagreed about whether there is a physician oversupply, in what specialties, and what the trend line for future demand will be. Even assuming that a physician surplus emerged, it is not at all clear that this should be staved off given the dynamics of the new marketplace.

At Montefiore, we have witnessed a changing physician environment. My institution has been aggressively pursuing the development of ambulatory care capacity in both low income and middle class neighborhoods, and is currently engaged in the development of 15 such centers. Given our commitment to underserved areas, we are grateful to find that physician recruitment has become easier, and it appears that physicians are exploring a wider array of options than they had in the past.

Proposing to cut Medicare GME expenditures by drawing a bright line distinction based upon medical school location has a superficial appeal as an easy way to cut GME programs. Of course, states that rely heavily upon graduates of foreign medical schools, such as New York, New Jersey, Nevada, North Dakota, Illinois, Connecticut, Michigan, and others, would be hard hit by such an approach, which would strip their accredited training programs of the support given to identical programs in other parts of the country.

Needless to say, such an approach would not distinguish among physician residents based upon quality. Many of our foreign-trained residents are among the best and brightest new physicians I have seen, and many IMGs practice in rural and urban areas of the country that are medically underserved. Withdrawing Medicare funding for residency positions when they are filled by graduates of foreign medical schools would also have a devastating impact on the communities served by such physicians during their training years. Many foreign-educated physicians supply essential services to hospitals in medically underserved communities, particularly in urban areas. Denying Medicare reimbursement for positions filled by such persons would cripple such institutions, and deny services to communities that rely upon them without any associated replacement funding or alternative workforce options.

GNYHA therefore urges the Committee to reject any proposals to restrict GME funding only to residency positions when they are filled by U.S. medical graduates as an action that would harm underserved communities and that would draw arbitrary distinctions not related to quality, service, or workforce goals.

The Importance of Maintaining DSH Payments

As noted above, hospitals around the country in both rural and urban areas have relied on DSH adjustments to their PPS rates to maintain their financial stability and capacity to provide services to a wide range of patients. The DSH adjustment was created in recognition of the fact that hospitals with high proportions of low income patients, measured by services to low income Medicare and Medicaid beneficiaries, experience higher costs than hospitals without such characteristics and whose costs are expected to be covered by PPS rates. As recognized by Congress when it enacted the DSH adjustment in 1985, hospitals with large proportions of low income patients must provide associated services not offered in other hospitals, such as increased security, translation, and social support and related activities, which give rise to a higher cost structure.

Such services also occur more frequently in teaching hospitals than in non-teaching hospitals, because the missions of academic centers include not just teaching and research, but also include providing the latest and best in medical care to the general population, serving the public health through specialized, advanced services to treat diseases like tuberculosis and HIV, and serving their communities. I outlined at the beginning of my testimony the myriad of patient care services delivered by my own institution, of which I am very proud, many of which are targeted at improving the health of low income persons. Missions like ours, and the patients we serve, are characteristics shared by many academic centers across the country, and give rise to a different complement of cost structures that should continue to be recognized by the Medicare program.

DSH funding is not an isolated component of our budgets that is reserved to care for low income patients; rather, it is an integral part of a medical center's revenue stream that enables us to deliver high quality services to <u>all</u> of our patients. Possible reductions in DSH funding would

deal a devastating blow to the ability of rural and urban hospitals to continue fulfilling their missions of delivering patient care to a broad spectrum of patients.

Conclusion

GNYHA and its member institutions are living in a new health care environment, one in which the marketplace has prompted many changes in the way we do business. We ask Congress to undertake changes in the Medicare program and to maintain its strong commitment to change. At the same time, we urge you to proceed with extreme caution to preserve and to protect those elements of the system that are the best that American medicine has to offer. We stand ready to assist Committee members in any possible way as you embark upon this task.

Mr. ENSIGN [presiding]. Thank you for your testimony. Mr. Hall, Congressman Hilliard was supposed to be here and he apologizes that he cannot. He wanted to thank you for being here and he wanted to, personally, introduce you and I am to make his apologies. We appreciate your testimony.

STATEMENT OF DENNIS A. HALL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BAPTIST HEALTH SYSTEM, BIRMINGHAM, ALABAMA

Mr. HALL. Thank you, very much.

I am delighted to be here today and to have the opportunity to address this Subcommittee on your budget reconciliation debate and specifically its impact on Medicare. I am the president of the Baptist Health System based in Birmingham, Alabama. We operate 11 hospitals, 7 long-term skilled care centers, 50-some clinics across the State, and 7 home health agencies. We admit about 75,000 patients a year, see another 600,000 patients as outpatients. In fact, we have emerged as the largest health care delivery system in our State and we now employ about 10,000 employees. So we have a great interest in this debate, here today.

I think, as all of you on this Subcommittee know, the Health Care Financing Administration for years has attempted to manage the skyrocketing costs of Medicare by simply racheting down payments to providers at rates lower than medical inflation. This strategy has backfired in every way possible because it has never addressed the root causes of the problem—overcapacity, lack of incentives to promote efficiency and public sector cost shifting. The latter, resulting in things we all hear about like $24 aspirins appearing on fully insured patient's bills. Well, the cost-shifting window is quickly being slammed shut as employers and purchasers are now moving into managed care plans, HMOs, and PPOs, and negotiating deep-pocket discounted fee schedules, per diems, and even the more aggressive capitation programs.

Last year our system lost $13.5 million taking care of Medicare beneficiaries. And that was $750 per patient. Medicare pays us approximately 90 cents for every dollar of expenditures that we lay out taking care of Medicare beneficiaries. And even though we have been reducing these losses, our costs are rising faster than the reimbursement for Medicare patients.

As we see it, you have about three options. You can raise taxes. I have not heard that discussed here today nor in any other forum. I do not think that is a politically viable option. Your second option is simply to continue to cut reimbursement to the providers. Since the eighties, when the prospective payment system was put in, Medicare funding has had absolutely no ties to the cost of providing care to the beneficiaries.

Our organization, like institutions all across this country, have squeezed about as much as we can out of our costs in an attempt to provide cost-effective, high-quality care and, to some extent, we have been successful. However, our projections indicate that over the next 7 years, the impact of this $270 billion cutback in Medicare funding could cause our system to lose more than $122 million taking care of Medicare beneficiaries.

Obviously, if we begin to report these kind of financial losses, our access to capital is quickly cut off and we are not able to obtain the kind of information technology that we need to computerize medical records and administrative procedures to bring even more efficiencies to our system or even to monitor clinical outcomes and to acquire or replace medical technology.

We believe the only viable option that you have is to reduce health care utilization by Medicare beneficiaries. We need to change provider incentives to encourage what, we would call, care shifting instead of cost shifting. And certainly we have learned by now that regulatory micromanagement does not work.

There are all kinds of examples of regulatory barriers to efficiencies. To name just a few: Regulations that require patients to spend 3 days in a hospital before they can go into a skilled nursing unit; regulations that require long-term hospitalized patients, who are candidates for long-term hospital care, to be admitted to another facility, outside your hospital, before Medicare will pay for it, or require you to lease space in your hospital to some other company or organization before Medicare will pay for it; regulations that will not pay for unskilled care at home and result in Medicare beneficiaries ending up in rehabilitation facilities at a much higher costs. There are all kinds of examples of these kinds of regulatory barriers.

The most significant opportunity that you have to change the rate of utilization of health care services by Medicare beneficiaries, in our opinion, is to encourage more beneficiaries to join Medicare HMOs or Medicare risk plans. All the estimates that I see, and all the examples around the country, in spite of testimony that I have heard here earlier today, indicate that we could cut hospitalization rates in half with Medicare risk plans. We operate a Medicare risk plan in Alabama with 4,000 Medicare beneficiaries and that has certainly been our experience, let alone the elimination of many diagnostic interventions.

In addition, it would strip out millions of dollars of administrative expenses in terms of managing the current Medicare billing situation. We spend about $6 million a year in our system simply managing the administrative side of Medicare that would be completely unnecessary if, indeed, we were taking care of Medicare beneficiaries through a Medicare risk plan.

And perhaps one of the last things that I would like to reinforce is the American Hospital Association's position that we need to establish a citizens' commission similar to the Federal Reserve or the Securities and Exchange Commission to ensure that health policy decisions regarding the future Medicare funding are based on the actual cost of delivering medical services to beneficiaries, and to depoliticize this process of deliberating about the future funding of health care.

I would like to, perhaps, conclude my remarks by simply saying to you that we want to emphasize that by simply cutting Medicare payments to providers is not going to achieve the results that anyone wants. These results are simply going to cripple the many already weakened health care organizations, placing even more burden on the remaining providers to take up the slack.

What we really need is a transformation of our delivery system, and this Subcommittee can recommend legislative incentives to encourage providers to work toward cost-effective, high-quality care.

I think the only hope to reduce the cost of care for all patients, including Medicare beneficiaries, is through more efficient programs of managed care and coordinated care. It is the only tool that I know that we have demonstrated that works in this country. The choice that you are going to make is not whether Medicare survives or languishes, but it is going to be how are we going to meet our obligation to provide adequate and accessible health care to all Americans, regardless of their age, gender, or race.

Thank you.

[The prepared statement follows:]

STATEMENT OF DENNIS A. HALL
PRESIDENT AND CHIEF EXECUTIVE OFFICER
BAPTIST HEALTH SYSTEM

Good Morning, Mr. Chairman and members of the Committee. My name is Dennis Hall. I am president of the Baptist Health System in Birmingham, Alabama.

I want to thank the members of this committee for allowing me to address some of the most critical issues surrounding the budget reconciliation debate and specifically its impact on Medicare. It is indeed an honor to represent the Baptist Health System and the many other not-for-profit hospitals like ours across the country which are struggling to deliver the most cost-efficient high quality health care in the communities we serve in this rapidly changing regulatory and business environment.

I come to you today as the president of Alabama's largest not-for-profit private health care delivery system, the Baptist Health System, headquartered in Birmingham. Our system is the majority shareholder of the state's third largest HMO with over nearly 70,000 members including nearly 4,000 Medicare risk members, as well as a preferred provider organization with 100,00 members throughout the state. We have eleven owned, leased and managed hospitals with over 2,100 acute care beds. We treat nearly 75,000 inpatients and 600,000 outpatients each year. The system offers the complete continuum of care including seven skilled nursing, home care and primary care in 50 clinics with over 120 physicians. Net revenues for our system this year will be approximately $700 million. We employ nearly 10,000 employees state wide.

The Health Care Financing Administration (HCFA), for years, has attempted to manage the skyrocketing growth of Medicare spending by continually ratcheting down on payments to providers at rates lower than medical inflation. By all accounts, this strategy has backfired because it never addressed the root causes of the problem: over capacity, lack of incentives to promote efficiency, and public-sector cost shifting. The latter condition has forced providers to cover their losses on Medicare by shifting costs which are not reimbursed to their insured patients; hence the infamous "$24 aspirin" which appears on privately insured patients' bills. But the "cost-shifting" window is slamming shut. More and more commercially insured employers are moving their employees to managed care plans-- either through preferred provider plans offering discounted charges or set fee schedules, or health maintenance organizations that negotiate per diem hospitalization rates with providers or more aggressive capitation programs. Future opportunities to shift costs have evaporated for many hospitals.

Last year our system lost over $13.5 million on providing care for Medicare patients. Medicare pays us roughly 90¢ for every $1.00 of our cost. Although our Medicare losses have been gradually declining, we do not expect that trend to continue as our costs are rising faster that reimbursement rates. Obviously, finding ways to at least break-even on Medicare is a major challenge for us, as it is for many not-for-profit institutions, since our policy has been and will continue to be to accept any patient, regardless of insurance status or ability to pay.

Options to Keep the Medicare Hospital Insurance Trust Fund Solvent

As we see it, there are three options to keep the trust fund solvent and preserve Medicare. The first is to immediately raise the current payroll taxes rate by 44 percent or more according to government estimates. It seems such an action may not be politically acceptable, based on the voters' reaction last November.

The second option is to cut reimbursement to providers. Since the implementation of the prospective payment system in the mid 1980s, development of health policy and decisions on Medicare funding have had no ties to the cost of providing care. We, like many other institutions, have squeezed about as much as we can out of our costs in an attempt to provide cost-effective high-quality care for Medicare patients under the current fee-for-service structure of our system. To a certain extent we have been successful. Over the last four years we have managed to reduce our Medicare losses by almost $4.0 million. However, our projections indicate that over the next 7 years, the impact of a $270 billion cutback in Medicare funding will cause our system to lose more than $122 million. And, as mentioned earlier, those losses can no longer be recovered by shifting the burden to our commercial customers.

Furthermore, as soon as our organization begins to report financial losses, our bond rating will likely drop. The resulting higher interest rates on future bond issues will make it nearly impossible to raise the capital necessary to support investments in essential systems like computerized patient records which are needed to monitor patient care "real time" and electronic billing which is required to improve administrative efficiency. We would also have to postpone the acquisition of information technology used to analyze and report clinical outcomes data.

The third and, we believe, the only viable option is to reduce health care utilization by Medicare beneficiaries. There are a number of programs the government can implement to help hospitals and physicians curb utilization and lessen the strain on the trust fund.

Change Provider Incentives:

First, we need to change provider incentives to encourage what we call "care shifting" as opposed to cost shifting. Certainly we should have learned by now that regulatory micro-management does not work. HCFA has been so concerned that providers will find loopholes and ways to creatively but legally game the system that they established rules that are counter productive and more costly to the system. For example, Medicare requires a patient to spend three days in the hospital before a skilled nursing stay is reimbursed, causing Medicare to pay for an unnecessary hospital admission. Another example relates to the Medicare beneficiary whose illness requires a hospital stay in excess of 25 days. In many cases care could be provided in a less costly long term care hospital environment. However, Medicare will only pay for this care if the hospital has a separate building, or pays an unrelated company to lease space in the hospital to provide the care. Both these alternatives increase the total cost of care. Our goal is to match patient acuity levels to the most appropriate and cost-effective care settings. Medicare regulations often prevent us from achieving that goal.

Under the current Medicare rules, approved home health agencies are not reimbursed for provided unskilled care as a stand-alone service, such as the use of a home health aide for personal care and assistance with activities of daily living. As a result, Medicare patients who are not sick enough to be in the hospital but too sick to be at home unassisted cannot take advantage of less costly home care services. For instance, a patient recovering from hip surgery may have to use inpatient rehabilitation costing an average of $5,000 a week as compared to home care services which may cost less that $1,000 a week.

Home health care has moved well beyond its traditional boundaries, making it possible for millions of patients to reduce or eliminate altogether their need for more costly inpatient treatment which holds down the total cost of care. For example, a home care program in Connecticut has decreased costs for managing patients with chronic obstructive pulmonary disease (COPD). The goal of the program was to provide more comprehensive home care services to COPD patients who previously required frequent hospitalizations. Average monthly costs for those patients' hospitalizations, emergency room visits, and home care fell from $2,836 per patient to $2,508 per patient, a savings of $328 per patient. Home care programs in our own system reduced cost of care for patients with ischemic heart disease by 77%, from $320 per day to $72 per day (excluding pharmacy and medical supply costs).

Change Beneficiary Incentives:

We also see a need to change incentives for beneficiaries to encourage them to seek preventive health care by taking advantage of health screening programs that can offer early detection of serious medical problems. If we can help beneficiaries identify health risks then it seems logical that we should be able to help them reduce those risks and thereby reduce health care costs. Those individuals who might be at risk for such catastrophic problems as heart attack or stroke could possibly be managed on an outpatient basis at a much lower cost than inpatient care. These measures may not just postpone the "inevitable," but potentially prevent costly medical interventions. Clearly, employers who have adopted health promotion programs see the returns on their investment in terms in reductions of their total cost of care.

We might also encourage beneficiaries to seek healthier life styles by maintaining ongoing relationships with them. BHS instituted such a membership program called Senior Choice which has grown to over 25,000 members in the ten years since its inception. The program offers members various health information and conducts wellness-oriented activities.

Expand Medicare Managed Care Programs:

Probably the most significant opportunity to change the rate of utilization of health care services by Medicare beneficiaries is to encourage more beneficiaries to join Medicare HMOs. Conservative estimates are that under managed care, Medicare inpatient days would drop to about 1,200 days or lower per 1,000 population from the current level of 2,700 days under the fee-for-service system, without compromising the quality of clinical outcome. A managed care structure can reduce cost while providing an integrated continuum of care-- better care at less cost.

One possible fallout of expanding Medicare HMO's would be to substantially reduce provider administrative costs. The Baptist Health System spends approximately $6 million annually for administration of Medicare claims including a portion of our business office, information systems and medical records. Other providers and physicians probably experience similar costs proportional to the size of their Medicare clientele. Eliminating Medicare claims processing would essentially eliminate most of these administrative costs.

Independent Citizens Commission:

An independent citizens commission similar to the Federal Reserve Board or the Securities and Exchange Commission should be established to ensure health policy decisions regarding Medicare funding are based on the actual cost of delivering medical services to beneficiaries. As proposed by the American Hospital Association, such a commission would de-politicize the Medicare program and allow Congress and the administration to respond more quickly to problems that could contribute to trust fund insolvency.

Medical Liability Reform:

Another way to reduce costs is medical liability reform. Clearly, malpractice insurance costs are reflected in Medicare payment rates. Medical liability reform will reduce premiums and consequently lower Medicare costs. The California Medical Injury Compensation Reform Act of 1975 seems to be a successful model which could be adopted at the federal level. Under such a program, caps would be set to limit non-economic damages. Double recovery of medical-expense damages would be eliminated. Future award payments would be made periodically rather than as a lump sum payment. The statute of limitations would be reduced, and a sliding scale would be set to decrease the attorney's contingency fee as the award increases.

Hospitals pay millions of dollars in malpractice liability insurance premiums annually and maintain large reserves for medical liability, money that could otherwise be devoted to improving patient care services. Physicians carry a similar burden. An experienced obstetrician, for instance, may pay as much as $65,000 in malpractice insurance premiums annually. And if a doctor has had a successful claim, the premium can jump to $80,000 or $90,000 per year. The Southern Medical Group, Inc., an emergency room management company of which BHS is a minority shareholder, pays over $350,000 in malpractice premiums for the six hospitals which contract with it to provide emergency room coverage. This translates to higher costs of care for everyone.

Antitrust:

Although antitrust laws are essential to prevent unfair business practices and promote competition, such protection as applied to health care can result in unnecessary and expensive duplication of resources and excess capacity. We believe the government should offer clear guidance to hospitals with respect to antitrust matters which encourages collaboration among providers based on the health needs of the local market. Such collaboration should reduce duplication, over capacity and lower costs. Today, with the uncertainty in this area, providers are hesitant to initiate creative arrangements that might have a positive impact on cost of care if there is a possibility of incurring an antitrust violation and the resulting treble damages.

Providers are not waiting for legislated health care reform or the impact of balanced budget to reinvent the health care delivery system. We are working together with employers and other health agencies to reduce costs while maintaining or improving the quality of care in terms of clinical outcomes and customer satisfaction. The Baptist Health System have a number of initiatives that have been underway for some time to ensure more efficient coordination of care within and among our various facilities and levels of care. The anticipated savings are dramatic-- almost $9 million as a result of downsizing our work

force, $4.5 million by standardizing medical supplies, another $4.5 million through clinical case management activities and $2 million through consolidation of clinical services.

However, there is a point of diminishing marginal returns. At some point continued efforts to cut staff and reduce services in an effort to control costs will ultimately have a negative impact on patient satisfaction and certainly on the quality of care. The people who come to us for care are sicker than ever before. Yet we have still managed to reduce the average length of stay from 6.23 days to 5.37 days, a 14% decrease.

Congressmen, I must emphasize that simply cutting Medicare payments to providers will not achieve the results you desire. Instead, such cuts will probably cripple many already-weakened health care organizations, placing even more burden on the remaining providers to take up the slack. What is needed is a transformation of our delivery system. This subcommittee can recommend legislative incentives to encourage providers on the path toward cost effective high-quality health care. Our only hope to generate cost savings for Medicare and other patients is through more efficient programs of managed care.

The choice we make is not just whether Medicare survives or languishes, but how we are going to meet our obligation to provide adequate and accessible health care to all Americans regardless of race, gender or age.

Mr. ENSIGN. Thank you, both, for your testimony.

We you like to inquire, Mr. Laughlin?

Mr. LAUGHLIN. Yes, thank you, Mr. Chairman.

Dr. Foreman, when Mr. Van Etten testified, he suggested that we eliminate payment of graduate medical school education. Could you tell us what the effect of this policy would have on an institution such as yours?

Dr. FOREMAN. I think, if I am not mistaken, did he recommend the elimination of all support of graduate medical education or just for international medical graduates? I think it was just the international medical graduates, sir.

Mr. LAUGHLIN. The question was given to me by somebody who was here when he testified and I was not here, so I do not know if that is much help.

Dr. FOREMAN. Yes, Mr. Houghton gave you that question, I saw it.

Mr. LAUGHLIN. That is correct, Dr. Foreman.

Dr. FOREMAN. Thank you, very much.

International medical graduates have come under discussion extensively in the last several years. And this is as a consequence of a growing concern on the part of a number of organizations about excess physician number in the work force and whether that is a bad thing and if it is a bad thing, what is the appropriate way to correct it?

Since we admit into graduate medical education about one-half as many international medical graduates each year as American medical graduates, and those graduates ultimately find their way into the physician work force, they represent a substantial portion of our physician supply in the United States, and those who believe that there is an excess of physicians, think that any reductions ought to take place first among international medical graduates.

But, it is not at all clear that we have an excess of physicians in the sense that their numbers are creating unwanted consequences. As a matter of fact, a number of people believe that it has taken a significant increase in the number of physicians in order for managed care to take hold in the United States.

There is very little doubt that international medical graduates have provided a vital service, both while they are in graduate medical education and after they graduate and go into practice.

Significantly, there has been a very high concentration of international medical graduates in institutions in large urban areas that serve the poor. There have been estimates made by credible researchers that indicate that between 75 and 300 hospitals in inner-city areas that are critically important to the provision of care of poor communities are dependent upon international medical graduates to provide that care.

This is particularly true in New York City. A very substantial number of the institutions, particularly the public general hospitals that serve the poor, get their medical care from international medical graduates.

The final point I wanted to reiterate is that although we think of international medical graduates as being foreigners, one-half of them, at least, are either American citizens, naturalized or native-born, or permanent residents in the United States.

It is our contention that if we were to remove graduate medical education funding for international medical graduates, we would critically impair the ability of those hospitals to deliver care to the inner-city poor.

Mr. LAUGHLIN. Mr. Chairman, do you have time for one more question?

Mr. ENSIGN. Yes.

Mr. LAUGHLIN. Dr. Foreman, I represent a very large rural area. Some of the counties I represent have no hospital in it, and of the 22 counties I represent, only 1 has more than 1 hospital in it. And I represent numerous communities in the range of 2,000 and smaller that have no doctor in there. My question to you is, what is your institution doing to influence or cause your graduates to go to rural America? Everything that you heard from the four Members of Congress who provide the leadership to the rural health coalition, representing both political parties, is absolutely true in the district I represent. I wonder what, in addition, does your institution do to provide this needed medical service? What suggestions do you have that we might better serve Rural America?

Dr. FOREMAN. There have been two historically underserved populations; one in rural America and one in inner-city America. And each has been historically underserved for different reasons. The inner-city populations have been underserved primarily because there has not been payment for medical services sufficient to attract medical practitioners, and because the practicing in the conditions in an impoverished community are very difficult.

In rural communities, isolation has been a very important factor in getting physicians into those areas. There is very good evidence, at least in the seventies, that as the numbers of physicians increased in the United States, there was a significant improvement in the penetration of physicians into rural areas. It is not clear, however, whether that progress has continued in the eighties and nineties.

There are areas of rural America, at least anecdotally, in which there has been a very substantial increase in the number of physicians serving rural populations, although not necessarily in the tiniest towns. That is, if one looks at north-central Pennsylvania, for instance, what has happened in towns like Williamsport or Danville where there are large institutions is that those institutions have attracted a large number of practitioners who serve the whole country, although the little villages in the countryside may not have the same increase in physicians.

Our institution is in the Bronx, not surprisingly that is not a rural county. It is, however, a highly urban and distressed county and we have had a substantial impact on moving physicians into the service of the urban poor. We now operate ambulatory care centers with over 70 physicians serving the poorest residents in our community. We are dedicated to expanding that network.

It is our belief that the growing number of physicians—I will not call it a surplus—in the competitive health care system which is now developing as a result of managed care—will reduce the economic opportunities in affluent, suburban metropolitan areas and create the conditions which will serve to foster the outmigration of physicians, both into rural areas and inner-cities. I think that that

is going to be a positive consequence of the growing physician work force.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Dr. FOREMAN. Thank you, sir.

Mr. ENSIGN. We just have a couple of minutes left, and we have a vote on, and we will have to take a break.

I just have a couple of questions. First of all, we know we have a limited amount of funds. We know that Medicare is going broke and the only way for this system to survive is to make some fairly significant institutional reforms to the whole Medicare system.

If we know we have a limited amount of dollars to use, first of all, would your suggestions be that since more of the inner-city hospitals—and this would be to Dr. Foreman obviously—serve the poor, should the graduate medical assistance dollars be going to more of those areas that serve the poor and let the wealthier hospitals fend for themselves and let the market play there?

What I am trying to set up here is that that is what they were trying to do to you.

Dr. FOREMAN. I understand. Let me go back to some questions, if I might, that I heard you ask one of the prior panelists because I think it is worth examining what the true costs of graduate medical education are, who pays them, and why they are what they are.

There is no doubt that graduate medical education trainees render a vital and important service. It just so happens though that that service costs more than it earns for the institution. And the evidence for that is pretty compelling on a macroeconomic basis. That is to say that if you look at the way that nonteaching hospitals have operated over the past decade, they have consistently had more than twice the amount of margin that the teaching hospitals have had across the country.

Mr. ENSIGN. Does that take into account more unpaid bills?

Dr. FOREMAN. I am sorry?

Mr. ENSIGN. In Las Vegas we have our county hospital, so you are having a lot of lower income people that do not pay their bills—does that take that into account?

Dr. FOREMAN. Yes. The overall teaching hospitals carry a mixed bag of burdens and responsibilities. They provide teaching, they provide high-tech services which are often underreimbursed.

Mr. ENSIGN. Maybe I did not state my point clearly. In other words, if you factored in that those people had paid their bills, now, do residents cost more—in other words, do hospitals with residents cost more than hospitals without?

Dr. FOREMAN. Yes. That is to say that even if you made up the underpayment for the uninsured, you would still have higher costs in teaching hospitals than you do in nonteaching hospitals, and there would still be lower margins based on the way patients care is paid for.

Mr. ENSIGN. Why?

Dr. FOREMAN. Basically because teaching hospitals have cost burdens, some of which are direct and measurable.

Let us look at the three payments that I discussed in my testimony today. If there were adequate payment for the poor, there would not be the requirement for disproportionate share payment.

That is clearly a payment targeted at the care of the poor and substitutes for those costs and, therefore, they would not be necessary.

But the direct medical education costs add in the measurable, auditable costs of the resident—salary, fringe benefits, faculty costs, and overhead. The indirect medical costs are a more complicated bag. They measure a lot of things indirectly.

Mr. ENSIGN. I understand how all those work, but why—I still have not had that addressed—why they are more expensive? Why is a hospital with residents more expensive? Where do the costs come in that make them less profitable?

Dr. FOREMAN. Well, they occur in several ways. First of all, teaching hospitals have a very substantial burden associated with complex care which is not recognized in the DRG system. That is to say a gall bladder is not a gall bladder is not a gall bladder. If you remove a gall bladder from a 35-year-old healthy young female, it is a relatively simple operation. If you take a gall bladder out from a 75-year-old patient who is overweight, has heart disease, and chronic lung difficulty, that is a different illness.

And those factors are not adequately accounted for in the payment scheme of DRGs. The result has been that the indirect medical education payments have served substantially as a proxy for complex care. They have also paid for the costs of introducing technology, and finally they have paid for the inefficiencies in the teaching process.

Mr. ENSIGN. OK. I guess you know my suggestion would have been to set up the system to clearly reflect the realities of what is happening, so that if you want to cut, you know where you are cutting, and if you do not want to cut, I think it would have been fairer to the entire system and would have worked out better in the long run. And perhaps we could at least make that part of our reforms that the costs are more indicative of what is going on out there.

I apologize. I have 3 minutes to go and vote and I will excuse you both, and I will call the next panel up, following the recess, in about 10 minutes.

Without objection, Congressman Hilliard's full statement will be made a part of the record.

[Congressman Hilliard's statement was not available at the time of printing.]

[Recess.]

Mr. ENSIGN. I would like to welcome the panel. We have Howard Hughes, former billionaire, with Geisinger Health Systems, Danville, Pennsylvania; Glenn Nelson, chair, Rural Policy Research Institute Regional Modeling Work Group; Keith Mueller, member, Rural Policy Research Institute; and Charlotte Hardt, member, Board of Trustees, National Rural Health Association.

I would like to welcome the panel and you have 5 minutes. We would appreciate your keeping your comments to around 5 minutes.

Dr. Hughes.

STATEMENT OF HOWARD G. HUGHES, M.D., GEISINGER HEALTH SYSTEM, DANVILLE, PENNSYLVANIA

Dr. HUGHES. Thank you, Mr. Chairman for the opportunity to present on behalf of the Geisinger Health System. I would like to ask that my full testimony be included in the hearing record.

Mr. ENSIGN. Without objection.

Dr. HUGHES. My name is Dr. Howard Hughes. By training, I am an emergency medicine physician and I am responsible for the operation of Geisinger's managed care programs. Briefly, the Geisinger Medical Center, founded 80 years ago, is a 577-bed facility in Danville, Pennsylvania. The medical system is a part of the Geisinger Health System which is the Nation's largest rural health care system. The medical center serves as the region's tertiary referral and the only level one trauma center in rural Pennsylvania.

Geisinger is a fully integrated health care system, serving more than 31 counties and 2.3 million Pennsylvanians. Because of the rural and diverse geographical nature of the Geisinger system, our physicians face unique challenges in providing timely and quality health care services to our rural elderly population.

Geisinger's HMO is the country's largest rural HMO with over 170,000 members, including a Medicare risk component with 6,000 members. We anticipate that our Medicare-Eligible Program will grow to over 15,000 members over the next 3 years.

The Geisinger Health Plan is a not-for-profit HMO. Our accountability is to the patients and employers we serve, not to the owners of a corporate entity. As a result, we have the highest percentage of premium dollars going directly to medical services and patient care, almost 93 percent, compared to the 82-percent average of the 13 other HMOs in the State of Pennsylvania.

At least 30 percent of our hospital admissions are Medicare patients, and we view with significant alarm the magnitude of proposed further cutbacks in Medicare funding that are planned over the next 7 years. Despite our efficiency, the current level of Medicare payments does not cover our costs and Geisinger loses money on every Medicare patient. Two years ago, Geisinger was undercompensated by almost $12 million.

With the proposed reductions in Medicare, we may lose significantly more than that on an annual basis. While managed care is a driving strategy of the Geisinger system, we believe that Medicare recipients should have a choice of coverage. Our experience proves that managed care offers, perhaps, the most realistic option for bringing about major efficiencies in our Nation's health care system. These advantages accrue for the benefit of all parties—the patient, the provider, and the government.

As Congress moves toward reforming the Medicare system, there is the expectation that providers will do better with less. To make certain that the full impact of whatever reforms forthcoming are positive, Congress must be attentive to the special infrastructure needed for rural providers.

First, there must be a sufficient amount of funds for medical education. Any decline in funding for the teaching institutions will directly limit the future supply of rural physicians. This ultimately will limit access to the health care system for the elderly and already underserved rural areas.

Second, to make health care reform truly efficient, technology must play an increasing role. We urge that any plan for reform include funding or, at a minimum, adequate reimbursement for telecommunications/telemedicine programs. At a time of declining revenues and margins, most rural providers, including Geisinger, will be unable to implement this necessary tool without Federal assistance.

Let me conclude by offering some specific recommendations that relate to Medicare in the rural marketplace. HCFA's payment rates vary widely between adjacent counties, whereas the HMO would observe no cost differences relating to which counties the members reside.

The current geographic areas should be redefined to achieve more homogeneous cost areas than the current county-by-county configuration. The AAPCC should be based on metropolitan statistical areas rather than counties. Rural counties should be grouped together rather than being given separate rates. HCFA should explore an alternative to the AAPCC to allow development of more rural plans.

Payment methods should eventually evolve into a market-driven process, thereby affording the benefits of a free market system to HMOs. Once an alternative plan is approved by HCFA, there should be a simple process for expanding the plan service area into contiguous counties. If the new counties are approved by the State's regulatory agency, that should be sufficient. The Federal expansion of the service area requirements should be streamlined.

Medicare beneficiaries should be able to purchase HMO coverage as supplemental coverage, as an alternative to Medicare risk coverage. The HMO rate would be based on the incremental benefits offered by the HMO over and above Medicare. Medicare would be the primary carrier and the HMO would provide coverage, under its rules, for the incremental benefits. This kind of carved-out plan was feasible until the Medicare supplemental reform of the late eighties. But now it is not available even though it offers substantial savings for the beneficiaries.

Allow Medicare risk plans to sell point-of-service plans, also called self-referred plans, or SROs, allow tax-exempt status for nonprofit plans that offer points-of-service options and, finally, HCFA should actively promote enrollment in Medicare risk plans. This includes a mechanism to allow beneficiaries to enroll directly in risk plans as soon as they become eligible for Medicare.

Thank you, Mr. Chairman, for the opportunity to be here. I would be happy to answer any questions.

[The prepared statement follows:]

Geisinger.

[redacted]

THE STATEMENT OF HOWARD HUGHES, M.D. ON BEHALF OF
THE GEISINGER HEALTH SYSTEM
BEFORE THE
SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS
JULY 20, 1995

Thank you Mr. Chairman and members of the Subcommittee for this opportunity to present Geisinger's unique perspective on Medicare reform issues as especially they relate to the delivery of health services and managed care in a rural environment.

My name is Howard Hughes, M.D. By training I am an Emergency Medicine physician. My managerial duties at Geisinger include those as Senior Vice President for Health Plans, including the HMO -- The Geisinger Health Plan. In this capacity I am responsible for the operation of Geisinger's managed care programs.

The Geisinger Health System

Briefly, the Geisinger Medical Center, founded 80 years ago, is a 577-bed facility in Danville, Pennsylvania and is the center of the nation's largest rural health care system. Geisinger is a fully integrated health system serving more than 31 primarily rural counties and 2.3 million people in central, northcentral and northeastern Pennsylvania. The Geisinger Medical Center, serves as the region's tertiary referral and the only Level 1 Trauma Center in rural Pennsylvania. Additionally, the System includes a 230-bed regional hospital and cancer center in Wilkes Barre, a chemical dependency treatment center near Scranton, and more than 60 physician practice sites in mostly rural and isolated areas.

Because of the rural and diverse geographical nature of the Geisinger System, our physicians face unique challenges in providing timely and quality health care services to our rural elderly population. These challenges include:

* Efficiently transmitting medical information between health care providers;
* Recruiting and retaining physicians in rural areas;
* Adequate and timely referral information; and
* Patient access to quality health care services.

Medicare Reform

Due to our location, Geisinger has special expertise in providing health care to an elderly population -- particularly the rural elderly. The Commonwealth of Pennsylvania has arguably the oldest population in the country with 15.4% of its residents 65 years or older. Geisinger's service area has a population that is proportionately older, with several counties we serve approaching 20%.

At least 30% of our hospital admissions are Medicare patients and, we view with significant alarm the magnitude of proposed further cutbacks in Medicare funding that are planned over the next seven years.

Charitable organizations that solicit contributions are required by the Commonwealth of Pennsylvania to provide the following statement: "A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement."

Geisinger Foundation
Danville, PA 17822
(717) 271-6461

Market forces and changes in health care have not limited Geisinger's growth or ability to provide quality health care services. This is in large part due to the establishment of Geisinger's Health Maintenance Organization in 1972. At that time, it was one of the nation's first rural HMOs. Now the Geisinger Health Plan is the country's largest rural HMO with over 170,000 members, including a Medicare Risk component with 6,000 members. We anticipate that our Medicare eligible program will grow to 15,000 members over the next three years. The Geisinger Health Plan is a non-profit HMO. Our accountability is to the patients and employers we serve, not to the owners of a corporate entity. Accordingly, Geisinger has the highest percentage of premium dollar going directly to medical services and patient care -- almost 93% -- compared to the 82 average of the 13 other HMOs in Pennsylvania.

There has been much unfounded concern about the absence of competition in many rural areas and the false conclusion that a single managed care program or other provider may inflate premiums. In fact, competition is heating up, even in rural areas of Pennsylvania where Geisinger was once the only provider. Even before the arrival of competition, however, our premiums, offered to federal employees, have traditionally been among the lowest in the country. As competing health plans have arrived in our service area, most have reduced their premiums to meet Geisinger's prices. This should help dispel the notion that lack of competition necessarily means higher prices for consumers.

Geisinger's extensive research in geriatric nutrition shows that 30% of our rural elderly are malnourished. This means that elderly patients come to us more seriously ill, their hospital stays are longer, and they require more aftercare. Compared to the 8 day stay for the well-nourished, the average stay is 11 days for the malnourished patient. The additional time, care and attention required by malnourished inpatients, just for Geisinger patients, costs an additional $20 - $25 million in health care resources annually. As we move to a capitated environment, we have an incentive to conduct nutritional screening among all new Medicare Risk enrollees. The potential impact on costs is great, not to mention the improvement in the quality of life for the elderly. This is the essence of managed care and managed care is our primary business strategy.

While managed care is a driving strategy of the Geisinger system, we believe that Medicare recipients should have a choice of coverage. Our experience proves that managed care offers perhaps the most realistic option for bringing about major efficiencies in our nation's health care system. These advantages accrue for the benefit of all parties -- the patient, the provider and the government.

As a rural, managed health care system, Geisinger can confirm the following conclusions from a study of the Group Health Association of America entitled, "HMOs and Medicare: Myths and Realities."

1. Current enrollment patterns in Medicare HMOs demonstrate that HMOs serve populations similar to those of Medicare Fee-For-Service.

2. HMOs have a proven ability to contain the growth of health care costs over an extended period of time.

3. HMOs are, by design, able to produce substantial savings over traditional Fee-For-Service medicine.

4. HMOs generate cost savings in the Medicare program by holding down costs in their plans and by producing savings in the marketplace as a whole.

5. The Medicare Risk program is producing savings.

6. The type of coordinated, prevention-focused care found in HMOs is well-suited to the needs of seniors.

7. Medicare beneficiaries who are enrolled in HMOs are more satisfied with their health plan and its coverage than FFS beneficiaries regardless of their health status.

8. HMOs have proven their ability to ensure that appropriate services are utilized in appropriate settings.

As Congress moves toward reforming the Medicare system, there is the expectation that providers will "do better with less." To make certain that the full impact of whatever reforms are forthcoming are positive, Congress must be attentive to the special infrastructure needs of rural providers.

First, there must be sufficient funds for medical education, Geisinger, as a major teaching center, has 200 physicians in training. For many this is their first experience in a rural setting. More than half of our graduates go on to practice in rural areas. So any decline in funding for the teaching institutions will directly limit the future supply of rural physicians. This ultimately will limit access to the health care system for the elderly in already underserved rural areas.

Second, the Geisinger Health System includes more than 60 clinic sites, most of them rural and some almost 150 miles from our Medical Center in Danville. To make health care reform truly efficient, technology must plan an increasing role. We urge that any plan for reform include funding or, at a minimum, adequate reimbursement for telecommunications/telemedicine programs. This can expedite the flow of information, reduce travel by patients and professionals and provide distance learning and continuing medical education. At a time of declining revenues and margins, most rural providers, including Geisinger, will be unable to implement this necessary tool without Federal assistance.

Let me conclude by offering some specific recommendations that relate to Medicare and the rural marketplace.

- HCFA's payment rates vary widely between adjacent counties, whereas the HMO would observe no cost differences relating to which counties the members reside. The current geographic areas should be redefined to achieve more homogeneous cost areas than the current county-by-county configuration. The AAPCC should be based on metropolitan statistical areas rather than counties. Rural counties should be grouped together rather than being given separate rates. HCFA should explore an alternative to the AAPCC to allow development of more rural plans.

- Payment rates are unstable from period to period, thereby making planning difficult. Unexplained aberrations in the current systems payment method must be eliminated.

- Payment methods should eventually evolve into a market driven process thereby affording the benefits of a free market system to HMOs.

- Once an alternative plan is approved by HCFA, there should be a simple process for expanding the plan's service area into contiguous counties. If the new counties are approved by the state's regulatory authority, that should be sufficient. The Federal expansion of the service area requirements should be streamlined.

- Medicare beneficiaries should be able to purchase HMO coverage as supplemental coverage, as an alternative to Medicare "risk" coverage. The HMO rate would be based on the incremental benefits offered by the HMO, over and above Medicare. Medicare would be the primary payor, and the HMO would provide coverage under its rules for the incremental benefits. This kind of "carve-out" plan was feasible until the Medicare supplemental reform of the late 1980's. But now it is not available even though it offers substantial savings to beneficiaries.

- Current rules say that an HMO cannot have more than 50% of its members in the Medicare plan. The other 50% must be commercial and/or Medicaid, but no more than 75% can be Medicare and Medicaid combined. This is an attempt to measure quality: it is assumed that if 25% of the members are commercial members with other options, then it must be a good plan. These limitations are obsolete and should be eliminated. There are better ways to gauge the quality of a plan, such as NCQA accreditation, which should be the standard.

- Allow Medicare risk plans to sell point-of-service plans (also called self referred options, or SRO's); and finally,

- Allow tax-exempt status for non-profit plans that offer points of service options, and

- HCFA should actively promote enrollment in Medicare risk plans. This includes a mechanism to allow beneficiaries to enroll directly in risk plans as soon as they become eligible for Medicare.

The current budget-driven approach towards a coherent Federal health care policy has created conflicting incentives between patients and health care providers, and access issues for the uninsured and underinsured. Health care policy reform is key to the improvement of our nation's health care system. Integrated regional systems of health care, like Geisinger, have a vital role to play in assisting the Congress in health care policy and Medicare reform.

Thank you Mr. Chairman, for the opportunity to present the views of the Geisinger Health System. We are available to assist Members of the Committee as it prepares Medicare reform legislation.

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Mr. ENSIGN. Thank you.
Dr. Nelson.

STATEMENT OF GLENN L. NELSON, PH.D., CHAIR, REGIONAL MODELING WORK GROUP, RURAL POLICY RESEARCH INSTITUTE; ACCOMPANIED BY KEITH J. MUELLER, PH.D., RURAL HEALTH DELIVERY EXPERT PANEL, MEMBER, RURAL POLICY RESEARCH INSTITUTE

Mr. NELSON. Thank you, Mr. Chairman, for devoting the time of this Subcommittee to the implications of the proposed Medicare policy changes for rural America. As you know, Medicare's central concern with the elderly and disabled is especially important in rural areas.

I am Glenn Nelson, chair of RUPRI, the Rural Policy Research Institute. I am accompanied by Dr. Keith Mueller, director of the Center for Rural Health Research at the University of Nebraska.

The full institutional context of our work is described in the written testimony. I ask that the written testimony be printed in the record.

Mr. ENSIGN. Without objection, all of your testimonies will be made a part of the permanent record.

Mr. NELSON. Thank you.

In my oral testimony I will emphasize the results of a new analysis of the spatial distribution of Medicare enrollments and payments that we believe are particularly relevant to this Subcommittee and also emphasize the most recent work of the RUPRI Health Delivery Expert Panel, represented by Dr. Mueller.

The following economic analysis is the product of the RUPRI Regional Work Group and the RUPRI Rural Health Economics Expert Panel. Rural people have a disproportionate economic interest in Medicare relative to urban people.

First, rural people are more likely than urban people to be enrolled in Medicare. The rural enrollment rate is 28 percent higher than the urban rate. Thus, a higher proportion of the rural than urban population will be affected directly by changes in Medicare policy.

Second, rural enrollees receive lower average Medicare payments than urban enrollees. Payments per urban enrollee are 23 percent higher than payments per rural enrollee. Changes in Medicare policy that narrow the rural/urban payment gap would improve the viability of rural health care systems.

The net result of these points is that Medicare payments averaged over all rural residents, including those not enrolled in Medicare as well as enrollees, are slightly above the U.S. average.

Next, we note that rural per capita income is lower than urban per capita income. Finally, we combine the slight differences in rural/urban per capita Medicare payments with the differences in per capita income for a significant result. In rural areas, the ratio of Medicare payments to income is 3.31 percent, as compared to 2.34 percent in urban areas. These percentages reflect the degree to which local income is dependent on Medicare and the rural percentage figure is 41 percent higher than the urban figure.

As a final note on the economic analysis, these results do not yet include the fiscal offset associated with a change in Medicare ex-

penditures, such as a change in the Federal budget deficit or a change in taxes. RUPRI hopes to make the initial analysis of these offsets available for the Congress by early fall.

The RUPRI Health Delivery Expert Panel, which Dr. Mueller represents, recommends four criteria to assess potential impacts in Medicare policy. First, because Medicare is a large source of funds in rural areas, the impact of policy changes on the financial security of rural providers is critical. While equitable payments that narrow the rural/urban payment gap could be helpful, new payment methodologies based on historical charges would jeopardize the financial health of many rural providers.

Second, because the lead institution in many rural health delivery networks, usually a rural hospital, is often in precarious financial circumstances, the impact of policy changes on the availability of appropriate rural health delivery facilities is important.

Third, widespread shortages of rural health care personnel which limit the access of rural people to adequate health care are well documented. Thus, the impact of Medicare policy changes on the availability of health professionals in rural areas is critical.

Fourth, integrated service delivery networks offer the potential of more cost-effective care in many rural communities. However, moving too rapidly toward risk-based managed care contracts or adopting payment policies that discourage network development could thwart its potential. The impact of Medicare policy changes on the integration, coordination of health services is a very important criteria.

These four critical health service delivery issues and the economic issues noted earlier are the focus of the continuing RUPRI study of rural Medicare reform. We would welcome further interaction with this Subcommittee as our study proceeds.

Mr. Chairman, we thank you for this opportunity to discuss the rural perspective. Dr. Mueller and I would be pleased to respond to questions.

Mr. ENSIGN. Dr. Mueller, do you have oral testimony, as well?

Mr. MUELLER. Thank you, Mr. Chairman.

My testimony was integrated into Dr. Nelson's testimony, as per the request of the Subcommittee. I will just add a few notable facts toward the discussion this afternoon that really play off of much of what you have heard earlier today. I will do those following the criteria of the Rural Health Care Delivery Panel.

One of those is supply and availability of physicians and other primary care providers remain a very serious and critical rural issue. As you heard earlier today there are over 5,000 physicians needed if we wanted to achieve a ratio of one primary care physician to every 3,500 rural Americans.

I say that especially following the panel that you just heard from, because in our written testimony you will notice that we have laid out for you, as you think about changing Medicare policy, both positive changes that could be made as a part of policy change, and sort of warnings of cautions to avoid.

One of those positive changes is to continue to encourage the development and use of innovative educational strategies to increase the supply of health professionals in rural areas.

A second point to note is the dependence of rural facilities on Medicare payments, whether those are hospitals or clinics or other facilities. The notion of the lead facility in a rural community being important is something that ought to be considered as Medicare payment policies are examined and reexamined. We believe that it would not be costly to be sure that through Medicare, which some facilities rely up to 70 percent of their revenue on, would remain high enough to sustain the health care availability for those rural citizens.

Those are just some of the highlights. As I said, the testimony was integrated into Dr. Nelson's and I would be happy to answer questions when we get to that.

[The prepared statement and attachments follow:]

The Rural Implications of Medicare Policy Reform:
Potential Impacts On Rural Economies

Presented By:

Dr. Glenn Nelson
Representing the RUPRI Regional Work Group

Mr. Chairman and Members, I appreciate the opportunity to testify regarding the unique features of rural America that are relevant to this Congress as you consider significant changes in Medicare policy. I am Glenn Nelson, Chair of the Regional Work Group of the Rural Policy Research Institute. RUPRI provides objective analysis and facilitates public dialogue concerning public policy impacts on rural people and places.

My objective in this testimony is to clarify the major financial and economic stake of rural people and places in Medicare policy, by reporting recent results from an on going RUPRI study of Medicare. Most of the empirical results of this analysis apply to 1992, which is the most recent year for which the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS) has compiled an integrated set of reliable enrollment and payment data. I am pleased to acknowledge the critical assistance provided by the Office of the Actuary in the Health Care Financing Administration in facilitating RUPRI's access to these data. My testimony summarizes five key findings in this analysis.

I. Rural people are more likely than urban people to be enrolled in Medicare. The rural enrollment rate is 28 percent higher than the urban rate.

The enrollment rate for Medicare Part A in nonmetropolitan areas is 16.2 percent of the population, as compared to 12.7 percent in metropolitan areas. Similar results hold for Part B, and for the aged and disabled components of each of Parts A and B. The higher enrollment rates in nonmetropolitan areas reflect the larger proportion of the population which is over age 65 and the larger proportion which is disabled. Summarizing the first point, a higher proportion of the rural than urban population will be affected directly by changes in Medicare policy.

II. Rural enrollees receive lower average Medicare payments than urban enrollees. Payments per metropolitanenrollee were 23 percent higher than payments per nonmetropolitan enrollee.

Total Medicare payments (both Part A and B) per enrollee in Part A, the more comprehensive enrollment measure, were $3,937 in metropolitan areas in 1992 but only $3,191 in nonmetropolitan areas. The gap is even greater when we compare the core counties of large metropolitan areas with nonmetropolitan counties not adjacent to metropolitan areas, that is, compare areas that are more distant from each other on the rural-urban continuum. The core counties of large metropolitan areas have an average payment of $4,321 per enrollee as compared to $3,137 per enrollee in nonmetropolitan counties not adjacent to metropolitan areas. In this case the urban figure exceeds the rural figure by 38 percent. The rural-urban gap is even more extreme if we consider Part B in isolation. Part B enrollees in core counties of large metropolitan areas have an average Part B payment of $1,633 as compared to $1,074 per Part B enrollee in nonmetropolitan counties not adjacent to metropolitan areas. In this case, which applies to over 8 million nonmetropolitan residents, the urban payment is 52 percent higher than the rural payment per enrollee.

The rural-urban gap in payment per enrollee reflects differences in utilization of health care services and also differences in reimbursement rates for services provided. As rural residents work to maintain and upgrade the capacity of their health care systems in order to improve access to health care and also work to retain and attract health care personnel, this large relative disadvantage in Medicare payments per enrollee becomes even more problematic. Summarizing my second point, changes in Medicare policy which narrow the rural-urban payment per enrollee gap would improve the competitive viability of rural health care systems and of rural communities. Changes in policy which widen the gap would decrease the viability of rural health systems, including decreases in their ability to retain and recruit health care personnel, and thereby decrease the attractiveness of rural communities as places to live and work.

III. The dollar impact of Medicare payment decreases per rural citizen (including those not enrolled as well as those enrolled in Medicare) would likely be slightly greater than the national average impact per citizen.

The net result of the contrasting rural-urban patterns with respect to enrollment rates and payments per enrollee is that Medicare payments averaged over all rural residents (including those not enrolled in Medicare as well as enrollees) are slightly above the average Medicare payment for the nation, (with the latter also calculated with reference to the total population). This measure is important, because it helps us estimate the average size of the dollar impact per person, as the impact of a change in Medicare payments diffuses widely through a local or regional economy. More precise measures can be developed using policy analysis models such as those we are developing at the Rural Policy Research Institute, but for now the per capita payment is a working estimate. The U.S. average Medicare payment per capita, with reference to the

total population--not just Medicare enrollees, was $502 in 1992. The average payment per capita in nonmetropolitan areas was $516, slightly higher than the U.S. average.

IV. Rural people have fewer financial resources to call upon to deal with financial shocks to their local and regional economies.

An examination of the four groupings of U.S. counties on a rural-urban continuum, which provides the analytic framework for the RUPRI regional model, reveals a strong association between the degree of rurality and lower per capita incomes. Per capita income in 1993 in the core counties of large metropolitan areas (the most urban of the four county groupings) was $23,843 and in the nonmetropolitan counties not adjacent to metropolitan areas (the most rural of the four county groupings) was $16,046. (The attached table reports figures for 1992 rather than 1993 per capita income for reasons of internal consistency within the table.) Summarizing my fourth point, a financial shock of equal dollar amount per capita in rural and urban areas would have a larger relative impact in rural areas, as measured by percentage changes in production, employment, consumption, income, and other economic variables.

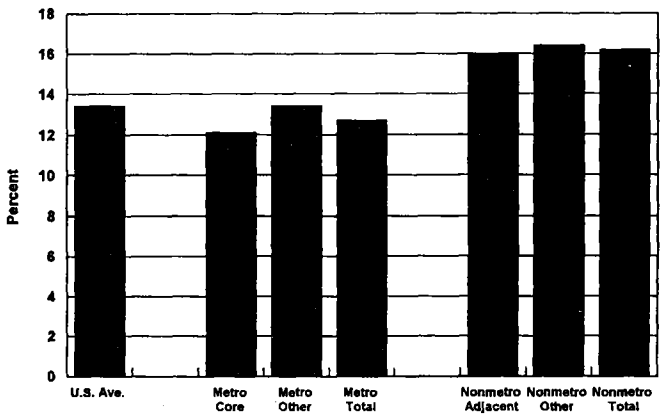
V. The impact of equal percentage reductions in Medicare payments in rural and urban areas would lead to relatively larger negative effects in the rural economy than the urban economy. The nonmetropolitan ratio exceeds the metropolitan ratio by 41 percent, which is a substantial difference. In nonmetropolitan areas the ratio of Medicare payments to personal income is 3.31 percent, as compared to 2.34 percent in metropolitan areas.

This conclusion flows directly from linking my third point on the scale of the impact of Medicare payments per capita and my fourth point on the per capita resources available to weather adverse financial shocks. Total personal income is a good, readily available measure of the size of a local or regional economy. A comparison of Medicare payments with total personal income is a good proxy for the relative importance of Medicare payments in affecting overall economic conditions in a region. Summarizing my fifth point, to the degree that cutbacks in Medicare payments are made at uniform percentage rates in urban and rural areas, the negative impacts on the overall local or regional economy will be relatively larger in rural areas. That is, when negative impacts are measured in percentage terms, the percentage changes will tend to be larger in rural than urban areas.

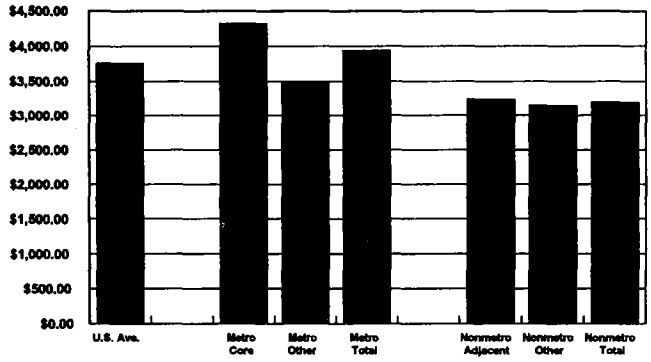
One final note: A limitation of the research summarized in these five points is that the analysis does not address the impacts of the off-setting fiscal decisions which would accompany a change in Medicare payments. For example, a cut in Medicare payments will be associated with a decrease in the federal budget deficit, with a tax cut, or with increased expenditures for another federal program--as compared to what would have occurred in the absence of the cut in Medicare payments. These fiscal off-sets have their own spatial impacts, which could be positive or negative. RUPRI is now developing estimates of the rural impacts of these off-sets, and we hope to have initial results of this work available for the Congress by early fall.

Thank you, Mr. Chairman. I would be pleased to respond to questions.

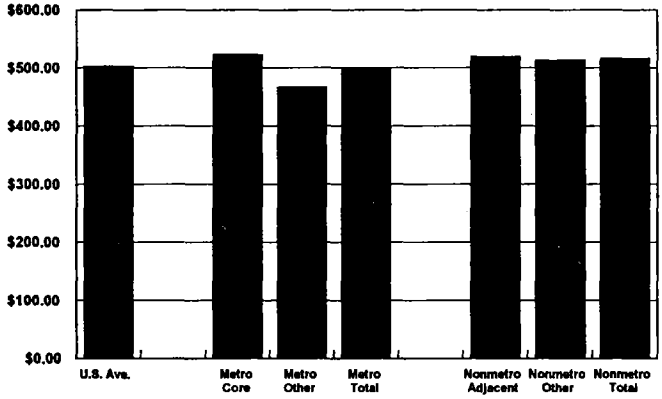
Percent of Population Enrolled in Part A Medicare



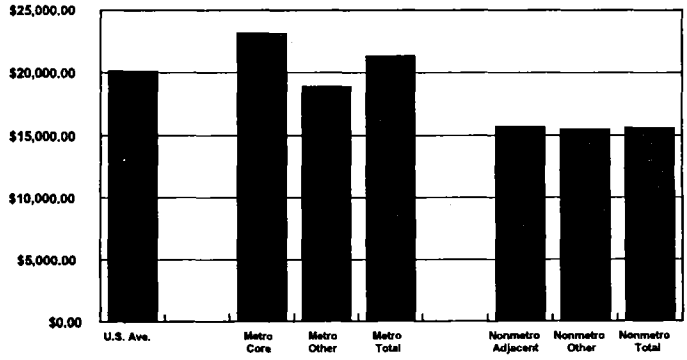
Medicare Payment per Enrollee



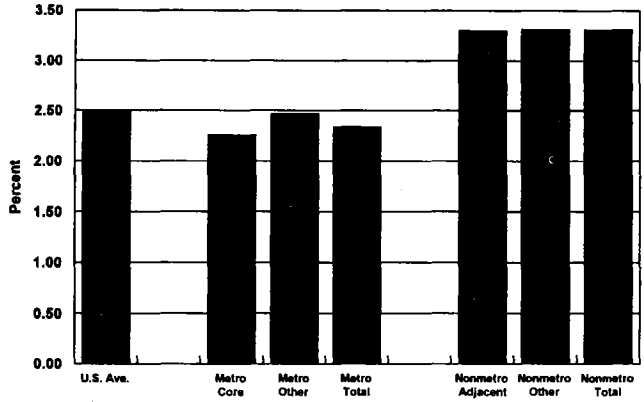
Medicare Payment per Capital (Total Population)



Personal Income per Capital



Medicare Payments as a Percentage of Total Personal Income



Medicare Enrollment and Payments by Parts A and B, by Aged and Disabled, and by Rural-Urban County Groupings for the United States in 1992

	Metropolitan County Groupings			Metropolitan County Groupings			United States
	Core Counties of Large Metro's	Other Metro Counties	Total	Adjacent to Metro	Not Adjacent to Metro	Total	Total
Enrollment							
Part A Total (thous.)	13,988	11,712	25,700	4,574	3,862	8,436	34,136
Aged (thous.)	12,736	10,540	23,276	4,090	3,440	7,560	30,806
Disabled (thous.)	1,252	1,172	2,424	484	422	906	3,330
Part B Total (thous.)	13,665	11,402	25,067	4,479	3,785	8,264	33,331
Aged (thous.)	12,526	10,332	22,858	4,032	3,392	7,424	30,282
Disabled (thous.)	1,139	1,070	2,209	447	393	840	3,049
Part B/Part A (percent)	97.7	97.4	97.5	97.9	98.0	98.0	97.6
Enroll. Relative to Pop. (percent)							
Part A Total	12.1	13.4	12.7	16.0	16.4	16.2	13.4
Aged	11.0	12.1	11.5	14.3	14.6	14.4	12.1
Disabled	1.1	1.3	1.2	1.7	1.8	1.7	1.3
Payments (mil.$)							
Part A Total	38,129	26,253	64,382	9,745	8,051	17,796	82,179
Aged	33,865	23,244	57,109	8,616	7,117	15,733	72,842
Disabled	4,264	3,009	7,273	1,129	934	2,063	9,336
Part B Total	22,316	14,494	36,810	5,061	4,066	9,127	45,937
Aged	20,103	12,942	33,045	4,501	3,600	8,101	41,146
Disabled	2,213	1,552	3,765	560	466	1,026	4,791
Total	60,445	40,747	101,192	14,806	12,117	26,923	128,115
Payments per Enrollee ($)							
Part A Total	2,726	2,242	2,505	2,131	2,085	2,110	2,407
Aged	2,659	2,206	2,454	2,107	2,069	2,089	2,365
Disabled	3,406	2,567	3,000	2,333	2,213	2,277	2,804
Part B Total	1,633	1,271	1,468	1,130	1,074	1,104	1,378
Aged	1,605	1,253	1,446	1,116	1,061	1,091	1,359
Disabled	1,943	1,450	1,704	1,253	1,186	1,221	1,571
Total/Part A Enrollment	4,321	3,479	3,937	3,237	3,137	3,191	3,753

(table contutinued on next page)

	Metropolitan County Groupings			Metropolitan County Groupings			United States
	Core Counties of Large Metro's	Other Metro Counties	Total	Adjacent to Metro	Not Adjacent to Metro	Total	Total
Payments Relative to Total Pop. ($)							
Part A Total	330	301	317	341	341	341	322
Aged	293	266	282	302	301	302	286
Disabled	37	34	36	40	40	40	37
Part B Total	193	166	181	177	172	175	180
Aged	174	148	163	158	152	155	161
Disabled	19	18	19	20	20	20	19
Total	523	467	499	519	513	516	502
Payments/Tot. Pers. Inc. (percent)	2.26	2.47	2.34	3.30	3.31	3.31	2.49
Bases for Comparative Measures							
Total Personal Income (bil.)	2,672	1,649	4,321	448	366	814	5,135
Population (mil.)	115.59	87.28	202.87	28.54	23.62	52.16	255.03
Pers. Income Per Capita ($)	23,116	18,893	21,299	15,697	15,495	15,606	20,135

Table Notes

This table is excerpted from the forthcoming RUPRI Data Report, Nonmetropolitan and Metropolitan Medicare Enrollments and Payments, which describes the data sources and methodology in considerable detail. Briefly, the underlying Medicare enrollment and payment data are extracted from county files maintained by the Office of the Actuary, Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. The data in this RUPRI analysis are not as all encompassing as some other sources of national and state data, and the reader may find that some of the national totals reported here are slightly less than those in other reports. The critical advantage of the data source used in this study over other sources is its use of the country as the basic unit of analysis which enables the spatial comparisons emphasized here. RUPRI analysts believe the relatively minor omissions from the data base used here do not introduce bias in the spatial comparisons. The population and income data are drawn from the Regional Economic Information System maintained by the Bureau of Economic Analysis, U.S. Department of Commerce.

The groupings of counties used to partition the counties into four mutually exclusive categories on a rural-urban continuum are described in detail, including illustrative maps, in the forthcoming publication noted above. The four groupings of counties are: 1) core counties of large metropolitan areas, 2) other metropolitan counties, 3) nonmetropolitan counties adjacent to metropolitan areas, and 4) nonmetropolitan counties not adjacent to metropolitan areas. The detailed description of these groupings is currently available in the previously published RUPRI report by Curtis Braschler and Glenn Nelson, Metropolitan and Nonmetropolitan Expenditures: Aid to Families with Dependent Children (AFDC), Food Stamps and Supplementary Security Income (SSI), RUPRI Data Report P95-4, June 8, 1995.

The Rural Implications of Medicare Policy Reform:
Potential Impacts on Rural Health Delivery

Presented By:

Dr. Keith J. Mueller
University of Nebraska Medical Center
Center for Rural Health Research

Representing the RUPRI Rural Health Delivery Expert Panel

Mr. Chairman and Members, I thank you for this opportunity to present, on behalf of this national panel of rural health policy experts, recommended criteria to use when considering the effects of changes in Medicare policies on the delivery of health services in rural areas. The RUPRI Rural Health Delivery Expert Panel has developed a set of criteria for use in examining the rural implications of changes in health policies. I will use results from the Panel's recent study of market force changes in rural health delivery, and general analysis, to adapt those criteria to changes in Medicare policies. RUPRI is now beginning a more thorough study of the potential rural impacts of Medicare changes, which will include a review of current knowledge regarding Medicare effects on rural health beneficiaries and providers, projected economic impacts of changes in these reimbursement policies, and expert analysis of the effects of Medicare policy changes. This will be an ongoing project, with the first results available later this year.

OVERVIEW

The rural health care delivery system is very fragile in many areas of our country. Health care providers cannot rely on high volumes of paying patients to build reserves or cover the costs of providing care to those unable to afford services or those, such as Medicaid and Medicare patients, who do not pay full costs. Feelings of isolation, low and inconsistent revenues, and lack of easy access to the latest technologies often discourage health professionals from practicing in rural areas. Extraordinary efforts are often necessary to provide adequate access to essential medical services for citizens of sparsely populated counties. Rural communities cannot always generate all the resources locally to overcome the problems

just mentioned, which means state and federal programs are often vital to the very existence of medical services in many areas of rural America. Medicare is a major resource of revenue for rural providers. The data presented today by the RUPRI Regional Work Group demonstrates why that is so -- the higher percentage of elderly in rural counties.

Given the importance of Medicare payments to rural providers and Medicare benefits to rural citizens, the RUPRI Health Delivery Panel recommends that careful consideration be given to the potential rural effects of any major changes in Medicare policy. We have developed specific criteria to use in such analysis. These are presented here, in order of concern to rural health delivery vis a vis Medicare changes, not necessarily in order of importance more generally: financial security, availability of facilities, availability of professionals, and integration of services. Our focus is on the health delivery system, with implications for recipients of medical services.

CRITERIA ONE: IMPACT ON FINANCIAL SECURITY OF RURAL PROVIDERS

Rural providers need adequate and stable funding from Medicare.

Rural providers are often quite dependent on public programs for funding, because rural communities are characterized by lower household income, more elderly people, and more part time or part year work. In this fiscal environment, reductions in Medicare revenue or increases that do not keep pace with costs will be difficult, and in some cases impossible, to absorb. Because of the very high proportion of elderly in rural areas, Medicare is a very large and critical source of payment for rural health care providers. Generating cost-savings in Medicare through such strategies as reducing disproportionate share payments, lowing payment increases below market basket adjustments, and shifting to a restricted capitation payment could jeopardize the financial life of rural providers. Achieving cost savings by designing new systems of payment (such as risk-based capitation) could threaten rural providers with financial ruin, particularly if such systems are based on historical charges, which have been much lower in rural than in urban counties. Where Medicare revenues are a large proportion of all revenues, and where charges have been low, because of cost advantages that may no longer exist, or deliberate policies to subsidize low charges from non patient revenue, using historical charges to set current reimbursements will create negative operating margins.

Potential effects of Medicare policy changes:

Positive: During recent years, policy changes in Medicare, linked to PPS for hospitals
and RBRVS for physicians, have reduced urban-rural disparities in payment. Further changes in policies designed to produce savings could further reduce those disparities and level the playing field for potential income of providers in urban and rural communities.

Negative: If historical charges are the basis for new systems of reimbursement, such as fixed capitation, new payments will not equal costs for many rural providers. Given the greater dependency of rural providers on Medicare revenues for financial security, this will place even greater financial stress on these facilities and could force at least some providers out of business.

CRITERIA TWO: IMPACT ON AVAILABILITY OF APPROPRIATE RURAL FACILITIES

The importance, and vulnerability, of rural facilities must be acknowledged.

Rural hospitals, primary care clinics, long-term care facilities and special facilities such as mental health facilities are critical for rural communities. The financial condition of these facilities and how they are integrated into rural delivery networks are critical issues in rural health system development.

Between 1980 and 1990, 330 rural hospitals in this country were closed. In rural hospitals today, Medicare payments account for approximately 40 percent of net patient revenue. In 1992, 31 percent of rural hospitals had negative total operating margins, comparing total revenue with total expenditures.

Rural hospitals and other facilities are often the core institutions in the integrated health delivery systems in rural areas. While there is a need for some rationalization of the form and function of many rural facilities, the financial stability of the lead institution in these communities is essential to ensure the continued viability of new networks.

The importance of flexibility in payment and regulation is a key rural issue.

As rural communities continue to experiment with new configurations for their essential facilities, such as medical assistance facilities or rural primary care hospitals, reimbursement policies will need to keep pace with changes that permit appropriate payment. Community leaders and providers may also need technical assistance to align local changes with federal policies related to conditions of participation and reimbursement.

Any specifications of essential community providers in new approaches which expand Medicare Select, while assuring access, should also acknowledge the diversity of providers in rural areas of different states. Designating only particular types of providers (e.g., federally qualified health centers and sole community hospitals) as essential providers to receive guaranteed payment fails to recognize the diversity of rural providers, including those in states with few of these designated provider types which have underserved areas being serviced by other types of rural providers.

Potential effects of Medicare policy changes:

Positive: Creating new policies related to reimbursement and regulations (conditions of participation) in Medicare provides an opportunity to establish in statute the flexibility that would be useful to rural facilities, such as recognizing as legitimate recipients of payment hospitals qualifying now in the Rural Primary Care Hospital demonstration program or the Medical Assistance Facility demonstration program.

Negative: Retaining the current classifications of rural facilities and reducing expected
revenues based on current charges would both limit changes in facility configuration and limit the resources available for transitions.

CRITERIA THREE: IMPACT ON AVAILABILITY OF HEALTH PROFESSIONALS IN RURAL AREAS

The supply and appropriate distribution of primary care and other health professionals are critical issues for the future of rural health.

For most rural areas, the only type of physician that is feasible and rational is a primary care physician-- especially general and family practitioners. To improve the availability of primary care physicians in rural communities, there is a need for a substantial expansion in the national supply of primary care physicians, and programs and incentives that encourage those physicians to practice in rural communities. For rural areas to achieve the standard physician-to-population ratio of 1 for every 3,500 persons, at least 5,085 primary care physicians would be required. Shortages have also been documented in the following professions, at least 70 percent of which are in rural areas: dental, 1,115 areas requiring 3,592 professionals; mental health, 832 areas requiring 4,033 professionals.

The need for a substantial increase in primary care physicians has become even more critical given the recent increase in competition for primary care physicians from urban based, managed care systems. This is especially the case in some specific regions of the country, including the southeast.

Many non-physician providers can provide high quality primary care in a cost-effective fashion that is acceptable to those living in rural areas. Those providers include nurse practitioners, physician assistants, and certified nurse midwives. They are especially effective as participants in multi-disciplinary teams of health professionals that serve rural areas -- for example, non-physician providers may staff clinics that are parts of systems that include physicians in other locations.

Current cost-effective programs are designed to impact the supply of providers and the infrastructure of the rural health care system.

Programs are in place which are designed to serve areas with special needs in a cost- effective manner. Examples include the National Health Service Corps, Migrant and Community Health Centers, and Rural Health Clinics. While changes may be appropriate in these programs and others, efforts to support innovative strategies for delivering health care in sparsely populated areas help sustain providers in those communities.

Potential effects of Medicare policy changes:

Positive: As changes are made in funding for Graduate Medical Education within Medicare, policies explicitly supporting primary care professional training and innovative efforts to encourage rural practice would help rural communities.

Positive: Direct reimbursement for innovative service models could be sustained and even enhanced, as part of new policies designed to achieve Medicare savings. In the long run, these policies could be cost-effective, by keeping care local through rural providers.

Negative: Deep reductions in Graduate Medical Educational payments, without alternative funding for training, could limit the nation's ability to produce the number of professionals necessary to alleviate current shortages.

Negative: Reimbursement policies that restrict payment to certain types of health professionals could limit the ability to use other professionals, such as non-physician primary care providers, to their fullest potential.

CRITERIA FOUR: INTEGRATION AND COORDINATION OF RURAL SERVICES

Incentives are needed to serve underserved areas and facilitate network development through reimbursement policies.

Many rural communities and providers are beginning efforts to develop integrated service delivery networks that will provide more cost-effective care and potentially serve as the vehicles for introducing managed care to rural America. Networks developed in large rural communities, or those developed in urban communities that extend into rural areas, may need special incentives in order to serve more sparsely populated areas. Rural communities wanting to develop locally-based networks, before potential incursion of urban-based systems, may need special financial and/or regulatory considerations in order to become viable. Programs designed to assist in developing rural networks should be used to continue assistance where needed, and provide analysis to use in developing payment and regulatory policies.

Payment policies can include special incentives to provide care in underserved, sparsely populated areas. Examples exist now: sole community hospital designation, bonus payments for physicians in small rural hospitals, and demonstration programs for new classifications of rural facilities.

Potential effects of changes in Medicare policy:

Positive: New reimbursement policies could include incentives to serve underserved areas.

Positive: Well-timed (i.e., when local communities are ready for change) changes in Medicare policy to encourage greater use of managed care could assist rural networks in making managed care plans financially viable. This is especially important in those rural areas with high percentages of local provider revenue derived from Medicare.

Negative: Reductions in expected reimbursement based on historical charges would limit resources that could be devoted to network development, and make rural providers less attractive for incorporation into networks.

Negative: Moving too rapidly to risk-based managed care contracts may result in externally-based providers dominating rural markets and cherry picking lucrative markets, because rural provider networks are not yet ready to compete with locally-based plans.

Thank you, Mr. Chairman, I would be pleased to respond to questions.

MEMBERS
RUPRI RURAL HEALTH DELIVERY EXPERT PANEL

Andrew F. Coburn, Ph.D. is the Associate Director for Research Programs and Associate Professor of Health Policy and Management in the Edmund S. Muskie Institute of Public Affairs at the University of Southern Maine. Dr. Coburn is also Director of the Maine Rural Health Research Center, one of seven national centers funded by the federal Office of Rural Health Policy. He is currently directing studies of rural health insurance coverage, Medicaid physician payment policies and long-term care. Dr. Coburn is an active member of the National Academy for State Health Policy.

Sam Cordes, Ph.D. is Director of the Center for Rural Community Revitalization and Development at the University of Nebraska-Lincoln. He is past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and a member of the National Research Initiative Advisory Committee, U.S. Department of Agriculture. He has published extensively on the economics of rural health care, and served as President of the American Rural Health Association.

Robert A. Crittenden, M.D., MPH is currently the Director of the Office of Education in the Office of the Dean, and an Assistant Professor of Family Medicine in the School of Medicine at the University of Washington in Seattle. He also is a primary care physician who has worked extensively with Native American and low-income people. In the past, Dr. Crittenden was staff for the commission that designed the Washington Basic Health Plan and a health policy fellow in the office of Senator George Mitchell where he worked on outcomes research, long term care and health reform. He has also served as health policy advisor to Governor Booth Gardener of Washington State and chaired the staff committee of the National Governor's Association when they developed their policy on health care reform.

Charles W. Fluharty, is Director of the Rural Policy Research Institute (RUPRI), a multi-state interdisciplinary research consortium which conducts research and facilitates public dialogue designed to assist policymakers in understanding the rural impacts of public policy choices. He was born and raised on a fifth generation family farm in the Appalachian foothills of eastern Ohio, where he returned following graduation from Yale Divinity School. As a educator, public policy analyst, association executive, and private consultant, his professional career has centered upon service to rural people, primarily within the public policy arena.

J. Patrick Hart, Ph.D., is Associate Professor and Director of Rural Health Education and Services Planning at the University of Minnesota-Duluth School of Medicine. Before accepting his current responsibilities, Dr. Hart held faculty positions at Tulane University, the University of Oklahoma, the University of Texas Health Science Center and the University of North Dakota. He is past President of the Board of Directors of the National Rural Health Association and past Chair of the Rural Health Committee of the American Public Health Association.

Keith J. Mueller, Ph.D. is Professor of Political Science and Director of the Center for Rural Health research in the Department of Preventive and Societal Medicine at the University of Nebraska Medical Center. He has published extensively on a variety of state and federal health care policy research issues, including a book, *Health Care Policy in the U.S.*, and a series of rural health policy briefs on national and state health reform legislation. He currently serves as President-Elect of the National Rural Health Association.

Wayne W. Myers, M.D. is Professor of Pediatrics and Director of the University of Kentucky Center for Rural Health in Hazard, Kentucky. Dr. Myers has also held academic appointments at the University of Alaska, Fairbanks and at the University of Washington School of Medicine, Seattle, where he served as Director of the WAMI Program, a rurally oriented medical education program in Washington, Alaska, Montana and Idaho. In addition, he has considerable experience as a policy advisor in health planning and rural health system development in Alaska, the U.S. Bureau of Health Professions and Indian Health Service.

MEMBERS
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Sam Cordes, Ph.D. is Head of the Department of Agricultural Economics and Director of the Center for Rural Community Revitalization and Development at the University of Nebraska-Lincoln. He is a past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and a member of the National Research Initiative Advisory Committee, U.S. Department of Agriculture. He has published extensively on the economics of rural health care, and served as President of the American Rural Health Association.

Gerald Doeksen, Ph.D., is Regents Professor and Extension Economist in the Dept. of Agricultural Economics at Oklahoma State University. He conducts research and provides extension programming on a variety of community service delivery problems. His work on health care issues includes research on the economic impacts of hospitals in rural communities, the development of rural emergency medical systems and rural mental health care, and community health care planning. Dr. Doeksen has received numerous professional awards, including the Research Award of the American Rural Health Association and the Distinguished Extension Program Award of the American Agricultural Economics Association.

Mark A. Edelman, Ph.D. is Professor of Economics and Public Policy, Iowa State University. He is ISU Campus Coordinator for RUPRI, and has directed numerous research projects analyzing rural impacts of public policy issues, including the recently released RUPRI Poll on National Health Care Reform Policy Preferences conducted by the Gallup Organization. Dr. Edelman serves as Coordinator of the Iowa Public Policy Education Project (PPEP), a nonpartisan, issue-oriented citizen education project that produces statewide satellite and TV broadcasts and conducts citizen surveys on public issues. He also serves as a consultant on several state health care reform studies.

Charles W. Fluharty, is Director of the Rural Policy Research Institute (RUPRI), a multi-state interdisciplinary research consortium which conducts research and facilitates public dialogue designed to assist policymakers in understanding the rural impacts of public policy choices. He was born and raised on a fifth generation family farm in the Appalachian foothills of eastern Ohio, where he returned following graduation from Yale Divinity School. As a educator, public policy analyst, association executive, and private consultant, his professional career has centered upon service to rural people, primarily within the public policy arena.

David Holland, Ph.D., is Professor of Agricultural Economics at Washington State University. He has over twenty years of research, teaching and consulting experience dealing with the use of multi-sector models for economic impact analysis. Dr. Holland's current work focuses on economic development planning and policy analysis. His Social Accounting Model permits alternative development strategies to be evaluated in terms of their impact on employment and the distribution of income.

Thomas G. Johnson, Ph.D., is Professor of Agricultural Economics Virginia Polytechnic & State University. Dr. Johnson has extensive research, teaching and consulting experience in regional economics and rural community economic development. He has received numerous professional awards, and is a past President of the Southern Regional Sciences Association. Dr. Johnson works closely with community leaders in Virginia and other states to estimate the future economic and fiscal impacts of various community policy proposals. His health care related research includes analysis of the economic impacts of rural community hospitals.

Timothy D. McBride, Ph.D., is Assistant Professor of Economics, Public Policy and Gerontology at the University of Missouri - St. Louis. Dr. McBride's research concerns public economics, with special emphasis on the economics of aging and health. He is the author of over a dozen research articles and co-author of a book, titled *The Needs of the Elderly in the 21st Century*. In the health policy area, Dr. McBride's research has focused on the uninsured, long-term care, and health care reform. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri-St. Louis after spending four years at the Urban Institute in Washington, D.C. He received his Ph.D. from the University of Wisconsin in 1987.

Glenn L. Nelson, Ph.D. is chair of the RUPRI Regional Modeling Work Group and an economic consultant in regional development policy. His current research focuses on the regional and sectoral impacts of changes in entitlement policies and associated fiscal policies. Nelson's experience includes direct involvement in governmental policy making, as well as in research and teaching. He was the State Economist of Minnesota in 1985-1987, Senior Staff Economist with the President's Council of Economic Advisers in 1982-1983, and an economist with the Office of Economic Opportunity and the Cost of Living Council in 1971-1974. He was a member of the faculty of Purdue University in 1974-1977 and of the University of Minnesota in 1977-1990. He resides in Ann Arbor, Michigan.

Shirley L. Porterfield, Ph.D. is Visiting Assistant Professor, in the Dept. of Political Science, Washington University in St. Louis. Dr. Porterfield has published numerous research articles on regional development issues, with particular emphasis on the impacts of industrial restructuring on employment, earnings, and fringe benefits. She is currently working on an analysis of workers and industries adversely impacted by implementation of the North American Fee Trade Agreement. Dr. Porterfield began her career at the Economic Research Service, US Department of Agriculture. She recently joined the faculty at Washington University after spending two and a half years at the Rural Policy Research Institute at the University of Missouri-Columbia. She received her Ph.D. from the University of Wisconsin in 1988.

Ron Shaffer, Ph.D. is Professor of Agricultural Economics and Community Development Economist, University of Wisconsin-Madison/Extension. Dr. Shaffer directs the National Rural Economic Development Institute, which is part of the National Rural Development Partnership. He has been a faculty member at the University of Wisconsin-Madison since January 1972, serving as Director of the University of Wisconsin-Madison/Extension Center for Community Economic Development since 1990. His extension efforts have emphasized working with Wisconsin communities to create comprehensive development strategies. He also teaches a graduate course and does research in the area of Community Economics. He has addressed questions of local development strategies in both domestic and international settings.

Ron Young, Ph.D. is the Kansas State Cooperative Extension Local Government and Rural Health Economist. Dr. Young has served Wisconsin state government as a team leader for program development and evaluation in the Division of Health and Social Services. He has also worked as the manager of data analysis for the CNA Insurance Companies. Dr. Young is currently participating in several state and national health policy and health economics-related initiatives. He is Director of the U.S. Cooperative Extension System's "Health Care Reform Education Development Project", serves as a member of the Kansas State Health Data Consumer Task Force, and is Associate Director of the evaluation project for the state's Senior Care Act. Dr. Young also directs an ongoing multi-country analysis of the economic impacts of rural hospitals.

Mr. ENSIGN. Thank you, Dr. Mueller.
Ms. Hardt.

STATEMENT OF CHARLOTTE L. HARDT, MEMBER, BOARD OF TRUSTEES, NATIONAL RURAL HEALTH ASSOCIATION

Ms. HARDT. Thank you, Mr. Chairman, and Members of the Subcommittee. I am Charlotte Hardt and I am a member of the Board of Trustees of NRHA, the National Rural Health Association. I am president of the State Association Council of NRHA. The National Rural Health Association would like to express their appreciation for this opportunity to present their views on the impact of Medicare on rural health care delivery. I also spent 6 years as a rural hospital administrator in a 20-bed hospital, so I am speaking from that perspective as well.

We recognize the urgent need to reduce the Federal deficit, but we believe a balanced approach must be taken to recognize and address the health care needs of American citizens living in rural and frontier communities. Rural providers will not be sustained by abruptly reducing Medicare with Draconian cuts. Rural areas, with their disproportionate share of the elderly, will suffer inordinately as you have heard over and over today.

If cuts need to be made and we are aware that they must, a well timed phaseout over time is preferred.

We heard about some of the biases in rural reimbursement today and NRHA recommends that the wage index reflect the price of labor by reimbursing rural hospitals with a fair occupational mix adjustment which is a real issue in many States.

The National Rural Health Association also believes that higher payments for primary care services can be achieved by reconfiguring the current fee schedule to a single conversion factor. That is also an issue, especially with some of our physicians in Forks, Washington, who think it is an awful thing the way it is now.

I want to talk a little bit about some of the human stories that are behind some of the facts, figures, and numbers you have been hearing today. We all know the story that if you have read about one rural area, that is all you have ever heard about and I want to tell you about a couple of those.

For example, Republic, Washington, is a mining and timber community of about 1,000 people up near the Canadian border. These people through the support of a public hospital district tax support Ferry County Memorial Hospital which is a 25-bed facility. They have 11 acute care beds, 4 swing beds, and 14 long-term care beds. They recruit and employ the providers in their local community. They pay their malpractice insurance. They provide emergency room service, obstetrical services. They have a home health agency they can contract with. They have a rural health clinic and they also have some subsidized housing that the hospital district has been able to help get going.

For the first time in 5 years this hospital has realized a 1-percent profit margin. They closed for a short time about 6 years ago due to a shortage of physicians. And this is one where an abrupt or heavy Medicare cuts would have a devastating consequence. The hospital would, most likely close, and losing a hospital in an area that is dependent on hazardous occupations like

timber and mining where you have to go over high mountain passes to the next facility would be disastrous. The ambulance often has to drive to meet the helicopters because of adverse weather conditions. In good weather, the nearest facility is 1½-hour drive.

Another rural community is Odessa, Washington, a community of about 1,500 people. It supports Odessa Memorial Hospital. They pay the highest hospital property taxes in our State, and they pay close to $4 a thousand in property values. This tax district subsidizes a 16-bed hospital with their 5 swing beds and 23 long-term care beds, home health services, a rural health clinic that is serviced by a physician and a PA, and assisted living apartments.

There was a recruitment effort to get that provider in there. The hospital district also provided support in the way of helping to pay off student loans ahead of time in order to even get this provider there.

This hospital, along with the next nearest hospital, which is 55 miles away, has contracted with their county commissioners to take on the public health functions of that county. This hospital is utilizing some pretty scarce resources to the maximum. They use their nursing staff to provide both public health and home health services.

This hospital is surviving on a very narrow margin, but they would probably be better off if they were not a hospital. They would be a substantially more viable facility if Congress could pass an alternative facility law, similar to the model project/demonstration project in Montana. Our State has such a law on the books but because Medicare does not provide compensation for it, the hospitals cannot afford to take advantage of that kind of downsizing.

The National Rural Health Association Policy Board has recently developed a white paper on managed care, looking at some of the things we were hearing about today. To be effective, those kinds of activities must be sensitive to practice environments in rural communities. An example is what recently happened in the community of Colfax, Washington. A California managed care organization came into Colfax and sold a Medicare/Medigap policy at an incredibly low rate. There was a big promotion and many people bought it.

Then the rural elderly residents found out they had to travel from 1 to 4 hours to take advantage of that cheap care. And, of course, who were they mad at? The hospital administrator because they were not part of the plan. What makes it interesting is the hospital, nor its providers were ever consulted or invited to participate in that particular plan.

Another thing is antitrust protection. In the same facility the five providers and the hospital joined with their community to make up the community provider organization. They have been challenged in front of our health care commission by some of the managed care organizations as being antitrust activities so they will not have to negotiate with them as a single block.

Rural communities are leading the way in many ways in designing innovative rural health care delivery systems that make sense for their unique health care needs. As you begin to craft Medicare reform policy, the National Rural Health Association looks forward to working with you to share quality health care services for Americans living in rural communities.

I thank you for your time with us today.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL RURAL HEALTH ASSOCIATION TO THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH, PRESENTED BY CHARLOTTE HARDT, MEMBER, BOARD OF TRUSTEES, NATIONAL RURAL HEALTH ASSOCIATION, JULY 20, 1995

Chairman Thomas and Members of the House Ways and Means Subcommittee on Health. I am Charlotte Hardt, Associate Director of the Eastern Washington Area Health Education Center at the Washington State University in Spokane, Washington. I am a member of the Board of Trustees of the National Rural Health Association (NRHA) and the President of the State Association Council of NRHA. The National Rural Health Association appreciates the opportunity to present its views on the potential impact of Medicare on rural health care delivery.

The National Rural Health Association membership is comprised of small, rural hospitals, community and migrant health centers, rural health clinics, primary care physicians, non-physician providers, educators and other rural health advocates.

The National Rural Health Association recognizes the urgent need to reduce the federal deficit. However, as you begin deliberations on Medicare reform, we believe that a more balanced approach must be taken to recognize and address the health care needs of American citizens living in rural and frontier communities.

HEALTH SYSTEMS FINANCING ISSUES

The National Rural Health Association believes that there are two major issues in financing health systems reform that must be considered as you debate Medicare reform. These are: (1) how to finance the overall system and (2) how to pay for services as well as reimbursement focusing on the patient/provider relationship.

Rural providers will not be sustained by abruptly reducing Medicare with draconian cuts. Rural areas, with their disproportionate number of elderly, will suffer inordinately with any decrease in Medicare funding. If cuts must be made, a well timed phase-out over time is preferred.

Achieving savings by reducing disproportionate share reimbursement, dropping hospital payment updates, eliminating sole community provider status, and moving towards a limited capitated rate could put rural providers in financial jeopardy.

Rural hospitals followed the mandate set by the Congress to reduce expensive inpatient services by providing more services that could be performed on an outpatient basis. They did exactly what the Congress sought to the point where now about 55 percent of rural hospitals' Medicare revenue are from outpatient services. Yet, rural hospitals will find that reductions in outpatient services, let alone reductions in the hospital updates, will substantially erode their financial base, causing vital services to be reduced or eliminated.

MEDICARE HISTORICAL BIASES

It is clear that historical biases in reimbursement to rural providers exist in our current health care system. Medicare pays rural providers up to 40 percent less than their urban counterparts for the same services. Costs for those services in rural communities are generally higher because rural providers cannot take advantage of economies of scale and many other reasons.

If new health systems are based on historical experiences, rural providers and their patients will be put at further risk of losing critical health care resources and services. The rural/urban Medicare differential, reform of the Medicare wage index and adjusting for occupational mix are reimbursement issues that have had a negative impact on delivery of care in rural communities. Rural providers are paid less than their urban counterparts. This lower reimbursement rate coupled with lower utilization rate translates into lower Medicare payments on behalf of Medicare beneficiaries. This situation becomes more critical as the trend moves towards greater use of managed care services. As rural hospitals have already driven their costs down in order to compensate for current Medicare discriminatory payments, there is little to no flexibility left in their budgets.

The National Rural Health Association recommends that the wage index reflect the price of labor by reimbursing rural hospitals with a fair occupational mix adjustment.

REIMBURSING PRIMARY CARE PHYSICIANS

Biases exist in the historical payment to rural primary care physicians. The Medicare reimbursement for office visits are substantially lower than the cost of providing the services. Medicare fees simply do not begin to cover the time and material that it takes to serve rural chronically ill elderly residents. NRHA is concerned about the Medicare fee schedule structure in that widely varying geographic schedules would continue the inherent biases in restrictive payment to primary care providers. Moreover, NRHA is concerned with the reduction in fees below current levels. Ultimately, access problems will arise for rural residents.

The National Rural Health Association believes that higher payments for primary care services can be achieved through reconfiguring the current fee schedule to a single

conversion factor. Moreover, NRHA supports 20 percent bonus payments to primary care providers, primary care physicians, nurse practitioners, certified nurse mid-wives and physician assistants who practice in health professions shortage areas.

GRADUATE MEDICAL EDUCATION

Increases in incentives for primary care training for all disciplines are critical to rural areas. It is the hope of the rural constituency that greater emphasis on quality training at rural ambulatory, hospital and non-hospital sites will become a recruitment point for luring primary care physicians and non-physician providers to practice in rural communities.

NRHA supports direct graduate medical education reimbursement to rural ambulatory, hospital and non-hospital sites and paying of local providers for their time to teach. Further, NRHA supports up-weighting direct medical education and indirect medical education payments for primary care residency positions.

LIVING IN ONE RURAL STATE

One pearl of wisdom about rural areas is "if you have seen one rural area, you have seen one rural area." There is incredible diversity in the rural health care delivery system. Take for example Republic, Washington. Republic is a mining and timber community of 1055 people near the Canadian border.

Through the support of a public hospital district tax, Republic supports Ferry County Memorial Hospital, a 25 bed facility with 11 acute care beds, 4 swing beds, and 14 long term care beds. The hospital recruits providers and pays their malpractice insurance. It has emergency room service, obstetrics services (delivering 35-40 babies annually), a home health agency, a rural health clinic, and it provides subsidized housing. For the first time in five years, the hospital has realized a one percent profit margin.

Ferry County Memorial Hospital is the last Hill Burton hospital built in the State of Washington. It closed for a short time about six years ago due to a shortage of physicians. Abrupt and heavy Medicare cuts would have devastating consequences on this rural community. The hospital would most likely close. As an employer, the economic impact of the closure, coupled with the layoffs in the timber industry would be disastrous. Losing the hospital would make employees who are already in high risk occupations more vulnerable if an emergency situation should arise. There would be no base for health care personnel. Physicians, nurse practitioners and physician assistants would leave the Republic community because they would no longer be subsidized by the provider district. Imagine an emergency situation, during ominous weather conditions, where the ambulance must drive between two mountain passes to meet the helicopter to fly a patient to the nearest hospital. In good weather, the nearest facility is a 1.5 hour drive.

Let us look at yet another rural community in Odessa, Washington. This community of 1500 people supports the Odessa Memorial Hospital through heavy property taxes of $4/$1000. This tax district helps to subsidize the 16 bed hospital, with 5 swing beds and 23 long term care bed services, home health services, a rural health clinic (serviced by a physician and a physician assistant), and assisted living apartments. As a recruitment effort, the hospital helped to pay off the school loans of a physician before she started to practice in the community.

Odessa Hospital, along with a hospital in Davenport, Washington, which is about 55 miles away, contracted with county commissioners to take on the public health functions of the county. Efficiently utilizing scarce resources to the maximum, the hospital uses the nursing staff to provide the public health and home health services.

Odessa Memorial Hospital is surviving on a very narrow margin. **It could be a substantially more viable facility if the Congress would pass an alternative facility law. This would be similar to the model in Montana, the medical assistance facility demonstration program and the model passed by the Washington State legislature.**

An alternative facility is a facility that is a little less than a hospital, yet more than a clinic. The facility would allow for vertical integration, have short stay beds for observation or short term illness, have a waiver of the hospital staffing requirements, and allow emergency room coverage. It probably would not have surgery capability, other than for outpatient surgery, would do low risk obstetrics, and could be staffed by mid-levels (nurse practitioners, certified nurse mid-wives and physician assistants). It would allow Medicare compensation for facility charges such as emergency room charges. This kind of rural community-based health care system could survive as an integrated entity, without all of the excessive regulatory requirements now burdening some rural hospitals.

MANAGED CARE

Major changes are occurring in the delivery of health care services in many parts of rural America. One of these changes is the development of service delivery networks with a managed care component. In some areas large urban-based managed care networks are expanding into

rural areas and contracting with local providers. In other areas, rural-based managed care plans have been organized at the community level.

The Rural Health Policy Board of the NRHA recently developed a white paper on managed care. It found that there are successful models of both urban-based and rural-based managed care models operating in rural areas. Rural managed care plans have the potential to lower the cost of medical care, improve the quality of care and help sustain the local health care system. With managed care plans, premium costs can be lower because the primary care physician acts as a coordinator or gatekeeper in the referral of patients to specialists. Managed care plans also have lower rates of hospitalization, and some offer financial incentives to provide clinical preventive services. Quality of care may be improved by assigning each patient to a primary care practitioner, thus providing a "medical home" to everyone enrolled in the plan. Also, since many rural physicians practice in relative isolation, rural managed care plans sometimes facilitate a greater sharing of information among physicians through utilization review and quality assurance activities.

To be effective, however, these activities must be sensitive to the practice environment and unique conditions prevailing in rural areas (e.g. longer hospital stays because of travel distances and road conditions). Moreover, rural essential community providers must have a protective status to keep systems in place, or they will be cherrypicked off by well-financed managed care organizations.

Now let me give you an example of what recently happened in Colfax, Washington. A California managed care organization came into Colfax selling a Medicare Medigap policy at an incredibly low price. There was a big promotion of the product. Then the rural elderly residents found that they had to travel one hour to four hours to receive this nice, cheap, centralized care. What resulted were calls from the elderly residents to the Colfax Hospital administrator complaining about having to drive such a distance for their health care services.

What makes this so interesting, is that neither the hospital, nor the providers were ever consulted or invited to participate in the plan. Now the hospital administrator is negotiating with the managed care organization to allow the Colfax community provider hospital organization to be a part of the plan. The consequence, however, is that the cost of the plan to the elderly will rise significantly.

The National Rural Health Association has made a number of recommendations regarding a managed care framework that assures high quality, affordable, and accessible health care to all rural residents. This framework includes state and local determination, consumer choices, strong financial incentives, patient protections, adequate coverage, and provider choice.

ANTITRUST

Antitrust protection is essential if rural areas are going to be able to play on that level field we keep hearing about. The ability of the providers and hospitals to unite with their community to form their own organizations able to negotiate with managed care organizations is crucial to protecting fragile rural systems that have been painstakingly built up by rural folks to take care of their own.

When a community such as Colfax, with its five physicians and small hospital, forms a community provider hospital organization (CPHO) and then is legally challenged by large state-wide managed care organizations who do not want to negotiate with them as a united group, something is wrong. Rural communities are trying to further reduce their extremely low costs by combining the management and other services of public health, home health, clinics, and hospitals, thereby sharing staff and reducing administrative costs. These kinds of efforts would be undertaken by more rural communities if the specter of antitrust was to be removed.

As you can see, inherent historical biases in reimbursement to all rural providers, coupled with a fragile health care system so dependent on Medicare reimbursement because of the disproportionately high elderly population living in rural and frontier communities, warrants the Congress to judiciously consider any Medicare reform policy changes. Consideration must be given to sustaining and allowing reimbursement for alternative rural health care systems. Policies that shift rural residents, particularly the poor elderly, into managed care plans need special attention in light of the paucity of volume to sustain the providers and the paucity of providers who practice in rural areas.

Rural communities are leading the way in designing innovative rural health care delivery systems that make sense for their unique health care needs. As you begin to craft Medicare reform policy, the National Rural Health Association looks forward to working with you to assure quality health care services for Americans living in rural communities.

Mr. ENSIGN. I thank the panel for their testimony.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I welcome my fellow friend from the Cornhusker State. We are glad to have you here and we are honored to hear your testimony.

My questioning would be in the regards of what has been your experience with the telemedicine approach in the rural hospital arena? I grew up in St. Paul, Nebraska, as you know, which is a small farming community. And even though I serve a largely urban area now, in Omaha, I am still very much intimately desirous to see a health care situation that is going to be good for everybody.

My whole family is involved in agriculture and some of the statistics that you lay out do concern me. But I am also aware of what we have in front of us in terms of the amount of money that the Medicare Trust Fund will have in its account, unless we are willing to do something now which is zero in 2002.

I disagree vehemently with my friends on the left who say let us fix Medicare temporary and make a little adjustment here, or let us raise taxes here and there to get it along another 2 or 3 years. I truly believe we need to have a structural change to the whole Medicare delivery service so that we can permanently secure the system ad infinitum.

I would like to hear how we could address rural America's needs in the Medicare situation. I touched on it this morning that maybe alliances like some of the things Nebraska is doing already might be a possible solution.

What ideas do you have in that area, and especially in the telemedicine area?

Mr. MUELLER. Thank you, Congressman Christensen, and thank you for welcoming me as a fellow Cornhusker. It is nice to be from a national championship State for at least 1 year.

The direct answer to the telemedicine question really has two parts. One, in terms of what we know clinically and by lots of evidence, we do not know a lot yet because in rural America, as you may know, telemedicine is still a fairly new technology, not widely used. In our own State there is a demonstration project underway in Carney that uses telemedicine to communicate between the Carney Hospital and about four or five hospitals around there so that physicians can use some of the secondary care available in Carney.

There are some States, Kansas and Georgia are two that come to mind, that have more experience, but still not quite enough to draw a firm conclusion. However, the preliminary evidence all points to it being a very positive development for rural America, that it is a way to have some subspecialty consultations available to rural primary care providers even though the subspecialist is not there.

And I can tell you, I just read results earlier today, of a survey of parents in Chadron and Gordon, Nebraska, out in our panhandle who were asked, What would you think about telemedicine as a means to get care for your children from pediatricians?, and the overwhelming response was favorable, as it is from providers.

So I think one answer is all indications are this is a promising development, we need to move it forward.

The second part of the answer is our reimbursement needs to move with that. And currently we have some problems trying to get not just Medicare but other insurers to recognize that providing consultation, through telemedicine, ought to be a reimbursable expense by the providers. And until it is, that will remain a stumbling block. Projects like Carney's now need special waivers in order to pay for that telemedicine.

So that is one of the positive things I was mentioning earlier, that as you recraft Medicare policy you can think about that, put that into the policy as a positive development.

To answer your question about alliances, that is another example of where recrafting policy can become a very positive development for rural. It goes to the fourth criteria of the Delivery Panel's testimony which is related to integrated services.

And what we are suggesting there is to think about ways in which payment could be linked to systems of care rather than individual providers. So, again, with a slight shift in how we reimburse which could very well—we have not had a chance and neither have your analysts to work out all the costs on this—but that could very well be cost savings in the long run, to reimburse a system so that you have integrated care. That is a boost for rural because if you did that with Medicare, you are doing it again with a revenue stream that amounts to anywhere from 30 to 60 percent of the revenue for the rural providers.

So if a net stream, you say, here is an incentive, that is a payment for systems for you to move even rapidly to an integrated system and an alliance, then we are likely to see that kind of movement.

Mr. CHRISTENSEN. I see that my time has expired, thank you, Mr. Chairman, thank you for your answer.

Mr. ENSIGN. The gentleman's time has expired.

Dr. HUGHES. Mr. Chairman, may I comment on that question?

Mr. ENSIGN. Certainly.

Dr. HUGHES. The Geisinger Health System is in central and northeastern Pennsylvania which is in a very rural area. We feel very strongly that telemedicine is going to be a very positive benefit, not only for the physician providers to provide them with expertise from a specialty service, but also for the patients.

Maybe a good example of that would be we have physicians that are as far as 150 miles from our major tertiary care center, where most of our specialists are located. These physicians who provide services in those communities are really the only access to medicine for a significant number of people that live within a radius of 40 or 50 miles.

As you can imagine, an individual who lives in that area and might suffer from cancer and receives chemotherapy would find it very, very difficult to get into a car, drive 50 or 60 miles to the closest facility that could administer that kind of care. Telecommunications and telemedicine really provides the primary care physician in a very, very small community to use the expertise of a specialist in a large medical center like we have, as the hub of our system.

To be able to provide that service much closer to home and prevent some of the difficulty and hardships that an individual has to go through to receive some care.

Mr. ENSIGN. I just have a couple of things to toss out to the panel and that is pretty consistent with the problems in rural America with health care and that is the lack of physicians and especially primary care physicians. Right now with graduate medical education what do you think, and just maybe your comments on a possible idea of tying, first of all, the graduate medical education subsidy to the resident so wherever they choose to go it would follow them. Tied to that in exchange for that money going with that resident, almost as a stipend, that person then would owe perhaps 1 year's service in rural America, especially the primary care physicians or 2 years or whatever it is. And if they choose not to do it, then obviously, they would have to pay the Federal Government back the money that it subsidized for their residency.

Dr. HUGHES. I would like to comment on that if I may. I think that is an idea that needs some support. I would tell you that in our own system, at the present time, we have about 200 residents in training. Our residency training programs have been in existence for many, many years. We graduate approximately 50 residents a year in various subspecialties, also including primary care specialties: Family medicine, emergency medicine, internal medicine, and so forth.

Literally over one-half of all of our residents in training who graduate in our programs remain in rural areas. We feel very strongly that the reason that they do that is because of their location of training. And certainly at the medical center in Danville, which is in a community of 9,000 people, by getting that exposure, by having been practicing medicine in a rural area, it really provides them with the first initiative to remain in rural America.

I think if we are able to not only use that kind of experience, which is already supporting what we would like to do, but then add to it something else, in addition to other incentives that would allow physicians in training to continue to look at rural America as a viable alternative for their practice would be very helpful.

Mr. ENSIGN. Any other panelists care to comment?

Mr. MUELLER. I would like to echo what Dr. Hughes says, that supporting programs that have proven track records of placing their graduates, people who leave the residency in rural areas, is a very valuable approach toward what you suggest. And adding to that, the ability for the money to follow the student is another means.

I think also part of what you point to—and I know this is not Medicare policy directly but it did come up earlier today as well—the concept that you are suggesting here is the concept of a national health service corps which has a mixed track record in evidence of physicians actually staying in all the rural communities to where they go, but has become an important means of at least having care in those communities. Because students who have completed their training have an obligation to go and practice in a rural community.

I think if we had a creative way to link the training incentives to that kind of posttraining experience, so that we have a rural experience that goes through graduate training and then postgraduate practice as part of maybe the National Health Service Corps program, then we have got that much better a chance of

someone who really comes to value and believe in the rural experience.

One final thing I would add to that in light of us having followed our colleague from New York City is we should expand that notion to be rural and underserved. I think he made a very valid point about inner cities in much of the same context and many of the same kinds of incentive programs.

Mr. ENSIGN. I would echo that concern as well and the reason I brought up the point is that attending veterinary school in Colorado, being a Nevada resident, Nevada paid three-quarters of our out-of-state tuition in exchange for returning for three out of the first 5 years out of vet school. If we did not want to come back, we just had to pay $50,000 and most of us went back. So it is a pretty strong incentive. But I agree with you, then they get the experience and there are a lot of people who do not understand how great it is living in rural communities. And this problem, over a short period of time, may go away. There may be enough of them then that stay to alleviate the problem.

I would like to thank the panel very much.

Ms. HARDT. Could I comment?

Mr. ENSIGN. Yes.

Ms. HARDT. I just wanted to make one comment about that. I think the earlier in the medical education the person is exposed to that rural experience the better off they are. We have seen some pretty good experiences of getting them early in medical school so they have seen this rural practice before they get enamored with the subspecialty world. I think the idea of tying those dollars to the schools that do turn out primary care physicians that do serve in rural and underserved areas is probably one of the most advantageous things you could do for rural communities.

Mr. ENSIGN. OK. I would like to thank the panel and call the next panel to the table.

Margaret Cushman, Susan Bailis, Kenneth Aitchison, John Mahoney, Phillip Hoffman, and Jeff Burman.

Mr. CHRISTENSEN [presiding]. Welcome to the Subcommittee and we will begin on the left with Ms. Cushman and we will just work our way to the right.

STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT AND EXECUTIVE DIRECTOR, VNA HEALTH CARE, INC., HARTFORD-WATERBURY, CONNECTICUT; ON BEHALF OF NATIONAL ASSOCIATION FOR HOMECARE

Ms. CUSHMAN. Thank you. My name is Peg Cushman and I am president of VNA Health Care serving greater Hartford-Waterbury, Connecticut. I am here representing the National Association for Homecare.

I commend you, Mr. Chairman, for holding this important hearing on issues related to solvency and budget reconciliation. My testimony will discuss specific legislative actions proposed to reduce growth rates of the Medicare home health benefit, including copayments, bundling of home health copayments into hospital DRGs, and I will also outline a proposal to ensure efficient quality home care.

We are deeply concerned about proposals before this Subcommittee to enact home care copays and to bundle posthospital home care costs into the hospital DRG rates. We strongly consider that both proposals would severely impair the accessibility, affordability and availability of care.

We urge Congress, instead, to implement a fair and equitable prospective payment system on a per episode basis. We believe that such a system would put the responsibility for appropriate service utilization on the provider's shoulders and create incentives to provide care in the most cost-effective manner.

We vehemently oppose the copayments on Medicare home health services. Home health copayments would create a substantial financial burden on Medicare beneficiaries. A 20-percent coinsurance, for example, would require the average Medicare home health beneficiary to pay over $900 in 1996, but about 15 percent of the estimated home health recipients would incur copays of more than $3,500.

A home health coinsurance is regressive and falls most heavily on millions of the poorest and oldest Medicare beneficiaries. Individuals over age 75 account for less than one-half of the total Medicare population, but nearly three-fourths of the home health beneficiaries, many of whom have fewer financial resources than the general Medicare population and the majority of whom are also women.

A coinsurance requirement would create strong barriers to those in need of care. Bundling would compromise the availability of home health care. Basing any posthospital payment on DRGs is inappropriate. DRGs, which are based on medical diagnoses, do not describe or predict the needs or the costs of home care services posthospitalization.

Bundling would make hospitals responsible for care provided outside of their setting and outside their expertise. Hospitals would be required to determine how much nonhospital care a patient needs and the best way to provide that care. Bundling would also vastly increase the administrative burden on the health care system by requiring multiple payment systems, one for posthospital patients, one for patients who did not enter the hospital but got onsite care straight from the community.

This would also result in tremendously uneven coverage decisions for patients with the same care needs. I urge you to vigorously oppose bundling of home care payments into the DRGs.

We propose the implementation of a per episode prospective payment system for home health care. Providers would receive a single payment, when a patient is admitted, that would cover the entire episode of care rather than paying for individual visits when they occur. Providers would have an incentive to manage the utilization in the most cost-effective manner.

The development of a per episode prospective payment system for home care has been long delayed by the absence of an adequate method to predict the resource utilization appropriate to the severity of the patient's medical condition, the degree of functional impairment, care giver availability, and other critical parameters.

We propose that Congress mandate development and testing of a valid case mix adjustor by the Secretary of Health and Human

Services within 2 years. And that a per episode prospective payment system be put in place immediately thereafter.

If a case mix adjustor is not ready in 2 years, we propose an interim prospective payment system be put in place which sets per visit rates with a per episode cap while the work on the case mix adjustor is completed.

This interim plan would encourage efficiency and appropriate utilization giving providers a share in the savings under the per visit and the per episode targets. A per episode prospective payment system for home care is far more cost effective than either copayments or bundling.

The National Association for Home Care prospective payment proposals are available in my written testimony. And the interim plan numbers presented are based upon a budget neutral plan. Those numbers could be adjusted to reach the savings desired. However, we also believe it would be irresponsible to target multibillion dollar savings in the absence of better case mix studies and adjustors to know what safe and effective patient care is.

We are also working as an industry to develop a consensus and a unified prospective payment proposal to put before Congress. And at the same time that the Subcommittee is looking at the other ways to reduce the Medicare costs, we have included in my written testimony four additional issues that we would like you to look at that would increase the efficiency and streamline the Medicare home care benefit.

We also have available to the Subcommittee information in detailed legislative proposals to address issues of fraud and abuse in homecare and we look forward to working with the Subcommittee on all of these important issues in the future.

Thank you for allowing me to testify and I would be happy to answer any questions.

[The prepared statement and attachments follow:]

STATEMENT OF MARGARET J. CUSHMAN
PRESIDENT AND EXECUTIVE DIRECTOR
VNA HEALTH CARE, INC.
ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE

My name is Margaret Cushman. I am President and Executive Director of VNA Health Care, Inc., of Hartford-Waterbury, Connecticut. I currently serve on the Government Affairs Committee of the National Association for Home Care (NAHC), which represents our nations's home care providers -- including home health agencies, home care aide organizations and hospices -- and the people, they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home health services to all individuals who require them. Toward this end, NAHC believes that America must do better at ensuring access to high quality home care and hospice services in both the acute and long-term care settings. These vital services provide millions of individuals -- the aged, infirm, and disabled -- the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity -- in their homes.

I want to commend you, Mr. Chairman, for calling this important hearing today on issues related to medicare solvency and budget reconciliation. As you know, home health represents a small, but growing part of the Medicare program. More enrollees than at any previous time are accessing in-home health services -- about 9 percent in 1994 compared to 2 percent 20 years ago. There are many contributing factors to this growth.

My testimony will discuss specific legislative actions that have been proposed to reduce the rates of growth in the Medicare home health benefit, including proposals to enact home care copays and to bundle home care payments into the hospital DRGs. I will also set out our own proposals for ensuring efficient, high quality home care.

FACTORS INFLUENCING RECENT AND HISTORICAL INCREASES IN THE UTILIZATION OF MEDICARE'S HOME HEALTH BENEFIT

The home health benefit has been a maturing program for most, perhaps all, of its existence in the Medicare program. In Medicare's earliest years of operation, home health expenditures amounted to only about 1 percent of the total. Therefore, although the benefit has increased at an average rate of 23.5 percent per year, it still represents a relatively small proportion of Medicare spending -- only about 8.7 percent of the total estimated for 1995.

Congress has long considered home health care a cost-effective benefit and has taken steps over the years to encourage its utilization. For example, Congress eliminated the prior hospitalization requirement and the 100 visit limit, the home health deductibles, Part B copays and broadened participation to include nonlicensed proprietary agencies. These amendments removed barriers to needed home health care and recognized the advantages of home health services over other acute care settings from the standpoints of patient preference and cost-effectiveness.

The home health benefit became especially useful in meeting the needs of patients who were discharged from the hospital "quicker and sicker" as a result of the 1983 enactment of the Medicare hospital prospective payment legislation. The percent of all Medicare hospital patients discharged to home health care increased to 18 percent compared to only 9 percent in 1981. Technological advances have also done much to make the home a safe and effective acute care setting. These factors together with the aging of the population, the increased paperwork burden, and an increased public and professional awareness of home health care have all contributed to the home health benefit's rapid increases over the past 25 years.

The home health benefit increases that occurred in the 1989-1992 period were almost double the 23.5 percent average experienced over the life of the Medicare program.

Coverage clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a so-called "chilling effect" in which some Medicare-covered claims were diverted to Medicaid and regrettably some patients

went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit gave NAHC the opportunity to participate in a rewrite of the Medicare home health payment policies. Just as a lack of clarity and arbitrariness had depressed growth rates in the preceding years, NAHC believes the policy clarifications that resulted from the court case have allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels. Data from the Health Care Financing Administration's (HCFA) Office of the Actuary indicates that the benefit has matured and that expenditure increases will fall to 7.8 percent by 1997. (See attachments 1 & 2).

Further, a recent report by the General Accounting Office, Budget Issues: Fiscal Year 1994 Budget Estimates and Actual Results, shows that Medicare home health care costs were well below projected levels of spending in 1994. Home care costs for 1994 were 12 percent, or $1.6 billion below estimated spending levels. Although HCFA assumed a slowdown in the growth in home health expenditures, the actual rate of increase slowed even more than anticipated, according to the GAO.

The National Association for Home Care urges Congress to take a close look at this report, coupled with data from the HCFA Office of the Actuary, which shows that the rate of increase in home care costs will continue to slow dramatically and level off to very modest levels by 1997.

Personnel shortage. Throughout much of the 1980s, the home care industry, along with the rest of health care, was suffering from a personnel shortage. Although there are still acute shortages of certain disciplines, it would appear that conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

New legislative requirements. In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA87 home health aide training and competency testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

New administrative changes. The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

LEGISLATIVE PROPOSALS

NAHC is deeply concerned about proposals before this Committee both to enact home care copays and to bundle post-hospital home care costs into the hospital DRG rates. We feel strongly that both these proposals would severely harm patient access to care, as well as the affordability and availability of care.

NAHC urges Congress instead, to consider implementing a fair and equitable per episode prospective payment system for home care. Such a system would put the onus for assuring appropriate utilization rates where it rightly belongs, on the providers' shoulders, and would put in place important incentives to ensure that care is provided in the most efficient, least costly manner.

NAHC Opposes Home Care Copays

NAHC vehemently opposes copayments on Medicare home health services. Home health copayments would create substantial financial burdens on Medicare beneficiaries. A 20 percent coinsurance would require the

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average Medicare home health beneficiary to pay over $900 in 1996. (See attachment 3). About 15 percent of the estimated 4.6 million home health recipients would incur copays of more than $3,500. Even a 10 percent coinsurance would require Medicare home health beneficiaries to pay average copays of over $480 in 1996. About 15 percent of these recipients would incur copays of more than $1,600.

A copayment will especially have an adverse impact on the elderly who are already health-care poor without this new expense. Seniors spend nearly twice as much of their income on their health care now as they did before Medicare began (10.6 percent in 1961 as compared to 17.1 percent in 1991). Most home health patients begin home care after a hospitalization. On average, these patients will have paid $1,700 or more in the preceding 12 months for Medicare premiums, deductibles and copays even before the first home health coinsurance comes due.

In addition, a home health coinsurance is regressive and falls most heavily on millions of the poorest and oldest Medicare beneficiaries. For example, individuals over age 75 account for less than half of the total Medicare population, but comprise nearly three-fourths of the home health beneficiaries.

Home health users also have fewer financial resources than the general Medicare population. About 12 percent of the elderly live below the federal poverty level, whereas nearly half of home health recipients are low income. Nearly three-fourths of the poor elderly do not own Medigap to help cover the costs of copays, and the Qualified Medicare Beneficiary (QMB) program, which is designed to help pay Medicare cost-sharing requirements for poor Medicare beneficiaries, does not provide adequate protection from these costs. Coinsurance for home health services, therefore, would fall most heavily on the oldest and poorest group of Medicare beneficiaries.

A coinsurance requirement for home health would also create strong barriers to care for those in need of home care. Home health was exempted from the Part B coinsurance in 1972 to encourage use of less costly, noninstitutional services. Reimposing coinsurance would dramatically undermine that effort.

Home health copayments are also inefficient and would add to the paperwork burden of home health providers. The collection of copayment amounts would create additional paperwork burdens. Many home health patients receive only a few visits (26 percent received fewer than 10 visits in 1992). Yet agencies would have to set up billing and tracking programs even for these relatively small amounts, increasing administrative costs.

Lastly, the Office of Technology Assessment (OTA) recently found that making patients responsible for copayments will keep them from seeking necessary care and could be especially harmful to those with low incomes.

NAHC Opposes Bundling

Bundling would severely compromise both the quality and availability of home health care, and may actually drive up Medicare costs.

Basing post-hospital payments on DRGs is completely inappropriate. DRGs are incapable of predicting the need for or cost of home health care after a hospitalization. The post-acute care needs of a patient can be completely different from the reason for hospital admission. Home care payments based on DRG rates would simply not match patient needs.

Bundling would require hospitals to be responsible for care provided outside of the hospital setting, and requires them to become fiscal intermediaries, in some respects. Under this proposal, hospitals would be required to determine how much non-hospital care a patient needs and the best ways to provide that care. Hospitals would make decisions about a patient's continuing care needs, as well as the appropriateness and quality of care. Hospitals should not be held liable for these decisions.

Bundling would vastly increase the administrative burden on the health care system, driving costs up in non-patient care areas. It would require multiple payment systems for home care -- one for post-hospital

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patients and one for patients entering home care from the community. It would also require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients, rather than using the current single-billing system under which agencies send all bills to their regional intermediary.

This two-track system will also result in tremendously uneven coverage decisions for patients with the same care needs. In the 1980's, coverage determinations among the different fiscal intermediaries were so great that HCFA moved to the current system of using 10 regional intermediaries as a way to ensure greater uniformity in coverage decisions. Bundling will fracture this system and put in place a system under which every hospital will interpret and apply coverage rules differently. Administrative nightmares would also be created for individuals who choose to receive their hospital care at nationally recognized institutions, but return home for their needed post-hospital home care. Increasingly, people are opting to undergo surgery or receive other hospital care at well-known hospitals, often flying to different parts of the country to receive the best possible care for their conditions. In these circumstances, bundling would require hospitals to monitor and make coverage and quality decisions about home care that is being delivered many miles away.

For these reasons, we urge you to vigorously oppose any effort to bundle home health care payments into hospital DRG rates.

NAHC Urges Enactment of PPS for Home Care

We propose the implementation of a per-episode prospective payment system (PPS) for home health care. PPS would be one way to create incentives for cost-effective utilization management. Under a per-episode PPS model, providers would receive a single payment when a patient is admitted that would cover the entire episode of care rather than paying for individual visits when they occur. In this system, providers would have an incentive to manage utilization in the most cost-effective manner.

The development of a per-episode PPS for home care has long been delayed by the absence of an adequate method to accurately adjust reimbursement to reflect the severity of the patient's medical condition, degree of functional impairment, caregiver availability, and other critical issues. NAHC proposes that a good case-mix adjustor be developed and tested by the Secretary of the Department of Health and Human Services within two years, and that a per episode PPS be put in place for home care immediately thereafter.

If a case-mix adjustor is still not ready after two years, we would propose that an interim prospective payment system be put in place, which sets per visit rates with a per episode cap, while work on the case mix-adjustor is completed. This interim plan would encourage efficiency and appropriate utilization by giving providers the opportunity to share in the savings under both the per-visit rate and episode targets. We would be concerned about moving to this interim plan too quickly since it would be an untested system. With changing financial incentives, some high cost patients may find it difficult to obtain care without an adequate case-mix adjustor. If this interim proposal were implemented, both provider and patient safeguards must be included.

While we are concerned about moving to a prospective payment system too quickly, we feel strongly that progress in moving the home care benefit into a prospective payment system must go forward and that a per-episode prospective payment system for home care is far more acceptable than proposals that have been advanced to bundle home care payments into the hospital DRG rates.

Attached to my testimony is an outline of our proposal for a Per Episode PPS, what we call "Plan A", and our interim "Plan B" proposal should Plan A not be ready in two years. (See attachment 4)

The industry has been working to come to a consensus on a unified PPS plan for home health.

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At the same time that the Committee is looking for ways to reduce growth in the Medicare home care benefit, we urge you to consider including in the reconciliation bill a number of proposals that would reduce unneeded regulations, increase efficiency, and streamline the Medicare home health benefit.

Include hospital-based agencies in the cost limits data base

Approximately one-quarter of the home care agencies in the U.S. are hospital based. Currently, both freestanding and hospital-based home health agencies are reimbursed for reasonable costs they incur in caring for Medicare beneficiaries up to certain limits, known as cost limits, which are set at 112 percent of the mean costs that freestanding agencies only incur in providing covered services.

Prior to 1993, hospital-based agencies received an add-on to the cost limits because of their higher administrative and general costs. OBRA93 eliminated the hospital based add on, but did not mandate that HCFA include these agencies' cost into the data base used to determine the average cost of providing home health services. As a result, both freestanding and hospital bases home health agencies are reimbursed under cost limits that use data from freestanding agencies only.

Congress should require HCFA to combine the costs incurred by hospital based agencies with those of freestanding agencies when calculating the cost limits. Not including all agencies' costs leaves one-quarter of all agencies unaccounted for in assessing the reasonableness of home health costs.

Permanently extend the waiver of liability for home health agencies, hospices, and skilled nursing facilities

The Medicare waiver of liability, which provides a safety-zone for home care, hospice and skilled nursing providers and patients, is scheduled to expire on December 31, 1995. The waiver of liability was created by Congress in 1972 to protect Medicare beneficiaries who are later determined to be ineligible or the services are later determined not to be covered. This cushion for error was created by Congress to encourage providers to render services to Medicare beneficiaries.

In 1972, the Health Care Financing Administration (HCFA) created a presumptive status for providers whereby the providers were presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submission of bills.

In the home health setting and for hospices, in order for an agency to be compensated under the waiver presumption, its overall denial of claims rate must be less than 2.5% of the Medicare services provided. For skilled nursing facilities, the denial of claims rate must be less than 5%. Any home health agency, hospice or skilled nursing facility that exceed these limits is not reimbursed under waiver regardless of whether it accepted beneficiaries and acted in good faith. This requirement forces providers to use due diligence in determining eligibility coverage. If the waiver expires, HCFA would make all coverage determinations on a case-by-case basis.

Without this buffer, providers would be compelled not to provide services under the Medicare program whenever there is a question of Medicare coverage. The result would be a chilling effect under which elderly and disabled individuals who might otherwise receive Medicare home health, hospice or skilled nursing services would have to pay for their care out-of-pocket or through private insurance.

Case-by-case review would also put an inordinate burden on many beneficiaries who would have to appeal denials and prove that the care in question should be covered.

This change would come at a time when more beneficiaries are in need of home care, hospice and skilled nursing services than ever before.

Congress should make permanent the waiver of liability for home health care and hospice agencies and for skilled nursing facilities in this year's reconciliation bill. Without this provision, the availability of Medicare home care, hospice and skilled nursing services may be severely compromised for many individuals in need of this care.

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Provide Access to Medicare HMO Enrollment Information to Home Health Providers

Medicare will not reimburse home health agencies for care provided to Medicare HMO enrollees , even though home health agencies are not told when a patient joined an HMO. In these cases, home health agencies are not paid for care they provide in good faith.

Despite the fact that the Health Care Financing Administration (HCFA) has implemented a nationwide data base known as the Common Working File (CWF) which contains the necessary information to determine the enrollment status of Medicare beneficiary, there is often significant lag time between when the beneficiary enrolls in a Medicare HMO and the entering of this information on the CWF database. Moreover, Medicare HMO enrollees often fail to fully understand that HMO enrollment and means they cannot go to any agency they choose.

To resolve this issue Congress should:

* Allow access to beneficiary enrollment information for Medicare-certified home health agencies which provide assurances that the patient authorization is on file with the agency;

* Establish a "hold harmless" provision under the Medicare Act to protect providers who in good faith provide care to HMO members and others not enrolled in the fee-for-service Medicare program; and

* Require HMOs to inquire about health services their enrollees are receiving from other providers and to send those providers notification of HMO enrollment.

As Congress provides more incentives for Medicare beneficiaries to enroll in Medicare HMOs, the need for timely enrollment status information becomes greater. Despite providers' best efforts at discovering HMO enrollment, information available from patients and families is frequently inadequate and unreliable, thereby subjecting home health agencies to significant financial losses. In absence of timely HMO enrollment information, home health agencies should not be denied payment for care provided before they were informed of the patient's HMO enrollment.

Make Medicare Regulations Apply Only to Medicare Reimbursed Care

Medicare certified home health agencies have to comply with Medicare regulations for all their patients, even non-Medicare, private paying individuals. Included in these regulations is the requirement that a written plan of care be established and periodically reviewed by a physician and that agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.

The plan of care must include the patient's mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other factors.

This means that a 30-year-old auto accident victim who wants bath services from a home health agency aide while he recuperates would need a physician's verbal approval before care could begin, followed by a detailed plan of care signed by the physician. Or, that normal new mother and baby cannot have home visits for assessment and teaching routine post-partum and newborn care without a physician's order and detailed plan of care, even though Medicare would not be paying for either of these individuals' care.

Regulations requiring that care be physician certified for non-Medicare paying patients is an unnecessary regulatory burden. In most instances, such an extensive care plan and physician certification for non-Medicare paying patients is not needed, especially if the patient is only seeking non-skilled or health promotion services. Moreover, nurses are qualified and authorized under state licensure laws and practice acts to order and supervise the provision of unskilled services and to carry out health promotion and teaching activities without the orders of a physician.

Once again, thank you for the opportunity to testify on these important issues. We look forward to working with you and I welcome any questions you may have.

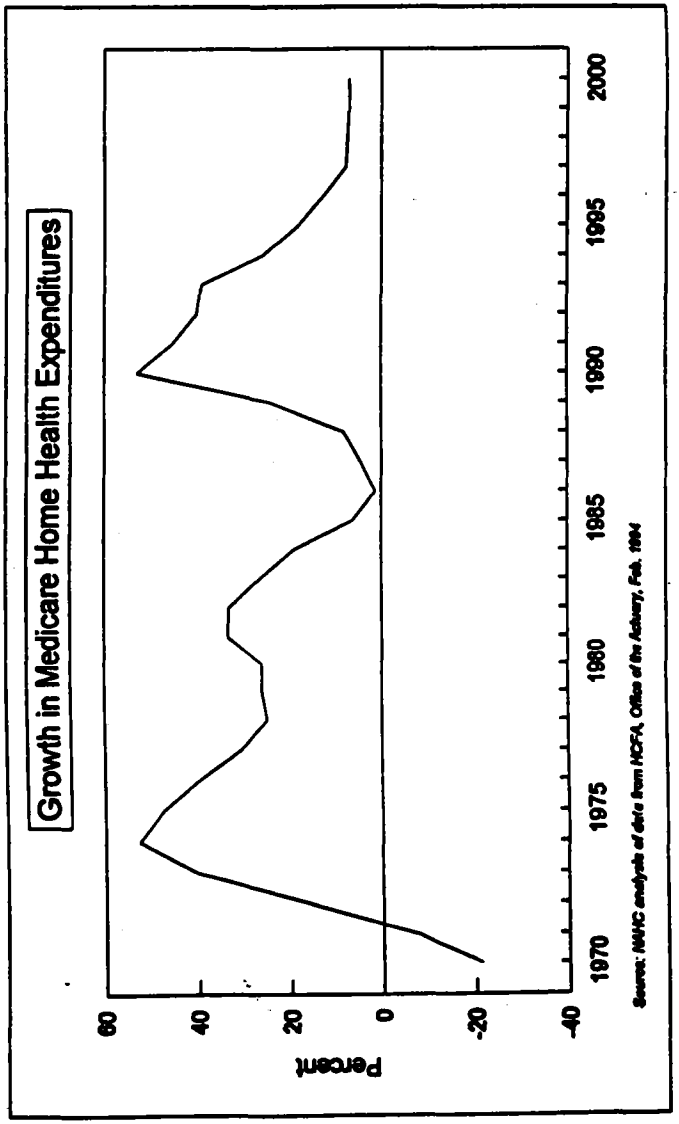
ATTACHMENT 1

Medicare Home Health: Visits, Clients and Incurred Expenditures

Calendar Year	Visits (1000s)	Pct. Change	Clients (1000s)	Pct. Change	$ Incurred (millions)	Pct. Change	Visits/ Client	Pct. Change	$$$/ Visit	Pct. Change
1989	46275	24.5%	1,685	6.5%	$2,527	24.3%	27.5	16.9%	$54.61	-0.2%
1990	69,565	50.3%	1,940	15.1%	$3,797	50.3%	35.9	30.6%	$54.58	-0.0%
1991	100,044	43.8%	2,223	14.6%	$5,472	44.1%	45.0	25.5%	$54.70	0.2%
1992	134,844	34.8%	2,523	13.5%	$7,848	39.8%	53.4	18.8%	$58.72	3.7%
1993	173,953	29.0%	2,900	14.9%	$10,279	34.4%	60.0	12.2%	$59.09	4.2%
1994	209,149	20.2%	3,220	11.0%	$12,570	22.3%	65.0	8.3%	$60.10	1.7%
1995	235,889	12.8%	3,460	7.5%	$14,891	18.5%	68.2	5.0%	$63.13	5.0%
1996	253,582	7.5%	3,635	5.1%	$16,491	10.7%	69.8	2.3%	$65.03	3.0%
1997	259,459	2.3%	3,705	1.9%	$17,906	8.6%	70.0	0.4%	$69.01	6.1%
1998	265,184	2.2%	3,765	1.6%	$18,956	5.9%	70.4	0.6%	$71.48	3.6%
1999	270,616	2.0%	3,830	1.7%	$20,185	6.5%	70.7	0.3%	$74.59	4.3%
2000	275,977	2.0%	3,895	1.7%	$21,452	6.3%	70.9	0.3%	$77.73	4.2%

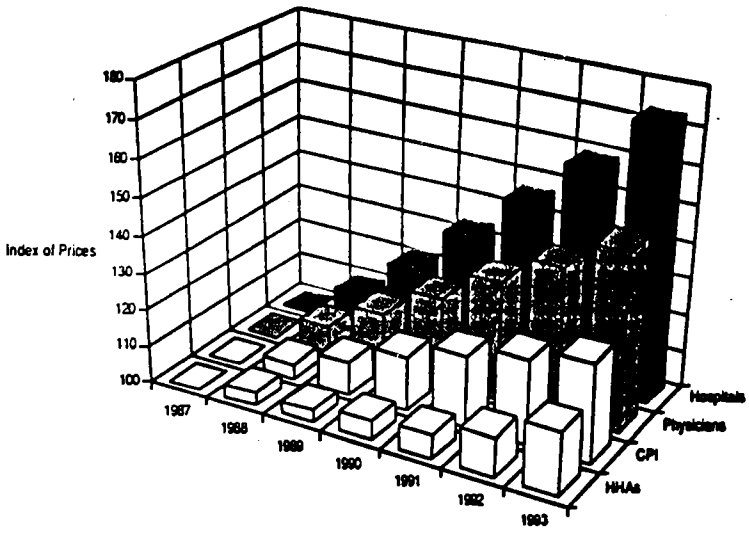
Source: HCFA, Office of the Actuary, 2/6/95.

ATTACHMENT 2



ATTACHMENT 3

NAHC Data Show that Home Care Is Still a Good Buy



Data collected from various sources and analyzed by NAHC show that from 1987 to 1993 the cost of living or consumer price index (CPI) increased by 27.1%, the cost of physician's services increased by 48.5%, and hospital costs soared by 73.4%. By contrast, home care costs increased by only 17% during the same period—about 60% of the increase in the CPI, and far below the rates of increase for other health care providers.

Updated Medicare Home Health Coinsurance Projections, 1996-2002

Year	Clients (thousands)	Total Visits (thousands)	Avg. Visit/ Client	Total Reimb. (millions)	Average Reimb./ Client	Average Reimb./ Visit	Average Copay/ Client	High User Bennies	High User Avg. Copay
1996	3,635	253,582	70	$16,491	$4,537	$65	$907	643,395	$2,913
1997	3,705	259,459	70	$17,906	$4,833	$69	$967	655,785	$3,103
1998	3,765	265,184	70	$18,956	$5,035	$71	$1,007	666,405	$3,232
1999	3,830	270,616	71	$20,185	$5,270	$75	$1,054	677,910	$3,383
2000	3,895	275,977	71	$21,452	$5,508	$78	$1,102	689,415	$3,536
2001	*3,960*	*281,748*	*71*	*$22,658*	*$5,723*	*$80*	*$1,145*	*700,832*	*$3,674*
2002	*4,024*	*287,342*	*71*	*$23,878*	*$5,934*	*$83*	*$1,187*	*712,248*	*$3,810*

Source: HCFA, Office of the Actuary (2/6/95)
(2001, 2002 projections extrapolated from HCFA data)

Mr. CHRISTENSEN. Thank you. All of your statements will be entered into the record, if that is your desire, as well as all your oral testimony. I wanted to make a point that Mrs. Johnson was sorry that she could not be here, Ms. Cushman, and she is honored to have you here testifying today. She was called away to another Committee.

We are honored to have Ms. Bailis' testimony at this time and thank you for keeping it within the 5 minutes, I really appreciate that.

STATEMENT OF SUSAN S. BAILIS, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, ADS GROUP; ON BEHALF OF AMERICAN HEALTH CARE ASSOCIATION

Ms. BAILIS. Thank you, Mr. Chairman. My name is Susan Bailis, and I am the executive vice president and chief operating officer of the ADS Group in Andover, Massachusetts. I am also the president of the Massachusetts Extended Care Federation and I am speaking today on behalf of AHCA, the American Health Care Association, a federation representing 11,000 nonprofit and for-profit assisted living nursing facilities and subacute providers nationally.

I also serve on the Prospective Payment Assessment Commission but I would like to clarify that I am speaking as a provider and as a member of the American Health Care Association. On behalf of AHCA, we appreciate the opportunity to testify today.

To put in context my comments, I would like to be clear that AHCA supports a free market and barrier-free continuum for the delivery of skilled nursing services. We believe that Medicare needs restructuring and we support efforts to reform the system.

We feel also that nursing facilities are meeting the challenge in the private sector and that Congress should examine our innovations, especially in our efforts to replace acute care with skilled nursing facility care. I would like to correct some statistics that Dr. Vladeck provided the Subcommittee this morning comparing acute and SNF costs of care.

The average daily cost of a hospital day is $980. The average cost of a SNF subacute day is $350. And the SNF day is $226 to the Medicare Program. So that we feel, in particular, that subacute care offers an opportunity to save money while preserving quality of care to frail elders.

However, there are currently barriers in the fee-for-service Medicare system that discourage the use of subacute care. Managed care and Medicare risk contracting is an example of efforts to remove some barriers in order to promote efficiency. An example of this is PacifiCare that has developed Medicare risk contracts where managed care uses SNF stays to reduce hospital costs. The single most important way to save money in a Medicare risk program is to reduce acute care utilization.

The chart on my right shows the reduction in hospital stays of PacifiCare between 1990 and 1993 from 1,089 days per 1,000 to 964 on the top line and the bottom, increased SNF stays from 497 to 676. So the chart displays the ability to replace acute care with SNF care which is at a significant savings to the system.

With risk contracting growing at 16 percent per year, and Medicare rules and regulations being more flexibly applied, there is a

real opportunity in this market driven system to seek cost containment. The American Health Care Association proposes some efforts to contain costs, including encouraging the growth of subacute care. With subacute care being 30 to 60 percent less than the cost of acute care, clearly a cost-effective option.

Among the key barriers are inefficiencies that we recommend be examined is the 3-day prior hospital stay which requires the hospitalization prior to SNF use. Eliminating that requirement just for five DRGs would save $500 million a year. A study that was done by ABT Associates demonstrates that a flexible approach to the 3-day prior hospital stay would achieve savings of $9 billion to the Medicare Program a year.

Another inefficiency that needs to be looked at is the payment for hospitals under a cost base and a prospective system with the use of hospital based skilled nursing facility care. A fundamental program that we recommend in terms of changes is prospective payment for skilled nursing facilities which offers cost control with rates related to acuity and appropriate provider efficiencies. As you know, this has been requested by Congress in 1990 and 1993, and there are clearly savings that would accrue through an implementation of a prospective payment system. We would like to see a statutory requirement for PPS by 1997.

Another recommended potential savings is through savings achieved through consolidated billing which would deal with fraud and abuse problems, and we have forwarded to staff a proposal for consolidated billing which would assist in eliminating abusive practices.

Other reforms we recommend, to summarize quickly, equalizing copayments for providers, enhancing long-term care, insurance, opposing new regulatory burdens that increase costs, and removing barriers to competition in the marketplace. We believe that postacute care bundling will not achieve those goals and will merely drive up the costs. So that in conclusion we recommend that nursing facilities offer the potential for savings for the Medicare Program, while maintaining quality of care.

I appreciate the opportunity to testify and will be delighted to answer questions.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF SUSAN S. BAILIS
EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER
ADS GROUP
ON BEHALF OF AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Committee, I am Susan S. Bailis, Executive Vice President and Chief Operating Officer of The ADS Group of Andover, Massachusetts. I am speaking today on behalf of the American Health Care Association, a federation of 51 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. I also serve on the Prospective Payment Commission, but let me clarify now that I am speaking only as a provider and as an officer of AHCA. On behalf of AHCA's members, and the one million plus residents of our member facilities, thank you for the opportunity to speak at this important hearing.

Let me begin by commending you, Mr. Chairman, for your efforts to expand the scope of America's thinking on Medicare and to truly tackle the critical problem of ensuring the program's solvency and improving the delivery and cost-effectiveness of its services. The task you are undertaking to restructure Medicare and improve the program are daunting, but from our preliminary view of where you are heading, it appears you are up to the task. Increasing options for seniors, reducing regulatory barriers to cost-effective care, and stimulating patient responsibility for savings and choices in care are critical. AHCA joins you in embracing these goals. In a free-market, where patients can make informed choices for care, our nursing facilities can offer skilled nursing care of the best quality available and at costs of 33% to 60% less than in a hospital-based setting.

OPTIONS FOR REFORM: OPPORTUNITIES FOR SENIORS

In a moment, I'll lay out specific options for achieving billions in cost savings, but now let me address the broader issues of how to structure a new Medicare program that ensures quality care, improves services and access where possible, and manages to slow the growth overall spending.

MEDICAL SAVINGS ACCOUNTS

First, the American Health Care Association supports increasing options through the innovative, free-market oriented approaches outlined in early drafts of the Subcommittee's proposals. In particular, AHCA has endorsed Chairman Archers Medical Savings Account legislation and wishes for its early enactment. Providing America's seniors with the choice in how to spend their health care dollars for the plan of their choice, especially with a multitude of options, makes perfect sense.

Encouraging citizens to establish Medisave accounts and to take more responsibility in their health care decisions is critical. Including catastrophic insurance protection as a prerequisite for MSA eligibility also is a admirable goal. We encourage adoption of MSA legislation as part of a package of options that include managed care or MediChoice plans and employer, association or union sponsored plans. Ensuring that these plans receive the same tax treatment and advantages under law is also an important goal so that competition is allowed to thrive.

SKILLED NURSING CARE UNDER MANAGED CARE

As you examine ways to find cost savings, then obviously you will closely scrutinize managed care. I highly recommend you examine how managed care is utilizing skilled nursing care to reduce hospital stays. Managed care has recognized the benefit of substituting SNF days for more expensive hospital days. In recent testimony before the Prospective Payment Commission, Dr. Roger Taylor, Executive Vice President with PacifiCare, one of the fastest growing managed care organizations in the nation, stated that a large percentage of their ability to save money was their ability to reduce hospital Medicare days per thousand through the utilization of SNF day substitution. In fact, if you will refer to the chart titled "Sicker and Quicker", you will see that PacifiCare has achieved a large part of its savings by reducing hospital stays from 1089 days per thousand members in 1990, to 964 in 1993, through correspondingly increasing their SNF days per thousand from 497 to 676.

Currently, 3.2 million Medicare recipients or 8.7% of all eligible beneficiaries are enrolled in managed care plans. Fully 76% of these beneficiaries are in risk contract plans and participation in these plans in 1994 increased by 16%. According to ProPAC, risk contract patients use hospitals less and length of stays are much shorter. Conversely, they utilize SNFs at a far greater rate. The reason: Substantial savings and quality. ProPAC confirms this on Page 72 of their recent report where they write:

> *"Beneficiaries in risk contracting HMOs were just as likely to use hospital, physician, and home health services as their fee-for-service counterparts, but they used fewer of them, according to the program's 1992 evaluation. This was not true, however, for nursing home use. HMO enrollees were likelier to use a skilled nursing facility, although the length of stay was similar to that of FFS beneficiaries. Apparently, plans were not limiting access to ambulatory and inpatient services, but were using skilled nursing facilities in place of some hospital days."*

AHCA supports the utilization of managed care to provide quality care and control costs. In particular, we commend the Congress for extending and expanding the Medicare Select Demonstration Project and for exploring ways to increase Medicare beneficiaries in managed care risk contracting. We believe the move by Congress to reexamine the entire Medicare program and its relationship to private sector efforts in managed care are welcome and will be fruitful.

In Orange County, California, where over 50% of Medicare eligible residents are enrolled in managed care risk contracts, artificial barriers that drive up costs - such as the 3-day stay rule - are avoided, and consumers are pleased with their coverage and care. The ability of managed care organizations to achieve cost savings by utilizing SNFs is something the Congress must examine. Follow the lead of the private sector and market-based reforms, and I believe you will find it easier to control Medicare costs.

In a free-market environment, where seniors have the option to participate in different federal plans that offer a variety of benefits, including the current program, skilled nursing care will thrive as it has in managed care. In the marketplace today, subacute care is a reality. In Medicare, it is not fully understood. In the marketplace, there is no three-day prior hospital stay. In Medicare, the three-day stay rules costs the program significant resources. In Medicare fee-for-service, transfer agreement requirements for reimbursing respiratory therapy cost millions per year. In the marketplace, we are providing ventilator patients with care that is half as much as hospital care, and in many cases weaning them after hospitals had given up on them. The positive role of subacute care in Medicare has not been fully acknowledged.

We eagerly await the elimination of unnecessary and burdensome rules, regulations and barriers to competition in the current fee-for-service program. In fact, we have specific and long-standing proposals that fit in with what you are attempting to accomplish.
Let me outline some of our proposals addressing cost containment and program reforms which are of the utmost importance in attaining a balanced budget.

AHCA COST CONTAINMENT PROPOSALS

SUBACUTE CARE: POTENTIAL SAVINGS - $46 Billion

Skilled nursing facilities offer subacute health care services at an average cost of 47% less than hospital-based SNFs. A report by Abt Associates, Inc. issued in June of 1994, identified 62 DRGs where SNFs are currently providing subacute care and estimated potential cost savings to Medicare if percentages of patients in these groups were treated in SNFs rather than in hospitals. Abt found a potential savings to Medicare of between $7.535 and $8.906 billion per year depending upon the accounting for empty hospital beds and partial waiver of the 3-day stay rule.

I recommend that the Subcommittee examine the Abt report in detail to see how legislative initiatives proposed by AHCA could potentially save billions of dollars to the Medicare program. In short, as SNF spending increases on Medicare subacute care, there is a corresponding decrease in acute care spending, especially for outlier patients.

While it is difficult to prove that subacute SNF days are replacing acute hospital days, perhaps there is a tell-tale sign in baseline budget figures released by CBO this year. CBO shows the hospital growth rate increasing at substantially less than previously predicted while the SNF growth rate in dollars is increasing correspondingly, faster. Since SNF spending is a small fraction of hospital spending, it makes sense that a small decrease in the anticipated growth in the hospital baseline would show a larger increase in SNF baseline spending if SNFs were competing for, and being utilized more, for subacute patients.

AHCA proposes that hospital subacute DRGs be examined and rebased according to severity of illness and length of stay. Particular attention should be paid to the relative costs of SNF subacute care compared to hospital-based subacute care. For instance, HCFA's estimate released this year found that hospital-based SNF care is on average $88 per day more expensive than identical care in a free-standing SNF. It is absolutely clear, however, that SNFs can provide subacute care at substantially lower costs than hospitals. In order to test this, AHCA proposes that the Secretary of Health and Human Services immediately waive the 3-day hospital stay requirement for patients in a group of five DRGs, including skin ulcers and chemotherapy, and achieve an estimated $500 million per year in savings in just a few years. The SNF stay would be allowed only as a substitution to a hospital stay as certified by the admitting physician.

If you will **refer to the chart which details DRG #410**, chemotherapy without acute leukemia, Abt Associates estimates that no prior-three day hospital stay would be required for over 50% of all patients with this condition. Under current law, a hospital would receive a full DRG payment of approximately $4,121 for this type of patient, and could, if it wishes, transfer the patient to a hospital-based SNF unit and receive cost-based reimbursement of another $1314 on top of the DRG. In fact, across the nation, hospitals are legally maximizing reimbursement - some call it double-dipping - for thousands of their patients. In contrast, AHCA proposes to eliminate this double-dipping ability, or in many cases, simply bypass the hospital altogether at a savings of approximately, in the case of DRG #410, perhaps as much as $4,000 per patient.

It is very important that CBO give this proposal a detailed analysis and not shrug off mention of the 3-day stay rule because of prior concerns when the Medicare Catastrophic Act was enacted and soon after repealed. We are talking about direct substitution for acute hospital stays and not the creation of new patients coming out of the so-called "woodwork" or any new subacute care benefit.

PROSPECTIVE PAYMENT: POTENTIAL SAVINGS - $1 Billion

Our second proposal involves redesigning the Medicare SNF payment system from a retrospective cost-based system to a prospective payment system (PPS). I want to express our appreciation, Mr. Chairman, for the support from your subcommittee for our proposal in the past. In particular, your support, along with Ranking Minority Member Stark and Congressman Cardin, has been very helpful in moving HCFA forward on our proposal. It is our understanding that they have almost completed a system to present to your subcommittee, thus, if the system is complete and addresses the key issues of capital and ancillary services, we would hope the subcommittee would include a SNF PPS in its plans for reform. Indeed, Congress has twice before requested in OBRA'90 and again in OBRA'93 that we move to a PPS by October of this year. HCFA promised the House Ways and Means Committee in testimony during late 1993 to have an interim system to the Congress by last June. We are pleased to continue to work with them on a cost-containing prospective payment system, and believe that a model PPS system would be ready to be fully implemented by 1997.

AHCA is very serious about curtailing administrative costs and building in incentives to save Medicare dollars. We support a case-mix, facility specific PPS that addresses costs in five costs centers: nursing services, administrative costs, fair rental value for property, ancillary services, and therapy services.

In regard to current billing practices for medical equipment and ancillary services, we desire strongly to work with HCFA and the Congress to eliminate any fraudulent billing for such items. In addition, we have been meeting and working with HCFA on salary equivalency issues and will briefly discuss a cost-savings proposal to address problem billing practices that have been identified by GAO and the Inspector General. In short, AHCA's model PPS is designed to be revenue neutral, with incentives built in to control future costs, and we believe that it could be designed to curtail unnecessary billings for equipment or special services and significantly reduce utilization.

Our model PPS is designed to promote quality care; to ensure equal access for high-acuity beneficiaries; maintain adequate capital formation to address future demographic trends; and achieve cost containment. In the past, Congress has requested a PPS for SNFs, and HCFA has promised to develop one. We would request that HCFA honor its word with a balanced and constructive PPS that can be implemented before 1998, and we encourage this Committee to provide a statutory requirement to do so.

CONSOLIDATED BILLING: POTENTIAL COST SAVINGS - Undetermined

In order to respond to reports of billing abuses by providers of services in SNFs, AHCA proposes to eliminate all third-party billing for Part A services under Medicare and provide SNFs with an option to bill for all Part B services as well. The vast majority of abuses outlined by the General Accounting Office and the Inspector General involved over-charging and fraudulent billing for services provided under arrangement between outside providers and SNFs. AHCA's proposal will require point of service billing and that SNFs directly oversee the provision of services to our patients, verify the services were truly provided for, and bill for these services directly. It is our responsibility to ensure billing in our facilities is accurate and honest and we intend to do so.

FRAUD AND ABUSE: POTENTIAL COST SAVINGS - Undetermined

In addition to developing proposals, such as consolidated billing that discourages fraud and abuse in our industry, AHCA has been actively working to eliminate fraud and abuse from the health care industry in general. AHCA is a founding member of the Coalition of Health Associations United Against Fraud and Abuse, which consists of 17 health care associations who are working with Congress and the Administration to eliminate fraud and abuse. The Coalition has developed an anti-fraud and abuse proposal and is actively seeking its introduction in the House and Senate.

The proposal is based on the following tenets:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;

- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;

- Protect Federal health care programs from unnecessary cost, utilization, and failure to deliver appropriate levels of care;

- Be appropriate for the changing health care market; and

-Separate willful from technical violations.

The Coalition's proposal will go a long way toward eliminating fraud and abuse from the health care industry by combining tough enforcement against those who intentionally violate the law, with education for those who seek to provide care within the complex rules of Medicare and Medicaid. I will submit under separate cover a summary of the proposal. I strongly recommend your Committee adopt this measure.

RESPIRATORY THERAPY: POTENTIAL COST SAVINGS - $1 Billion

One therapy service that is being provided in SNFs but is not reimbursed by Medicare directly is respiratory therapy. Abt Associates, Inc. will shortly release a study which estimates that the cost savings of utilizing SNFs rather than acute care settings in one DRG alone, #475 tracheostomy, one of the most costly DRGs, would save up to $990 million over five years. A 1993 CBO preliminary cost estimate predicted a $100 million revenue loss over five years due to a 10% increase in SNF service utilization. However, the estimate acknowledged that offsetting savings may be realized -- *"if ventilator patients were moved from hospitals to SNFs, then fewer resources might be used in the treatment of these patients."* We strongly concur and there is ample proof in the marketplace that this is in fact, taking place..

AHCA requests that your subcommittee reexamine this issue in view of recent data and increased utilization of SNFs for such care, despite the lack of direct reimbursement. Hospitals providing ventilator care charge upward of $1,000 per day for such care compared to approximately $350 per day charged by subacute SNFs. Costs billed by hospitals for such care are also driven higher when provided in SNFs under contractual arrangement. Administrative add-ons are also billed, where if the services were provided directly by SNF employees, these costs would not be incurred.

EQUALIZE COPAYMENTS: POTENTIAL COST SAVINGS - $28 Billion

Finally, in regard to home health care, we applaud efforts to move patients into the least restrictive and most cost-effective setting, but due to the different acuity of nursing facility residents and patients that can be treated at home, we do not see home care as competing with nursing facilities, but as an essential part of the health care continuum. For instance, average activities of daily living (ADL) measurements for home health patients are 2.5 of 5 vs. 3.9 of 5 for SNF patients. We would support, however, that copayments be applied equally.

SNFs residents are currently burdened with a copayment after 20 days of 1/8th of the annual hospital deductible amount. This is a steep $89.50 per day copayment that almost eliminates any benefit after the 20th day of a SNF stay. We would encourage your subcommittee to impose equal copayments for home care and SNF services and eliminate the unworkable current SNF copayment. This proposal would raise billions of dollars for deficit reduction, make consumers better buyers of services, and provide equal treatment for post-acute care providers.

LONG TERM CARE INSURANCE: A KEY TO FINANCIAL SOLVENCY

Let me conclude my remarks on cost containment and innovation by endorsing and supporting efforts by the Congress to improve long term care insurance by clarifying income tax rules and providing basic policy standards. You, Mr. Chairman, along with Mrs. Johnson, have provided vital leadership on this issue and are to be commended.

Probably the best long-term way to reduce government costs is to build on the private side of the existing public/private partnership for long term care by encouraging more senior citizens to purchase long term care insurance policies early on. A 1994 study by Cohen, Kumar and Wallack found that each long term care policy kept in effect can save Medicaid as much as $15,000 per policyholder.

Perhaps most importantly, the tax clarifications awaiting your approval and passed by the House are the most critical factor in slowing the growth in Medicaid spending on long term care. In fact, it should be our mutual goal of phasing-out, privatizing or vouchering the Medicaid long term care program into a private insurance program. This Committee must look at new alternatives and go beyond simply block granting the program and moving the problems of long term care financing to the States. Private, long term care insurance is the key.

POST-ACUTE CARE BUNDLING: ANTI-FREE MARKET, ANTI-QUALITY

One recommendation that was suggested as an option by the House Budget Committee is bundling all post-acute care services into the hospital DRG system. This is an extremely flawed and unreasonable proposal which would not obtain the cost savings estimated by the Congressional Budget Office. Chairman Thomas, your opposition to the proposal is very much appreciated and warranted. For example:

- Post-Acute care was designed to reduce higher acute hospital costs - the bundling proposal would shift services back to higher cost centers

- SNFs and home care are cost effective alternatives to hospitals -this proposal flies in the face of the hospital PPS system

- SNFs and home care offer free-market options for consumers - this proposal eliminates competition for services by bringing all services under hospital control

- HCFA is years away from having the data to implement such a system - HCFA is perhaps three years away from a SNF PPS and 18 months behind that on home health

- Hospitals are ill-prepared and do not have the immediate service capacity to offer cost effective post acute services

- This is an antiquated proposal that has found little support - studies show serious design and accountability problems with such a system. A bundling system of this type is unworkable.

Bundling in theory may sound like it makes sense. In fact, as proposed in the House, it would strike at the heart of free-market competition, access to care and most importantly, quality of care. Hospitals would attempt to dump costly outlier patients on SNF, rehab and Home Health providers that would have to refuse to take these patients they could not possibly afford to take with a DRG add-on. Much less one reduced by whatever the hospital determines to be a reasonable mark-up or administrative charge.

RELATED MEDICARE RECOMMENDATIONS

Let me briefly make a few final recommendations to the Committee before wrapping up. These include:

- extend the waiver of liability provisions protecting innocent providers who make unintentional paperwork mistakes

- allow providers to make reasonable and customary charges for services rendered under the related party rules

- oppose HCFA attempts to "fully certify" Medicaid and Medicare beds in nursing facilities. This proposed policy could lead to upcoding and over-utilization due to the huge number of new Medicare beds that would be made available for services. The potential cost of this proposed rule should be examined closely by this Committee

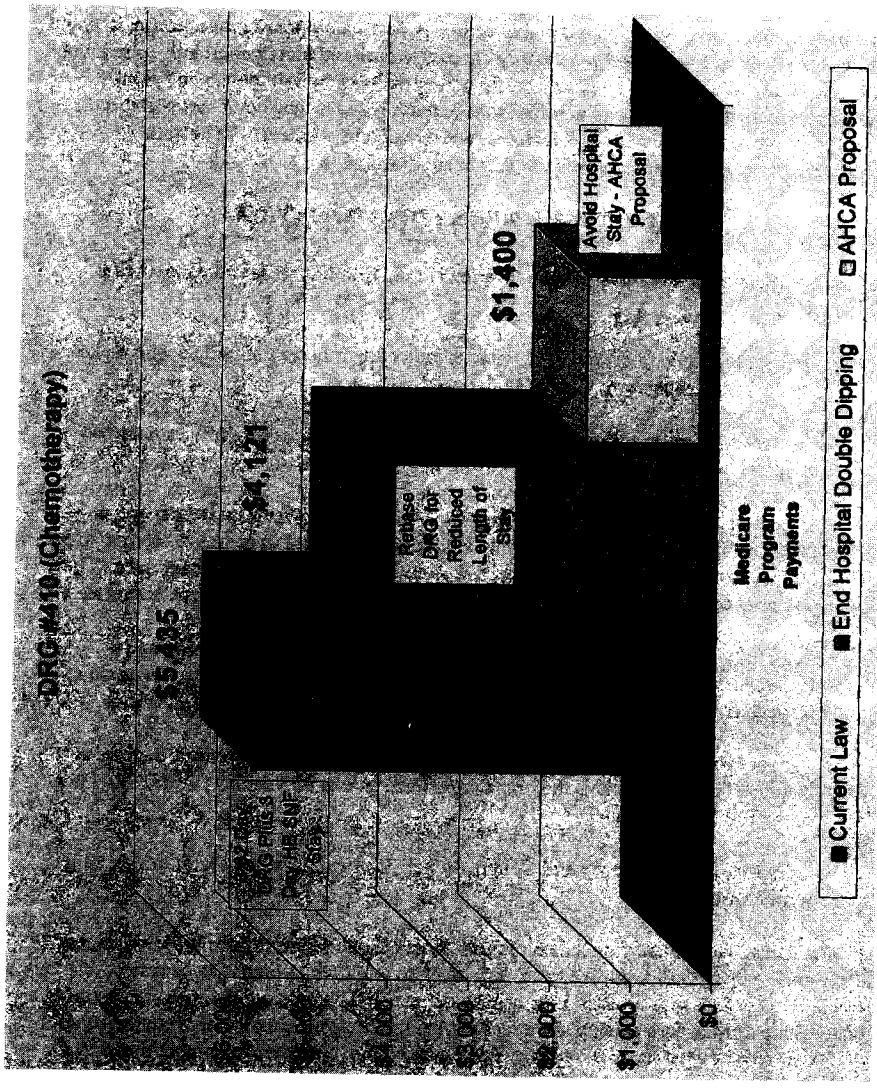
- carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, are not abused by over-zealous inspectors and are enforced fairly and evenly

- adopt ProPAC's recommendation on Page 49 of this year's report to Congress to examine "paying hospitals that transfer patients to non-PPS settings a per diem intend of the full DRG amount"

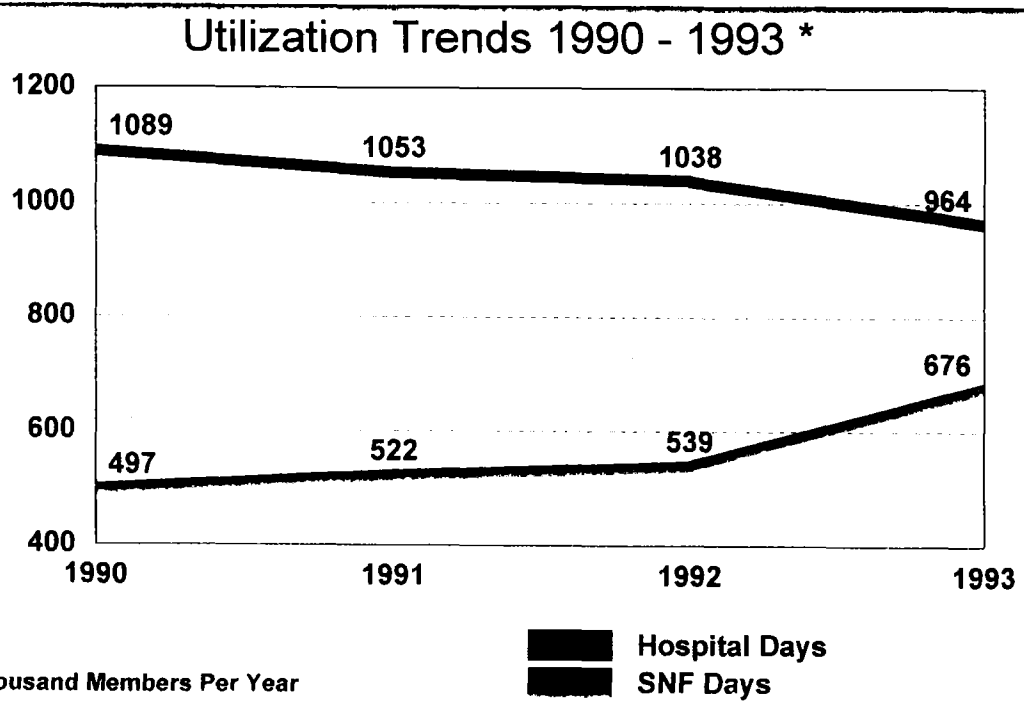
- support previous agency and Congressional efforts to place a moratorium on long term hospitals.

Mr. Chairman, we applaud your subcommittee and staff on the early drafts we have seen of the direction you are heading. We wish very much to work with you on the specifics, especially regarding subacute and post-acute care. America's nursing facilities are capturing a greater share of Medicare patients for a reason - competition and innovation. We hope you will take notice of what the marketplace is doing and remove barriers to competition that remain in place in an antiquated and broken fee for services system.

Thank you Mr. Chairman. I'll be glad to answer any questions.


DRG #410 (Chemotherapy)
$5,435
$4,135
$1,400
Release DRG for Reduced Length of Stay
Avoid Hospital Stay - AHCA Proposal
Medicare Program Payments
$0
$1,000
$2,000
$3,000
Current Law
End Hospital Double Dipping
AHCA Proposal

Quicker and Sicker



* Per Thousand Members Per Year
Data from PacifiCare of California

Mr. CHRISTENSEN. Thank you, Ms. Bailis.
Mr. Aitchison.

STATEMENT OF SY SCHLOSSMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN REHABILITATION ASSOCIATION; AS PRESENTED BY KENNETH W. AITCHISON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, KESSLER INSTITUTE FOR REHABILITATION, INC.

Mr. AITCHISON. Thank you, Mr. Chairman. My name is Ken Aitchison and I am the president of Kessler Institute for Rehabilitation in West Orange, New Jersey. I appear before you today on behalf of the American Rehabilitation Association and in particular, for Mr. Sy Schlossman, who was to have been in this chair.

I have worked in medical rehabilitation for approximately 30 years. Since much has been said about the rural community, the first part of that was in North Dakota at the University of North Dakota Rehabilitation Hospital and most recently at the Kessler Institute.

Kessler is a 4-location, 320-bed rehabilitation hospital in northern New Jersey. Perhaps you best know us now for having admitted Christopher Reeve following his tragic accident. He is currently a patient in our West facility.

Our field, medical rehabilitation, addresses itself to a single end, the elimination or mitigation of disability. Most of our patients come to us after having had a stay in an acute care hospital. Last year, 1994, approximately 400,000 people were admitted to rehabilitation hospitals and units. Totally there are about 200 rehabilitation hospitals and 800 units across the country. In addition, many more patients receive care as outpatients.

Many of the conditions associated with admission to a rehabilitation hospital are as the result of advancing age. As a consequence, the great majority of our patients are Medicare beneficiaries, thus, rehabilitation hospitals, perhaps more than any other segment of proposed Medicare reform, will be affected by the changes that might be adopted.

Rehabilitation in hospital units have been reimbursed since 1983 on what is known as the TEFRA system. The temporary measure that has per discharge limit ceilings. That system has three problems about which I wish to speak.

First it does not adjust for change in case mix, and/or increased acuity of patients. Second, it places pressure upon us to cut average length of stay, as a means of reducing per discharge costs.

Third and finally, it overtly encourages and subsidizes new providers. With respect to that particular event, it is our recommendation that the Subcommittee consider capping the TEFRA limits of new hospitals and units at 150 percent of the national average. And in the case of the longer term established providers, similarly providing a floor at not less than 70 percent of the national average.

We should, however, be seeking a more permanent solution and to that end it ought to be replaced with a prospective payment system.

Our field has, for some years now, been addressing a program known as functional related groups, or FRGs. HCFA has heard

about this and is in the process of considering an awarding of a contract to further explore it, and we believe that it holds great promise as a building block to further reduction of health care costs. That work should be expedited.

In the longer term, reimbursement for rehabilitation care ought to compensate all providers based on services provided. We ought to seek to eliminate perverse aspects of the system, such as the explicit message now inherent in the system to avoid serving severely disabled patients.

A PPS for rehabilitation, even if budget neutral upon adoption, would result in considerable savings to the Medicare Program if the subsidies for new providers were eliminated.

We also recommend that the Medicare Act be amended regarding the definition of a rehabilitation hospital and/or unit. Under the current system, to qualify for Medicare participation, 75 percent of those discharges from a rehabilitation hospital must fall within 1 of 10 categories. That is a system based on practice patterns of approximately 20 years ago. We believe that four additional diagnoses, pulmonary, chronic pain, cancer, and cardiac ought to be added.

We also recommend that the basing of TEFRA limits for long-term care hospitals be on the basis of current costs. The FRG system, about which I just spoke, does not apply to this particular segment of the industry and they, too, suffer the same problems under the TEFRA limit.

Finally, Mr. Chairman, I wish to speak briefly about bundling. I understand that the Chairman and other Members of the Subcommittee have expressed their opposition to this proposal and we certainly appreciate this position. However, I would like to explain from the rehab hospital perspective why we believe this to be a poor idea.

Principally our opposition to bundling is because of its potentially adverse effects on patient care. It creates a conflict of interest—a very, very strong financial incentive to deny or abridge rehabilitation services. In addition, there is no basis for computing the amounts by which DRGs ought to be increased to provide for rehabilitation and there is no current system to monitor whether or not care is appropriately provided under such a system.

Mr. Chairman, the considerations that this Subcommittee and Congress have with respect the long-term implications to Medicare, and in particular, for disabled community are considerable. We hope that our ideas will help you in addressing this problem and look forward to responding to questions as appropriate.

Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF KENNETH W. AITCHISON
PRESIDENT AND CHIEF EXECUTIVE OFFICER
KESSLER INSTITUTE FOR REHABILITATION, INC.
ON BEHALF OF AMERICAN REHABILITATION ASSOCIATION

This statement is submitted on behalf of the American Rehabilitation Association (formerly NARF) for the committee's hearings on Medicare and Budget Reconciliation Issues. I am Sy Schlossman, Interim President and CEO and have over 20 years experience as the chief executive officer of a freestanding rehabilitation hospital, Moss Rehabilitation Hospital in Philadelphia and a large rehabilitation unit, Sister Kenny Institute in Minneapolis.

The American Rehabilitation Association (formerly NARF) is the largest not-for-profit organization serving vocational, residential and medical providers in the United States. The established leader in the field of rehabilitation for more than a quarter century, American Rehab serves its more than 800 member facilities by effecting changes in public policy, developing educational and training programs, and promoting research. In addition, it provides networking and communications opportunities, all of which help to ensure quality care and access to services to more than four million persons with disabilities each year.

There is a critical need for reform of the current Medicare payment policy for PPS exempt rehabilitation hospitals and units exempt from the prospective payment system (PPS). The present system is harmful to patients and providers alike and is wasteful for the Medicare program. No one - not HCFA, ProPAC, providers or consumers - defends the status quo. We urge reform of this payment system, that it be thorough and immediate, and that any proposals to include the services of rehabilitation hospitals and units, skilled nursing facilities and home health agencies with the DRG payments to acute hospitals be rejected.

I. Defects of the Present System

When the Medicare PPS was enacted in 1983 rehabilitation hospitals and units were excluded because the data used to develop that system did not account for cases with longer lengths of stay, including rehabilitation cases. Such facilities continue to be paid through cost reimbursement, subject to per-discharge rate-of-increase limits imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA limits were intended to be a temporary means of controlling costs pending adoption of a PPS. They are still in place 12 years later and have produced serious, and unintended, distortions in the delivery of rehabilitation services for the following reasons:

- TEFRA limits do not adjust for change in case mix and/or increased acuity of patients. This means that any increase in intensity of services or length of stay is likely to cause a hospital or unit to exceed its TEFRA limit.

- TEFRA limits place pressure on rehabilitation hospitals and units to cut average length of stay as a means of reducing per-discharge cost. By treating all rehabilitation discharges as having the same value, the system provides a strong incentive to treat short stay, less complex cases and avoid more severely disabled patients. The government is telling hospitals to avoid severely disabled patients and not to develop programs to treat them.

- New hospitals and units can establish limits based on contemporary wage levels and other costs, thereby achieving much higher limits than older hospitals. Accordingly, hospitals in the same service area may have widely differing TEFRA limits and reimbursement for similar services. This encourages the development of new providers, which are reimbursed at much higher levels, and seriously distorts the positions of competitive providers.

- This system virtually prohibits the development of programs by existing providers, because any change in services that increases average length of stay or intensity of services will likely result in costs over a TEFRA limit, while encouraging the development of new rehabilitation hospitals and units. This adds unnecessary cost while eroding the service capacity of established institutions.

- The administrative process for adjustment of TEFRA limits does not provide a remedy because it does not produce timely decisions and does not recognize many

How is the government hurt by these effects? First, because new hospitals are paid more, the system encourages capital spending. Second, the Medicare program is paying many new hospitals and units considerable amounts in incentive payments while not covering the cost of service to many older facilities. This is a disservice to beneficiaries. Any system that so seriously distorts the allocation of payment with no regard for patients needs or services delivered will distort quality and availability of services.

Data available from HCFA for Medicare reporting years ending between October 1, 1992 and August 31, 1993 contained cost report information for 128 rehabilitation hospitals. Of these 67 were under their limits, 23 were over their limits and 38 had no limits (because they were new). Those facilities over limits had and average cost per day of $562. Those under their limits had a cost per day of $559. Thus, presuming cost per day reflects intensity, there is no evidence of differing intensity of services. The average TEFRA limits for those with cost over their TEFRA limits was $11,122. The average for those under their limits was $15,267.

The difference in payment between these groups does not reflect a difference in services provided, but rather the vagaries of the Medicare system. The picture for rehabilitation units is similar.

II. Medicare Reform

A. Cost Reimbursement/TEFRA Should be Replaced by a PPS for Rehabilitation

Prudent use of scarce resources and the interests of patients dictate that this system be replaced with a prospective payment system (PPS) specific to rehabilitation as soon as possible. Marginal changes in the TEFRA system will not, at least as it affects providers of rehabilitation services, eliminate its basic defects.

It should be replaced with a PPS for PPS exempt rehabilitation hospital and rehabilitation unit services that makes payment based on patients' needs for services. By doing so Medicare payment will eliminate the bias in the present system against more disabled people and treat all providers equally, thus removing the preferential treatment and incentives for new facilities, and therefore unnecessary cost to the trust fund.

Our association sponsored research to fashion such a system. A research team at the University of Pennsylvania developed a patient classification system based on Functional Related Groups (FRGs). This classification system includes age, diagnosis and functional ability on admission to rehabilitation. It predicts duration and intensity of rehabilitation services. The Health Care Financing Administration (HCFA) has issued a request for proposals to evaluate this system and design of a payment system based on it. We are encouraging and supporting this effort in every way possible.

The first law of governmental action is that research and analysis will expand to fill the time available. This is a major concern for us. The best evidence of this reality is the fact that in the Omnibus Budget Reconciliation Act of 1990 the Congress directed the Secretary of HHS to submit recommendations on reform or replacement of TEFRA by April 1, 1992. Almost three years after that deadline no such recommendations have been forthcoming. Hence, we believe that a statutory deadline for implementation of a PPS for rehabilitation is badly needed to force this matter to a conclusion.

Therefore, **we recommend** that any Medicare legislation considered this year include a provision setting such a deadline. We suggest that this be for cost reporting periods beginning on and after October 1, 1996.

B. Modification of Criteria for Definition of Rehabilitation Hospitals and Units

Rehabilitation hospitals and units must meeting certain criteria established by regulation for exclusion from the Medicare PPS. These are contained in 42 CFR 412.23. Among these is a requirement that not less than 75% of a provider's inpatients be in one or more of 10 diagnostic categories. These are:

* stroke;
* spinal cord injury
* amputation:

* major multiple trauma;
* fracture of femur (hip fracture):
* brain injury:
* polyarthritis, including rheumatoid arthritis;
* neurological disorders, including multiple sclerosis; motor neuron disease, polyneuropathy, muscular dystrophy and Parkinson's disease; and
* burns.

This list was adopted from the practice of rehabilitation facilities in the 1970s. Over the past 20 years it has become increasingly common for rehabilitation hospitals and units to treat other patients with other diagnoses, including particularly those with pulmonary conditions, chronic pain, cancer and cardiac problems. The functional limitations of each of these, often post-surgery, can be improved through rehabilitation.

The present criteria for exclusion of rehabilitation hospitals and units from the Medicare PPS are established by regulations, not statute. For several years the rehabilitation community, through this association and otherwise, has urged HCFA to revise the pertinent regulations, to no avail.

We recommend that this committee correct this problem by legislation by adding the above referenced four conditions to the criteria for exclusion.

We advocate this change for two reasons. First, it is important to a number of hospitals now excluded from PPS as long term care hospitals. Many of these function as rehabilitation hospitals, but are precluded from qualifying for exclusion from the PPS as such because they have significant numbers of patients in one or more of the four diagnostic categories we seek to have added to the exclusion criteria. The matter is increasingly critical for institutions that have reduced lengths of stay to try to mitigate financial damage from TEFRA limits.

ProPAC recently released figures showing that, on average, long term hospitals are reimbursed on about 75% of cost because of TEFRA limits. Enclosed is a schedule we prepared from HCFA data that indicates large TEFRA penalties for this group. As a practical matter the only way to reduce per discharge cost significantly is to reduce lengths of stay. But, long term hospitals have a floor of 25 days, beyond which is loss of exclusion. (The need for rebasing of TEFRA limits of long term hospitals is discussed below).

The logical course for such facilities is to be excluded from the PPS as rehabilitation hospitals, but the provision of significant services to pulmonary, cancer, pain and/or cardiac patients is a barrier to doing so.

The second reason these conditions are important is the effect of current rules on institutions now excluded as rehabilitation hospitals and units. Those that operate programs for patients in the four conditions must constantly monitor their admissions in these categories to avoid going over 25%. Admissions should reflect the needs of patients and the current practice of rehabilitation in the field rather than such artificial regulatory considerations.

C. Need for Oversight of TEFRA Adjustment Process

Section 1886(b) of the Medicare Act provides that a provider with operating cost over a TEFRA ceiling may seek administrative adjustment of its TEFRA limit by HCFA. The law requires that HCFA issue the provider a decision on a complete application within 180 days of its receipt and that a full explanation of the decision be provided to the applicant. The law also provides for assignment of a new base year for determination of TEFRA limits "which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services."

While the authority vested in the Secretary is sufficient to permit proper adjustment of limits to recognize changes in services and inequities between new and old providers, the adjustment process is flawed in its implementation.

It is beyond the scope of this statement to critique the administration of these provisions by HCFA. However, **we recommend that** the committee examine this matter through oversight hearings, GAO inquiry or otherwise with respect to the following points:

- Timeliness of decisions. The statutory requirement for issuance of decisions within 180 days is routinely violated by HCFA, while filing requirements are strictly enforced against providers. Currently applications take a total of 14-16 months before a decision is received.

- Failure to use rebasing authority. HCFA has refused to use the authority to rebase providers, while acknowledging the disparity of treatment between newer and older providers.

- Inconsistency. Standards for adjustment are not applied uniformly, without explanation.

- Absence of explanations. While the law requires that a provider receive a "detailed explanation of the grounds" on which its application is approved or denied decisions often do not address issues raised and do not explain actions taken.

D. Interim Modifications of the TEFRA System Pending A PPS for Rehabilitation

We recommend enactment of legislation to set October 1, 1996 for implementation of a PPS for rehabilitation hospitals and units. If a later deadline is adopted **we recommend** certain modifications to the TEFRA system as it is applied to such providers.

First, we recommend that there be a floor on TEFRA limits, set at 70% of the national average. Presently there are some rehabilitation hospitals and units with limits as low as $3,000, while the national average is over $12,000. These providers are required by Medicare coverage guidelines to provide the same levels of nursing and therapy services as other hospitals and units. Because Medicare coverage guidelines require similar services there should be some comparability of payment. We suggest 70% of the national average TEFRA limit as a floor to provide relief for hospitals and units stuck with extremely low limits.

Second, we suggest that any new rehabilitation hospital or unit certified after date of enactment receive a TEFRA limit no greater than 150% of the national average. It is completely inequitable for the Medicare program to continue to reimburse new facilities at far higher rates than older ones - while both compete for staff and patients. The inequities presented by the widely varying limits of current providers will be eliminated only through adoption of a PPS. In the meantime, some small measure of sanity can be introduced into the system by capping limits for new facilities.

E. TEFRA Limits Should Be Recalculated Based on Contemporary Cost for Long Term Care Hospitals

The serious distortions and inequities of the TEFRA system for rehabilitation providers can and should be solved by the adoption of a PPS for rehabilitation hospitals and units. We believe that the patient classification system discussed above provides a sound basis for doing so at an early date. Well over 90% of patients treated in rehabilitation hospitals and units fall into the classification categories represented by FRGs and payment for the balance can be easily computed through averaging and/or provision for outliers.

A PPS for rehabilitation will not, however, remedy the impact of TEFRA limits on long term care hospitals, except for those facilities that are recognized by the Medicare program as rehabilitation facilities. The sole criterion for exclusion of a long term care hospital from the PPS is maintenance of an average length of stay of over 25 days. The types of patients treated in this group of facilities vary widely and the patient classification system developed for rehabilitation does not apply to most of them.

The adverse effect of TEFRA on long term care hospitals has been profound. ProPAC reports that in fiscal years ending 1989 long term care hospitals as a class were reimbursed only 75% of cost by the Medicare program and in FY 1991 75% were over their TEFRA limits. This is because many such facilities were Medicare providers when the TEFRA system was adopted in 1982 and have limits based on base years that are not representative of current costs.

Exhibit A shows the position 75 long term care hospitals. These data are drawn from the HCFA PPS-IX Minimum Dataset and are the most current data so reported by HCFA. The cost reports contained in this data base are for fiscal reporting periods ending in the period 10/1/92-8/31/93.

In 1994 HCFA separately reported that there were 115 long term hospitals excluded from the PPS. This absence of 40 hospitals from the Minimum Dataset cannot be conclusively explained. It is likely that many are new facilities. To the extent that this is the case, they were not subject to TEFRA limits and would not be affected by rebasing of limits. Similarly, there would be no increased Medicare payment to these hospitals from rebasing.

These data show that the average TEFRA limit for facilities over limits was only $11,181. For those under limits the average was $21,740. This is a huge difference, for which there is no sound public policy.

Since a PPS is not a prospect for this group of facilities **we recommend** rebasing of TEFRA limits to current cost. In the process incentive payment of providers under their TEFRA limits should be protected.

We have given the Committee staff a draft bill that would accomplish these recommendations.

III. The Proposal to Bundle Post Acute Care into the DRG Hospital Payments Is a Bad Idea

This proposal, which appeared in letter from Mr. Shays and some of his colleagues on the Budget Committee to the chair of the full committee and this subcommittee, would require that post acute care services be brought under the diagnosis related group (DRG) based prospective payment system (PPS) used to pay acute care hospitals under Medicare. Post acute care includes the services of rehabilitation hospitals and units, skilled nursing facilities and home health agencies. We are concerned that it is an easy way to cut expenses without concern for patient care.

We are extremely concerned about this proposal and believe that it should not be considered during the reconciliation process. Instead the separate prospective payment system for rehabilitation referenced above should be adopted.

It would increase DRG payments and make the DRG provider responsible for rehabilitation services. Presently DRG payments cover only the acute stay. The rehabilitation provider, if it is a rehabilitation hospital or unit, is paid reasonable cost, subject to a limit known as a Tax Equity Fiscal Responsibility (TEFRA) limit.

We oppose post acute care bundling, as it is known, for a number of reasons. Acute care medicine addresses the immediate medical condition of patients, focusing on the pathology and chemistry of a given diagnosis. Rehabilitation is concerned with the patient's ability to function -- to perform activities of daily living, work, and otherwise enjoy life. Thus, in the acute phase a physician attending a stroke patient is concerned with reducing cranial swelling and the potential for another Cardiovascular Accident (CVA) through drug therapy. Rehabilitation is concerned with restoring or improving patients' ability to walk, talk, use their arms and adapt to any residual limitations of these functions. This is done through the interdisciplinary provision of physical, occupational, speech and other therapies, as well as psychological counseling to deal with the depression that often accompanies newly experienced physical disability. Rehabilitation also involves working with families and others who are affected by the patient's condition, and whose response is likely to affect the patient's progress. While good medical practice calls for the coordination of these different types of services, in concept and philosophy they are quite different.

Several nationally known figures, such as violinist Itzak Perlman, baseball umpire Steve Palermo and actor and dancer Ben Vereen, as well as some members of Congress are dramatic proof of what rehabilitation can do in overcoming disabling conditions and assuring people can contribute to our society.

The fundamental problem with bundling rehabilitation into the DRGs is that it creates a conflict of interest for acute providers, who will have an incentive to deny or abridge rehabilitation services. And, many hospitals are simply ill prepared, nor have the desire to assume the responsibility or liability for, these services. Only 800 acute hospitals have

rehabilitation units, and there are only 190 freestanding rehabilitation hospitals. If there are 5,000-6,000 hospitals in the country, this represents less than 20%. Both those with and without units have an incentive to shorten or eliminate rehabilitation services, but the incentive is particularly telling in the case of a hospital that must refer the patient to another provider for services.

Also, there is no basis for computing the additional DRG payments for rehabilitation (and/or other post acute services). Such costs vary widely depending on the patient's diagnosis, age, degree of impairment, family circumstances, medical condition, and other factors. Studies done by the American Rehabilitation Association (then NARF), and the RAND corporation and the Medical College of Wisconsin, after the DRGs were passed, confirmed that they did not predict nor cover the length of stay or cost of rehabilitation. And, use of aggregated post acute care Medicare data would penalize hospitals focusing on particularly old or severely involved patients, further creating incentives to limit services to those who need them most.

Furthermore, there is no way to monitor whether care is appropriately provided under such a system, in other words, to measure outcomes and thereby hold the hospital accountable. Rehabilitation providers are unique in the health care system in that they focus on outcomes -- improved functional capabilities of patients. A decline in utilization of their services, which would accompany bundling, may result in a loss of such focus and in higher levels of residual impairment and dependency.

And, we believe there a series of additional mechanical, legal, policy and other questions that include, for example, the implications with respect to antitrust, self referral and state certificate of need laws. Finally, even HCFA's own researchers on this subject have cautioned about the serious design issues that arise with respect to the rates of payment and accountability for the delivery of care. They strongly urge that all the methodological issues be resolved and a demonstration be done before such a proposal is implemented.

For these reasons we believe that bundling rehabilitation into the DRGs is arbitrary and harmful to patients. Instead, the FRGs should be adopted for rehabilitation. We hope they will serve as the basis for a PPS for rehabilitation. FRGs do not, however, tie to DRGs. Rather, the primary element is the functional status of a patient upon admission to rehabilitation. Therefore, we believe this proposal to bundle services into the DRGs should not be considered by the Committee.

IV. Future Initiatives

The committee's announced intention to consider alternatives to the present structure of the Medicare program is to be applauded. We are particularly concerned with the fragmentation of rehabilitation services due to current institutional definitions, coverage guidelines and division of services between Part A and Part B. Our association has several committees working to fashion proposals to address these matters and hope to submit further recommendations to you in the near term.

Our guide in this undertaking is care for patients and provision of services in the least restrictive and most cost beneficial environment, subject to the ultimate goal of maximum recovery of function and ability to live independently and productively.

Thank you for your consideration of the recommendations set forth above.

Respectfully submitted,

AMERICAN REHABILITATION ASSOCIATION

Sy Schlossman
Interim President and CEO
Attachment: Long Term Hospitals Status Sheet

MEDICARE COSTS VS. TEFRA LIMITS
LONG TERM HOSPITALS

Total Hospitals Reporting	75
Under Limits	19
Over Limits	40
No Limits	16
Average Length of Stay (total)	28.46
Average Length of Stay (Under)	27.68
Average Length of Stay (Over)	28.60
Average Length of Stay (No Limit)	30.18
Average No. Medicare Days (Total)	7,538
Average No. Medicare Days (Under)	11,813
Average No. Medicare Days (Over)	6,270
Average No. Medicare Days (No Limit)	5,631
Average No. Medicare Discharges (Total)	266
Average No. Medicare Discharges (Under)	427
Average No. Medicare Discharges (Over)	219
Average No. Medicare Discharges (No Limit)	187
Average Cost Per Discharge (Total)	$15,877
Average Cost Per Discharge (Under)	$13,004
Average Cost Per Discharge (Over)	$16,050
Average Cost Per Discharge (No Limit)	$23,178
Average TEFRA Limit - All Discharges (Under)	$16,308
Average TEFRA Limit - All Discharges (Over)	$11,831
Average TEFRA Limit - per Hospital (Under)	$21,740
Average TEFRA Limit - per Hospital (Over)	$11,181
Average Cost Per Day (Total)	$588
Average Cost Per Day (Under)	$470
Average Cost Per Day (Over)	$561
Average Cost Per Day (No Limit)	$768
Average Medicare Cost Under Limits	$1,410,101
Average Medicare Cost Over Limits	$925,145
Total Medicare Cost Under Limits	$26,791,922
Total Medicare Cost Over Limits	$37,005,813
Total Incentive Payments (Under Limits)	$4,740,793
Total Cost Sharing (Over Limits)	$6,388,328

Date Source: PPS-IX Minimum Dataset
For fiscal periods beginning on or after 10/01/91 and ending by 08/31/93

Mr. CHRISTENSEN. Thank you, Mr. Aitchison.

Mr. Mahoney, we would be pleased to hear your testimony at this time.

STATEMENT OF JOHN J. MAHONEY, PRESIDENT, NATIONAL HOSPICE ORGANIZATION

Mr. MAHONEY. Thank you, Mr. Chairman.

My name is John Mahoney. I am president of NHO, the National Hospice Organization. Prior to coming to my position with NHO, I directed a hospice in Boulder, Colorado.

For more than a decade, hospice care has received bipartisan support from this Subcommittee. I would like to thank you for that support and the opportunity to testify here today.

In announcing this hearing, Chairman Thomas indicated that the Subcommittee is looking for innovative policy alternatives to reduce the rate of increase in Medicare spending. Hospice care is just that. Hospice is a proven cost saver that has been reducing Medicare outlays since it became a Medicare benefit in 1983.

Begun in 1974, today there are over 2,000 hospice programs serving more than 300,000 patients in the United States. The National Hospice Organization is a nonprofit, public benefit organization established in 1978 and located in Arlington, Virginia. Its mission is to be an advocate for the needs of the terminally ill.

Hospice care is an interdisciplinary, individualized form of care that emphasizes pain control and symptom management rather than attempting curative treatment. A team of hospice professionals, including nurses, physicians, social workers, home health aids, pastoral, and other counselors and specialists develop and follow a patient-centered care plan that includes input from the patient and family.

Hospice services are provided by this team primarily in a patient's home, most often with the assistance of family and friends, as well as volunteers. Hospice care is made available by most hospice programs regardless of ability to pay.

A recent study conducted by Lewin-VHI compared the relative costs of hospice care and conventional care for Medicare beneficiaries with cancer. Analysis of beneficiaries' claims found that for every dollar Medicare spent on hospice patients, it saved $1.52 in Medicare part A and part B expenditures.

This study was undertaken to determine whether the results of the Health Care Financing Administration major study of hospice costs, completed in 1988, still holds true today. Using the same methodology, Lewin-VHI examined Medicare part A and part B claims of almost 200,000 beneficiaries, a sample size nearly 14 times greater than the HCFA study.

Lewin-VHI found that hospice cost savings have actually increased since the previous study. In 1986, Medicare saved $1.26 for every dollar spent on part A expenditures for hospice users. In 1992, the part A savings had climbed to $1.41.

Approximately 28 percent of Medicare expenditures go toward care delivered in the last year of life. Almost 50 percent of those costs are expended in the last 2 months of live. The majority of these costs are associated with hospitalizations and the associated costs of high-tech interventions.

NHO believes that if hospice care use by Medicare beneficiaries continues to grow more savings will accrue. If, on the other hand, the rate of hospice use declines, costs to Medicare would rise proportionately.

The Medicare hospice benefit is an alternative to the more costly forms of care for the terminally ill. Hospice is the quintessential managed care. For a fixed rate per day, Medicare proved hospices provide a comprehensive set of services to the terminally ill that addresses their physical, spiritual, and psychological needs.

As the Subcommittee deliberates on the Medicare budget, the NHO respectfully raises the following concerns. Because hospice is such a small piece of the Medicare budget, hospice faces the risk of getting lost in the shuffle or being confused with other services. Hospice is not home health care, nor is it long-term care. Hospice is specialized care for the terminally ill. Its purpose, as well as its reimbursement method, are very different.

The Subcommittee needs to recognize these differences, and based on the proven cost savings to the Medicare Program, continue the current method of reimbursement for hospice care.

Currently, managed care organizations contracting with HCFA to care for Medicare beneficiaries on a risk-basis are not required to provide hospice care. They are required to inform their terminally ill patients about the availability of Medicare-certified hospice in the service area. If an HMO patient elects hospice care, Medicare reimburses the hospice directly and payment to the HMO is reduced. This current system is efficient and should continue.

Hospice is part of the solution to making Medicare more cost effective, not part of the problem. But as important as the cost savings are, the quality of life that hospice provides to terminally ill patients must not be overlooked.

It has often been asked if people are afraid to die? And is it not depressing working with dying people? The truth is people are not so much afraid of dying as they are afraid of dying alone or dying in pain or being a burden to their families and losing their dignity.

In hospice care, promises are made to patients that to the very best of the hospice's ability that patient will not be in pain, they will not die alone, they will never be a burden, and they will remain in control of their lives. Hospice care is not depressing because it is about life, not death.

Thank you.

[The prepared statement follows:]

STATEMENT OF
JOHN J. MAHONEY, PRESIDENT
NATIONAL HOSPICE ORGANIZATION

ON

REVIEW OF THE MEDICARE HOSPICE BENEFIT

BEFORE

THE SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

July 19-20, 1995

In announcing this hearing, Chairman Thomas indicated that the Subcommittee is looking for innovative policy alternatives to reduce the rate of increase in Medicare spending. Hospice care is just that. Hospice is a proven cost saver that has been reducing Medicare outlays since it became a Medicare benefit in 1983. The National Hospice Organization (NHO) has been a strong supporter of the Medicare hospice benefit since its inception.

The National Hospice Organization is a non-profit, public benefit organization established in 1978 and located in Arlington, Virginia. Its mission is to be an advocate for the needs of the terminally ill. This mission is supported by over 2000 hospice member programs across the country and more than 3500 individual members who are engaged in providing hospice care at the bedside of the dying every day.

THE BASICS OF HOSPICE CARE

Hospice care is an interdisciplinary, individualized form of care that emphasizes pain control and symptom management rather than attempting curative treatment. A team of hospice professionals (including nurses, physicians, social workers, home health aides, pastoral and other counselors, and other specialists), develop and follow a patient-centered care plan that includes input from the patient and family. Hospice services are provided by this team primarily in a patient's home, most often with the assistance of family and friends, as well as volunteers.

Hospice care is based on a philosophy which embraces six significant thoughts:

- Death is a natural part of life. When death is inevitable, hospice will neither seek to hasten nor to postpone it.
- Hospice care establishes palliation as an appropriate clinical goal. When no cure is available, hospice team members' skills are used to manage those symptoms which impede the patient's quality of life.
- Hospice recognizes death as a spiritual as well as a physical experience. Psychological and spiritual pain can be as significant as physical pain and deserve the same attention.
- Patients and their families are the unit of care. Self-determination is valued. Individuals empowered with knowledge can make choices about how and where they will be cared for in their final months. Hospices have learned that to effectively care for these patients, they cannot separate the patient from their environment. That environment includes their home, their families and their friends.
- Bereavement care is critical to supporting families for at least a year after the death of the patient.
- Hospice care is made available by most hospices regardless of ability to pay.

COST SAVINGS

A recent study conducted by Lewin-VHI, *An Analysis of the Cost Savings of the Medicare Hospice Benefit*, documented that it is possible to provide compassionate and comprehensive hospice care to terminally ill patients at a significantly lower cost than traditional medical treatment. This study compared the relative costs of hospice care and conventional care for Medicare beneficiaries with cancer. Analysis of beneficiaries' claims found that for every dollar Medicare spent on hospice patients, it saved $1.52 in Medicare Part A and Part B expenditures. In the last year of life, hospice patients on average incurred $1,786 less in costs than those who did not select the Medicare hospice benefit.

This study was undertaken to determine whether the results of a Health Care Financing Administration (HCFA) major study of hospice costs completed in 1988 still holds true today. Using a methodology almost identical to that of the 1988 HCFA study, Lewin-VHI analyzed the most recent Medicare claims data available from HCFA's National Claims History file. They examined Medicare Part A and Part B claims from 1991 and 1992 for almost 200,000 beneficiaries -- a sample size nearly 14 times greater than the HCFA study.

Lewin-VHI found that hospice cost savings have actually increased since the previous study. In 1986, Medicare saved $1.26 for every dollar spent on Part A expenditures for hospice users; in 1992, the Part A savings had climbed to $1.41.

Approximately 28 percent of Medicare expenditures go toward care delivered in the last year of life. Almost 50 percent of those costs are expended in the last two months of life. The majority of these costs are associated with hospitalizations and the associated costs of high-tech interventions. NHO believes that if hospice care by Medicare beneficiaries continues to grow, more savings will accrue. If on the other hand, the rate of hospice use declines, costs to Medicare would rise proportionately.

THE MEDICARE HOSPICE BENEFIT

The Medicare hospice benefit is an alternative to the more traditional and costly form of care for the terminally ill. In order to qualify for the hospice benefit, two physicians must certify that the patient is terminally ill with a prognosis of six months or less. The Medicare beneficiary who elects hospice care waives his/her rights to most other standard Medicare benefits for treatment of the terminal illness.

Hospice is the quintessential "managed care." For a fixed rate per day, Medicare-approved hospices provide the following services:

- Physician services
- Nursing care
- Medical appliances and supplies
- Drugs for symptom management and pain relief
- Short-term inpatient and respite care
- Homemaker and home health aide services
- Physical and other therapy
- Social work services
- Spiritual care availability
- Volunteer participation

Approximately 90 percent of hospice care is provided in the home. The Medicare per diem for routine home care is approximately $90.51 whereas hospitalization for terminally ill patients--often in intensive care units--can cost up to $1000 per day in some areas.

CONCERNS ABOUT MEDICARE CHANGES

As the Subcommittee deliberates on the Medicare budget, the following concerns must be raised.

- Because hospice is just a small piece of the Medicare budget--approximately $1.2 billion in 1994--hospice faces the risk of getting lost in the shuffle or being confused with other services. Hospice is not home health care nor is it long term care--hospice is specialized care for the terminally ill. Its purpose as well as its reimbursement method are very different from the just mentioned services.

  The Subcommittee needs to recognize these differences and based on the proven cost savings to the Medicare program, continue the current method of reimbursement for hospice care. Many hospice providers are small programs and any change in reimbursement could have an extremely negative impact on hospice services particularly in rural areas. Because the hospice benefit is reimbursed on a per diem basis, many of these programs would not be able to absorb the ever-escalating cost of medications needed for the more complex care for some patients.

- Hospice is a proven cost saving managed care program for the terminally ill. It is important to remember that hospice care savings are based on the comprehensive, interdisciplinary nature of the benefit, as defined by current Medicare law. If these services were "unbundled," the savings for the Medicare program would be reduced and might possibly be eliminated. Therefore, NHO urges the Subcommittee to continue to require Medicare certification of hospice compliance with existing statutory conditions of participation.

- Currently, managed care organizations contracting with HCFA to care for Medicare beneficiaries on a risk basis are not required to provide hospice care. They are required to inform their terminally ill patients about the availability of Medicare-certified hospices in the service area. If an HMO patient elects hospice care, Medicare reimburses the hospice directly and payment to the HMO is reduced. This current system is efficient and should continue. It would be ill-advised to establish a system that would create another layer of bureaucracy by having a managed care organization manage hospice, another "managed care" provider.

CONCLUSION

In conclusion, the Medicare hospice benefit is a proven cost saving alternative to the more traditional and costly form of care for the terminally ill. Hospice is part of the solution to making Medicare more cost effective--not part of the problem. But as important as the cost savings are, the quality of life that hospice provides to terminally ill patients must not be overlooked.

Hospice care is a community-centered, patient/family-focused, cost-effective way of humanely caring for terminally ill people when curing the patient is no longer possible. It is an important alternative to both the high-tech impersonal approach of traditional care and the desperation of euthanasia, most usually publicized by Jack Kevorkian physician-assisted suicides.

It is often asked if people are afraid to die, and isn't it depressing working with dying people. The truth is, people are not so much afraid of dying as they are afraid of dying alone, of dying in pain, of being a burden to their families and losing their dignity. In hospice care, promises are made to patients, that to the very best of hospice's ability, they will not be in pain, they will not die alone, they will never be a burden and they will remain in control of their lives. Hospice care is not depressing, because it is about life and not death.

Mr. CHRISTENSEN. Thank you, Mr. Mahoney, for that excellent testimony.

Mr. Hoffman, we would be pleased to hear your testimony.

STATEMENT OF PHILLIP I. HOFFMAN, CHIEF FINANCIAL OFFICER, OUTREACH HEALTH SERVICES; ON BEHALF OF HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. HOFFMAN. Thank you, Mr. Chairman. My name is Phillip Hoffman and I am the chief financial officer of Outreach Health Services which provides Medicare covered home health services throughout the State of Texas through both for-profit and nonprofit organizations.

I am testifying on behalf of my company and the Home Health Services and Staffing Association, whose diverse membership includes both large and small home care providers which operate over 1,500 offices in virtually every state and employ nearly half a million care givers.

My work experience includes participation in both phase one and phase two of the prospective payment demonstration projects funded by the Health Care Financing Administration. I have also participated in the PPS work group which consists of representatives from for-profit, nonprofit, hospital-based, and free standing home health agencies that has been working over the past year to develop a prospective payment system. The work group has developed a prospective payment proposal I will describe today as an alternative to copayments.

To place this discussion in context, home health expenditures currently constitute approximately 11.5 percent of all part A spending and just 7 percent of all Medicare spending. Increasing concern has been expressed by ProPAC and others, however, over the rate of increase in Medicare expenditures for home health services which has approached 25 percent over the past 2 years.

While much of that growth can be attributed to the trend of providing health care outside of the institutional setting, there is concern that some of that growth may be caused by the current cost reimbursement system which provides an incentive to furnish unnecessary visits, incur unnecessary costs, and unnecessarily extend services to patients. The current system provides no incentive for home health agencies to operate efficiently.

Overlaying copayments on the existing system does nothing to curb the inefficiency and abuse caused by that system.

Copayments simply shift a portion of the costs of that inefficient system to the patient in the form of a sick tax and erect a barrier to those who need care, especially the elderly with low incomes. Imposing copayments also creates an incentive for patients to remain in the higher cost hospital setting because there is no copayment on the first 60 days of hospital care covered by Medicare. Copayments also further burden the Medicaid Program because certain beneficiaries are eligible to have their copayments and deductibles covered by Medicaid.

There is general agreement in the home health industry that high-quality services can be provided in a more cost-effective manner through prospective payment. The PPS work group has developed such a plan and it has been scored by the accounting firm of

Price Waterhouse. Their conservative estimate of savings which can be generated by this plan is between $19 and $29 billion over 7 years.

The proposal is currently being reviewed and scored by CBO. A detailed description of the plan is attached to this testimony but the most significant features are as follows.

First, a cap would be established on the aggregate payments any home health agency could receive from Medicare in any fiscal year based upon the episodes of care rendered by the agency.

Second, providers would be allowed to share in up to 40 percent of the savings achieved by keeping their payments for the year below the aggregate per episode cap. Providers, therefore, would have an incentive to control utilization, a concept which is absent from the current system.

Third, to maintain cash flow, home health agencies would be reimbursed for visits at a prospectively set rate based on the average regional cost of service.

Fourth, the per visit rates and the per episode caps would be established for a base period and updated annually at a rate that is less than the projected growth in expenditures.

We believe this proposal has the following advantages. It provides an effective mechanism for the government to control the growth rate in Medicare home health expenditures while preserving freedom for clinical decisions to be made by the physician, the patient, and the provider.

It creates incentives for home health providers to become more cost effective and innovative, and rewards those that do.

It achieves true savings to the overall health system rather than shifting costs to the patient from other programs.

It avoids adding needless administrative costs, thereby, helping to preserve home health services as a low-cost treatment option. And it significantly reduces the incentive for waste and abuse.

We do not contend that the work group proposal is the perfect prospective payment system or the one that might ultimately evolve. In fact, the plan is designed to be refined as experience is gained and data is generated over the next 3 years by the phase two demonstration project.

We are also coordinating with the National Association of Home Care in the development of this proposal and believe there is general agreement with respect to the plan's basic concepts. We believe, however, that the proposal is far superior to the current system with copayments. This Subcommittee expressed its intent in OBRA 1987 and 1990 that home health reimbursement be switched to prospective payment. That intent has not been fulfilled, reportedly because no prospective payment system was ready for implementation.

After 9 years it is clear that we will never have a prospective payment ready for implementation without explicit direction from Congress. The work group has developed a system with broad industry support. It saves money, improves efficiency, and avoids penalizing the patients or cutting the benefits.

Rather than adhering to an antiquated inefficient system or making it worse with copayments, we believe it is time to get on with implementing a prospective payment plan.

I appreciate the opportunity to present this proposal and would be glad to answer any questions.

[The prepared statement and attachments follow:]

HEARING BEFORE THE UNITED STATES COMMITTEE ON WAYS AND MEANS

Room 1100 Longworth House Office Building
Thursday, July 20, 1995

Medicare Savings And Budget Reconciliation Issues

TESTIMONY OF PHILLIP I. HOFFMAN, M.B.A.

Mr. Chairman, my name is Phillip I. Hoffman. I am the Chief Financial Officer of Outreach Health Services, which provides Medicare covered home health services throughout the State of Texas through both for-profit and nonprofit organizations. I am testifying on behalf of my company and the Home Health Services and Staffing Association, whose diverse membership includes both large and small home care providers which operate over 1,500 offices in virtually every state and employ nearly 1/2 million caregivers.

My work experience includes participation in both Phase I and Phase II of the Prospective Payment Demonstration projects funded by the Health Care Financing Administration. I have also participated in the PPS Work Group, which consists of representatives from a broad cross-section of the home health industry (for-profit, nonprofit, hospital-based, and free-standing) that has been working over the past year to develop a prospective payment system. The Work Group has developed the prospective payment proposal I will describe today as a substitute for the current cost reimbursement system and as an alternative to copayments.

According to the General Accounting Office, Medicare expenditures for home health services in 1994 were $12 billion, which was 12% **lower** than had been projected in February of 1994.[1/] By comparison, Medicare expenditures for all Part A services grew to $102.8 billion, which was 1.5% **higher** than had been projected. Thus, the growth rate in home health expenditures, which had been expected to decline, actually declined much more rapidly than had been predicted. **Home health expenditures currently constitute approximately 11.5% of all Part A spending and just 7% of all Medicare spending.**

Increasing concern has been expressed by ProPAC and others, however, over the rate of increase in Medicare expenditures for home health services, which has approached 25% over the past two years.[2/] While much of that growth can be

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1/ "Medicare: High Spending Growth Calls for Aggressive Action," GAO/HEHS-T-95-75, 15-16 (February 6, 1995).

attributed to the trend of providing health care outside of the institutional setting, there is growing concern that some of that growth maybe caused by the current cost reimbursement system, which provides an incentive to furnish unnecessary visits, incur unnecessary costs, and provide services to patients for as long as possible. The Office of the Inspector General has found that the current system even encourages unscrupulous providers to pad their cost reports with personal and other unallowable costs and to file claims for visits that were not made.[3/] Providers that seek to furnish services in a more cost effective manner simply receive less reimbursement under the current system.

Overlaying copayments on the existing system does nothing to curb the inefficiency and abuse caused by that system. Copayments simply shift a portion of the cost of that inefficient system to the patient in the form of a "sick tax" and erect a barrier to those who need care, especially the elderly and those with low incomes. Imposing copayments also creates an incentive for patients to remain in the higher cost hospital setting, because there is no copayment on the first 60 days of hospital care covered by Medicare.

It must also be conceded that copayments are a cut in the Medicare benefit rather than simply a reduction in the future rate of growth. Copayments also further burden the Medicaid program because certain beneficiaries are eligible to have their copayments and deductibles covered by Medicaid. Perhaps worst of all, copayments exacerbate the waste and inefficiency of the current reimbursement system by increasing administrative costs for providers and the government, while not improving the administration of benefit. In addition, bad debts which result when providers cannot collect copayments are charged to the Medicare program as an allowable cost.

There is a broad-based consensus in the home health industry that high quality services can be provided in a more cost effective manner if a prospective payment system could be established that provides incentives for controlling costs and disincentives for waste and inefficiency. The Work Group has developed such a proposal, which we believe could be implemented within 1 to 1 1/2 years because it uses current payment procedures combined with the prospective payment methodology

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2/ See testimony of the Prospective Payment Assessment Commission. Hearing before Committee on Ways and Means Subcommittee on Health, Trans. at 15-16 (February 6, 1995).

3/ See Statement by the Office of the Inspector General, Department of Health and Human Services before Committee of Ways and Means Subcommittee on Health, Trans. at 3-4 (February 6, 1995).

which has been approved by HCFA for the Phase II Demonstration Project. A detailed description of the plan is attached, but the most significant features are as follows:

1. A cap would be established on the aggregate payments any home health agency could receive from Medicare in any fiscal year based upon the episodes of care rendered by the agency. (An episode would be defined as 120 days after admission, as in the Phase II Demonstration Project funded by HCFA.)

2. Providers would be allowed to share in up to 40% of the savings achieved by keeping their payments for the year below the aggregate per episode cap. (Providers, therefore, would have an incentive to provide necessary services for **less** than the cap rather than an incentive to increase their costs up to a limit as under the current system. The trust funds would receive at least 60% of the incentive based savings.)

3. In order to maintain cash flow, home health agencies would be reimbursed for visits made during the year at a prospectively set rate based on the average cost of the service in the region.

4. The per visit rates and the per episode caps would be established for a base period and updated annually at a rate that is less than the projected growth in expenditures.

Simply stated, the proposal provides for per visit reimbursement subject to an annual aggregate cap.

This proposal has been scored by the accounting firm of Price Waterhouse as achieving savings of between $19 billion and $29 billion over 7 years, a savings which Price Waterhouse believes to be conservative. Savings may well be even greater, if home health providers respond to the incentives of this plan, as we believe they will. More importantly, these are true savings to the overall health delivery system rather than a cost shift to the patient or to insurers and other third party payors.

We believe this proposal has the following advantages:

1. It provides an effective mechanism for the government to control the growth rate in Medicare home health expenditures while preserving latitude for clinical decisions to be made by the physician, the patient, and the provider.

2. It creates incentives for home health providers to become more cost effective and innovative and rewards those that do.

3. It achieves true savings to the overall health system rather than shifting costs to the patient or other programs.

4. It avoids adding needless administrative costs, thereby helping to preserve home health services as a low-cost treatment option.

5. It significantly reduces the incentives for waste and abuse.

6. It can be implemented in the near future using available data and existing procedures and can be refined and ultimately converted to a "pure" per episode prospective payment system based upon data generated over the next three years by the Phase II Demonstration Project.

7. By avoiding a "sick tax" imposed on patients through copayments and providing incentives for providers to furnish cost effective services, this proposal will have strong support in the consumer and provider communities.

We do not contend that the Work Group proposal is the perfect prospective payment system or the system that might ultimately evolve. In fact, the plan is designed to be refined as experience is gained and data is generated over the next three years by the Phase II Demonstration Project. We are also coordinating with the National Association for Home Care in the development of this proposal and believe there is agreement with respect to the plan's basic concepts. We believe, however, that the proposal is far superior to the current system or to the current system with copayments.

This Committee expressed its intent in OBRA '87 and '90 that home health reimbursement be switched to prospective payment.[4] That intent has not been fulfilled reportedly because no prospective payment system was "ready" for implementation. After nine years, it is clear that we will never have a prospective payment system "ready" for implementation without explicit direction from Congress. The Work Group has developed a system that has broad industry support. It saves money, improves efficiency, and avoids penalizing the patients or cutting the benefit. Rather than adhering to an antiquated, inefficient system or making it worse with copayments, we believe it is time we got on with implementing a prospective payment plan.

I appreciate the opportunity to present this proposal and would be glad to answer any questions.

Enclosure

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[4] See § 4207(c) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) and § 4207(c) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).

PROSPECTIVE PAYMENT SYSTEM: A MORE EFFECTIVE ALTERNATIVE TO COPAYMENTS FOR CONTROLLING THE GROWTH IN HOME HEALTH EXPENDITURES UNDER PART A OF THE MEDICARE PROGRAM

MAY 18, 1995

Beginning approximately nine months ago, representatives of national and state home health service providers began meeting as the "PPS Home Health Work Group" to study whether a prospective payment system could be developed, based upon currently available data, that would more effectively control the rate of growth in home health expenditures under the Medicare program than would the imposition of a copayment. The Work Group included providers of all auspices -- nonprofit, tax-exempt, proprietary, hospital-based, and free-standing.

The Work Group has developed a prospective payment system for home health services which could be implemented in 1996 using existing payment procedures, would achieve significant savings both near and long term, and would provide a rational transition to a pure per episode prospective payment system in the future once more reliable date is available from the per episode demonstration project currently being conducted by the Health Care Financing Administration. The Work Group believes that this proposal serves the interests of the government, the providers, and the beneficiaries far better than would the imposition of copayments.

Copayments are bad public policy because they:

(a) increase administrative costs of an already inefficient reimbursement system while not improving the services;

(b) shift costs to the Medicaid program, private insurers, or the patient rather than effect true savings;

(c) deprive the elderly and disabled poor of access to health care services that have been determined by their physician to be medically necessary;

(d) penalize the most cost effective providers the most severely; and

(e) create an incentive for physicians to keep patients in the hospital because there is no Medicare copayment for the first 60 days of inpatient hospital care (42 U.S.C. § 1395e(a)(1)).

The Prospective Payment System developed by the Work Group is far better public policy because it:

(a) provides an effective mechanism by which the government can control the growth rate in home health expenditures while preserving latitude for clinical decisions to be made by the patient, the physician, and the provider;

(b) avoids adding needless administrative costs, thereby helping to preserve home health care as a low cost treatment option;

(b) achieves true savings by reducing the growth rate in expenditures while not shifting costs to patients or other programs;

(c) creates incentives for home health providers to become more cost effective and innovative and rewards those who do; and

(d) can be implemented in the near future using available data and can be refined and ultimately converted to a pure per episode prospective payment system as data is generated over the three year term of the Phase II prospective payment demonstration project.

This prospective payment system has been scored by Mr. Jack Rodgers of the accounting firm of Price Waterhouse as saving **at least** $19 billion over 7 years.

For more information, contact Jim Pyles at 202-466-6550.

PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES COVERED UNDER PART A OF MEDICARE

MAY 18, 1995

Present Law

Home health agencies that are certified for participation in the Medicare program are entitled to receive reimbursement for the costs actually incurred in providing services to Medicare beneficiaries that are covered under Part A of the Medicare program. Certified home health agencies may receive cost reimbursement up to a limit of the costs estimated to be necessary for the efficient delivery of needed health services. The limit is currently set at 112% of the mean of the labor and non-labor per visit costs for freestanding agencies.

Section 13564(a) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) provided that no changes would be made in the home health per visit cost limits for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996. In addition, § 13564(b) of OBRA '93 provided that, effective for cost reporting periods beginning on or after October 1, 1993, hospital-based home health agencies would no longer receive an adjustment to their cost limits for administrative and general costs as they had since 1980.

In § 4207(c) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Secretary of Health and Human Services was directed to develop and test alternative prospective payment methods for home health services and deliver a final report to Congress no later than December 1991.

In § 4207(c) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), the Secretary was directed to develop a modified or prospective payment reimbursement system for home health services and submit the proposal to the Senate Finance Committee and to the House Ways and Means Committee by not later than September 1, 1993.

The Secretary has initiated two demonstration projects to test prospective payment systems for home health services. The first project (Phase I) tested a prospectively set per visit methodology and was completed in September of 1994. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. The second project (Phase II) will test a per episode prospective reimbursement methodology and is scheduled to commence on July 1, 1995 and run for a period of three years.

Prospective Payment System for Home Health Services

Summary

Home health services will be paid on a per visit basis subject to a per episode aggregate cap. The per visit payment rate will be established at a reduced percentage of the cost limits. The per episode cap will be based on the regional average cost for an episode of care as defined in the Phase II demonstration project. Both payment amounts will be established using base period costs which will be adjusted annually to account for changes in the home health market basket index.

Per Visit Payment

The Secretary will establish a per visit rate of reimbursement by discipline for Medicare certified home health agencies in each Metropolitan Statistical Area and Non-Metropolitan Statistical Area as prescribed in the home health cost limit rules. The per visit rate of reimbursement will be set at 105% of the mean labor and non-labor costs for all home health agencies within a region.

Per Episode Cap

For the purposes of computing the per episode cap, an episode of care will be defined, as in the Phase II demonstration project, to include all covered services delivered during a period of 120 days following the initial admission of a beneficiary. A separate cap amount will be calculated by the Secretary for each of the 18 case categories used in the Phase II case mix adjustment methodology.

A single case mix adjusted aggregate per episode cap will be determined for each home health agency annually by multiplying the episodes in each case category times the per episode cap for that category and summing the products.

As soon as sufficient data is available, the Secretary will make a determination (subject to notice and an opportunity for public comment) with respect to whether the regional variations in the per episodes caps should be eliminated.

Savings Sharing

Home health agencies that are able to keep their total payments for the year below their annual aggregate per episode cap will share in the savings at a graduated rate which will increase with the percentage by which total payments are less than the cap.

The potential shared savings will range from 5% to 40% and will increase as the percentage by which the home health agency's total payments are below the cap increases, up to 20%. A provider whose total payments for a year were 1% under the annual aggregate per episode cap would be entitled to approximately 5% of the savings, while a provider whose total payments were 20% under the cap would be entitled to 40% of the savings. The percentage of savings share would not increase if a provider's total payments were more than 20% under the per episode cap.

Home health agencies would not be entitled to payments which exceed the annual aggregate per episode cap.

Home health agencies would be permitted to seek such exceptions and exemptions to the annual aggregate per episode cap as are currently available under the cost limit rules (*e.g.*, sole community provider and extraordinary circumstances). The intermediaries will be required to make a determination on any such request within 120 days after the provider certifies that it has provided all information it feels is relevant.

Outliers and Extended Care Cases

Home health agencies which provide services to patients for longer than 120 days would be paid at their usual per visit rate, but those payments would count against the annual aggregate per episode cap.

The Secretary would designate certain disorders or combinations of disorders which require a steady and predictable range of services over an extended period of time (*e.g.*, blind diabetics) where a home health agency's opportunity to provide the services in a more cost-effective way is limited. For such cases that are certified in the first 120 days of service, the provider would be paid thereafter a flat monthly rate based upon the average cost incurred by providers in the region in furnishing services to such patients.

Updates

Both the per visit payments and the regional per episode caps would be computed initially on a base period and then updated annually based on the home health market basket index.

Non-Routine Medical Supplies

Non-routine medical supplies will be paid on a separate fee schedule which will cover acquisition cost and a flat percentage for handling. These payments will not count against the per episode cap.

Conversion to Pure Per Episode Reimbursement

Within three years of the implementation of this reimbursement system, the Secretary will provide a report to Congress concerning the conversion of this reimbursement system to a pure per episode reimbursement system based on information generated from the Phase II demonstration project.

Quality

Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by proceeding to implement a revised survey and certification process which emphasizes patient satisfaction and successful outcomes.

Home health agencies will be required to provide services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

Savings

Significant savings will be achieved by providing incentives for providers to become more cost effective by controlling the rate of expenditure growth and by reducing administrative costs both for the providers and for the government.

The plan achieves immediate, intermediate, and long term savings in the following ways:

First, immediate and continuing savings will be achieved by establishing per visit rates based on reduced cost limits.

Second, significant savings will be achieved beginning with the end of the first year through the application of the aggregate per episode cap.

Third, substantial long term savings will be generated by reducing the rate of expenditure growth through the use of the home health market basket index to update the per visit payment rates and the per episode caps.

Further savings should be achievable through reduced administrative costs both for providers and for the federal government for the following reasons:

1. cost reports could be reduced in complexity or eliminated entirely, and there will be no retroactive disallowance of costs, and, therefore, no reimbursement appeals;

2. intermediaries will be required to determine patient eligibility and coverage of only one skilled qualifying service in order for an episode to begin; therefore, there will be no retroactive claims reviews or denials and few appeals; and

3. intermediaries will be required to make medical necessity determinations for extended care cases, but all denials will be prospective only, thereby eliminating costly retroactive denials and appeals.

Additional savings will be achieved as providers lower their total payments to less than the per episode caps.

Effective date

This reimbursement system will be implemented no later than six months after the date of enactment.

* * * * *

Rationale

Per visit payment with a per episode cap was used in order to develop a plan that could be implemented immediately using currently available data and procedures while putting home health services on the path to per episode prospective payment.

The definition of an episode was borrowed from the Phase II demonstration project funded by HCFA in order to be able to use the data generated by that project over the next few years to improve and refine the prospective payment plan.

An aggregate per episode cap was employed in order to provide the government with control over expenditures while reserving clinical decisions to the provider, the physician, and the patient. It was also felt that this would be a low cost method of controlling the growth in spending.

A 45-day break in service between episodes was included in order to prevent providers from "gaming" the system by discharging and readmitting patients in order to generate more episodes. The providers' annual aggregate per episode cap is case mix adjusted to discourage providers from seeking to increase revenues by accepting only less acutely ill patients.

A savings sharing provision was included in order to discourage providers from maximizing their payments per episode in order to reach the cap.

A separate reimbursement method was established for patients who need acute care services over a long period of time to avoid creating an incentive for providers to cease treating these patients.

For more information, call Jim Pyles at 202-466-6550.

JCP/jlr

Mr. CHRISTENSEN. Well, thank you, Mr. Hoffman, I appreciate that.

Mr. Burman, we would be pleased to hear your testimony at this time.

STATEMENT OF JEFF BURMAN, ASSISTANT VICE PRESIDENT, GUARANTEE TRUST LIFE INSURANCE CO.; AND PRESIDENT, COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Mr. BURMAN. Thank you, Mr. Chairman. My name is Jeff Burman and I am the assistant vice president of Guaranteed Trust Life Insurance Co., and I am also president of CAHI, the Council for Affordable Health Insurance. The Council, also known as CAHI, is an association of small-to-medium insurance companies that was formed in 1992 to fight for free market solutions to the Nation's health care problems. We also represent hundreds of individual members, which includes some of the Nation's leading actuaries, physicians, attorneys, insurance agents, and other Americans interested in free market solutions to the Nation's health care dilemmas.

Mr. Chairman, I could take this opportunity to thank you for conducting these important hearings on possible Medicare reform solutions and the Council for Affordable Health Insurance looks forward to working with the Subcommittee in the months ahead to develop fair and equitable reforms for all Americans.

My comments today will focus only on some of the potential solutions that would produce short-term or first-year savings to the Medicare Program. We are continuing to develop more options which we will provide the Subcommittee on an ongoing basis.

We have reviewed the Medicare Program and will soon publish a long-term solution to saving the Medicare Program, while at the same time, producing substantial savings to the program without cutting benefits or reducing provider payments. We approach the problem of short-term Medicare reform with three goals in mind. It had to begin to lower Medicare outlays, it had to set the stage for or be consistent with longer term reforms, and had to be relatively noncontroversial since the time for public education is so limited.

The Council for Affordable Health Insurance does not necessarily endorse each item but recognizes they are all viable options to produce immediate savings to the Medicare Program.

The option number one is to restructure the reimbursement methodology for risk contracts. Possible ways to adjust the methodology include, reduced reimbursement levels so it is more in line with the provider's actual costs. Number two, is to adjust the reimbursement level based on the health status of the beneficiary. Number three, base the AAPCC on HMO costs as opposed to Medicare Program costs. Number four, develop a system of retrospective experience refunds. And number five, award risk contracts based on competitive bids.

Our next option is to limit beneficiaries' ability to switch at will between the Medicare risk contracts and the fee-for-service program. We believe this ability to switch back and forth between the two programs creates an antiselection situation for the fee-for-service program.

Next, we suggest expanding the Medicare risk contracts to include non-HMOs. Currently, only HMOs can qualify for Medicare risk contracts. Under a competitive bidding system, expanding the number and type of risk takers will generate more competition and, therefore, lower costs to the program.

The next option would be to adjust the part B deductible to account for recent increases in medical inflation and index it in future years. The part B deductible has remained constant since its inception, while Medicare inflation has been increasing over the years. Looking back only 5 years, the deductible could be increased by 50 percent to account for medical inflation. After this initial adjustment from $100 to $150, the part B deductible should then be adjusted annually based upon actual program costs.

The next option is to create appropriate levels of cost sharing to decrease utilization. The current system of Medicare and Medicare supplement insurance programs results in many beneficiaries having first dollar coverage. Imposing more appropriate cost-sharing requirements would constrain utilization, therefore, reduce program costs. Alternative ways to move from first dollar coverage include the following: Modify Medicare supplements, standardization plans so that Medicare part A and part B deductibles are no longer covered; freeze Medicare supplement coverage of Medicare deductibles at current levels; allow for the development of innovative Medicare supplement products that encourage cost sharing and personal responsibility.

Our next suggestion is set the Medicare part B premium at 30 percent of the fee-for-service cost. Currently, the part B premium is running at 30 percent of the fee-for-service cost. Although the current law requires that it be at 25 percent, we suggest that the law be changed to accommodate its current level.

Next is empower Medicare beneficiaries to detect fraud in the program and reward them for doing so. Significant data suggests there is a tremendous amount of fraud that goes undetected. We suggest creating a program that would allow for the beneficiaries to detect this fraud and bring it to the attention of the program. We believe this will reduce total utilization and cost, however, we are concerned that perhaps administration of the system would, in some ways, create a bureaucracy that might outweigh the benefit, and therefore, we suggest a cost-benefit analysis be done before implementation.

Adjust the Medicare eligibility age is the next option. Our recommendation or suggestion is that the Medicare eligibility age be changed from the first of the month preceding the individual's 65th birthday to the first of the month following the individual's 65th birthday.

The next option is to institute a part A premium. There are several ways this can be implemented. One of the ways that we are suggesting is to create a higher deductible plan that would be free to beneficiaries, however, the current program with a lower level could be available for a premium.

Next is to revise the at-home recovery benefit. At present this benefit is unlimited and Medicare pays the full costs. Two steps could be taken to constrain home health care costs. First, is to develop a more objective benefit trigger. Second, to move the home

health care benefit from part A to part B and treat home health care as any other part B benefit.

Next is to adjust the rates for service that have become less expensive. We are concerned that HCFA needs to more closely monitor trends and cost of services and adjust the rates to reflect any decreases that may be taking place as the result of new technologies and procedures.

And, last, create targeted subsidies. We recognize that these copays, higher deductibles, and premiums could perhaps create hardships for individuals and, therefore, we recommend looking at targeted subsidies for lower income beneficiaries.

These solutions are proposals that we believe should be investigated and scored for savings. Speaking for the Council for Affordable Health Insurance I am convinced that now is the appropriate time for Congress to do all it can to restore the fiscal integrity of the Nation's Medicare Program.

I appreciate having the opportunity to testify and would be pleased to answer any questions.

[The prepared statement follows:]

Statement by Jeff Burman, Vice President, Guarantee Trust Life Insurance Company and President of the Council for Affordable Health Insurance

Mr. Chairman, my name is Jeff Burman and I am Vice President of Guarantee Trust Life Insurance Company and I am also president of the Council for Affordable Health Insurance. The Council, also known as CAHI, is an association of small to mid-sized insurance companies that was formed in March of 1992 to fight for free market solutions to the problems in the health care system. We also represent several hundred individual members including some of the nation's leading actuaries, physicians, insurance agents and Americans interested in free market solutions to the nation's health care problems.

Mr. Chairman, I would like to take this opportunity to thank you for conducting these important hearings on possible Medicare reform solutions. Our comments today have been developed by the Technical Committee and the Senior Issues Committee of the Council for Affordable Health Insurance. These committees include some of the nation's top actuaries and experts on senior issues. We applaud the 104th U.S. Congress' resolve to save the Medicare program from certain bankruptcy, and we look forward to working with this committee in the months ahead to develop fair and equitable reforms for all Americans.

My comments today will focus only on those potential solutions that would produce short term or first year savings to the Medicare program that we have developed to date. However, we are continuing to develop more options which we will provide this committee on an ongoing basis. The Council for Affordable Health Insurance has reviewed the Medicare program and will soon publish a long-term solution to saving the Medicare program while at the same time producing substantial savings to the program without cutting benefits or reducing provider payments.

We approached the problem of short term Medicare reform with three goals in mind:

1. It had to begin to lower Medicare outlays.
2. It had to set the stage for, or be consistent with, longer term reforms, and
3. It had to be relatively non-controversial, since the time for public education is so limited.

The Council for Affordable Health Insurance does not necessarily endorse each item, but recognizes that they are all viable options to produce immediate savings to the Medicare program.

- **Restructure the reimbursement methodology for Medicare risk contracts.** Under current law, HMOs are reimbursed at 95 percent of the adjusted average per capita cost (AAPCC) of the Medicare program. However, the experience of Medicare risk contracts is well below this reimbursement level. The reimbursement methodology should be adjusted so that the Medicare program realizes some of the savings generated by Medicare risk contracts. Possible ways to adjust the methodology include the following:
  - A. Reduce the reimbursement level so it is more in line with actual costs.
  - B. Adjust the reimbursement level based on the health status of the beneficiary.
  - C. Base the AAPCC on HMO costs, as opposed to Medicare program costs.
  - D. Develop a system of retrospective experience refunds.
  - E. Award risk contracts based on competitive bids.
- **Limit beneficiaries' ability to switch at will between Medicare risk contracts and the fee-for-service program.** The current program allows individuals who select the Medicare risk contract program and become ill to switch back to the Medicare program. The result is to shift the cost of caring for the sickest of the elderly back onto Medicare. Medicare beneficiaries should have the opportunity to change plans

once annually, such as during their anniversary month, and in the case of a qualifying event (such as the death of a spouse). Switching back and forth between the two programs at will, however, should not be allowed.

- **Expand Medicare risk contracts to non-HMOs.** Currently, only HMOs can qualify for Medicare risk contracts. Under a competitive bidding system, expanding the number and types of risk takers will generate more competition, and therefore lower costs to the program.

- **Adjust the Part B deductible to account for recent increases in medical inflation, and index it in future years.** The Part B deductible has remained constant since its inception, while medical inflation has been increasing over the years. Looking back only five years, the deductible could be increased by 50 percent to account for medical inflation. After this initial adjustment from $100 to $150, the Part B deductible should then be adjusted annually based upon actual program costs.

- **Create appropriate levels of cost-sharing to decrease utilization.** The way in which the program is currently structured encourages over-utilization of health care services because the Medicare beneficiary who purchases Medicare supplement insurance has first dollar coverage. Imposing more appropriate cost-sharing requirements would constrain utilization, and therefore program costs. Alternative ways to move away from first dollar coverage include the following:

  A. Modify the Medicare supplement standardized plans so that Medicare deductibles are not covered as benefits.

  B. Freeze Medicare supplement coverage of Medicare deductibles at current levels. Any future increases in Medicare deductibles would not be covered by Medicare supplemental insurance, but would be the responsibility of the beneficiary.

  C. Allow for the development of innovative Medicare supplemental products that encourage cost sharing.

- **Set the Medicare Part B premium at 30 percent of fee-for-service costs.** Although current law states that the Part B premium be 25 percent of the cost of the program, the actual premium today is closer to 30 percent because program costs are lower than expected. Rather than lowering the Part B premium to comply with current law, the premium calculation law could be changed to 30 percent. The 30 percent figure should be based on average per capita costs of the core fee-for-service program (excluding Medicare risk enrollees) to more closely reflect the true costs of the core Medicare Part B program.

- **Empower Medicare beneficiaries to detect fraud in the program, and reward them for doing so.** There have been wide reports of Medicare fraud by individuals and providers in the health care delivery system. Patient self-auditing of Medicare bills is one way to detect this fraud. Beneficiaries should be empowered to investigate for fraud, and should share in any savings resulting from discovering fraudulent claims. However, there is a question of whether the added administrative costs would exceed any savings; therefore, before implementation, a cost-benefit analysis should be undertaken.

- **Adjust the Medicare eligibility age.** Right now, individuals become eligible for Medicare on the first day of the month in which they turn 65. If this provision is changed so that the individual becomes eligible on the first day of the month following his/her 65th birthday, the program could immediately save one month's cost for all new enrollees. Longer term, the eligibility age for Medicare needs to be raised.

- **Institute a Part A premium.** Under this proposal, there would still be a Part A program which would be automatic and free. However, the deductible would be raised significantly from its current level. Part A coverage with the current deductible would be available for a premium.

- **Revise the home health care benefit.** At present, the home health care benefit is unlimited, and Medicare pays the full cost. Consequently, home health care costs are increasing 20-25 percent a year. Two steps could be taken to constrain home health care costs:

A. Develop a more objective trigger for the benefit. As the program currently operates, the medically necessity trigger is not limiting home health care services to those situations for which the benefit was introduced (i.e., individuals who would other wise be hospitalized). Therefore, a more appropriate trigger mechanism is necessary.

B. Move the home health care benefit from Part A to Part B, and treat home health care as any other Part B benefit (e.g., a 20 percent copay with a 101 day maximum per benefit period). Note: moving the home health care benefit to Part B may effect the Part B premium.

- **Adjust rates for services that have become less expensive.** The cost of some services has dropped precipitously, but Medicare has not revised their rates (an example is laser cataract surgery). HCFA needs to more closely monitor trends in the costs of services and adjust rates to reflect cost decreases.
- **Create targeted subsidies.** It must be recognized that not all Medicare beneficiaries enjoy the same ability to meet premiums, copayments and deductibles. Therefore, any increases in out-of-pocket costs should be accompanied by targeted subsidies for lower-income beneficiaries, possibly including refundable tax credits.

These solutions are proposals that we believe should be investigated and scored for savings. Many of our proposed solutions have been echoed by other witnesses representing various points of view. Speaking for the Council for Affordable Health Insurance, I am convinced that now is the appropriate time for the U.S. Congress to do all it can to restore the fiscal integrity of the nation's Medicare program. I appreciate having this opportunity to testify and would be pleased to answer any questions you may have regarding these reform proposals. Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Thank you, Mr. Burman, for your testimony and thank you, panel, for your excellent testimony on the issue.

I just have a few questions. It is late in the day and we will let you go.

I guess some of you on this panel would not agree with Mr. Burman's testimony. The home care, I believe I heard your testimony earlier, and you said that you were vehemently against any kind of copay in terms of home health care.

I think that we have to lay a lot of ideas out on the table. First of all, as we know, the Medicare trustees have said that we have a serious problem. That we will run out of money in the year 2002 and we cannot just go bury our heads in the sand and say the problem is going to go away. We cannot keep increasing taxes and get the program along another 2 or 3 years. I think we need a structural change. I think we need something that is going to take care of the problem for a very long time. I think we need to look at a lot of ideas and that is what these hearings have been about.

One of the things that I do enjoy and I enjoyed the testimony of the hospice care very much because I believe that that is definitely an area that we have to look more to and that is letting people take care of themselves in their last 6 months of life. I think that we ought to look at even expanding that length of time that I think Medicare currently reimburses. I am not for sure on that.

How long is it that Medicare reimburses hospice care?

Mr. MAHONEY. Mr. Chairman, Medicare reimburses hospice care currently under three periods of 90-, 90- and 30-day periods, and then an unlimited period until the person dies.

Mr. CHRISTENSEN. Have you examined, anyone on this can answer, have you examined the Medisave approach? I would like testimony on that and what your feelings are toward the Medisave?

Ms. Bailis.

Ms. BAILIS. I do not think that we are prepared to testify on that at this point. We need to explore it more.

Mr. CHRISTENSEN. OK. You ran out of time, and I wanted to find out what that chart was.

Ms. BAILIS. Yes, I did run out of time and I did not want to go over my time, but I thank you for giving me that opportunity. This chart demonstrates the savings that could be achieved by replacing acute care with subacute care for treatment of the same illness. In this particular situation, DRG number 410 for chemotherapy, which clinicians believe could be treated in the subacute setting, without compromising quality at all. You can see that the cost of providing that service in a hospital when there was also care provided in the hospital-based skilled nursing facility which is about 47 percent more expensive than a free-standing nursing facility, the cost is over $5,000.

The cost, the payment for the DRG is $4,000. That same treatment could be provided in a SNF for $1,400. So the savings, $1,400 compared to either $4,000 or over $5,000, is significant. And again, we believe it could be provided without a compromise in quality.

Mr. CHRISTENSEN. I remember Mr. Vladeck's testimony this morning stating that he did not think that the savings from hospitals to SNFs was that significant. I think his testimony said maybe one-third. You obviously would disagree with those figures?

Ms. BAILIS. No. The statistics that I indicated are the accurate ones. They come from actuaries, they come from HCFA. A hospital day, the average cost is $980 compared to a SNF day the average cost is $226, or a subacute day is $350. The clear evidence that SNF care is significantly less expensive and can replace acute care is demonstrated by the heavy use of SNF care by managed care programs where they are free to make use of SNF care without the barriers that the fee-for-service Medicare Program involves.

Mr. CHRISTENSEN. Ms. Cushman, do you have similar statistics that point out your cost savings in terms of savings, versus say, in-hospital stays?

Ms. CUSHMAN. Yes, we do and we have some of those attached to my written testimony and can provide more, both in detailed graphs and case cost examples.

Mr. CHRISTENSEN. OK.

[The information entitled References on Home Care Cost Effectiveness is being retained in the Committee's files.]

Ms. CUSHMAN. If I could follow up on the hospice, the National Association for Home Care also represents hospice providers, but more importantly my agency is also a hospice provider. I do not know if Mr. Mahoney can verify this or not, but one of the concerns that we have with hospice, even within the length of time that it is now available is that referrals for hospice are frequently coming much, much too late in the individual's illness so that both the compassionate services that could be provided are not provided earlier in that period of time, but they are also using more restorative care as opposed to palliative care for a longer period of time.

So I would urge that as you are considering expanding that benefit, you also give thought to expanding a more appropriate utilization of that benefit earlier.

Mr. MAHONEY. If I could add a brief comment, I would have to very much agree with that. Hospice care is currently available to people with a prognosis of 6 months or less but the average length of stay for people in hospices is considerably less than that, approximately 55 days. And the median length of stay is much less than that.

One of the biggest problems we have is in getting people to understand what hospice care is and how it is available and that goes to the education of physicians and discharge planners and others.

Mr. CHRISTENSEN. Mr. Burman, do you have any comments on Medisave?

Mr. BURMAN. No, I am afraid I do not.

Mr. CHRISTENSEN. OK. Mr. Aitchison, you made a comment in your written testimony about a functional group, what was the name of that?

Mr. AITCHISON. Functional related groups.

Mr. CHRISTENSEN. Could you elaborate just a little bit more?

Mr. AITCHISON. It is a system that our industry has addressed for the better part of 5 years now and it breaks down Medicare beneficiaries into approximately 60 classifications based upon age, utilization of services, and in our field, outcome.

We have found that there is ways of grouping those folks, identifying the consumption of resources and believe that that is an effective prospective payment system that could be employed through legislative change and, therefore, eliminate some of these perverse situations we now see where there is the disincentive to serve the high-cost patient. You would pay according to the particular patient's needs, no matter the location, and that would be a more equitable way to go.

Mr. CHRISTENSEN. I thank the panel for their time and their indulgence of this late hour in the day and thank you for your testimony very much.

[Whereupon, the hearing was adjourned to reconvene on Tuesday, July 25, 1995, at 10 a.m.]

SAVING MEDICARE AND BUDGET RECONCILIATION ISSUES

TUESDAY, JULY 25, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

Chairman THOMAS. The Subcommittee will come to order. This is the third day of hearings on the larger question of saving Medicare and budget reconciliation. My understanding is that we are going to go forward with the hearing without any of our Minority participants. We are holding hearings and they are holding press conferences.

The first panel will consist of Dr. Henley, Kenneth Plitt, Dr. Levin, and Dr. Gee. If they will come forward we will be pleased to hear their testimony.

Oh, I apologize. I was looking at the list and that is our first panel but our first witness will be Sarah Jaggar, Director of the Health Financing and Policy Issues, U.S. General Accounting Office. I apologize, Ms. Jaggar. I was looking at the panels and there was no space between where the room is and the first witness.

Any written testimony that you have will be made a part of the record, and you may proceed to inform the Subcommittee. The time is yours.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Ms. JAGGAR. Thank you, Mr. Chairman, and good morning to the Members.

I am pleased to be here today to report on the efficiency and the effectiveness of the clinical practice guidelines developed under the auspices of the Agency for Health Care Policy and Research, otherwise known as AHCPR. With me today are Jennifer Grover on my left, and Donna Bulvin, two researchers who have worked directly with us on this study.

First, a word of background. AHCPR was created by the Congress in 1989 to serve as the Federal Government's focal point for medical effectiveness and outcomes research. AHCPR has three main responsibilities: supporting research on health care costs, quality, and access issues; collecting and analyzing data for the Na-

tional Medical Expenditure Survey; and supporting research on medical effectiveness which includes sponsoring the development of clinical practice guidelines.

Clinical practice guidelines are designed to help medical practitioners and patients make decisions about prevention, diagnosis, and treatment of specific clinical conditions. AHCPR spends about 3 percent of its total budget, or $6 million in fiscal year 1995, directly on contracts for guideline development and other costs for printing, dissemination, and so forth, bringing their total guidelines related expenditures to about 15 percent of their annual budget. However, these guidelines are in many ways the agency's flagship project.

To date AHCPR has developed and issued 16 guidelines and has 6 more underway. They cover such topics as treatment of pressure ulcers, management of cancer pain, cataracts in adults, and low-back problems in adults.

To develop a guideline, the agency first sponsors an extensive literature review to examine the scientific evidence about a particular clinical condition. The agency also organizes a panel of 15 to 20 noted clinicians and experts representing all different perspectives on the topic, including the consumer.

The panel is to assess the soundness of all the scientific research and develop the guidelines which are extensively reviewed by professional societies and so forth before being finalized. Guideline development has taken from 18 to 42 months.

Once completed, the guidelines are widely disseminated by AHCPR. Each guideline is produced as a long or text version, a clinician's quick reference guide, and a patient guide that supplies consumers with information about the medical condition, treatment alternatives, their risks and benefits, and suggests questions to discuss with physicians. For your information, I believe you have a copy of the guideline on heart failure in the folder that you have with you today. You can see they are in the three parts of the guidelines that I mentioned.

More than 15 million copies of AHCPR's different guidelines have been distributed by mail to national and State medical and nursing societies, consumer groups, and other interested parties. The guidelines are also available online through the agency's fax-on-demand service, and on CD–Rom.

In brief, we found that AHCPR's clinical practice guidelines have received mixed reviews. The agency has been praised for its use of a rigorous evidence-based methodology, for multidisciplinary panels, and for emphasis on health care consumers. However, some have found that the guidelines are not user friendly and this has possibly affected their use. AHCPR has been criticized for the broadness of the guideline topics and the presentation of the public information in selected instances.

The agency is aware of these criticisms and is taking action to improve its guideline development efforts. Specifically, they have plans to modify topic selection so that guidelines are easier to implement, develop more user friendly guidelines by making them shorter and clearer, to incorporate information on cost of treatment options, and expand public/private partnerships in their development.

Questions remain as to the extent to which health care practitioners implement the guidelines sponsored by AHCPR. Our discussions with primary care physicians indicate that AHCPR earliest guidelines were not widely used by primary care physicians although other groups do use them more extensively. This may be changing, however, as additional guidelines are disseminated and become more well known and accepted and as the practice of medicine in the United States changes. Medical directors of health plans that create their own guidelines told us that AHCPR products are used regularly by their guideline drafting committees.

To better track the use of its guidelines, the agency collects information from user groups. Some of these groups have reported cost savings and improved patient outcomes from implementing the guidelines. For example, preliminary data from one peer review organization showed a 75-percent reduction in prostate surgery and savings of more than $1.3 million in five hospitals after educating providers and patients about AHCPR's guidelines alternatives. At your request, we are now studying how managed care organizations use clinical practice guidelines.

Mr. Chairman, this concludes my formal remarks and we will be pleased to answer any questions that you may have.

Mr. JOHNSON [presiding]. Thank you, I appreciate your testimony.

If you have some written testimony you want to enter into the record, you are welcome to do that.

Ms. JAGGAR. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF SARAH F. JAGGER, DIRECTOR
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to report on clinical practice guidelines sponsored by the Agency for Health Care Policy and Research (AHCPR). In 1989, the Congress created AHCPR within the Public Health Service as the federal government's focal point for effectiveness and outcomes research.[1] As part of this effort, the Congress directed the agency to sponsor the development of clinical practice guidelines. Ideally, the widespread use of clinical practice guidelines can optimize care, eliminate waste, and avoid unnecessary procedures. These guidelines are designed to help medical practitioners and patients make decisions about prevention, diagnosis, and treatment of specific clinical conditions. Typically, AHCPR guideline development entails a consensus of expert medical opinion, a synthesis of current scientific evidence, or a combination of these approaches. The guidance is disseminated with the understanding that the local medical community will tailor it to meet their particular practice needs and the individual circumstances of patients.

In light of congressional concerns regarding AHCPR, you asked us to examine the efficiency and effectiveness of the agency's clinical practice guideline efforts. My remarks today are based on our ongoing work on the use of AHCPR's clinical practice guidelines to improve health care quality and control costs. We contacted numerous physician organizations, managed care organizations, researchers, and providers to learn of their experiences with AHCPR's guidelines. We also reviewed the agency's legislative and budgetary history, as well as recent studies on AHCPR's practice guidelines.[2]

In brief, we found that during AHCPR's first 5 years, its performance has received mixed reviews from potential users of clinical practice guidelines. On one hand, the agency has demonstrated strengths in the difficult process of guideline development. It has been praised for its use of a rigorous, evidence-based methodology, multidisciplinary panels, and emphasis on health care consumers. On the other hand, however, weaknesses in the guidelines themselves make them not very user-friendly. Specifically, the agency has been criticized for the broadness of the guideline topics selected and the formats in which they are published. The agency is aware of these criticisms and plans to modify its guideline development efforts to improve the timeliness and presentation of its clinical practice guidelines.

For these and other reasons, questions remain as to the extent to which health care practitioners implement the guidelines sponsored by AHCPR. Our discussions with primary care physicians indicate that AHCPR's earliest guidelines are not widely used. This may be changing, however, as the guidelines become more well-known and accepted. Also, medical directors of health plans that create their own guidelines told us that AHCPR products are used regularly by their guideline-drafting committees. To better track the use of its guidelines, the agency has recently started to collect information from user groups. Some of these groups have claimed cost savings and improved patient outcomes from implementing the guidelines.

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[1]The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) created AHCPR. In addition to guidelines, other agency activities include funding health outcomes research and rural health demonstration projects, providing technical assistance to states involved in health care reform, and conducting the National Medical Expenditure Survey.

[2]Studies reviewed include those issued by the Institute of Medicine, the Office of Technology Assessment, the Physician Payment Review Commission, and the George Washington University.

BACKGROUND

Today, there is a wide range of potential developers and users of clinical practice guidelines. Individual physicians, nurses, health plans, insurers, and regulators have become increasingly interested in using guidelines to improve patient outcomes, control costs, decrease liability, and reduce variation in physician practice patterns. They may choose from over 24,000 guidelines developed by over 75 organizations.[3] In addition to physician organizations and private research groups, there are multiple federal sources of guidelines, including the U.S. Preventive Services Task Force, the National Institutes of Health, and the Centers for Disease Control and Prevention.[4]

To date, AHCPR has sponsored the development of 16 clinical practice guidelines, ranging from preventing pressure ulcers in adults to post-stroke rehabilitation, and 6 more are under way (see app. I). The agency organizes a panel of 15 to 20 clinicians and experts to develop each of its guidelines. AHCPR's clinical practice guidelines have taken between 18 to 42 months to complete depending on the scope and complexity of the topic. AHCPR's contribution to the guideline development process is primarily financial and administrative; agency officials do not participate in the panel's deliberations or in the writing of the guidelines that it sponsors.

More than 15 million copies of AHCPR's guidelines have been distributed by mail to national and state medical and nursing societies, consumer groups, and other interested parties. The guidelines are also available on-line, through the agency's fax-on-demand service, and on CD-ROM.

AHCPR operates with a budget of about $163 million and a staff of approximately 270 full-time equivalents. Funding for its clinical practice guideline contracts is estimated to be $6 million or 3 percent of its total budget per annum. This amount understates the total resources devoted to clinical practice guideline activities because other separately funded activities support the guideline effort (see app. II).

AHCPR'S GUIDELINE DEVELOPMENT PROCESS SETS METHODOLOGY STANDARD

We found support for AHCPR's guideline development process. In particular, users had praise for its conduct of extensive literature reviews, the balanced composition of its panels, and the explicit recognition of consumer interests. They contended that the agency is in a unique position to foster unbiased evaluations of the scientific literature and that this role enhances the efficiency of local guideline development efforts.

Developing valid clinical practice guidelines requires in-depth and objective analysis of the scientific evidence on a topic. (Where the scientific evidence is absent or incomplete, the guideline recommendations reflect the professional judgment of panel members and consultants). For example, to develop the guideline on human immunodeficiency virus (HIV) early evaluation and management, the panel had to assess the soundness of all the

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[3]Questions have been raised about whether topics selected by AHCPR duplicate guideline efforts of other public and private groups. However, some experts believe that duplication of topics reflects concerns that guidelines may vary in quality or need to be updated.

[4]The U.S. Preventive Services Task Force issues guidelines that focus on preventive care, the National Institutes of Health publishes consensus statements on preferred medical practices, and the Centers for Disease Control and Prevention publishes guidelines on public health topics.

scientific research written on the topic, which amounted to about 36,000 references. The Office of Technology Assessment estimates that AHCPR's literature reviews have taken up to 9 months and have cost up to $235,000. Because this is such a time-consuming and resource-intensive process, few private organizations that develop clinical practice guidelines can undertake such an exhaustive review.

AHCPR's methodology for guideline development is also perceived as being more open and less biased than the process in private organizations because each panel represents broad interests.[5] Panels are composed of experts from diverse backgrounds and clinical expertise and also include consumer representatives. For example, the panel that developed the low back pain guideline included orthopedists, osteopaths, an emergency medicine physician, a radiologist, a chiropractor, an occupational health nurse, a physical therapist, a community health nurse, a physiatrist, and a patient representative. In addition, the agency also has the unique ability to attract nationally recognized experts who can serve as opinion leaders to encourage acceptance of the guidelines.

In contrast, private groups that develop clinical practice guidelines, such as physician organizations, generally limit participation in guideline development to physicians only. A survey of internists suggested that confidence in a guideline is more likely if produced by their physician organization.[6] However, some health plan representatives told us that they would be concerned about using a guideline developed by these groups because they perceive a potential conflict of interest.

Another notable feature of AHCPR's efforts is its emphasis on consumers. Few private organizations involve consumers of health care services in the guideline development process or consider them as guideline users. In contrast, AHCPR includes a consumer representative on each panel that develops guidelines.[7] Furthermore, AHCPR publishes a patient guide on each topic that supplies consumers with information about the medical condition, treatment alternatives and their risks and benefits, and suggests questions to discuss with physicians.

While there is general agreement on the high quality of the guideline development process, there is some criticism regarding its efficiency and expense. As noted earlier, guideline development is a resource-intensive and time-consuming process. However, establishing select panels for each guideline results in a

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[5]In spite of its efforts to be relatively inclusive, AHCPR's guidelines are subject to criticism by affected parties. For example, some eye surgeons disagreed with AHCPR's cataract guideline recommendation that a patient's level of visual dysfunction rather than the presence of a cataract alone should dictate the need for surgery. In the case of AHCPR's low back pain guideline, a company that manufacturers a device that is used in back fusion surgery disagreed with the recommendation that most uncomplicated back pain did not require surgery.

[6]Sean R. Tunis and others, "Internists' Attitudes About Clinical Practice Guidelines," Annals of Internal Medicine, Vol. 120, No. 11 (June 1, 1994), pp. 956-63.

[7]AHCPR publishes a request for consumer representatives in the Federal Register. Representatives are selected based in part on their familiarity with the guideline topic and whether they or a close relative have the condition or disease.

loss of expertise in performing the tasks associated with guideline development. The assessment of the scientific literature is complex and expensive and requires experience and skill to perform well. By having inexperienced members convene for each guideline, the panel process compromises timeliness and cost-effectiveness.

GUIDELINES ARE NOT USER-FRIENDLY

Criticisms have been voiced that the guidelines generated in the AHCPR process are not user-friendly and therefore difficult to implement. Potential users have noted problems with the topics selected, the readability of the information presented, and the discussion of treatment options. These and other impediments may contribute to the slow adoption of AHCPR guidelines into medical practice.

Clinical practice guideline experts and a variety of users report that AHCPR's topics are too broad and often result in guidelines that are too long, difficult to follow, and vague. In its 1995 report, the Institute of Medicine noted that focusing on more narrow topics would better address the problems of most interest to clinicians and other users, and would ease the implementation and evaluation of guideline use.[8] For example, the agency might develop a clinical practice guideline on the pharmacological management of a heart attack rather than a heart attack in general. Similarly, a 1995 George Washington University study found that because AHCPR's practice guideline topics focus on broad medical conditions rather than on specific medical services, they generate longer, more complex issues to be dealt with in the guidelines.[9] In fact, the length and complexity of the guidelines are one reason physicians do not implement them in their daily practices.

One of the most widely voiced criticisms we heard about AHCPR's clinical practice guidelines was that the texts require too much time to read. One physician told us that it takes about 5 hours to read the long version of a guideline and that the shorter clinician's version (AHCPR's Quick Reference Guide) is not clear by itself. Furthermore, AHCPR's practice guidelines are long in comparison to guidelines developed by other sources. For example, AHCPR's guideline for depression is 2 volumes and 327 pages, while a large health maintenance organization developed a guideline for depression that is 1 volume and 44 pages.[10]

Further complicating their implementation and use, AHCPR's clinical practice guidelines are not always presented in ways that physicians find clear and easy to understand. For example, many physicians prefer graphics, such as algorithms or tables, for the presentation of information, and AHCPR's practice guidelines rely mostly on text. Furthermore, when graphics are used in AHCPR's guidelines, the flow of information, such as from one treatment decision to another, is sometimes confusing. For example, figure 1 shows a flow diagram from AHCPR's urinary incontinence guideline.

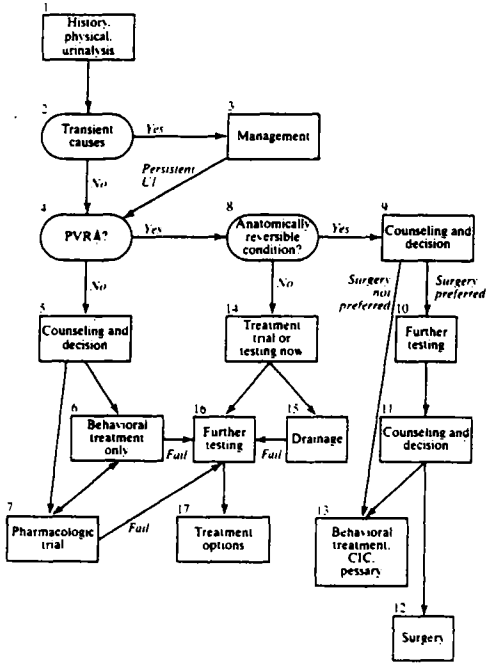
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[8]Institute of Medicine, Setting Priorities for Clinical Practice Guidelines (Washington, D.C.: National Academy Press, 1995).

[9]Center for Health Policy Research, Development of Designs for Evaluation of the Process of Clinical Guideline Development (Washington, D.C.: The George Washington University, 1995).

[10]Jonathan Brown and others, "The Paradox of Guideline Implementation: How AHCPR's Depression Guideline Was Adopted at Kaiser Permanente Northwest Region," Journal on Quality Improvement, Vol. 21, No. 1 (Jan. 1995), pp. 5-21.

Figure 1: Excerpt from AHCPR's Guideline on Urinary Incontinence in Adults



Note: The numbers in the figure correspond to paragraphs in the accompanying clinical practice guideline text.

Source: AHCPR, Urinary Incontinence in Adults, March 1992.

We also learned that the agency's guideline recommendations are sometimes confusing to providers because they are not explicit. For example, the otitis media practice guideline states that "tympanotomy tubes are to be inserted in a child's ears to manage bilateral otitis media with effusion that has lasted a total of 4 to 6 months." The word "total" can be interpreted in two ways: some might interpret it to mean the child has an intermittent problem that adds up to 4 to 6 months; others interpret it to mean 4 to 6 months of a continuous problem.

Another criticism of AHCPR's guidelines is that the guidelines generally do not include specific information about the cost-effectiveness of alternative therapeutic approaches in their guideline recommendations. For example, AHCPR's urinary incontinence guideline recommended that biofeedback techniques be considered as treatment alternatives to surgery. However, the guideline did not discuss the cost savings that might be realized with biofeedback techniques. This information is important to many guideline users, especially managed care organizations. Harvard Community Health Plan, for example, always considers cost-effectiveness during its guideline development process. In its

1992 report, the Institute of Medicine recommended that a clinical practice guideline should include information on both the health and cost implications of alternative treatment strategies.[11]

AHCPR PLANS TO STRENGTHEN GUIDELINE PRODUCTS AND PROCEDURES

AHCPR plans several changes to its clinical practice guidelines and the development process. In particular, the agency intends to sponsor more narrowly focused guideline topics and to streamline its development process. Through these changes, AHCPR hopes to make its guideline development process more efficient and its guidelines more user-friendly. The agency's proposed changes include

-- modifying guideline topic selection so that topics are of greater value, have sufficient scientific evidence to minimize reliance on expert opinion, and are easier to implement;

-- developing more user-friendly guidelines by making them shorter and clearer, including specifics for implementation in clinical settings, and incorporating information on costs of treatment options;

-- establishing standing guideline development panels on several broad areas of medicine (core panel members will focus on the evaluation and analysis of evidence; they will be supplemented by specialists as necessary); and

-- expanding public/private partnerships for the development and dissemination of new practice guidelines (private organizations could include disease associations, pharmaceutical companies, or managed care organizations).

ANECDOTAL EVIDENCE SUGGESTS AHCPR'S GUIDELINES MAY BE BENEFICIAL

Anecdotal evidence indicates that providers who implement AHCPR's clinical practice guidelines improve patient outcomes and achieve cost savings. The following are examples:

-- Preliminary data from one peer review organization showed a 75-percent reduction in prostate surgery and a savings of more than $1.3 million in five hospitals after educating providers and patients about AHCPR's guideline alternatives.

-- A health care system that implemented AHCPR's pressure ulcer prevention guideline for 6 months reported savings of $240,000 in one California hospital.

-- A California medical center reported that AHCPR's pain management guideline helped decrease the average length of stay for chest surgery patients by 5 to 7 days.

-- One year after adopting AHCPR's urinary incontinence and pressure ulcer guidelines, a Tennessee nursing home reported lowering the number of incontinent patients from 52 to 18 and those with pressure ulcers from 14 to 5.

-- A home health care agency in Omaha reported that primary care physicians are more aggressively identifying and treating depression in homebound, elderly patients because of AHCPR's depression guideline.

-- A training center in New Orleans reported using AHCPR's HIV guideline to train physicians and nurses in Louisiana,

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[11]Institute of Medicine, Guidelines for Clinical Practice: From Development to Use, 1992.

Mississippi, and Arkansas to treat patients in a primary care setting rather than a more costly setting.

Health care experts caution that not all clinical practice guidelines result in cost savings and could increase costs. For example, officials in North Carolina reported increased costs when the state adopted AHCPR's recommendation to test all newborns for sickle cell disease. While some health care analysts believe that widespread use of clinical practice guidelines may not initially decrease health care spending, others contend that over time, more effective health care through implementation of guidelines will slow the rate of health care cost growth.

At your request, we are currently conducting a study to determine if and how managed care organizations use clinical practice guidelines and how AHCPR's future guidelines can best serve this segment of the health care market. We expect to report the results of this work in early 1996.

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Mr. Chairman, this concludes my formal remarks. I would be happy to answer any questions from you and other members of the committee.

APPENDIX I APPENDIX I

AHCPR'S CLINICAL PRACTICE GUIDELINES
PUBLISHED AND UNDER DEVELOPMENT

Published	Date
Acute Pain Management: Operative or Medical Procedures and Trauma	March 1992
Urinary Incontinence in Adults	March 1992
Pressure Ulcers in Adults: Prediction and Prevention	May 1992
Cataracts in Adults: Management of Functional Impairment	February 1993
Depression in Primary Care: Volume I: Detection and Diagnosis Volume II: Treatment of Major Depression	April 1993
Sickle Cell Disease: Screening, Diagnosis, Management and Counseling in Newborns and Infants	April 1993
Evaluation and Management of Early HIV Infection	January 1994
Benign Prostatic Hyperplasia: Diagnosis and Treatment	February 1994
Management of Cancer Pain	March 1994
Unstable Angina: Diagnosis and Management	March 1994
Heart Failure: Evaluation and Care of Patients with Left Ventricular Systolic Dysfunction	June 1994
Otitis Media with Effusion in Young Children	July 1994
Quality Determinants of Mammography	October 1994
Low Back Problems in Adults	December 1994
Treatment of Pressure Ulcers	December 1994
Post Stroke Rehabilitation	May 1995

Under Development

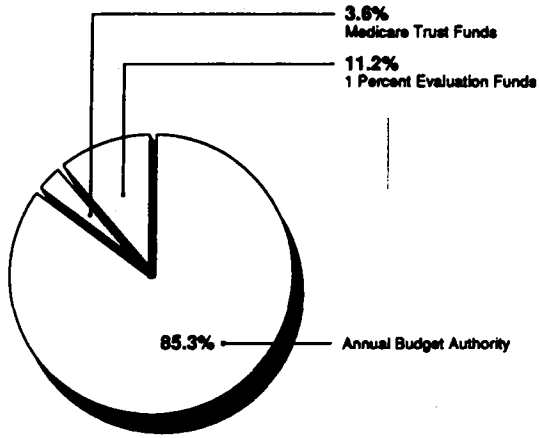
Cardiac Rehabilitation
Recognition and Initial Assessment of Alzheimer's and Related Dementias
Smoking Prevention and Cessation
Screening for Colorectal Cancer
Chronic Pain: Headache
Urinary Incontinence in Adults - Update

AHCPR'S FISCAL YEAR 1995 BUDGET

AHCPR was created by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) as part of the Public Health Service. AHCPR's activities are concentrated in three areas. First, AHCPR awards numerous grants and contracts for research on health care costs, quality, and access issues. Second, it collects and analyzes data on policy issues of immediate concern to health policymakers, most particularly for the National Medical Expenditure Survey (NMES), which provides information on the availability of health care and health care expenditures. Finally, the agency supports a variety of activities within its Medical Treatment Effectiveness Program, including the development of clinical practice guidelines.

In fiscal year 1995, AHCPR had a staff of 271 full-time equivalents, and a total budget of $163 million,[12] provided through three sources. The agency receives the majority of its funding through an annual budget authority. This amount is supplemented with Medicare trust funds and a portion of 1-percent evaluation funds from the agencies of the Public Health Service that receive appropriations. In fiscal year 1995, the agency's budget authority was $139 million. AHCPR received an additional $5.8 million from the Medicare trust funds to support research relating to the health care needs of the Medicare population. In addition, the agency received $18.2 million from 1-percent evaluation funds to support NMES and other studies. Figure II.1 shows AHCPR's funding sources for fiscal year 1995.

Figure II.1: AHCPR Fiscal Year 1995 Funding Sources

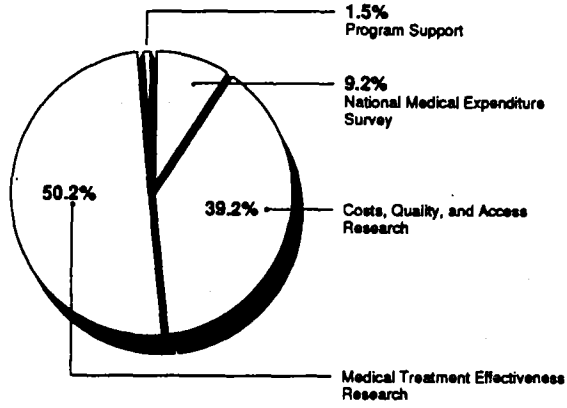


Most of AHCPR's expenditures are made for medical effectiveness research and research on costs, quality, and access.

[12]Excludes reimbursements of approximately $9 million and excludes a proposed recision of $3.132 million.

In fiscal year 1995, the agency will spend $15 million on NMES; $64 million on costs, quality, and access research; $82 million on medical treatment effectiveness research; and $2.4 million on program support. Figure II.2 shows AHCPR's expenditures for fiscal year 1995.

Figure II.2: AHCPR Fiscal Year 1995 Expenditures



Most of the agency's expenditures are made in the form of research grants and contracts. In fiscal year 1995, these expenditures are estimated to be $127.1 million. The agency will support an estimated 167 large grants, generally in the amount of $250,000 or more annually. AHCPR will also award 14 small grants, which are usually 1-year grants for about $30,000 each, to new investigators. The agency will support 26 dissertations at about $20,000 to $25,000 each. AHCPR also will support 97 contracts and interagency agreements in fiscal year 1995, which include the clinical practice guideline contracts. Table II.1 shows a summary of the grants and contracts to be supported by the agency in fiscal year 1995.

Table II.1: Grants and Contracts to Be Supported in Fiscal Year 1995

Types of grants and contracts supported	Number supported	Estimated cost
Large grants	167	$72.1 million
Small grants	14	1.0 million
Dissertations	26	0.5 million
Contracts and interagency agreements	97	53.5 million
Total	304	$127.1 million[a]

[a]Estimated dollars; excludes support for research management, and not adjusted for a proposed fiscal year 1995 recision.

Mr. JOHNSON. Can you give me an idea of how you determine which guidelines you are going to develop and why it takes so long to develop them—18 to 42 months, I am told.

Ms. JAGGAR. The process that AHCPR uses to develop guidelines is one that involves working off certain criteria and then a large amount of consensus building. To this end, because they are concerned and directed to assure that the guidelines reflect largely upon Medicare and Medicare populations, they use groups of people to decide what are the most important issues that should be looked at. And the determination includes examining and considering the caliber of the scientific evidence that is available, the number of people who would be affected by the guidelines, and the kind of difference that those guidelines could make.

Mr. JOHNSON. But who makes those decisions and how, for example, did you determine that you wanted to do heart failure?

Ms. JAGGAR. To clarify, Mr. Thomas, I am with GAO, not with AHCPR so that——

Mr. JOHNSON. OK, I understand. Well, did you all look at that?

Ms. JAGGAR. No, sir. We are looking at the use of the guidelines, themselves, but the general process involves working with leaders all around the country, clinicians and clinical research to determine what the most important areas of contribution are.

For example, of the 10 most costly conditions for Medicare patients, guidelines have been developed by AHCPR to look at 9 of those 10 areas.

Mr. JOHNSON. Well, do you have assurance from your investigation that physicians are actually using these things?

Ms. JAGGAR. Yes, sir. We have looked at this and we find that there is widespread use in many instances. Other groups are finding——

Mr. JOHNSON. Well, wait 1 minute, in many instances, what does that mean? If it is not used generally then I do not think that it is worthwhile.

Ms. JAGGAR. The purpose of the guidelines, there are multiple purposes of the guidelines. And they are developed to provide a basis for action. And, in many instances, the action will be taken by HMOs, managed care organizations, insurance companies, large groups of individuals who are making coverage decisions or who are deciding, trying to influence the behavior of physicians.

There are different studies that have been done. GHAA has shown that up to 41 percent of their physicians have been using the guidelines that they have developed. But in addition——

Mr. JOHNSON. One percent, did you say?

Ms. JAGGAR. No, 41 percent.

Mr. JOHNSON. Oh, 41?

Ms. JAGGAR. Yes, sir. And the important thing is that the guidelines—because of their breadth and their importance—are often adopted and adapted for local use by physician groups to reflect the things that they think are important. They are tailored, as it were, to the practice that they perform locally.

Mr. JOHNSON. Is there any other organization that develops similar guidelines, the AMA, for example?

Ms. JAGGAR. Yes, sir. In fact, there are many different organizations that do; some within the government, itself, and some that

are private associations. But the guidelines are developed in many different forms.

The characteristics of AHCPR's guidelines which is probably unique is the breadth of the research that they do into the existing scientific evidence as a basis for the guidelines. For example, in developing a guideline on HIV, they researched over 36,000 different scientific references to consolidate that information and pull it together so that the best of the scientific knowledge could be known. And many private organizations do not have the ability do that and pull that together.

Mr. JOHNSON. How did you develop the cost savings that you mentioned in your testimony?

Ms. JAGGAR. That was reported by another organization.

Mr. JOHNSON. So you do not know that it is accurate?

Ms. JAGGAR. No, sir, I do not know that it is accurate. AHCPR does not—I will add, if I might—that AHCPR does have additional calculations that it has developed about possible cost savings and they have quite a lengthy catalog, as it were, of reports on a State-by-State basis that they have received about how the guidelines have been used and where cost savings have been achieved.

Mr. JOHNSON. Is that based on State input, generally?

Ms. JAGGAR. Primarily input from the people who are actually using it, whether it be at the physician level of an institution or provider level, a hospital level, managed care plan, and insurance company.

Mr. JOHNSON. So you do not find it duplicitous then?

Ms. JAGGAR. I think that the purpose of the AHCPR guidelines and the function that AHCPR serves is a unique one. Many other organizations do develop guidelines. In many instances they work off the AHCPR guidelines to adopt those and adapt those for their purposes.

Mr. JOHNSON. How much money comes out of Medicare for the funding of that organization?

Ms. JAGGAR. That is $6 million out of the Medicare Trust Fund.

Mr. JOHNSON. That is $6 million a year?

Ms. JAGGAR. Yes, sir.

Mr. JOHNSON. And where is the other funding? Is there other funding?

Ms. JAGGAR. Yes, sir. The total funding for the fiscal year 1995 budget is about $163 million, and about $18 million comes from the 1-percent evaluation fund. And about $6 million from the Medicare Trust Fund and the residual which is about $136 million, if my math is correct, comes from——

Mr. JOHNSON. Is that right out of the Treasury then?

Ms. JAGGAR. Yes, sir.

Mr. JOHNSON. OK.

Thank you, very much.

Do you have any questions, Mr. Christensen?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Thank you, Ms. Jaggar, for your testimony and I know you are here representing the GAO so that anything I might say that might be unfavorable toward the Agency for Health Care Policy and Research is not directed at you because you are here giving us the GAO's perspective. Is that correct?

Ms. JAGGAR. Yes, sir.

Mr. CHRISTENSEN. Mr. Chairman, I know it is only $163 or $183 million and mere millions around here does not seem like much to the bureaucrats, but I think you have put your finger on the problem and I see a lot of duplication of services here.

I am not sure what the Agency for Health Care Policy and Research does that is different from a lot of the medical schools around this country, the New England Journal of Medicine, and a lot of the guidelines put out by the AMA.

How many employees, Ms. Jaggar, does the Agency for Health Care Policy and Research have?

Ms. JAGGAR. In total it has about 270 FTEs, full-time equivalents.

Mr. CHRISTENSEN. And that is just since 1989 when the government put this agency together?

Ms. JAGGAR. Correct. The agency was put together in 1989.

Mr. CHRISTENSEN. And who requested the government to put this agency together?

Ms. JAGGAR. Well, there were a number of congressional leaders who were interested in this and also there were a number of, I think, well-known and esteemed researchers who felt that this was a function that was important. So some of the congressional leaders are still around and there is some support for the agency throughout Congress.

Mr. CHRISTENSEN. OK. And you say it is widespread use or, for example, this heart failure evaluation and care of patients with left-ventricular systolic dysfunction. You say it is adhered to, or would you say not so much so, or are people using it? What is your general feeling toward that?

Ms. JAGGAR. Well, we found that the use varies. AHCPR has embarked upon and continues to embark upon a very aggressive dissemination policy. The numbers we have are that between 15 and 18 million copies of these have been disseminated. They work with the professional agencies, the nursing associations, and other organizations to make sure that this information gets out to physicians.

And I think you know, yourself, that physicians are probably as inundated as you are with materials to read. That is why the design of these is such that, as you have a three-part product in your hand, a large book that goes into considerable detail, a smaller guide which is a quick reference guide for physicians to be able to use as a reference point, and then a patient part which can be used by them for working with their physicians.

Mr. CHRISTENSEN. Ms. Jaggar, would you see this as mainly a service to those people who have been in the practice for a while and have not kept up with some of the latest trends in the medical community or is this for people that are just graduating from medical school?

Ms. JAGGAR. Probably more the former, but I would clarify that and state it a little differently. With the extensive research that is going on in certain areas, for example, HIV, I am not sure that anyone who is not a researcher in the area could, him or herself, keep up with the variety of things, the developments that there are.

So by pulling this together they are doing something that no one else might be doing. In addition, when they put together their panels to develop these guidelines, they pull together individuals who represent the wide variety of issues. For example, the low-back pain panel included a chiropractor, as well as physicians, consumers, and physical therapists. So what you are doing is pulling together the information that exists and putting professionals minds to look at what is the best course of action.

A noted researcher, Dr. David Eddy, from Duke University, has mentioned that his experience is that between 10 and 50 percent of the practice of medicine in the United States is unnecessary and so what AHCPR is trying to do with these guidelines is help physicians sort through what is necessary, what has the best result for the individual patient.

Mr. CHRISTENSEN. Ms. Jaggar, thank you for your testimony.

Mr. Chairman, I would submit that this is yet another Federal agency that is not needed. While I think it does a good job, it is doing a service that several other entities are already providing. I would submit, for the record, that we ought to look at eliminating this agency.

Mr. JOHNSON. Thank you, Mr. Christensen.

Mr. CHRISTENSEN. I thank you for your time.

Mr. JOHNSON. Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Ladies, nice to see you this morning. Guidelines are always important. AHCPR has sponsored 16 clinical practice guidelines which you have been referring to.

Let me ask you this question, Suppose AHCPR did not exist at all? Suppose, as is the inclination of some people, that it were eliminated, what would happen?

Ms. JAGGAR. I think that what would be missing from the debate about medical practice and from the kinds of cost-saving efforts of a number of organizations would be an authoritative, impartial source about what is the best treatment for specific conditions.

Because if——

Mr. HOUGHTON. So there would not be that authoritative impartial source available to make comments and to set guidelines and standards?

Ms. JAGGAR. Indeed, there would be other sources, but the fact that AHCPR's guidelines reflect the perspectives of different individuals, different groups who may have an interest, it would mean that an organization trying to either use these guidelines verbatim or to adopt them, adapt them for their own purposes, have a comfort level that these were unbiased, that these were not intended to encourage a treatment that would be perhaps more costly but not necessary for the individual.

Mr. HOUGHTON. OK, but from a practical standpoint, suppose that were true. So you do not quite have the essence of impartiality. You do not quite have this sort of, this overall look which, as I understand it, the budget is about $6 million a year, is that right?

Ms. JAGGAR. The total budget is about $160 million a year.

Mr. HOUGHTON. That is $160 million for AHCPR?

Ms. JAGGAR. For AHCPR, about 15 percent goes for guidelines. They fund a number of grants and contracts that do medical effec-

tiveness studies and medical outcomes studies, yes. They have other functions.

Mr. HOUGHTON. I see. But anyway, getting back to the original question, would the Nation be able to exist, would we still have reasonably sensitive and practical guidelines to go by, although they may not be quite as impartial?

Ms. JAGGAR. There would be different guidelines that could be used and adapted for different purposes. Those would, indeed, exist. With the emphasis that exists on cost cutting and on the most effective care that can be given to individuals, I think that guidelines are increasingly showing great value. For example, in the State of Maine, they are experimenting with using some guidelines and writing them into law as a protection against medical malpractice. So there are multiple purposes to which guidelines are being used. And the impartiality and the objectivity is valued by some, by many, as an important contribution that AHCPR's guidelines make.

Mr. HOUGHTON. Sure. I am going to make a statement and you tell me whether I am way off base. Your answer to me says that we can get along without this.

Ms. JAGGAR. It is a policy decision for Congress.

Mr. HOUGHTON. Thank you, very much.

Ms. JAGGAR. Yes, sir.

Mr. CHRISTENSEN. It is amazing how we ever got by before 1989 without this agency, it is just amazing. And I would say that researchers will always defend spending more money to do research, and so I would just again reiterate my support for looking very strongly at seeing if we cannot save the Federal Government and the American taxpayer another $180 million.

Mr. JOHNSON. Thank you.

Thank you, panel, for being with us this morning. Ms. Jaggar, we appreciate your attendance and your comments.

Ms. JAGGAR. Thank you.

Mr. JOHNSON. Will the next panel please come forward.

Douglas Henley, Dr. Henley is with the American Academy of Family Physicians; Nurse Kenneth Plitt, on behalf of the American Association of Nurse Anesthetists; Dr. Bernard Levin, on behalf of the Gastroenterology Leadership Council; and Dr. Gee, from the American Urological Association.

Thank you, gentlemen, for being with us this morning.

And for the record, it was $163 million, according to the testimony, $6 million of which comes from Medicare.

Thank you.

Dr. Henley, and all of you may put your remarks in the record, and you are welcome to speak as you desire.

Dr. Henley.

STATEMENT OF DOUGLAS E. HENLEY, M.D., PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. HENLEY. Thank you, Mr. Chairman and Members of the Subcommittee. My name is Dr. Douglas Henley and I am president-elect of the American Academy of Family Physicians. On behalf of our 80,000 members, I appreciate the opportunity to comment on issues related to the future of the Medicare Program.

When Medicare was created 30 years ago it was designed to replicate the private health insurance market. In the years since, the private sector has responded to increasing competition by evolving beyond the traditional insurance model to one now characterized by competing plans bidding for covered lives on the basis of cost, quality, access, and service.

The Academy believes that Medicare should no longer be shielded from the changes occurring in the larger health care market. Medicare beneficiaries should be provided with a range of health plan choices accompanied by incentives to select the more cost-effective alternative.

Mr. Chairman, what is essential for this Subcommittee to understand is that every viable strategy for delivering high-quality accessible health care, while achieving Medicare savings, is based on the greater availability of primary and preventive care services. This holds true whether you are talking about managed care plans or the fee-for-service sector.

The evidence for the savings that primary care brings is contained in previous Academy testimony before this Subcommittee. These studies demonstrate that no matter which Medicare reforms Congress ultimately adopts, costs will not be brought under control until the availability of primary care is greatly enhanced.

Expanding the choices available to Medicare beneficiaries will convert Medicare into a defined contribution program. Each beneficiary would receive an actuarially determined amount of Medicare expenditures to be used to purchase the health insurance plan of his or her choice. The method by which this per capita amount is calculated will be a key determinant of your success in reforming Medicare.

Our experience with the current adjusted average per capita cost method gives us grave concern about Medicare's ability to actuarially and accurately calculate adjusted per beneficiary amounts. It is widely understood that the current method is fundamentally flawed. Significant variation in payment across the country is the result, far more than can be justified on the basis of differences in utilization and cost.

Providing all Medicare beneficiaries with meaningful health plan options will require substantial improvement over current methods to calculate the adjusted, per capita contributions. Presenting each Medicare beneficiary with a defined contribution and an array of health plan choices is designed, in part, to increase sensitivity to health care costs.

We believe it reasonable to instill an additional degree of cost sensitivity in the fee-for-service sector by modifying the Medicare part B premium and the part A deductible according to beneficiary income. Extending the 20-percent coinsurance payment to clinical lab and home health care services is also needed.

The Academy has previously testified before this Subcommittee regarding the Medicare physician fee schedule. Let me simply reemphasize today that it is critical for you to return the fee schedule immediately to one conversion factor and a single-volume performance standard. It is also essential to revise the method by which the volume performance standard is calculated.

Meeting the health care needs of beneficiaries under a reformed Medicare Program will require substantially improved access to primary care and preventive care services. Unfortunately, the primary care infrastructure in this country has been badly neglected for decades. Restoring a primary care foundation to the U.S. physician work force must be among the highest priorities for Medicare reform. In order to make primary care services available to Medicare beneficiaries, Medicare GME funding must support primary care training and training based in ambulatory settings.

In the short-term Medicare reform should number one, limit the number of funded first year residency positions to 110 percent of the number of 1994 U.S. medical school graduates. Number two, eliminate the penalty in direct and indirect GME payments for the time that residents spend in nonhospital ambulatory training facilities. Number three, up-weight direct and indirect payments for primary care residency positions. Number four, limit such payments to the first 3 years of residency training. And, number five, remove these components from Medicare capitation rates and redirect these funds for primary care and ambulatory-based training.

These recommendations are similar to those contained in the most recent report of GME, the Council on Graduate Medical Education, and are estimated to yield more than $6 billion in budget savings over the next 5 years.

Mr. Chairman, expanding the choice of health plans will disconnect Medicare's GME support from the current process by which these funds are distributed. It, therefore, becomes necessary that a new mechanism for GME funding be created.

Given this, it does not seem to us to be a bit step for you to consider extending GME support to all payers. After all, it only seems right that Medicare contribute its fair share, but no more than its fair share.

My written statement contains a summary of the Academy's proposals for long-term GME reform. In addition, that written statement also contains recommendations regarding a variety of regulatory matters that are of critical importance to family physicians.

We hope that you have time to read those. The stakes are extremely high as this Subcommittee undertakes the important task of reforming the Medicare Program. At the end of this legislative session, you must be able to assure older Americans that their access to comprehensive, cost-effective health care services has not been compromised and that the Medicare Program has a fiscally viable future.

Although reconciling deficit reduction with beneficiary access to high-quality care may seem contradictory on its face, this is not necessarily so. Reforming the Medicare Program to take full advantage of a revitalized primary care infrastructure will achieve both goals. Indeed, support for primary care puts the Medicare Program in a position to interface effectively with the marketplace as it shifts into integrated systems of care.

As you work to craft a reformed Medicare Program, please do not hesitate to call upon the Academy. Family physicians are eager to work with you on this challenging undertaking.

We thank you for the opportunity to speak today and I would be happy to address any questions that you may have.

[The prepared statement and attachment follow:]

Statement of the
American Academy of Family Physicians
to the
Committee on Ways and Means
Subcommittee on Health
Regarding
Saving Medicare and Budget Reconciliation Issues
Presented by
Douglas E. Henley, M.D.
July 25, 1995

My name is Douglas E. Henley, M.D., and I am President-elect of the American Academy of Family Physicians. On behalf of the Academy's 80,000 members, I appreciate the opportunity to comment on a number of issues related to the future of the Medicare program.

As has become eminently clear, a substantially lower rate of growth in Medicare expenditures cannot be achieved through minor modifications in the Medicare program. Less obvious but no less important is the fact that Medicare's promise to elderly and disabled beneficiaries of high quality, accessible health care has been steadily eroded by Medicare's increasingly anachronistic coverage policies. Medicare savings will not be achieved and access to high quality health care services will not be ensured without major Medicare reform.

When Medicare was created 30 years ago, it was designed to replicate closely the models of health insurance then in use by private insurers. Physicians were paid on a fee-for-service basis, and hospitals received cost-based reimbursement. While the Medicare program has made notable advancements in developing the DRG system for hospital reimbursement and the resource-based relative value scale for physician payment, it remains basically an insurance program that pays the bills it receives from providers.

In contrast, the private sector has responded to an increasingly competitive market and evolved beyond the traditional insurance model. Private payers now employ a wide variety of techniques to restrain costs and improve quality. Among these techniques are selective contracting, capitation, risk-sharing, clinical guidelines, consumer information, and many others. The private market is now characterized by competing plans bidding for covered lives on the basis of cost, quality, and service.

The Academy believes that Medicare should no longer be shielded from the changes occurring in the larger health care market. Medicare beneficiaries should be provided with a range of health plan choices, and those choices should be accompanied by incentives to select the more cost-effective alternatives.

This committee faces the challenge of developing the Medicare policy recommendations necessary to ensure the solvency of the Medicare Trust Fund. Many of the Medicare reform proposals now under consideration are intended to stimulate market competition on the basis of price and quality. These proposals are based on the assumption that, given the proper incentives, health plans can deliver high quality, accessible health care at lower rates of expenditure growth.

What is essential for this committee and the Congress to understand is that every viable strategy for achieving these important goals is based on the greater availability of primary and preventive care. This holds true whether talking about managed care plans or the fee-for-service sector.

The evidence for Medicare savings attributable to primary care is contained in Academy testimony presented previously to this committee. **These studies demonstrate that no matter which Medicare reforms Congress ultimately adopts, the cost explosion in the program will not be brought under control until the availability of primary care services is greatly enhanced.**

Expanded Choice

Expanding the choices available to Medicare beneficiaries and instilling the system with incentives for cost-effectiveness would convert Medicare from a program with defined benefits to one with a defined contribution. Each beneficiary would be credited with an actuarially fair share of Medicare expenditures, which he or she would then use to pay for the insurance plan of his or her choice.

The method by which this per capita amount is calculated will be a key determinate of your success in reforming Medicare. Presumably, the method for calculating the Medicare per capita contribution would resemble that now used to calculate Medicare's adjusted average per capita cost (AAPCC). The application of the AAPCC method would, thereby, be extended well beyond the current risk contracts to all options except the residual fee-for-service program.

for calculating the AAPCC are fundamentally flawed. County-level AAPCCs are calculated by adjusting a national average per capita fee-for-service cost by a five-year average of the ratio of county to national per capita fee-for-service expenditures. This amount is then risk adjusted for the expected costs of its enrollee mix based on disability, age, gender, welfare status, and institutional status. The resulting AAPCCs vary widely across the country. In 1993, they ranged from $168 to $599. The AAPCCs for urban counties are generally much higher than those for rural counties. As a result, virtually all currently enrolled beneficiaries reside in urban areas. This variation in AAPCC payment rates is far more than can be justified on the basis of differences in utilization and costs. Providing all Medicare beneficiaries with meaningful options will require substantial improvements over the current methods used to calculate the AAPCC. Otherwise, Congress risks further deterioration of health services and access by institutionalizing inequitable payment rates.

The Academy strongly urges that the flaws in the AAPCC method be addressed before attempting utilize a such a method to calculate Medicare's per beneficiary contribution.

Cost sharing

Presenting each Medicare beneficiary with a defined Medicare contribution and an array of choices is designed, in part, to increase beneficiary sensitivity to the costs of health care. We believe it reasonable to instill an additional degree of cost-sensitivity in the fee-for-service sector by modifying the Medicare Part B premium and Part A deductible according to beneficiary income and extending the 20 percent co-insurance payment to clinical laboratory and home health care services.

However, we are concerned about excessive increases in the out-of-pocket costs of beneficiaries who elect to remain in the residual fee-for-service program. A wide array of choices will not be available uniformly to all Medicare beneficiaries, particularly rural beneficiaries. Inadequate health insurance coverage together with the historic problems of reimbursement inequities between rural and urban institutions and providers creates extraordinary challenges for rural providers interested in forming local integrated service networks and managed care systems. The methods used for setting premium and capitation rates, especially the AAPCC, in rural areas will have important implications for the survivability of rural health services. In addition, the higher costs of serving an older, lower-income population in need of enabling services means that without adequate risk-adjustment, smaller locally-based rural networks will find it difficult to assume risk. These issues are immediately relevant to expanded choice under the Medicare program.

Preventive Benefits

Medicare's limited fee-for service coverage of preventive services undermines the ability of primary care physicians to manage the care of their patients in the most cost-effective manner (see attachment). The Academy believes that proven preventive services should be covered with minimal cost-sharing. These are the services that, over the long term, will help bring down health care spending. We might point out that the private sector is beginning to recognize the value of preventive services in very explicit terms, with some progressive systems going so far as to incorporate traditional public health strategies into their operations.

In addition to providing coverage of proven preventive services, it is extremely important that Congress specify the process used to evaluate preventive services for coverage under the benefit package. We believe that Medicare reform legislative should require the use of an explicit, outcome based method, rather than one based on expert opinion. The process used by the U.S. Preventive Services Task Force is an appropriate example. The Academy also supports incorporating considerations related to cost-effectiveness in evaluating preventive services.

Medical Savings Accounts

One of the most frequently mentioned options for a reformed Medicare program is a Medical Savings Accounts. The Academy has taken no position on MSAs, either for or against. However, we do have two concerns about their potential impact.

First, widespread use of individual MSAs could lead to market segmentation and higher Medicare costs for individuals enrolled in the other Medicare options during the out-years. That is, if healthier individuals elect the MSA option, those remaining in the insurance pool with have a higher risk profile, which will result in upward adjustments to Medicare's contributions. Premium dollars for low-risk beneficiaries will have been removed from the pool.

Second, MSAs' incentives to economize on health care purchases could cause some individuals to forgo important primary and preventive services, or to rely on others of unproven effectiveness. One approach to this problem would be to define services that qualify for tax-free distribution of MSA funds, which should include primary care services and those preventive services identified by the U.S. Preventive Services Task Force. While advocates of unrestricted patient choice would object, we

would argue that it is an interim necessity until better information on the cost- and medical-effectiveness of health care services is available to consumers.

At a minimum, there should be provision for a formal evaluation of the impact of MSAs on access to primary and preventive care and on risk selection in the insurance market.

Graduate Medical Education

As noted above, meeting the health care needs of elderly and disabled beneficiaries under a reformed Medicare program will require substantially improved access to primary care and preventive services. Unfortunately, the primary care infrastructure in the U.S. has been badly neglected for decades. Restoring a primary care foundation to the U.S. physician workforce must be among the highest priorities for Medicare reform.

The documented shortage of primary care physicians is profound and growing worse. There are currently 2,682 counties or parts of counties remain designated as primary care health professions shortage areas (HPSAs). This means there is less than one primary care physician for every 3,500 persons in those areas.

In contrast, health maintenance organizations call for a ratio or one provider for each 2,000 persons. To achieve this, 11,964 additional primary care physicians are needed in shortage areas.

The aggregate supply and specialty mix of physicians currently produced in the U.S. medical education system are a direct reflection of the financial incentives in the federal programs supporting these activities. Specifically, the strong inpatient bias in Medicare's current graduate medical education support and Medicare's traditional under-payment for primary care services have influenced powerfully the distribution of the physician workforce towards specialization. Ironically, while the market for medical care increasingly demands more primary care services, the medical education system continues to produce a surplus of physicians narrowly trained in subspecialty fields. Changing the specialty mix of the physician workforce will require a reversal in the current incentives and establishing a meaningful connection between the market for medical care and medical education.

Short-term GME Reforms

In order to make primary care services available to Medicare beneficiaries, Medicare GME funding must support primary care training and training based in ambulatory settings. We understand that under a reformed Medicare program, Congress will need to develop a new mechanism for distributing Medicare's share of graduate medical education funds. In the short term, Medicare reform should include the following:

- **limit the number of funded first year residency positions to 110 percent of the number of 1994 U.S. medical school graduates;**
- **eliminate the penalty in DME and IME payments for the time that residents spend in non-hospital ambulatory training facilities such as physicians offices, group practices, community health centers, and HMOs.**
- **up-weight DME and IME payments for primary care residence positions;**
- **limit DME and IME payments to the first three years of residency training; and**
- **remove the DME and IME components of the Average Adjusted Per Capita Cost (AAPCC) from Medicare capitation rates and redirect these funds for primary care and ambulatory training.**

These recommendations are similar to those contained in the most recent report of the Council on Graduate Medical Education and are estimated to yield more than $6 billion in budget savings over five years.

Long-term GME Reforms

In the longer term, expanding the choice of health plans under the Medicare program will disconnect Medicare's GME support from the current processes by which these funds are distributed. A smaller portion of Medicare payments will be made through the physician fee schedule and DRG payments, and a greater portion will be through managed care arrangements. The shift in how beneficiaries receive care will remove Medicare's contribution to GME from the usual payment flows. It will be necessary to redirect Medicare's teaching support through a separate, yet-to-be-created payment stream. It seems logical to extend this necessary change by requiring all other payers to contribute their proportionate share toward the costs of graduate medical education and, thereby, limiting Medicare to only its fair share of GME costs.

Long-term GME reform should include the following provisions.

- **The direct and indirect costs of graduate medical education should be shared by all payers, public and private. Once the projected annual expenditures for graduate medical education are determined, an annual GME contribution should be applied to all premiums so that all payers contribute a proportionate amount.**

- **There should be an initial limit on the number of eligible first-year allopathic and osteopathic residency positions equal to 110 percent of the number of U.S. allopathic and osteopathic medical school graduates. This limit should be phased in over a period not to exceed five years.**

- **There should be a national goal to increase the number of physicians practicing in the primary care specialties of family medicine, general internal medicine, and general pediatrics.**

- **A broadly representative public-private entity should be established for the purpose of:**

  - **projecting the aggregate need for the medical care workforce in the health care delivery system;**
  - **developing recommendations regarding the number of residency positions on a national basis, including the number of international medical graduates (IMGs), and the appropriate number of generalists to specialists;**
  - **making recommendations regarding GME payment incentives in accordance with national workforce needs.;**
  - **conducting on-going research that will ensure the availability of appropriate data on which to base workforce decisions; and**
  - **evaluating and monitoring the efficacy of all recommendations and their implementation, ensuring that the process allows for flexibility and reevaluating recommendations as appropriate.**

- **Direct medical education payments should be based on a national average per-resident amount. Per-resident amounts should be weighted to recognize legitimate variation in direct costs due to variables such as the use of ambulatory training facilities and regional differences in wages and wage-related costs. Eligibility for DME payments should be based on national workforce goals. Entities eligible for receipt of DME payments from the national workforce account should be those institutions sponsoring residency programs, which could include teaching hospitals, medical schools, health maintenance organizations, group practices, federally qualified health centers, approved training consortia, or other entities, including ambulatory-based programs. Entities receiving DME payments would have to submit documentation demonstrating that DME funds are expended only for direct costs of graduate medical education.**

- **The public-private entity would determine the indirect costs of graduate medical education in ambulatory and inpatient training facilities. Indirect costs include legitimate differences in patient care costs between teaching and non-teaching facilities. Both inpatient and ambulatory institutions serving as training sites for eligible residency programs could receive payments for the indirect costs of graduate medical education.**

Medicare Payment to Teaching Physicians

Medicare Part B pays for the patient care services provided by attending physicians who practice in teaching settings as long as such payments do not duplicate Medicare GME payments. HCFA has a long-standing requirement for the physical presence of the attending physician in supervised teaching settings in order to bill Part B.

Despite negotiations extending over many years, HCFA will soon release a proposed rule that will impose overly stringent requirements regarding Medicare Part B payments to family physicians who supervise residents in the teaching setting. These new regulations are incompatible with the requirements for teaching family practice residents and will have a devastating impact on financial viability of our residency programs. The future of many programs will be in question. Ironically, the impact runs directly counter to the growing need in the Medicare population for primary care services.

At a minimum the new regulations will force family practice residency programs to hire additional faculty, a daunting task due to the added cost and severe shortage of faculty. There are currently 600 faculty vacancies in family practice training programs, and this number is expected to double in the next few years. With stricter physical presence rules and the inability to either find or afford additional faculty, residency programs will be unable to bill Medicare Part B for services. This effectively makes Medicare beneficiaries uncompensated care. Family practice residencies already render more uncompensated care than any other training program.

Because they are ambulatory based, family practice residency do not generate significant revenues for their sponsoring hospitals. Often it is the hospital that must subsidize the residency program. Moreover, a quarter of family practice programs are in public hospitals, many of which already have negative margins. If residency programs lose these Medicare revenues, the only alternative from the hospitals' perspective may be to terminate the programs.

A proposed rule on payment for Part B services in the teaching setting was published in 1989, and would have protected the supervisory relationship between the attending family physician and the family practice resident as well as the requirement that family practice residents establish primary relationships with their patients. Unfortunately, this proposed rule was never finalized. **In order to ensure an adequate supply of family physicians to serve the Medicare population, the Academy urges Congress to establish in statute the intent of the 1989 proposed regulation affecting Part B payment for services of supervising physicians in a teaching setting.**

Medicare Physician Fee Schedule

Either by virtue of residing in an area with limited Medicare choice options or because of personal preference, many beneficiaries will remain in the residual fee-for-service program. It is, therefore, important Medicare fee-for-service payments ensure the ready availability of primary care services. The Medicare program generates savings when primary care physicians in general, and family physicians in particular, are available to and used by beneficiaries.

Such favorable prospects for savings stand in stark contrast to Medicare's inadequate reimbursement for primary care services. It troubles the Academy greatly to know that over 28 percent of family physicians nationwide no longer accept new Medicare patients. In some areas up to 40 percent of family physicians do not take new Medicare patients.

Inadequate reimbursement is the most commonly cited reason for this problem. Simply put, family physicians are finding it more and more difficult to accept new Medicare patients, because to do so jeopardizes the financial stability of their practices. On average, it costs approximately $134 per hour to operate a family practice, while the Medicare payment rate for visit services is less than $100 per hour.

Of additional concern is that Medicare fees will continue to plummet downward as a percentage of private sector rates. Because of cuts already mandated in OBRA93, Medicare fees are projected to drop to 54 percent of private sector rates. The disparity between program versus private fee rates may force even more family physicians to consider closing off their practices to new Medicare patients. Hence, we are genuinely concerned that further reductions in Medicare physician fees may create real access problems for elderly patients especially those in rural and inner-city areas.

In order to ensure appropriate access to primary and preventive care, the Academy supports the following modifications in the Medicare physician fee schedule.

- **A Single Conversion Factor and a Single Volume Performance Standard (VPS).**

Separate VPSs and fee updates for three categories of services has led to distortions in the worth of relative values so that they no longer reflect resource-based relative values. The RVUs in each category are no longer worth the same amount. Currently, the conversion factor for surgical services is 8.4 percent and 14.0 percent higher than the conversion factors for primary care and other non-surgical services, respectively. Because the conversion factor updates are permanent, consecutive higher updates for surgical services are compounded.

- **Revise the formula for calculating the Medicare volume performance standard so that projected increases in per capita gross domestic product (GDP) plus two percentage points substitute for the five-year rolling average growth in volume and intensity.**

By taking a fixed four percentage point reduction from the five-year trend in volume and intensity, the performance standard factor unlinks the volume and intensity factor from actual trends in health care delivery. Regardless of how much physicians reduce the volume and intensity of services, volume and intensity must be reduced by an additional four percentage points or the updates will be reduced. In addition, using historic growth rates will eventually undermine the incentive to control volume and intensity.

- **Modify HPSA bonus payments to provide 20 percent bonuses to physicians providing services in HPSAs and eliminate bonuses for non-primary care services in urban areas.**

Because of flaws in Medicare's bonus payment program, almost half of the bonus payments accrues to physicians who provide little or no primary care. In addition, almost 15 percent of bonus payments go to urban, hospital-based subspecialists.

Regulatory Environment

The ability of physicians and other health care providers to respond effectively to the financial incentives under Medicare reform will be unduly constrained in the current regulatory environment. Many of the existing laws and regulations were developed when providers acted in a much more independent fashion and were designed to prevent collusive activities that would be injurious to the public. Now, as providers seek to engage in highly efficient, cooperative ventures, these laws are in need of modification.

Physician Self-referral

While we support wholeheartedly government efforts to weed out costly fraud and abuse, the self-referral law, as it now stands, is not the solution to the problems of inappropriate referrals and over-utilization of services. This law is overly broad and out of step with commonplace practice arrangements--such as the use of shared in-office ancillary facilities by solo practitioners.

Several changes are needed in the self-referral law to make it more attuned to the business aspects of a physician's practice and sensitive to patient needs, while maintaining its anti-fraud intent. For example, it is unreasonable to prohibit a physician's practice from providing durable medical equipment to his or her patients. If a physician sets a broken leg, the law requires the patient to hobble elsewhere for the crutches rather than receiving them from the doctor who set his leg.

Perhaps most important to family physicians is the need for a shared facilities exception in the law. Such an exception is urgently needed for without it the practice of family physicians who share common office space, equipment, and personnel with their colleagues is greatly jeopardized.

Many family physicians practice independently by choice but lack the resources to purchase costly diagnostic equipment and hire additional staff to operate an in-office laboratory. It is common practice for solo physicians to share facilities for ancillary services with other solo physicians in the same building. Such arrangements are cost-effective and enable the participating physicians to furnish immediately to their patients on-site access to ancillary services. The only option remaining under the law is for these physicians to refer their patients--at great inconvenience and higher cost--to outside facilities for services that they previously handled in a timely fashion on-site.

The Academy supports an exemption for shared facility services that are:

- **furnished by the referring physician who is a shared facility physician or by an individual directly employed or directly supervised by such a physician;**
- **furnished at a shared facility in a building in which the referring physician provides substantially all of the services of the physician unrelated to the provision of shared facility services;**
- **furnished to a patient of a shared facility physician; and**
- **required to be billed by the referring physician.**

Antitrust Reforms

The purpose of anti-trust statutes is to ensure meaningful and fair competition among both buyers and sellers of goods and services. To the extent that Medicare reform is achieved by moving beneficiaries into organized, integrated health plans, the nature of the market for physician services will be fundamentally altered.

The American Academy of Family Physicians believes that in the context of Medicare reform, strict adherence to traditional antitrust doctrine will prove counterproductive in efforts to realign the incentives of the health care system. A more flexible approach is needed, one capable of evolving with the changing demands of a reconfigured health care marketplace.

Therefore, the Academy further recommends that Congress:

- **require the Attorney General, in consultation with the FTC and HHS, to establish competition guidelines consistent with the scope of health care reform and to solicit nominations for additional safe harbors for collective activity by health care providers;**
- **require the agencies to develop a single set of standards and procedures for expedited case-by-case approval, and to provide a "certificate of review" to those entities so approved; and**

- **require that joint activities in the health care industry that fall outside the safe harbors be analyzed by the "rule of reason," in which competitive benefits are weighed against competitive harms.**

We note that the last recommendation is imperative for rural and frontier areas, where highly concentrated markets assure that virtually *any* collaborative activity will exceed the safe-harbor thresholds. Therefore, the Academy also recommends that Congress establish a separate standard for joint ventures in rural areas that is not predicated on market share statistics. Instead, the standard should be based on "compelling" evidence of pro-consumer gains in efficiency and quality-of-care.

Liability Reform

One of the more pressing health care problems is that of medical liability. The malpractice crisis contributes significantly to the cost and quality problems that plague our health care system. Addressing this difficult issue will make an important contribution to your efforts to reform the Medicare program.

Academy members experience daily the negative impact of the medical liability crisis on access to health care services and overall system costs. Its most serious threat is to women's health care in rural, inner city, and economically depressed communities, which have difficulties attracting qualified medical care providers. The public is paying an unnecessary premium to support a medical liability system that serves equitably neither patients nor their providers.

The Academy supports federal tort reforms including:

- **a $250,000 limit on non-economic damages,**
- **reducing awards by the amount of compensation from collateral sources,**
- **allowing periodic payment of awards over $100,000,**
- **limiting attorneys' contingency fees,**
- **replacing joint and several liability with proportionate liability among the defendants in a case,**
- **a modified statute of limitations,**
- **mandatory and binding alternative dispute resolution (ADR) systems,**
- **requiring an expert affidavit signed by a specialist who practices in the same medical specialty as the defendant, and**
- **the use of approved clinical guidelines as an affirmative defense.**

CLIA

The Clinical Laboratory Improvement Amendments of 1988 (CLIA'88) are perhaps the most onerous federal law presently imposed on family physicians. Today, it is painfully obvious the level of regulation, expense and exasperation inflicted on physician office laboratories has no relationship to improvements in patient care or safety.

Family physicians routinely perform lab tests to get the immediate diagnostic results needed to begin prompt appropriate treatment for their patients, and to monitor care while it is being delivered. The choice, timing, and interpretation of lab tests are integral to a physician's decisions regarding subsequent diagnostic and treatment interventions; lab procedures are not a separable aspect of clinical medicine. An essential part of family medicine's commitment to patient care is quality testing in physician office labs.

As a result of hefty compliance fees and burdensome paperwork requirements, thousands of family physicians have reluctantly closed down their office labs. In 1992, nearly 93 percent of family physicians had office labs but by 1994 only 79 percent of our members had office labs--a 14 percent drop in only two years. Moreover, many simple and common laboratory tests are no longer performed by family physicians because of intrusive federal control. CLIA requirements have forced nearly 40 percent of family physicians to stop doing the rapid strep test or else to send a collected specimen to an outside lab. The most intolerable aspect of CLIA is the hardship imposed on patients, especially the elderly, the disabled, and those living in underserved or remote areas, who cannot travel to outside labs for testing ordered by their family doctor. When patients delay or cancel treatment because they cannot obtain simple lab tests in their own doctor's office, this is a clear sign that government micro-management of physician office labs must stop.

The Academy is very appreciative for the introduction of HR 1386 by Rep. Bill Archer and for the co-sponsorship of Representatives Christensen, Johnson, and McCrery. **HR 1386 exempts of all physician office labs from CLIA requirements except when performing pap smears. We urge Congress to pass it.**

Clinical Guidelines and Primary Care Research

Health plans and insurers are placing increasing emphasis on the clinical competencies of primary care physicians. Yet, our nation's health care cost and access problems can be traced directly to an over-emphasis on costly inpatient and subspecialty care and to the consequent geographic maldistribution of health care providers. Solving these problems will require a substantial investment in the primary care infrastructure. As noted above, part of the necessary investment will be workforce reform accomplished through a realignment of Medicare physician training incentives. However, equal attention must also be paid to the highly relevant but to date largely ignored area of primary care research.

For the most part, the focus of medical education and research has been on the catastrophic or end-stage medical problems in referred and hospitalized patients. As a result, the training of physicians and the research agenda have focused almost exclusively on inpatient evaluation and treatment -- despite the fact that over 95 percent of all medical conditions are evaluated and treated outside of hospitals. Although a defining feature of American medicine, this base of knowledge in narrow subspecialty fields has frequently little or no relevance to the basic, entry-level concerns that afflict most people -- the very conditions treated on a daily basis by the primary care specialties of family medicine, general internal medicine, and general pediatrics. If this trend continues unabated, the scarcity of primary care research will seriously undermine new strategies to train more generalist physicians and emphasize cost-saving preventive care in the evolving health care delivery system.

Accordingly, a primary care research agenda is crucial. The Agency for Health Care Policy and Research established recently a Center for Primary Care Research within the agency. Such a center, if adequately financed, would provide new tools to family physicians and other generalists as they serve millions of beneficiaries each year. Much of primary care research focuses on the development and assessment of protocols of care that are intended to make the best use of this country's strained health care dollars.

The Academy believes that Congress should support AHCPR and its new emphasis on primary care research, which is designed to better assist the primary care physician in diagnosis and treatment of the beneficiary population most commonly seen in the ambulatory care setting. Priority areas include:

- Research on the diagnostic process in primary care settings, designed to assist the generalist physician to evaluate the myriad of presenting symptoms, differentiate self-limited diseases from those requiring ongoing or intensive treatment and initiate treatment. This line of research is intended to streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.

- Research to improve the effectiveness of medical care as the physician, in collaboration with the patient, designs and implements effective treatment plans that reconcile the idiosyncrasies, preferences, and needs of the patients with the clinical realities of the illness.

- Research related to the development of clinical guidelines, including evaluations of the practical usefulness of clinical guidelines.

- Research to improve access to health care and cost-effectiveness of care focusing on primary care training and experience and the role of frontline, primary care physicians.

Telemedicine

Appropriately designed telemedicine capabilities may have the potential to improve the quality, accessibility, and cost-effectiveness of health care services. By creating ready access to information (e.g., medical libraries, diagnostic test results, CME courses), telemedicine may reduce the time demands on practicing physicians, especially those in remote settings. By facilitating consultation, telemedicine may also assist clinical decision-making, decrease unnecessary referrals, improve patient retention and continuity of care, and help retain health care resources in underserved areas.

The potential uses of telemedicine are vast, but more evaluation is needed to adequately assess the capabilities, costs and reimbursement policies that should appropriately follow. While the clinical and professional applications of computer bulletin boards, centralized data bases, image transmission, and videoconferencing technology have stimulated considerable lay interest, they have not been systematically evaluated in the context of medical practice. Above all, the history of the evolution of modern health care technologies makes it clear that the development of telemedicine systems must be driven by the needs of rural physicians and their patients, rather than by the technology itself.

Numerous and significant issues which will determine the eventual contribution of telemedicine to patient care have yet to be addressed. Issues of concern to the Academy include the development of standards of quality and appropriateness of services across a range of practice and clinical circumstances; the use of non-physician providers in telemedicine consultations; issues of privacy and

medical records management; liability; credentialing, interstate licensure and practice; and reimbursement policy.

Reimbursement should be made for physician services that are reasonable and necessary, meaning that they are safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The means for delivering the service should not be a primary consideration; the critical test is whether the service is medically reasonable and necessary. However, reasonable requirements should be linked to telemedical service delivery, such as a request for the service by the patient's attending physician, the needed medical judgment of a consultant physician, and a requirement that the telemedical consultation be included in a patient's written medical record.

Conclusion

The stakes are extremely high as this Committee undertakes the important task of reforming the Medicare program. At the end of this legislative session, Congress must be able to assure older Americans that their access to comprehensive, cost-effective health care services has not been compromised and that the Medicare program has a fiscally viable future. **Although reconciling deficit reduction with beneficiary access to high quality care may seem contradictory on its face, this is not necessarily so. Reforming the Medicare program to take full advantage of a revitalized primary care infrastructure will achieve both goals.** Indeed, support for primary care puts the Medicare program in a position to interface effectively with the marketplace as it shifts to integrated systems of care. Moreover, improvements in the fee schedule that narrow the gap between reimbursement levels for primary care and other families of services would ensure access to the very type of service on which managed care is built.

As you work to craft a reformed Medicare program, please do not hesitate to call upon the American Academy of Family Physicians. Family physicians are eager to work with you on this challenging undertaking.

Thank you for this opportunity to speak with you about the Medicare program. At this time, I would be happy to answer your questions.

The Ambulance Down in the Valley

'Twas a dangerous cliff, as they frankly confessed,
though to walk near its crest was so pleasant.
But over its terrible edge there had slipped
a duke and full many a peasant.
So the people said something would have to be done,
but their projects did not at all tally
Some said, "Put a fence 'round the edge of the cliff"
Some, "Put an ambulance down in the valley".

Well, the cry for the ambulance carried the day,
for it spread through the neighboring city.
A fence may be useful or not, so they say,
but each heart became brimful of pity.
For those who had slipped over the dangerous cliff
and dwellers on highway and alley
Gave pounds and pence, not to put up a fence,
but an ambulance down in the valley.

"For the cliff is all right, if you're careful", they said,
"and even if folks slip and are dropping,
It isn't the slip that hurts them so much
as the shock down below when they're stopping."
So day after day, as those mishaps occurred,
quick forth would the rescuers sally
To pick up the victims who fell off the cliff
with their ambulance down in the valley.

Then an old sage remarked, "Tis a marvel to me
that people give far more attention
To repairing results than to stopping the cause,
when they'd much better aim at prevention.
Let us stop at the source all this mischief, " cried he
"Come neighbors and friends, let us rally.
If the cliff we would fence, we could almost dispense
with the ambulance down in the valley."

"Oh, he's a fanatic," the other rejoined
"Dispense with ambulance? Never!
He'd dispense with all charity, too, if he could.
No! No! We'll support them forever.
Aren't we picking up people as fast as they fall?
shall this man dictate to us – shall he?
Why should people with sense stop to put up a fence
while an ambulance waits in the valley?"

Author Unknown

Mr. JOHNSON. Thank you, sir.

Mr. Plitt, would you go ahead with your testimony and we will question the whole panel at the end.

STATEMENT OF KENNETH C. PLITT, CERTIFIED REGISTERED NURSE ANESTHETIST, MILL CREEK, WASHINGTON; ON BEHALF OF AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Mr. PLITT. Thank you, Mr. Chairman and Members of the Subcommittee. My name is Ken Plitt, and I am a certified registered nurse anesthetist or CRNA from Mill Creek, Washington. I am pleased to be testifying today on behalf of AANA, the American Association of Nurse Anesthetists.

The AANA is the professional association that represents 26,000 practicing CRNAs, comprising more than 96 percent of the nurse anesthetists in the United States. Today, CRNAs administer more than 65 percent of the anesthetics given to patients each year in the United States and are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capabilities.

We work in every setting in which anesthesia is delivered, providing services for all types of surgical procedures from the simplest to the most complex.

ANNA is suggesting two items relating to part B reimbursement reform. The first is deference to State law on the issues of supervision of CRNAs. The current Medicare hospital and ambulatory surgical center conditions of participation for anesthesia services restricts CRNA practice by requiring physician supervision of CRNAs. This Federal regulation exists despite the fact that many State laws allow nurse anesthetists to practice without such supervision.

In fact, 29 States have no supervision or direction requirement concerning nurse anesthetists in nurse practice acts, board of nursing rules and regulations, medical practice acts, or their generic equivalent.

The current regulations are problematic for the following reasons. First, some surgeons have been dissuaded from working with nurse anesthetists believing that they may be subjecting themselves to liability for supervising the CRNA. Whether or not a surgeon will be held liable when working with a CRNA depends on the facts of the case, not on the particular license of the anesthesia provider.

Second, surgeons have no affirmative obligation to direct or control the anesthetic process, despite the existing Federal requirement to supervise. And, in fact, are entitled to rely upon nurse anesthetists as the anesthesia experts.

Finally, the Federal supervision requirement has an anticompetitive effect since it acts as a possible disincentive for CRNAs to be utilized. This is clearly a matter that should be left to the States, and the language we are suggesting merely states that Congress should refer to State law.

We would also like to discuss the matter of equity in reimbursement for two anesthesia providers working on a single case. The current Medicare regulation states that if a CRNA and an anesthe-

siologist work together on one case and the involvement of both providers is not required as a matter of medical necessity, the anesthesiologist may bill the case as if he or she personally performed it and receive 100 percent of the payment.

In practice, this means that unless the CRNA is an employee of the anesthesiologist not only does CRNA lose, but so does the hospital which often is the CRNA's employer, thereby serving as a disincentive for hospitals to employ nurse anesthetists.

These regulations should be changed to reflect that both the CRNA and anesthesiologist have participated in the case and, therefore, each provider should receive one-half of the Medicare payment. We believe that what we are requesting in this matter is budget neutral.

The last item on which we would like to comment deals with standards for managed care. Knowing of your intention to reform Medicare and perhaps allow some Medicare recipients to move into managed care plans, you may wish to consider some basic reforms.

Many managed care plans arbitrarily eliminate entire classes of health professionals solely based on the type of license or certification they hold. This is particularly the case in managed care plans where various types of non-M.D. health professionals, such as CRNAs, are unable to compete to provide the same or similar care as MDs.

Decisions to include practitioners in a managed care network should be based on evidence of cost effectiveness, quality, and availability of health professionals. We recognize the value of managed care as a means of controlling costs, while providing necessary care and believe what we are suggesting on these issues is neither antimanaged care nor any willing provider type legislation.

During the last Congress our association, along with other nonphysician provider groups, worked with representatives in the managed care industry to negotiate a compromise approach to prevent arbitrary discrimination against health professionals based solely on their license or certification.

The antidiscrimination language we are suggesting was supported by non-M.D. health professionals and managed care organizations in 1994 and was included in many of the major health care reform bills last year.

I would like to thank you for the opportunity to testify and I look forward to responding to your questions.

[The prepared statement follows:]

TESTIMONY OF KENNETH C. PLITT, CRNA
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Chairman Thomas, members of the Subcommittee, good morning, my name is Ken Plitt and I am a Certified Registered Nurse Anesthetist (CRNA) in Mill Creek, Washington. I am pleased to be testifying today on behalf of the American Association of Nurse Anesthetists (AANA).

BACKGROUND INFORMATION ABOUT AANA AND CRNAs

Before discussing our proposals for reform, I would like to provide some information about our association and the CRNAs it represents. The AANA is the professional association that represents over 26,000 practicing CRNAs; the AANA is comprised of more than 96 percent of the nurse anesthetists in the U.S.

Founded in 1931, the American Association of Nurse Anesthetists (AANA) is the professional association representing CRNAs nationwide. The AANA has produced educational and practice standards, implemented a certification process for nurse anesthetists in 1945, and developed an accreditation program for nurse anesthesia education in 1952. The AANA was a leader in forming multidisciplinary councils with public representation in order to fulfill the profession's autonomous credentialing functions. The AANA, as a professional association, or through its credentialing councils continues to update educational and practice standards, position statements, guidelines, and its accreditation, certification, and recertification processes. The credentialing processes are broadly recognized by appropriate public and private agencies.

Today, CRNAs administer more than 65 percent of the anesthetics given to patients each year in the U.S. CRNAs provide anesthesia for all types of surgical cases. CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capabilities. They work in every setting in which anesthesia is delivered, including hospital surgical suites and obstetrical delivery rooms; ambulatory surgical centers; and the offices of dentists, podiatrists and plastic surgeons.

CRNAs are professional registered nurses, independently licensed to practice nursing within the scope of the nurse practice acts and other state laws and regulations in each of the 50 states. The practice of anesthesia is a recognized specialty within both the nursing and medical professions. CRNAs administer anesthesia and anesthesia-related care in four general categories: (1) preanesthetic preparation and evaluation; (2) anesthesia induction, maintenance and emergence; (3) postanesthesia care; and (4) peri-anesthetic and clinical support functions, such as resuscitation services, acute and chronic pain management, respiratory care, and the establishment of arterial lines.

CRNAs administer anesthesia for all types of surgical procedures, from the simplest to the most complex, and as a profession, continue to compile an enviable safety record. Based upon a 1988 study by the Center for Health Economics Research, nurse anesthetists were regularly involved in the same decisionmaking processes related to anesthesia as were physician providers.

History of Nurse Anesthetists

Nurses were the first professional group to provide anesthesia services in the U.S. Established in the late 1800s as the first clinical nursing specialty, nurse anesthesia developed in response to the growing need surgeons had for specially trained anesthetists.

anesthesia services at home and abroad. Nurse anesthetists also taught the provision of anesthesia services to physicians and nurses from allied countries when serving with them. Many nurse anesthetists received foreign decorations for their contributions during World War I. While there were some physicians who had devoted their practices to anesthesia, and made significant contributions to the war efforts, the formalization of physician education in the field of anesthesia did not become prevalent until after World War II. Only seven anesthesiology residencies for physicians, of at least one year of specialty training, were in existence at the outbreak of World War II.

Nurse anesthetists have been the principal anesthesia provider in combat areas in every war the United States has been engaged in since World War I. CRNAs have received medals and accolades for their dedication, commitment, and competence. In World War II, there were 17 nurse anesthetists to every one physician anesthetist (anesthesiologist). In Vietnam, the ratio of CRNAs to anesthesiologists was approximately 3:1. During the Panama strike, only CRNAs were sent with the fighting forces. Several nurse anesthetists have suffered combat wounds during war time service, and two were killed in Vietnam (their names are engraved on the Vietnam Memorial Wall in Washington, D.C.).

Nurse anesthetists have been pioneers in anesthesia for specialty surgery, particularly related to lung and heart surgery. They were involved in the development of anesthesia equipment for utilizing certain anesthesia techniques.

CRNAs were the first specialty nursing group to receive direct Medicare Part B reimbursement under the Omnibus Budget Reconciliation Act of 1986.

Education of CRNAs

There are currently 91 accredited nurse anesthesia education programs in the U.S., 85 (93%) of which offer a master's degree. The remaining programs are modifying their curricula to meet the requirement for all programs to offer master's degrees beginning in 1998. In addition, selected nurse anesthesia education programs are offering master's degrees and clinical nursing doctorate options for CRNAs pursuing graduate preparation. Other programs are considering the clinical doctorate at the entry level.

Requirements **for admission to a nurse anesthesia program**:
- A Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree;
- A license as a registered nurse;
- A minimum of one year of critical care nursing experience.

Once a nurse is admitted to the program, nurse anesthesia education programs comprise 24-36 months of graduate work including both classroom and clinical experiences. The classroom curriculum emphasizes anatomy, physiology, pathophysiology, biochemistry, chemistry, physics and pharmacology as they relate to anesthesia. The primary clinical component provides experience with a variety of anesthesia techniques and procedures for all types of surgery and obstetrics.

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education while CRNAs receive nursing education. However, the anesthesia part of the education is very similar for both providers. CRNAs and anesthesiologists are both educated to use the same anesthesia process in the provision of anesthesia and related services.

AANA MEDICARE REFORM PROPOSALS

Medicare Reimbursement Reform

AANA is suggesting two items for Part B reimbursement reform. Barriers currently exist that restrict the practice of CRNAs, leading to unnecessary increases in the cost of anesthesia in particular and overall health care costs in general. These barriers also limit many patients' access to quality health care services. CRNAs are an essential component of the health care solution because they provide access to high quality, cost-effective anesthesia services.

Defer to State Law on Supervision of CRNAs

The current Medicare hospital condition of participation for anesthesia services and the Medicare ambulatory surgical center condition of participation for coverage for surgical services restrict CRNA practice by requiring physician supervision of CRNAs. The requirements for physician supervision of CRNAs in these regulations should be eliminated and replaced with language requiring that CRNAs practice in accordance with state law.

Under the Health Care Financing Administration's (HCFA's) Medicare conditions of participation for anesthesia services and ambulatory center conditions for coverage for surgical services, the current regulations state that a hospital or ASC, which furnishes anesthesia services may only permit anesthesia to be administered by a "qualified anesthesiologist, a doctor of medicine or osteopathy, a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law, a certified registered nurse anesthetist who is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed (emphasis added) or by an anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed." (As adopted, 51 F.R. 22010 (June 17, 1986, effective September 15, 1986) and amended at 57 F.R. 33878 (July 31, 1992, effective August 31, 1992)).

Medicare regulations require physician supervision of CRNAs as a condition for hospitals or ASCs to receive Medicare payment, despite many state laws allowing nurse anesthetists to practice without such supervision. In fact, 29 states have no such supervision or direction requirement concerning nurse anesthetists in nurse practice acts, board of nursing rules/regulations, medical practice acts, or their generic equivalents. No state nurse practice act or board of nursing regulation requires nurse anesthetists to be supervised by an anesthesiologist. In addition, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) does not require that CRNAs be supervised by an anesthesiologist.

The federal government should not require physician supervision when so many states have determined that such a requirement is unnecessary.

The federal supervision requirement creates several problems for CRNAs. First, some surgeons have been dissuaded from working with CRNAs, believing they may be subjecting themselves to liability for "supervising" the CRNA. The principles governing liability of a surgeon when working with a CRNA are the same as those governing the liability of a surgeon when working with an anesthesiologist. Whether or not a surgeon will be held liable when working with a CRNA depends on the facts of the case, not on the particular license of the anesthesia provider.

St. Paul Fire and Marine Insurance Company has been the underwriter for the AANA's Professional Liability Insurance Program for more than ten years. St. Paul, the largest medical malpractice underwriter in the U.S., bases their yearly professional insurance premium for CRNAs on previous claim losses. For the period 1990-95, there has been an average annual decrease of 6.8% in CRNA professional liability insurance premiums due to decreased claims.

Second, the federal supervision requirement creates an inaccurate perception among some surgeons that they have an obligation to direct or control the substantive course of the anesthetic process. In fact, surgeons have no affirmative obligation to direct or control the anesthetic process, despite the existing federal requirement to "supervise." Surgeons are entitled to rely upon nurse anesthetists as anesthesia experts. The federal supervision requirement, however, sometimes creates unnecessary confusion in this regard.

Finally, the federal supervision requirement has an anticompetitive effect since it acts as a possible disincentive for CRNAs to be utilized. This is clearly a matter which should be left to the states and the language we are suggesting merely states that Congress defer to the states.

The Health Care Financing Administration (HCFA) began to look at this issue in October, 1994 when it released a draft regulation about hospital conditions of participation which eliminated the current requirement that CRNAs be supervised by a physician and defers to state law instead. It is our understanding that the issue may be addressed in a proposed rule which may be issued in

December, 1995; however, given the fact that this problem has been pending for several years and it is unclear whether HCFA's proposed rule will mirror its draft regulation, we are requesting that Congress include this reform in its Medicare reforms this year.

Equity in Reimbursement for Two Anesthesia Providers Working on a Joint Case

The current Medicare regulation on payment for the services of CRNAs states that if a CRNA and anesthesiologist work together on one case, the anesthesiologist may bill the case as if he/she personally performed it and receive 100 percent of the Medicare payment. Currently, payment may be made for the nurse anesthetist service only if documentation is submitted to and approved by the carrier showing it is medically necessary for the nurse anesthetist to be involved in the procedure. Due to the stringent "medical necessity" criteria used by many carriers, no Medicare payment is typically made to the CRNA involved in such a case, even if the CRNA was the provider actually administering the anesthesia to the patient.

In practice, this means that if the CRNA is working jointly on a case with an anesthesiologist and medical necessity cannot be adequately proven to the carrier -- not only the CRNA loses, but so does the hospital which often employs the CRNA. This serves as a disincentive to hospitals to employ CRNAs who cannot balance bill, earn less than anesthesiologists, can be educated at less cost than anesthesiologists, and therefore may be better suited to a managed care environment in the long run.

This regulation should be changed to reflect that both the CRNA and anesthesiologist have participated in the case and, therefore, each provider should receive half of the Medicare payment. Specifically, the Medicare payment to the nurse anesthetist should be one-half of 100 percent of the fee schedule amount otherwise applicable if the anesthesia service was personally performed by the anesthesiologist alone and the Medicare payment to the anesthesiologist should be one-half of 100 percent of the fee schedule amount otherwise applicable if the anesthesia service was personally performed by the anesthesiologist alone.

What we are requesting is budget neutral. We are simply suggesting that if CRNAs are working jointly on a single case with anesthesiologists, CRNAs -- or the hospital which employs the CRNA (if employed by a hospital) -- should be paid half of the fee. This will give hospitals added flexibility.

Standards for Managed Care

Finally, we suggest that in concert with this Committee's intention to reform the Medicare program, especially the possibility of creating more options for beneficiaries under managed care or within the context of incremental health care reform, Congress should consider some basic standards of fair play concerning managed care plans and providers generally.

Revising our health care delivery system to ensure consumer health care needs are met requires guaranteeing a level playing field for all health care professionals. Legislation that prohibits providers from arbitrarily excluding qualified health professionals and provides assurances of consumer choice, access, and quality is fundamental to the success of incremental reform of our health care delivery system.

Managed care is not coming. It is already here. Enrollment continues to grow at a rapid rate. While the emphasis of managed care organizations has been in the areas of cost containment, significant problems have arisen regarding restriction of consumer choice of provider and compromised quality of care delivered. But before we go down the managed care road any further, it is important for Congress to consider a few basic standards designed to ensure that employees or consumers have access to high quality health care providers.

Nondiscrimination of health care professionals in managed care plans

Many managed care plans arbitrarily eliminate entire classes of health professionals solely based on the type of license or certification they hold. This is particularly the case in managed care

plans where various types of non-MD health professionals such as CRNAs, are unable to compete to provide the same or similar care as MDs. Decisions to include health professionals in a managed care network should be based on evidence of cost effective, quality care, and availability of health professionals. Legislation is needed to prohibit health plans from excluding health professionals based on their license or certification. Additionally, legislation must require that health plans have a sufficient number and variety of health professionals to ensure consumer access to a full range of necessary health care services. This is particularly important in rural and underserved areas where the ratio of patients to physicians is often dangerously high.

CRNAs are generally quite willing to work with health plans as price-conscious providers. Unfortunately, all too often such cost savings are eliminated when there are requirements that CRNAs and other non-MDs work through physician "middle-men" employers or contractors who extract such savings themselves rather than passing it on to consumers. Plan credentialing and facility privileging barriers significantly contribute to this process because provider recognition is traditionally biased toward such "middle-men."

As a CRNA, I know of numerous occasions where the health plan refuses to even entertain the inclusion of nurse anesthetists in its plan, because the medical director is MD-oriented. This is not only true for CRNAs but for tens if not hundreds of thousands of other non-physician providers. This inhibits competition and may in fact keep some provider reimbursement rates artificially higher than they ought to be.

CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, allowing these medical facilities to provide obstetrical, surgical, and trauma stabilization services which otherwise would not be provided. Delay of needed surgical and other health services has an impact on health outcomes and increases total health care costs. In the absence of anesthesia capabilities for rural hospitals, many patients would be forced to travel great distances in order to receive surgical services.

Inability of these essential providers to contract with health plans often forces the CRNA to bill the patient directly as an out-of-network provider, leading to hard feelings between the hospital, surgeon or obstetrician, anesthetist, insurer and enrollee. This is in spite of the fact that in most cases the CRNA is willing to enter into good faith contract negotiations with the plan.

Health plan policies have enormous implications for plan enrollees and the health professionals who care for them. These policies should be based on patient needs and not merely plan profitability. Well publicized standards for utilization review practices, denial of care, and the selection and elimination of health professionals in health plan networks must be evident and made available to plan enrollees and health professionals.

What we are suggesting on these issues is **not** "anti-managed care" legislation. We recognize the value of managed care as a means of controlling costs while providing necessary care. During the last Congress, our association along with other non-physician provider groups worked with representatives of the managed care industry to negotiate a compromise approach to preventing arbitrary discrimination against health professionals based solely on their license or certification. This approach, supported by non-MD health professionals and managed care organizations, was included in many of the major health care reform bills.

Congress ought to take a cue from the states on this issue. If the states have recognized the value of various non-MD health professionals to provide quality care by virtue of their licensure and scope of practice, then doesn't it make sense that managed care plans ought to come to the same conclusion? No health professional should be excluded from a plan **solely** on the basis of the type of licensure or certification he or she possesses, so long as he or she is qualified to perform those services designated by the states.

What we are suggesting is **not** "any willing provider" language. It does not require a health plan to enter into a contract with every individual practitioner, but rather would require the plan to have representatives of a variety of health professions in its network. Health plans would maintain the discretion to contract selectively on the basis of an individual health professional's

reputation, professional qualifications, or other appropriate factors while being prevented from refusing to contract with entire health professions who are otherwise licensed by the state.

Furthermore, the basic provisions we suggest will not prevent health plans from managing costs. If a plan already includes a sufficient number and type of a health professional (geographic saturation) the plan may then exclude any additional applicants.

Although historically, managed care utilized some types of non-MD health professionals, many non-MDs are now being excluded from the managed care networks based on the type of license or certification that they hold. This is especially true for health plans that have a "MD-only" policy, or requires MD supervision of services that non-MDs can provide independently based on their education and training. Because of these discriminatory policies, non-MDs are many times not permitted to affiliate with health plans or enter into contract negotiations despite lower costs and availability.

Health Plan Capacity Requirement

A health plan should have the appropriate capacity to provide adequate services in a practitioner's area. Health plans should be required to offer a range of health professionals, specialties and practice settings provides assurances that health plans can accommodate the access and specialty needs of consumers throughout the entire designated service area, and that consumers will maintain the freedom to choose between two or more types of health professionals who are credentialed to provide the same service in alternative practice settings, or that hospitals might have more flexibility in choosing with whom they decide to contract.

Non-MD health professionals are particularly important in meeting the accessibility needs of consumers in rural and underserved areas. In many situations, these are often the only qualified health professionals available to provide care.

Due Process Provisions

Finally, we suggest that if a health care plan denies a claim or permission for a consumer to receive care, it's only fair that the plan offers an explanation. In addition, if the plan decides to eliminate the employee's health care provider from the network, that too deserves an explanation -- both to the individual as well as the health care professional. Full disclosure is only fair, especially to those who are paying the bills -- employers and their employees.

Thank you for the opportunity to testify. I look forward to responding to your questions.

Mr. JOHNSON. Thank you, sir, we appreciate your testimony.

Dr. Gee, would you please proceed. I am saving the best for last from Houston, you know.

STATEMENT OF WILLIAM F. GEE, M.D., VICE CHAIRMAN, HEALTH POLICY COUNCIL, AMERICAN UROLOGICAL ASSOCIATION

Dr. GEE. Thank you, Mr. Chairman.

Mr. Chairman, and Members of the Subcommittee, I am William F. Gee, M.D., a practicing urologist from Lexington, Kentucky, and vice chairman of the Health Policy Council of AUA, the American Urological Association.

I am pleased to have the opportunity to present the views of AUA's more than 8,500 members on the restructuring of the Medicare Program and other budget reconciliation issues.

I will now summarize our longer statement and submit it for the record.

AUA acknowledges the need to assure the financial viability of Medicare for the current beneficiaries and future generations who will depend upon the program for their health insurance. We accept the need to revamp the Medicare Program to incorporate the best experience of the private sector, particularly those ideas that have been proven to be cost effective, while maintaining a high level of quality medical services.

AUA is prepared to work with Congress to find ways to resolve the program's financial problems, while continuing to meet the Nation's commitment to the health care of its senior citizens. As you move to expand beneficiary choice of health plans, and simultaneously increase sensitivity to the cost of medical care, we urge you to embrace the following elements in a new program design.

One, maintain the beneficiary's right to choose their own physicians and assure them that their needs for specialized medical services will not be denied. Congress should assure that beneficiaries have an affordable system that provides freedom of choice of provider, in addition to allowing the choice of health plan benefit. Individuals who have entered managed care networks should retain the ability to opt out when necessary.

Two, Congress should correct the flaws in the current Medicare payment system and encourage the provision of medical care in the most appropriate setting by eliminating the financial incentives to provide services in the most expensive institutional locations. Proper recognition of physician practice expenses for surgical and diagnostic procedures will encourage them to use more cost-effective outpatient and office-based settings.

Three, in order to ensure an adequate supply of physicians to meet the future needs of Medicare beneficiaries, all players in the Medicare scene must contribute to the cost of graduate medical education.

Four, Medicare's current restrictions on the financial incentives that health plans can offer physicians should be carried forward into the new system and enhanced, if necessary.

Five, health care providers should have the ability to bargain effectively with managed care organizations. Physician-sponsored

health plans should have every opportunity to compete on an equal basis for Medicare's business.

Six, Medicare benefit structure should be the gold standard for evaluating other health plans that will be entering into the Medicare market. In this regard, AUA recommends that Medicare cover the early detection of prostate cancer. Prostate cancer closely parallels breast cancer in age of onset, incidence, and death rate.

Seven, currently the fee schedule update is built on three volume performance standards. AUA sees no compelling evidence to abandon this system. Separate targets and updates need not interfere with the achievement of budget targets.

Eight, a new, more competitive Medicare Program should not be built around price alone, but must have a foundation of medical value. AUA is committed to the development of medical care guidelines and research into the outcomes of treatment. The new Medicare system must incorporate these standards and guidelines not only to reduce outlays for unnecessary services, but also to assure that cost pressures do not discourage provision of effective quality medical care.

Nine, we seek your help in reducing some of the unnecessary costs that are imposed on the health care system in order to develop a more cost-effective Medicare Program. Congress should complete the work it began earlier this year on reform of the Nation's tort system.

Ten, in addition, the clinical laboratory improvement amendments of 1988 have imposed additional regulatory burdens and costs on physicians who provide laboratory services in their offices. There is scant evidence that this regulatory structure has made any difference in the quality of laboratory services. AUA strongly supports H.R. 1386, introduced by Chairman Archer, to eliminate these requirements.

Eleven, limits on physicians self-referral can inhibit the ability of physicians to share expensive medical equipment or to organize their practices most efficiently to compete in new markets. These restrictions need to be revised.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions you or Members of the Subcommittee may have.

[The prepared statement follows:]

TESTIMONY OF WILLIAM F. GEE, M.D.
AMERICAN UROLOGICAL ASSOCIATION, INC.

Mr. Chairman and Members of the Subcommittee: I am William F. Gee, M.D., a practicing urologist from Lexington, Kentucky, and the Vice Chairman of the Health Policy Council of the American Urological Association (AUA). I am pleased to have the opportunity to present the views of AUA's more than 8,500 members on the restructuring of the Medicare program and other budget reconciliation issues.

Many urological diseases and conditions, such as prostate cancer, benign prostatic hypertrophy and urinary incontinence, are most common among older men and women. Thus a substantial portion of many urological practices consists of men and women who are covered by the Medicare program. Many practices have a 60% Medicare caseload, and 80% is not unusual in sunbelt states and other retirement areas. The decisions this Subcommittee and Congress makes about the future of Medicare will significantly impact our members and their patients.

Many analysts have determined that the solvency of the Medicare program, particularly the Part A trust fund, is at risk. AUA acknowledges the need to assure the financial viability of Medicare for current beneficiaries and future generations who will depend upon the program for their health insurance. Congress is currently considering proposals that would offer beneficiaries a broader choice of health insurance plans, with a significant increase in the availability of managed care programs. AUA agrees that the financial solvency of the program cannot be assured unless beneficiaries and providers become far more sensitive to the costs of health care than they are today. We accept the need to revamp the Medicare program to incorporate the best experience of the private sector, particularly those ideas that have been proven to be cost effective while maintaining a high level of quality medical services.

Choice of health plan, including fee for service, managed care and medical savings accounts, could dramatically change the behavior of beneficiaries and providers of health services and help manage Medicare's rate of growth at more prudent levels.

Congress has adopted a course of deficit reduction that is expected to lead to a balanced budget. AUA hopes that such fiscal prudence will benefit all citizens. As a major entitlement program, Medicare will have to play a leading role in the effort to balance the budget. AUA believes that the present program structure is not consistent with the fiscal goals that have been endorsed. Unless there is a substantial reorganization of the Medicare program, Congress will not be able to meet its goals of financial restraint and medical service quality. AUA is prepared to work with Congress to find ways to resolve the program's financial problems while continuing to meet the nation's commitment to the health care of its senior citizens.

For thirty years Medicare has helped senior citizens and disabled Americans receive outstanding medical services with dignity and compassion. Yet it is increasingly clear that the structures of health care financing and delivery that made sense in 1965 are no longer working as well as they once did. As Congress revises Medicare, AUA urges that the best attributes of the system be retained, so that the dignity and compassion that have exemplified the system are maintained.

As you move to expand beneficiary choice of health plans, and simultaneously increase their sensitivity to the costs of medical care, we urge you to embrace the following elements in the new program design.

1. Maintain the beneficiaries' right to choose their own physicians and assure them that their needs for specialized medical services will not be denied. AUA is proud to be an active member of the Patient Access to Specialty Care Coalition which includes nearly 100 organizations that represent patients and their families, and the health professionals that serve their healthcare needs. This Coalition is committed to maintaining choice of health care provider and access to medically needed, specialized health services in the rapidly changing health care environment. Congress should assure that beneficiaries have an affordable system that provides freedom of choice of provider. Individuals who have entered managed care networks should retain the ability to "opt out" when necessary. This flexibility will protect beneficiaries from any possible failures of health plans to provide high quality, medically appropriate services on a timely basis. It can also help ease the transition from a completely open health care system to one that is more restrictive.

2. Congress should correct the flaws in the current Medicare payment system and encourage the provision of medical care in the most appropriate setting by eliminating some of the financial incentives to provide services in the most expensive institutional locations. For example, Medicare is now reviewing the way that physician practice costs are paid. There are many services in urology that are not adequately reimbursed for the costs of the supplies used. For example -- cystoscopy is a procedure which entails introducing a telescopic type of instrument with fiber optic illumination into the urinary bladder for diagnostic purposes. It is most often performed in the urologist's office and is one of the most common procedures in urology. Every cystoscopy requires a surgical tray of supplies costing approximately $44, plus other indirect costs not recognized in the current payment scheme. If the practice costs of this and other procedures are properly recognized in the new system, then physicians will have incentives to

provide services in the office setting, which will be more cost effective. If the study is used to cut practice expenses for surgical and diagnostic procedures, then physicians will have incentives to move these services into the institutional setting, at a much higher cost.

AUA is concerned that the current study of practice costs just initiated by HCFA is underfunded and will have an insufficient sample size to produce complete data. Cost restraints mean that the researchers will have to extrapolate data for many services. As was learned in the development of the Medicare physician fee schedule work values, extrapolation is a very unsatisfactory substitute for research and data.

Finally, the study relies on a closed panel process for developing direct cost information. There should be more input from the specialty societies than the current design allows.

Congress should also reexamine the price limits and constraints that now exist and determine if they continue to be appropriate for a new Medicare system. For example, balance billing limits may have little relevance in a system of negotiated rates or capitated payments.

Likewise, if the current Medicare fee schedule is to remain a part of the payment structure, then it needs many refinements. The current five year review of physician work values has been most frustrating to AUA. The Medicare Part B Medical Directors were asked to review all codes to determine if values were too high or too low. Their initial list of overvalued procedures contained one third of all urological services. After consultation with HCFA, AUA succeeded in reducing that list by more than two thirds. It was clear that the Medical Directors had not followed the rules used by everyone else who reviewed physician work values, nor did they understand the procedures they were reviewing, as evidenced by their comments and the criteria they used.

AUA has now expended substantial resources to counter these uninformed allegations about the relative work of 43 urological procedures. HCFA's process for updating the fee schedule has a number of flaws and Congress should correct these problems as it moves forward with its rewrite of Medicare, particularly if Congress sees a large role for the current fee schedule in the future.

3. In order to assure an adequate supply of specialist physicians to meet the future medical needs of Medicare beneficiaries, all players in Medicare must contribute to the cost of graduate medical education. In order to meet the budget targets, it is clear that graduate medical education (GME) funding from Medicare will be part of the equation. AUA recommends that all private and public health plans contribute to the cost of education and tertiary care in teaching hospitals.

4. Keep the financial incentives of health plans and their gatekeepers consistent with the medical needs of Medicare's elderly and disabled population. Medicare's current restrictions on the financial incentives that health plans can offer physicians should be carried forward into the new system and enhanced if necessary.

5. Make sure that the playing field is level. Health care providers should have the ability to bargain with managed care organizations without fear of unfair antitrust Federal Trade Commission regulations. Physician sponsored plans should have every opportunity to compete on an equal basis for Medicare's business.

In order to facilitate the creation of physician sponsored health plans and to encourage more cost effective medical practice by permitting physicians to share specialized and expensive equipment, the current "Stark II" restrictions on self referral need to be revised.

6. Use the Medicare benefit structure as the "gold standard" for evaluating other health plans that will be entering the Medicare market. If the federal government is the purchaser of plans and/or services on behalf of the elderly and disabled covered by Medicare, then there must be a clear standard to assure that the taxpayers' dollars and the benficiaries' contributions are well spent. In some cases, the benefit package needs to be updated to bring Medicare more into the mainstream of current medical care. Opening a 30 year old benefit structure up to more competition will not solve the fiscal ills the program faces now and will face in the future.

In this regard, AUA recommends that Medicare cover the early detection of prostate cancer. Over the next year, 200,000 new prostate cancers will be diagnosed, and over 40,000 men will die from this disease. Prostate cancer closely parallels breast anger in age of onset, incidence and death rate. Medicare covers the screening for breast and cervical cancer. Congress should act this year to add early detection of prostate cancer to the benefit package.

A recent Office of Technology Assessment (OTA) study concluded that prostate cancer screening could be just as cost effective as other screening tests covered by Medicare. Medicare coverage would help assure that financial barriers would not limit the availability of prostate cancer screening. Coverage of screening would allow men to have the information they need to determine what course of treatment they want and need at a stage in the disease when treatment options are still possible.

7. In any new Medicare program, Congress must have a system for updating the payments to providers. Currently the fee schedule update is built on three volume performance standards--primary care, surgery and all other services. Since surgery has not exceeded its growth targets for several years, the differential in conversion factors has grown. The MVPS system works as designed. Physicians services with slow or no growth are rewarded and those with high growth are penalized. AUA sees no compelling evidence to abandon this system. Separate targets and updates need not interfere with the achievement of budget targets. However, if Congress does make a change then we suggest that the relative positions be maintained and that a single update factor be adopted. Surgery should not be penalized for growing at a rate below the targets.

8. A new, more competitive Medicare program should not be built around price alone, but must have a foundation of medical value. AUA is committed to the development of medical care guidelines and research into the outcomes of treatment. Members of this Subcommittee were leaders in the federal government's efforts to stimulate this side of medical science. We believe you have succeeded in your efforts because the private sector, including AUA, has taken up the challenge of determining what works, and what doesn't in medical care. The new Medicare system must incorporate these standards and guidelines, not only to reduce outlays for unnecessary services that provide little or no benefit to patients, but also to assure that cost pressures do not discourage the provision of effective medical care.

9. A new Medicare system will only succeed if providers of health services are given the opportunity to compete in the new environment and are able to find sufficient rewards to sustain a medical practice. We seek your help in reducing some of the unnecessary costs that are imposed on the health care system, particularly on physician practices.

Congress must complete the work it began earlier this year on the reform of the nation's tort system. Medical tort reform must be part of the new equation if we are to end spiraling professional liability costs. The House version of tort reform contains many of the critical elements sought by the health care community and we urge its enactment into law.

The Clinical Laboratory Improvement Amendments of 1988 have imposed additional regulatory burdens and costs on physicians who provide laboratory services in their offices. There is scant evidence that this regulatory structure has made any difference in the quality of there services. AUA supports H.R. 1398, introduced by Chairman Archer to eliminate these requirements.

Mr. Chairman, the federal government must fulfill the nation's commitment to the health needs of our disabled and elderly citizens. AUA believes that many changes will be required to Medicare if we are to meet that challenge in the coming years. Given the opportunity, our members can continue to provide medically appropriate, cost effective services to their Medicare patients. We want to work with the Members of this Committee to craft a set of Medicare revisions that keep the patients' well being paramount while addressing the financial needs of the program.

This concludes my statement. I would be pleased to answer any questions that you or the Members of the Subcommittee may have.

Mr. JOHNSON. Thank you, sir, we appreciate your testimony.

Dr. Levin, did you bring this humid weather up here with you?

Dr. LEVIN. Not intentionally, sir.

Mr. JOHNSON. Well, go ahead with your testimony and thank you for being here.

STATEMENT OF BERNARD LEVIN, M.D., VICE PRESIDENT, AND BETTY B. MARCUS CHAIR IN CANCER PREVENTION, M.D. ANDERSON CANCER CENTER, HOUSTON, TEXAS; ON BEHALF OF GASTROENTEROLOGY LEADERSHIP COUNCIL

Dr. LEVIN. Thank you, Mr. Chairman and Members of the Subcommittee. My name is Bernard Levin, and I am vice president for cancer prevention at the University of Texas, M.D. Anderson Center in Houston, Texas. I am also professor of medicine at the Cancer Center and practice as a gastroenterologist with an emphasis on colon cancer.

I appreciate very much the opportunity to testify before the Subcommittee today on behalf of the Gastroenterology Leadership Council, a coalition of four organizations representing physicians specializing in gastrointestinal disorders.

I am here to talk about a disease that will affect 138,000 Americans this year and kill 55,000 people in the United States. It is a disease that people do not like to talk about and it is preventable and curable when detected early. Colorectal cancer is the disease that I am referring to.

People do not know much about colorectal cancer and are surprised to learn that it is the second deadliest cancer, killing more people than breast or prostate cancer.

Many think that it is a disease that affects only men and not something that women need to worry about. In fact, this is a myth.

Colorectal cancer strikes men and women in almost equal numbers. In fact, about the same number of women, over age 65, die from colorectal cancer as they do from breast cancer. The high death rate is especially tragic when one realizes that with early detection colorectal cancer is one of the most preventable and curable cancers. Most colorectal cancers develop from benign polyps. Finding and removing these polyps reduces the risk of colorectal cancer by up to 90 percent.

Detection and prevention strategies are well documented and highly effective. Leading scientific organizations, including the American Cancer Society and the American College of Physicians, recommend screening for normal risk individuals beginning at age 50. The National Cancer Institute has recognized that screening for colorectal cancer reduces mortality.

Just this year, two new reports by the U.S. Preventive Services Task Force and the Office of Technology Assessment highlight the importance of screening for this disease. In fact, the Office of Technology Assessment report estimates colorectal cancer screening to be in the same range of cost effectiveness as mammography.

And screening for this disease is provided to most Federal employees through the Federal Employee Health Benefit Program. Unfortunately, Medicare does not now pay for these screening services and because of the lack of Medicare reimbursement many pri-

mary care physicians are reluctant to recommend tests that they know will not be covered by Medicare.

Education about this preventable disease is key. And Medicare coverage of these screening services is critical in efforts needed to reduce the incidence and the mortality resulting from this cancer. Colorectal cancer is costly in both human and economic terms. Patients often suffer through years of chemotherapy, radiation therapy, surgery, and hospitalization if the disease is not detected at an early stage.

In my own practice, at M.D. Anderson Cancer Center, I am saddened by the number of patients who come to me at an advanced stage knowing that many of these illnesses could have been prevented with appropriate early detection. And I am constantly amazed at how few people know that they are at higher risk of this disease if a family member suffered from this illness.

We are very supportive of H.R. 922 introduced by Congressman Cardin and cosponsored by a majority of Members of this Subcommittee which would provide Medicare coverage for these screening services.

We recognize that the Subcommittee is charged with achieving savings of $270 billion in Medicare costs. But as the Subcommittee looks to restructure Medicare, we believe it is appropriate and necessary to review Medicare's current benefit package and to provide coverage for effective preventive services which save money and lives. Until Medicare begins to provide benefits that will encourage early detection and treatment, we stand little chance of effectively reducing the devastating impacts and fatality rates of our Nation's number two killer, cancer.

Mr. Chairman, Members of the Subcommittee, thank you for your attention and this opportunity to address the Subcommittee.

[The prepared statement follows:]

TESTIMONY OF BERNARD LEVIN, M.D.
GASTROENTEROLOGY LEADERSHIP COUNCIL

Mr. Chairman and Members of the Committee, I am Dr. Bernard Levin, Vice President and Betty B. Marcus Chair in Cancer Prevention at the M.D. Anderson Cancer Center in Houston, Texas. I appreciate the opportunity to testify before the Committee today on behalf of the Gastroenterology Leadership Council (GLC).

The GLC is a working coalition of scientific and professional organizations in the field of digestive diseases. It is composed of the American Association for the Study of Liver Diseases (AASLD), the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE). Collectively, the GLC represents nearly 10,000 physicians nationwide specializing in gastrointestinal diseases.

The GLC urges the Committee to provide Medicare coverage of colorectal cancer screening services. We recognize that there is an added cost to Medicare for these screening services, and this request appears to run counter to the Committee's goal of achieving $270 billion in Medicare savings. However, early detection and prevention of colorectal cancer yields savings in terms of both additional healthy years of life and health care costs. We believe that as the Committee considers ways to restructure the Medicare program, it is important to review current Medicare benefits and to provide coverage for effective preventive services which save money and lives.

Colorectal Cancer Screening

Medicare coverage for preventive services currently includes screening for cervical and breast cancer, pneumococcal vaccines and hepatitis B vaccines. Colorectal cancer screening benefits are not now provided under Medicare. **Yet, colorectal cancer is the second deadliest cancer in this country in both men and women -- killing more people than either breast or prostate cancers.** Moreover, it is one of the most preventable types of cancer.

About 140,000 new cases of colorectal cancer will be diagnosed and about 55,300 people will die from the disease in 1995. The disease is most common in people over 50.

Many people believe colorectal cancer is a man's disease. This is a myth. Colorectal cancer strikes men and women in almost equal numbers. In fact, about the same number of women over age 65 die from colorectal cancer as from breast cancer.

The high death rate from colorectal cancer is especially tragic when one realizes that it is one of the most preventable types of cancers and curable when detected early. Most colorectal cancers develop from benign polyps. Finding and removing these polyps reduces the risk of colorectal cancer by 90 percent. The stark reality is that too many of these cancers go undetected until they are past the curable stage.

Detection and prevention strategies are well documented and highly effective. Leading scientific organizations, including the American Cancer Society, the National Cancer Institute, and the American College of Physicians, recommend screening for normal risk individuals beginning at age 50.

Just this year, two new reports demonstrate the effectiveness of this preventive service. The nation's leading expert panel on prevention -- the U.S. Preventive Services Task Force -- will be issuing its updated recommendations for preventive services in September 1995. This report is expected to recommend screening for colorectal cancer beginning at age 50. In addition, an April 1995 study done by the Office of Technology Assessment shows colorectal screening to be cost-effective.

This preventive service is already provided to most Federal employees. **Every major Federal employee health care plan recognizes the effectiveness of colorectal cancer screening services and provides coverage for these services.**

The GLC specifically recommends Medicare coverage of 3 screening tests:

- annual fecal occult blood test for normal risk patients age 50 and over;
- flexible sigmoidoscopy for normal risk patients 50 and over, once every 3 to 5 years; and
- colonoscopy exams for high risk patients. Persons with higher than average risk should include individuals with family history or prior personal experience of cancer or precursor neoplastic polyps; a history of chronic colitis; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

H.R. 922

We are very supportive of H.R. 922, the Colon Cancer Screening and Prevention Act introduced by Congressman Cardin earlier this year. We are especially pleased that 7 of the 13 members of this Subcommittee are already cosponsors of this bill.

This bill would provide coverage of 3 tests under Medicare:

1. annual fecal occult blood tests for persons age 50 and older. Payments for this test would be limited to $5 in 1996.
2. flexible sigmoidoscopies once every 4 years for normal risk patients age 50 and older.
3. colonoscopies no more often than once every 2 years for persons at high risk of this disease.

We believe this bill would be extremely effective in detecting and curing colorectal cancer and urge the Committee to include these provisions in the Medicare Reconciliation bill. Colorectal cancer is costly in both human and economic terms. Patients often suffer through years of chemotherapy, surgery and hospitalization. In fact, the most recent data have shown that colorectal cancer has led to over 125,000 Medicare hospital admissions in one year. Each of those admissions led to costly diagnostic, surgical and medical therapeutic interventions. Surely, it is both more cost effective and more medically appropriate to prevent than to treat this disease. While the savings to Medicare would be realized over a period of years, we do not believe that even by CBO's methodology that this benefit would be prohibitively expensive.

Until Medicare begins to provide benefits that will encourage early detection and treatment, we stand little chance of effectively reducing the devastating impact and fatality rates of our Nation's number 2 cancer killer, colorectal cancer.

Other Issues

- **Single Conversion Factor**: We urge the Committee to adopt a single conversion factor for the Medicare physician payment system. Currently, there are three separate conversion factors: surgical, primary care, and other non-surgical. These separate conversion factors have resulted in significant distortions in the Medicare fee schedule. While the physician fee schedule was originally designed to pay the same amount for services that involve equal physician work, the current program results in payments being significantly higher for surgical procedures than for non-surgical services requiring the same amount of work. The Physician Payment Review Commission has consistently recommended to Congress that a single conversion factor be adopted. We urge the Committee to make this change in the Medicare Reconciliation bill.
- **Technical Improvement if Single Conversion Factor Not Adopted**: If Congress does not adopt a single conversion factor, we urge the Committee to consider a technical improvement which would assure greater fairness to providers, and which would have only nominal, if any, budgetary impact.

We believe the upper and lower gastrointestinal (GI) endoscopic procedures (CPT Codes 43200-45385) should be included in the surgical update for purposes of the annual update. The upper and lower GI endoscopic procedures are classified as surgical in the CPT manual and for many other purposes by HCFA. Yet, HCFA has refused to include these procedures under the surgical update. HCFA should apply a fair and consistent standard to endoscopic services. HCFA should also be instructed to affirm the current "O" day pre/post operative global period.

- **Access to Specialty Care**: Screening for colorectal cancer generally falls to primary care physicians as points of first contact with the medical system. The treatment and management of this disease is usually a function of medical and surgical specialists, such as gastroenterologists and GI surgeons. As this Subcommittee approaches its restructuring of Medicare and the changes to provider payments that will be part of this year's budget reconciliation, we urge you to include safeguards to assure beneficiaries that they will continue to have access to the specialized medical services they need.

  As Medicare moves to a model incorporating patient choice of health plan and delivery systems, especially managed care plans, we ask that you incorporate protections for beneficiaries that will balance the need to reduce spending with the need to provide medically appropriate care. For example, if primary care gatekeepers are to be part of the new system, their financial incentives need to favor the medical needs of patients. Medicare already has standards on incentive plans in Medicare HMOs and competitive medical plans, and we recommend that they be retained in the new structure.

  Choice of personal physician and easy access to specialty care are prized attributes of the Medicare program, and are highly valued by beneficiaries.

  There seems to be little dispute that Medicare needs a significant reorganization. However, the strengths of the system, such as ready access to specialty care and choice of physician should not be lost in this effort, but should be retained for future generations of beneficiaries.

Thank you for considering these issues.

Mr. JOHNSON. Thank you, sir, we appreciate your testimony. I hope some day we can stop cancer entirely. I know you do, too. You all do good work down there.

Dr. Henley, in your testimony you mention flaws in Medicare's health professionals shortage area, bonus payment program, and I wonder if you could elaborate on that and enlighten us on how you think we could fix that?

Dr. HENLEY. Well, the concern we have there, Mr. Chairman, is that the bonus payments that currently go to physicians who serve in underserved areas, a significant percentage of those payments are going to subspecialists whose reimbursement rates are still significantly higher than those in primary care.

We would assert that primary care physicians who practice in underserved areas, be they inner city or rural, should be the ones who are receiving those bonus payments and that would be the correction that we would wish to see.

Mr. JOHNSON. When you say primary care physicians, are you referring to someone's family doctor or are you talking about HMO operations?

Dr. HENLEY. No. We are talking about family physicians, general internists and general pediatricians.

Mr. JOHNSON. OK, thank you.

Mr. Plitt, you talked about anesthesiologist and I wonder if you could tell me why you think it is necessary for an anesthesiologist and a certified registered nurse anesthetist to be on the same case at the same time? You talked about splitting the payment.

Mr. PLITT. In most settings, we find that there is a team environment that takes place. And typically that involves one anesthesiologist and a number of nurse anesthetists that they have coverage requirements for.

Medicare recognizes payments for those situations and splits the Medicare payment in a manner of 50–50. There is no such requirement though, and we think it is a glitch in the system, for those situations where there is a single case. The most likely example where that takes place would be an emergency that would take place after normal scheduling hours. Both a nurse anesthetist and a anesthesiologist are on call and they are involved in the case.

In some cases the requirement is that the patient's acuity is such that two pairs of hands are required throughout the case. But in many cases, that is not the situation. It is just that the anesthetist is providing the anesthesia and the anesthesiologist is available.

Mr. JOHNSON. So does the doctor request both or do they just come with the deal?

Mr. PLITT. Well, if there is a contract enforced between the hospital and an outside contracting group of anesthesiologists, the anesthesiologist may have the right, contractually, to be involved in every case. The problem comes up if the hospital is the employer of the nurse anesthetist and the anesthesiologist just assumes they are going to come in and provide the labor and management of that anesthetic.

Unfortunately, under that scenario, there is no payment mechanism for the hospital.

Mr. JOHNSON. And you are telling me the surgeon has no control over those people.

Mr. PLITT. The surgeon always has the right to request the anesthesia provider they want.

Mr. JOHNSON. Including whether he wants a nurse anesthetist or not?

Mr. PLITT. Correct.

Mr. JOHNSON. OK, thank you.

Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

I really would like to ask Dr. Henley a question, if I could. It is sort of a broad question and I guess I am selfish in asking it, because this is such a complicated issue that we are dealing with here. I have never had any issue, in all my life, that has been so complicated to try to understand in terms of some of the basic fundamentals.

You originally talked a little bit about the history of Medicare and how it started and how it tried to replicate what was going on in the private sector. Then, of course, the private sector has gone beyond Medicare and used a whole variety of devices to try and control costs.

It seems to me that one of the issues, in order to get back to a proper relationship of those who pay and those who receive, is to create some sort of an incentive system. Maybe you could explain a little bit why the emphasis is on primary care? This is sort of a sine qua non for that. And also maybe go into some of the specific steps which bother me because it further complicates the issues.

And you obviously know a great deal more about this than I do—limit the number of funded first year residency positions to 110 percent, limit the DME, IME pays for the first 3 years of residency—it seems to me that we are trying to simplify, we are trying to go back to the things which originally prompted the Medicare system.

And to sort of superimpose things like that. I wonder whether it is replicating what the private system is doing or is going far beyond that. So that is number one.

The other thing is why is it important—and I think I know why, but maybe you could explain a little better—to focus on primary care? Why is that sort of the quintessential point to bring this whole thing back into perspective?

Maybe you could discuss those two issues?

Dr. HENLEY. I would be happy to, sir.

Again, we believe very strongly that a system that has a proper infrastructure of primary care services, those services provided by family physicians, general internists, and general pediatricians is critical to the access problems and the cost problems of the Medicare Program.

We, again, have, as I alluded to earlier, we have presented previous testimony to this Subcommittee that recites the appropriate scientific literature that does, indeed, show that when patients access the system through a primary care physician as their first point of contact that their outcomes do not change and, yet, the cost of care goes down.

And we feel that those studies are valid, are reasonable and ones that you should take into consideration as you reform the Medicare Program.

That dovetails into the whole issue of the work force reform issue. Now, I would be the first to agree with you that while the market is evolving in terms of how health insurance is provided. That same market is taking advantage of the graduate medical education system and its funding, which is primarily through Medicare now.

It is interesting to me that that private market has not been more forceful, quite frankly, in demanding the types of physicians that it needs more of, that being family doctors and other primary care physicians.

We see, and have felt for many years, that that market is not going to evolve, even though the demand is there, the medical education system in this country with the long road that it has from start to finish is not going to evolve rapidly enough unless some force is created to direct that direction. That it is not going to occur according to market demands.

We believe there should be a public/private entity that directs the course of work force reform in this country. And the short-term measures that we have alluded to in our statement, such as the 110-percent cap on graduates of U.S. medical schools, is a big step in that direction, along with other necessary GME work force issues in order to achieve an appropriate specialty mix of primary care physicians and subspecialists.

Dr. HENLEY. I understand that and I appreciate that. And that is the simple and maybe the right way of doing it. Thou shalt, that is it, no question.

That is not how the private system works. The private system works through a competitive process which creates incentives. It is not a directive that you will have 110 percent of the number in 1994 U.S. medical school graduates in residency. It is different.

Now, maybe we should chop up Medicare into three or four competing units in order to get the incentive into the system. The thing that I worry about is that we can freeze in some sort of a dictum, a papal bull that says thou shalt do such and such a thing. And, yet, at the same time, it is frozen and cannot be changed and maneuvered and be progressive the way the private system is. That is what I worry about with some of these dictums that you have in your five points.

Dr. HENLEY. Well, I would assert, sir, that the goals that we have in there are not absolute dictums. We certainly favor an evolving system and one that is clearly updated on a periodic basis to meet the needs of the physician work force in this country. But there is a disconnect between the graduate medical education system in this country and the demand in the market. And we would simply assert that to the extent that Federal dollars are spent on graduate medical education, it seems only appropriate that those funds be spent based upon the needs of the country.

And now if, in fact, the private market needs 1,000 more cardiologists in the future, by whatever method that they wish that to be determined, then let them pay for it. But, to the extent that Federal dollars are used in the system and agreement is reached by a public/private entity that we need a certain mix of generalists to subspecialists, then let the Federal dollars flow to achieve that goal.

Dr. HENLEY. Well, I have overstayed my time.

Thank you, Mr. Chairman.

Mr. ENSIGN. The gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I apologize to the panel as we were off celebrating the 30th birthday of Medicare and we hope it will not be the last one.

And I just had a chance to kind of catch up on your testimony. Dr. Henley, I did not catch in here any discussion of the proposed cuts. Do you suppose that your practice could survive and continue to provide the same level of care to Medicare beneficiaries if you had approximately a 25-percent reduction in the amount that Medicare pays?

Dr. HENLEY. If that was the end result of the process, Mr. Stark, I do not think so. However——

Mr. STARK. That is the intended—those are the cuts that the Republicans are putting forth, that is what the $270 billion in cuts would mean, assuming, for a moment, that they are spread equally.

Now, I know that you would rather see hospitals cut, and the hospitals would rather see the doctors cut, but let us assume that we just do it across the board. What would happen, would you be able to maintain the level of treatment that you now provide to Medicare beneficiaries with receiving 25 percent less?

Dr. HENLEY. Well, again, let me answer it this way. Under the proposals that I have seen before this Congress now, Medicare expenditures will continue to increase at a rate of 7 or 8 percent per year.

Mr. STARK. Yes, but it will still be 25 percent less than they were going to be going up.

Dr. HENLEY. Yes, I understand that, yes, sir, but if the Medicare beneficiaries are offered greater choice, and they use their defined contribution to purchase different insurance options——

Mr. STARK. I guess I am asking you—you practice medicine now, do you not?

Dr. HENLEY. Yes, sir.

Mr. STARK. OK. I guess I am just asking you, relative to your practice, not the rest of the world—where do you practice, Doctor?

Dr. HENLEY. In Fayetteville, North Carolina, southeastern North Carolina.

Mr. STARK. All right, could you, in Fayetteville, provide in your own practice, it is a group practice?

Dr. HENLEY. Yes, sir.

Mr. STARK. OK. Could you provide, with 25 percent less revenue, the same level of care to your patients who are Medicare beneficiaries?

Dr. HENLEY. If all those savings came from my payment rates, no, sir.

Mr. STARK. That is what I thought.

Now, another question, just to give me an idea, What does an MRI head scan cost in Fayetteville?

Dr. HENLEY. MRI is probably about $1,500.

Mr. STARK. Angioplasty?

Dr. HENLEY. I would not try to guess on that one.

Mr. STARK. And arthroscopy, the thing they do to my knee?

Dr. HENLEY. Probably in the range of about $500 to $600.

Mr. STARK. Now, you talked in here about the idea of cost sharing would instill a degree of sensitivity—I presume you mean in the patients.

Dr. HENLEY. Yes, sir.

Mr. STARK. Well, if you do not know what an angioplasty costs, how do you expect my mother to have the remotest idea? I do not even know what it is. I just had to ask some things that somebody said you did not do in your office. Because my contention is that most doctors do not know the cost of services to which they refer patients with any degree of accuracy. But if you tell me to go, I will go. I am an obedient patient. And hope to hell I pass the test. Most of your patients, I will bet you, do not question, Do I need that test? Do they really. You tell them to take the test and they go, do they not?

Dr. HENLEY. That is usually true.

Mr. STARK. OK. Now, I do not think that they are going to make any change, maybe you do. Do you think if they had to pay 25 percent instead of 20 percent that they would stop and question your judgment and do you want them to?

Dr. HENLEY. I think there is the potential there just for that. Because again, under a reform system, where cost sensitivity is introduced I do believe that both physicians and patients will begin to be more critical about where they receive their services and at what cost.

I know under some of the managed care plans that I operate under now where I am an advocate on behalf of my patients, I do, in fact, look for quality at the lowest cost and that is achievable.

Mr. STARK. In every area except angioplasty.

Dr. HENLEY. That is not true.

Mr. STARK. Thank you.

Thank you, Mr. Chairman.

Mr. ENSIGN. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Dr. Henley, thank you for your testimony. And I would agree when you raise Medicare spending from $4,800 per Medicare recipient to $6,700 per Medicare recipient in the year 2002, that is an increase.

And so, yes, we are going to be increasing it 6 to 7 percent a year, but not increasing it at 10 percent, which currently is causing the whole system to go bankrupt according to the trustees.

I wanted to ask your opinion, Dr. Henley, as well as Dr. Gee and Dr. Levin about the use of the Agency for Health Care Policy and Research and some of the testimony that was elicited from Ms. Jaggar in the first panel.

Do you use the Agency for Health Care Policy and Research's guidelines and their literature and their information on a regular basis and/or do most primary care physicians or other physicians use their research and their writings and their guidelines on a regular basis or even a some-time basis?

Dr. HENLEY. Well, if I may go first, sir, as a practicing family doctor in rural North Carolina, I find that the Agency for Health Care Policy and Research and their guidelines are extremely beneficial to my every day conduct of health care for my patients.

Their method of guideline development and their Center for Primary Care Research offer to me, as a practicing clinician, the best method that I know of in order to help chart the course of care for my patients.

You spoke earlier of the guideline on congestive heart failure. They came out with a recent guideline regarding the treatment and diagnosis of low-back pain. And I would assert that those guidelines are in use by primary care physicians, family doctors, in particular. I certainly use them every day and they are effectively helping me transition from the diagnosis of an important disease, but also better treatment and better outcomes at lower cost for those same conditions.

Mr. CHRISTENSEN. Prior to 1989, this agency did not even exist. Is its function one that the private sector can do? I would like to hear Dr. Gee's and Dr. Levin's testimony as well on my time.

Dr. GEE. Yes, Mr. Christensen. The American Urological Association developed guidelines on the treatment of benign prostatic hypertrophy or the problem that older men have with urination and a committee of urologists developed these guidelines and then with that governmental agency, published them together, although the bulk of the work was done by the urologists and the agency acted more in an editorial capacity.

We employed the Gallup organization to survey urologists, just this past September, to see how they were complying, if that is the right word, with the guidelines, and we found out that they have had an impact in how urologists treat benign prostatic hypertrophy. In particular the amount of surgery has decreased as there are some drugs available for treating this problem and use of these drugs has increased.

So I think the guidelines in our specialty have had an impact, however, our guidelines are written by our organization.

Mr. CHRISTENSEN. Thank you.

Dr. Levin.

Dr. LEVIN. Specialty organizations have developed guidelines for colorectal cancer screening. The advantage of having the agency review and critically evaluate and use evidence-based outcomes research is that they are regarded as an impartial and, thereby, critical agency for evaluation of these guidelines.

So I think they will be useful. In my own particular area we are looking toward the publication this year of the agency's guidelines for screening for colorectal cancer.

Mr. CHRISTENSEN. Prior to 1989, how did you get along?

Dr. LEVIN. Various organizations have promulgated their own guidelines, including the American Cancer Society and the National Cancer Institute. What this provides is a more indepth look at the value of those guidelines. Certainly they exist. This adds substantiation and discusses in great depth whether the evidence really exists and we are looking forward to their publication.

So my view would be that they do provide value.

Mr. CHRISTENSEN. I think they do provide a valuable service but we spend $160 to $180 million for that value. When we are tightening the belt all the way around and we are facing a $5 trillion debt, there are some things that we have to look at to see if it is really worth the $170 to $180 million. And seeing if that role could be ful-

filled in the private sector, the medical schools, or in the other like organizations that are putting out those guidelines.

So I thank you for your testimony.

Thank you, Mr. Chairman.

Mr. ENSIGN. Thank you.

I just have a couple of questions for the panel. Dr. Henley, you brought something up in response to Mr. Stark's testimony where you become an advocate for the patient. And his question was, Because you did not know the cost of a couple of procedures in your area, how will the average citizen know those costs?

As a practicing veterinarian, we have specialties and subspecialists in our field of medicine, as well. And I had to be the advocate for that person. As a matter of fact, we would have surgeons come to town. We had a couple of different surgeons. They are not really common in veterinary medicine and they would come from southern California to Las Vegas. And for a particular procedure I knew the quality of each person's work and I also knew the prices. I had to know the prices because I had to go back and point out to the person that was paying the bill.

I think that was the whole point of the exchange that the two of you had is that a lot of the reasons that we do not know is that there is no reason for anybody to know what something costs. It is this whole third-party payer mentality that we have that there is no accountability, therefore, I will just go wherever the doctor tells me. The doctor does not really care because it is not coming out of that person's pocket, it is coming out of an insurance company's pocket or an HMO's pocket. And so that is where some of the market forces need to come into the medical field so that when your patient cannot, you, as a primary care physician can become the patient's advocate and get out there in the marketplace and help them shop for an MRI.

Las Vegas is a good example of that. An MRI in Las Vegas can go for as little as $325 or as much as $1,800. And if you do not have somebody to tell you why to go get this MRI over here or why that MRI over there and if you are not paying for it yourself, your doctor has no interest in doing that as well.

So I think that what you pointed out to me was very telling and one of the biggest problems we have in our whole medical system. Your comments.

Dr. HENLEY. Well, I would agree entirely, sir. Again, I would point back to some personal experiences I have had recently. Up until about 1989 I did obstetrics in my practice but stopped at that point in time.

But now I refer a lot of my pregnant women to OB–GYN physicians for their care. Many of those women now have 25 percent copays for their services for their obstetrical care. I have got 16 different OB–GYN physicians in Fayetteville that I can refer to, all of whom, I think, do excellent obstetrical care. But I can guarantee you that in the last 2 years I have now found out what they charge individually for that total global OB package and it varies greatly, despite the fact that the quality is the same.

And my patients are interested, when they have to pay that 25 percent of an x amount, they are interested in what that amount is. It may not always direct their care to the less expensive physi-

cian with the same quality but clearly they begin to ask the questions, and I do, too.

Mr. ENSIGN. Do you think that them asking the questions, the prices that doctors would charge would be affected?

Dr. HENLEY. Indeed.

Mr. ENSIGN. Market forces, interesting.

Just a question for the nurse anesthetist and once again, there were not too many veterinarians who could afford to hire an anesthesiologist though. We became our own anesthetist but we also used what were called animal health technicians for our anesthetist. So I have great respect for the work that you do and your field.

Can you provide us some insight into the rationale that the certified registered nurse anesthetist must be supervised, and why has the Medicare Program adopted such a policy?

Mr. PLITT. I cannot tell you exactly when that went into effect but the reason we are coming to you is because the trend is clearly more toward the elimination of supervision requirements in the States. So we find that while practice is pretty much consistent across the country, the State statutes vary all across the board.

So what we have found is some barriers when we go in to apply for privileges or apply to plans for care, if that supervision requirement at the Federal level exists, because there is a question about how the Medicare system might treat those hospitals relative to their participation in the Medicare system. So we look at it more than a technical glitch that we would like to see cleaned up and really get to the point of bringing the regulations in line with the law at the current State level.

Mr. ENSIGN. I would like to thank the panel.

Mr. STARK. Could I have a second round, just 1 minute, Mr. Chairman? Because I have a hunch that what Dr. Henley and I were talking about perhaps was somewhat misinterpreted. It has often been suggested that an increase in copayments will reduce utilization. Now, I do not suppose Dr. Henley or anybody else on the panel would suggest that the OB services would not be used. They might to go midwifery but I am suggesting that whether or not the copayment is 20 percent or 25 percent is not going to change a mother's or prospective mother's mind as to whether to have that service or not. Indeed they may shop.

But on the other hand, most insurance companies, including Medicare, pay a maximum fee which generally is the accepted fee. And my real question is, Will people reduce, will they not get a test because suddenly it is 25 percent rather than 20? And I happen to think not. And I would think that all of you physicians on the panel would not stop requiring a test just because there is going to be a percentage change in the copays.

There is some feeling, which I disagree with, and I would be curious as to whether Dr. Henley agrees, that increasing the copayments stops utilization. It may increase a little shopping, but do you think, doctor, really that it—it is going to take more money out of people's pockets, but I have a hunch they are going to find it.

Do you really think that people will not take the test that you ask them? Set OB aside, because that is something that you usually do not have a patient's choice on.

But that extra copayment will stop people from getting needed treatment or do you want them to?

Dr. HENLEY. Well, we certainly do not advocate people not getting the care that they need. I guess my concern, Congressman, would be that in today's environment where there is this third-party entity, the health insurance market, be it Medicare or whatever, that pays this huge bill for health care services, there is a disconnect between what the cost is and what the necessity is.

And I encounter patients every day where, be it prescription drugs that may be covered by their plan, be it certain ancillary tests that they need, they feel that they need that test often because of what they have heard from their friends and their neighbors and so forth. For example, the young child who gets a head injury out on the football field in practice. I evaluate that young man and determine that, no, he does not need a head CAT scan.

But the parents come to me and say, well, he was not quite knocked out, Dr. Henley, but let us get one anyway because the health insurance plan is going to pay for it.

And it is not necessary and then that puts me into a situation, automatically, where I become not an advocate for them, to some extent. Well, if there is a difference in the way that the system pays for those services where they do, in fact, have perhaps a higher cost sensitivity to the issue, then maybe that can make that dialog between me and my patient a bit more healthy and productive.

Mr. STARK. I do not know, Doctor. I can only speak as a patient. This happened once to my son. He fell off a horse but we did not have CAT scans in those days.

The question is, if I knew I had to pay 20 percent I probably would have gone ahead anyway. Would I not have done it if it was 25 percent? And I do not think that, if you are concerned, if you are going to pick it up. Now, if you are saying let us go from free to 20 percent, as some people are advocating for say, lab services, this may very well stop that utilization.

But in my mind, I say, But will it stop it when it ought not to be stopped? Will it stop the blood test that they ought to have because they have got to pay $5 out of the $20? And that is a fine call. And I do not think that you want to be part, I do not, of deterring people from getting necessary—and I cannot determine that—that is what I have, I trust my physician to tell me that, and I imagine your patients do, too.

And you get this extra 5 percent one way or the other in there and I think you mess up the relationship that I have been comfortable with, doing what the doctor tells me to do.

Dr. HENLEY. Well, again, I think that there is a difference between 20 and 25 percent but it is also what is the 20 and 25 percent of what total amount? And again that is where some of the degree of sensitivity needs to be. That same MRI scan that I mentioned that averages $1,600 or $1,500 in Fayetteville varies anywhere from one institution from $1,200 to $1,800. Why is there that $600 difference?

Mr. STARK. When it only costs $800 in California and they are making a fat profit at that. You and I are in the wrong business, Doctor.

Dr. HENLEY. But you have got a good market in southern California as well.

Mr. STARK. Dr. Gee, I just wanted to say to you, too, did you come up with that standard that my urologist told me to never get more than 200 yards away from a urinal? Is that one of the procedures that——

Dr. GEE. That is correct, unless you are wearing a Depends.

I would just like to very briefly comment on what Dr. Henley said. I think he brought out an important point. There is a difference between what the doctor recommends sometimes and what the patient wants. And if the doctor thinks the patient needs a CAT scan of the head then they will get it.

But in his example, it is like with prostate cancer. We know in our guidelines that men with early prostate cancer if they are being evaluated for treatment, surgery, or radiation do not need a bone scan. We did not know that 10 years ago. We got bone scans on everybody and many of these are Medicare patients. Now, we tell the patient you do not need a bone scan because we know that one 1 out of 400 might be positive. And that is a test that costs anywhere from $200 to $800.

But the patient wants the bone scan, so we say, all right, you want the bone scan. We order it because Medicare is paying for it. On the other hand, if I say, you need a bone scan because your PSA is 30 and we are trying to decide whether your cancer has spread, then I will push to do it.

I think this might cut down some on tests the patient sort of requests but are in that gray area.

Mr. STARK. Thank you.

Mr. ENSIGN. The gentleman from Louisiana has a question.

Mr. MCCRERY. Yes. Just a quick question to the panel. I think it is brokered in the context of patient/doctor relationship and taking the advice of the doctor and the doctor being forthright in discussing the benefits of certain tests and the utility of certain tests.

There may be judgment involved in some of these decisions and the doctor may want to discuss the options with the patient and let the patient have the ultimate decision but my question is, before we move more in that direction, do we need medical malpractice reform?

Dr. HENLEY. Well, I will jump in on that one. Yes, sir, we do. I think, again, the medical liability system that we have in this country now, I do not think serves providers or patients very well at all. I think it clearly interferes with our interactions with our patients on some occasions. It leads to higher costs of medical care. And I think appropriate liability reform, much like they have in California, where Congressman Stark is from, with a cap on noneconomic damages and elimination of collateral sources of income and figuring those into the equation, and so forth, would be extremely valuable not only to the physicians but to our patients. And it would save an extremely huge amount of money for this country.

Mr. MCCRERY. Anybody disagree with that?

[No response.]

Mr. MCCRERY. Thank you.

Mr. ENSIGN. That last question also came from an attorney so we respect that question.

Thank you very much, panel, for your excellent testimony. We would like to call the next panel up.

Bert Hood, chairman of the board and president and chief executive officer of LabOne; Alvin Salton, president and director of Community Medical Laboratories for American Associations of Bioanalysts; Richard Rapp, senior vice president, Apria Healthcare, on behalf of Home Oxygen Services Coalition; and James Liken, member, board of directors, National Association for Medical Equipment Services.

Each of you will be given 5 minutes. When the amber light comes on you have about 1 minute to go. And, without objection, your full statements will be included in the record.

Mr. Hood, would you like to begin?

STATEMENT OF BERT HOOD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, LABONE, INC., LENEXA, KANSAS

Mr. HOOD. Mr. Chairman, I am Bert Hood, chairman, president, and chief executive officer of LabOne, Inc. I appreciate the Subcommittee giving us the opportunity to testify today.

Further, I applaud the efforts of this Congress to reform the Medicare Program. By encouraging patient choice and using the forces of the competitive free market, you have embarked on a process that can bring health care costs under control, a process that will have our full support.

Mr. Chairman, this Subcommittee is faced with several daunting challenges. You are charged with continuing to assure the highest quality outcomes for American citizens in health care services and, at the same time, extracting substantial savings from the Medicare system whose trustees' project will go broke in the very near future.

I believe the clinical laboratory industry can assist you in reaching these goals and perhaps in ways that you might not expect.

My testimony today will highlight two initiatives that I know will infuse new competition in the laboratory industry and introduce the capacity for patient choice that will have dramatic long-term benefits for cost reduction.

First, we would suggest that the Congress immediately undertake a reduction in the Medicare clinical laboratory fee schedule from its present 80 percent of median charges to 65 percent of the median charges over the next 3 years with no adverse effects on the industry or our ability to deliver quality services.

Coupled with a 3-year extension of our current policy of freezing the MEI updates for laboratory services, the Subcommittee will achieve savings in excess of $7 billion over 7 years.

Second, we propose a programmatic change which will have a long-term effect of promoting beneficiary choice. By introducing mandatory direct billing for private payers, as is now required in Medicare, Congress can set the laboratory industry and our consumers on a trend toward patient choice and free market competition that will pay enormous dividends and reduce cost.

Our vision at LabOne is to encourage patient choice and drive down artificially high prices in health care. We charge one fee to

all payers, which amounts to a charge level approximately 60 percent below commercial rates and 30 percent below the Medicare fee schedule.

Any discussion of Medicare fee schedule requires an understanding of how Medicare encourages perverse market incentives and acts as an effective barrier against change. Prior to 1985, laboratory tests were sold at discounted wholesale prices to doctors who, in turn, marked up the price of the test to the patient who submitted a claim to an insurance company, self-insured employer, or to the Medicare carrier. When health care costs inflated astronomically in the early eighties, the government enacted legislation prohibiting physicians from billing Medicare and made it mandatory for laboratories to directly submit bills to Medicare carriers.

Medicare realized immediate savings from these new clinical laboratory fee schedules and the laboratory industry witnessed windfall revenues as it replaced discounted, wholesale prices to doctors with much higher direct payments from Medicare. At that point the name of the game was to "get Medicare business and get all you can." In 1991 the GAO studied Medicare reimbursement for clinical laboratories and identified the practice of using Medicare to offset deep discounts to physicians. The GAO recommended that the fee schedule be reduced further to eliminate the cost shift to Medicare. The rate is now set to go to 76 percent of the median in 1996.

Nevertheless, the GAO prophecy continues. The market remains a patchwork of discounting, markups, and multilayered fee schedules that defy the most skilled practitioner, much less the layman, to determine the true cost of laboratory testing. Accordingly, LabOne suggests that the Medicare payment for outpatient clinical laboratory services be reduced from its present 80 percent in 1995 to 65 percent of the median charges over the next 3-year period, coupled with the MEI freeze update. Such reductions will allow rates to more accurately reflect market price costs and will foster competition in the industry.

The Congress is considering major changes in the Medicare Program to reflect market developments and to expand patient choice. We applaud this common sense approach and have adopted a similar principle in the design of our laboratory testing benefit plan.

Finally, Mr. Chairman, Congress should address the direct billing for private laboratory services. Already a success in Medicare, direct billing is endorsed by the entire industry and its principles are contained in H.R. 1461, the Direct Billing Act, introduced by Congressman Fred Upton and Sherrod Brown. It is important to note, however, that by itself direct billing is not a panacea for the immediate lowering of laboratory prices. As a matter of fact, there will be a windfall as some entities reap all or portions of the markups now gleaned by physicians.

That is why competitive incentives must come into play. Direct billing coupled with reductions in the Medicare fee schedules to eliminate the reverse cost shift will bring educated payers and informed buyers to the same table with a full range of sellers to compete head to head based on quality, service, and price.

In conclusion, Mr. Chairman, let me be clear about my purpose in responding to your very kind invitation to come to the Subcommittee. I did not come to indict the laboratory industry. I did come, however, to shed some light on a complex set of policies and pricing practices, some directed by government, some archaic remnants from the outdated private market, which result in companies being trapped in a gilded cage of dependency on inflated Medicare fee schedules.

Thank you.

[The prepared statement follows:]

TESTIMONY OF BERT HOOD
LABONE, INC.

Mr. Chairman, I am Bert Hood, Chairman, President and CEO of LabOne, Inc. I want to express my appreciation to you and the Committee for giving us the opportunity to testify today. Let me say at the outset that as a health care service provider, a tax payer and as one with a parent who is a Medicare beneficiary, that I applaud the efforts of this Congress to reform the Medicare system. By encouraging patient choice and using the forces of a competitive free market you are embarked on a process that can bring health care costs under control, a process that will have our full support.

Mr. Chairman, this Congress and this Committee is faced with several daunting challenges. You are charged with continuing to assure the highest quality outcomes for American citizens in health care services and products and, at the same time, extracting substantial savings from a Medicare system whose trustees project will go broke in the very near future.

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My brief testimony today will highlight two initiatives which I know will infuse renewed competition in the laboratory industry and introduce a capacity for patient choice that will have dramatic long-term benefits for cost reduction.

First, we would suggest that the Congress can immediately undertake a reduction in the Medicare clinical laboratory fee schedule, from its present 80% of median charges to 65% of median charges over the next three years, with no adverse effects on the industry or our ability to deliver quality services. Coupled with a similar three year extension of the current policy of freezing Medical Economic Index (MEI) updates on laboratory services, the Committee will achieve savings in excess of $7 billion over seven years. This is equivalent to the projected savings from introducing a 20% co-insurance on laboratory services for beneficiaries - a proposal we would suggest is fraught with dangers, both substantive and political, and one we would urge you to reject.

Secondly, we propose a programmatic change which will have a long-term effect of promoting beneficiary/payer choice. By introducing mandatory direct billing - for private payers as is now required in Medicare - the Congress can set the laboratory industry and our consumers on an inexorable trend toward patient choice and free market competition that will pay enormous dividends in reduced costs. It is my understanding that several members have developed such a proposal in HR 1461, the Direct Billing Act of 1995 and we commend it to your attention and review.

Mr. Chairman, in order to put these proposals in some context, I believe it is important to tell you a little about LabOne and about my experience and views concerning the lab industry.

LabOne is located in Lenexa, Kansas (the greater Kansas City area). The company has served the insurance industry for the past 23 years. We are the largest risk assessment laboratory in the country. In January of 1994, LabOne expanded its test menu, entering the market as a full service clinical laboratory. LabOne performs clinical laboratory tests for 12,000 persons each day. Throughout our history, our commitment to quality, both internally and through external programs, has helped us achieve our high standard of excellence. Accreditation includes that of the College of American Pathologists, the Health Care Financing Administration's Clinical Laboratory Improvement Act certification, the Substance Abuse and Mental Health Services Administration (for drugs-of-abuse), and a number of private sector peer review programs.

The laboratory industry has evolved in the past twenty years from one which primarily consisted of locally owned private laboratories to one which is now dominated by national corporate laboratories. I have witnessed this change while serving in the clinical laboratory industry since 1974 in several management capacities: operations, information systems, marketing, sales, and ultimately as chief executive officer of a large clinical laboratory company.

Our vision at LabOne fits well with what you and a number of Members in the Congress are suggesting in reforming the Medicare program to encourage patient choice and foster market forces to drive down artificially high prices in the health care. LabOne has introduced patient choice into the clinical laboratory market and has applied innovations in technology that enable us to offer high quality testing services at low prices. We charge one fee to all payers, which amounts to a charge level approximately 60% below commercial rates and 30% below that of the Medicare fee schedule.

LabOne's experience over the last eighteen months has convinced us that quality lab testing is and can continue to be delivered far more economically than current public and private sector market prices suggest. We believe a close review of the entire industry's billing practices would show that laboratories can provide testing at a fraction of what it is presently billing Medicare and most other private payers.

The Lab Industry and Medicare Fee Schedules

Any discussion of Medicare fee schedules requires a brief history of the economics of the clinical laboratory industry. In so doing, we will better understand how the Medicare program provides perverse market incentives in the current system and acts as an effective barrier against change.

Prior to 1985, the laboratory industry's only source of revenue, private and public, was through the sale of laboratory test services to physicians and hospitals. Tests were sold at discounted wholesale prices to doctors who in turn marked-up the price of the test to the patient who in turn submitted a claim to an insurance company, self-insured employer, or to the Medicare carrier.

When health care costs inflated astronomically in the early eighties, payers, including Medicare, were alarmed at the rate of increase in outlays. With respect to laboratory services, the government responded with the enactment of legislation to prohibit physicians from directly billing the Medicare program for laboratory testing in the mid-eighties. Clinical laboratories were charged with the responsibility of directly submitting bills to the Medicare carriers. The Health Care Financing Administration, under statutory direction, began implementation of a clinical laboratory fee schedule which determined what laboratories would be paid for clinical laboratory services. While the Medicare program realized some immediate savings from the elimination of physician mark-ups for laboratory tests, the laboratory industry witnessed windfall revenues as it replaced discounted wholesale prices to doctors with much higher direct payments from Medicare. The clinical laboratory industry thought it had died and gone to heaven with Medicare as its most lucrative payer.

The name of the game became, "get Medicare business, get all you can." Clinical laboratories employed two business strategies. They further discounted charges to physicians for non-Medicare patient testing, in return for a physician's Medicare business. Physicians increased their margins from the mark-up on testing of private pay patients, while laboratories received a steady stream of revenue from Medicare business. Thus, the notion that laboratories could subsidize their private sector business with the higher-priced Medicare business took root.

Additionally, large clinical laboratories aggressively expanded their operations through mergers and acquisitions of local and regional laboratories. Market penetration was increased and large laboratories expanded their access to more physician practices and their lucrative Medicare referrals.

Past Congresses and Administrations began to grapple with the growth in the Medicare program through reduction in the fee caps in the Medicare clinical laboratory fee schedule. In 1991, the Government Accounting Office (GAO) studied Medicare reimbursement for clinical laboratories and identified the laboratory industry practice of using Medicare to offset deep discounts to physicians for commercial (non-Medicare/Medicaid) lab work. GAO

recommended that the fee schedule be reduced further to eliminate the cost shift to Medicare. The Congress did act, but not as aggressively as the GAO recommended. In OBRA 93, the Congress ratcheted down the Medicare Clinical Laboratory Fee Schedule on a glide path as follows: 88% of the median in 1993, 84% in 1994, and 80% in 1995. The rate is set to go to 76% of the median for 1996.

Never-the-less the GAO prophecy continues, the market remains a patchwork of discounting, mark-ups and multi-layered fee schedules that defy the most skilled practitioner much less the layman to determine the true cost of laboratory testing. Cost shifting has continued unabated. Medicare remains a highly profitable and sought after source of revenue for laboratories. To reverse this trend, the Medicare Fee Schedule must be reduced to accurately reflect market prices.

LabOne suggests to the Congress that Medicare payment schedule for outpatient clinical laboratory services be reduced about 18%, from its present (1995) level of 80% to 65% of median charges over a three year period. Coupled with a freeze in the CPI update for those same years, such a reduction will save about $7.2 billion over several years, will more accurately reflect market prices/costs, and foster competition in the laboratory industry.

In summary, Medicare payment for clinical laboratory services will more closely reflect the trend that is emerging in the industry. If accomplished at the rate we suggest, the playing field will be substantially leveled, the drive to secure Medicare business will be on par with that of non-Medicare business, and the importance of the middle man will be diminished and, coupled with other actions we suggest, a healthy future for America's laboratory industry, large and small will be assured.

Patient Choice

We understand that the Congress is considering major changes to the Medicare program to allow for its continued existence well into the next century. In order to keep pace with the evolution of the private sector health care market, the Medicare program will have to reflect market developments. One option is to expand patient choice, as it exists today for the non-Medicare population. Possibilities include a variety of managed care plans, medical IRAs, self-insured options, as well as traditional Medicare fee-for-service.

We applaud this common sense approach to Medicare and health care in general. Not only do we support it in concept, but we have adopted the very same principle in the design of our laboratory testing benefit plan.

In brief, the plan works likes this. LabOne offers health insurers and self-insured employers significant savings on the cost of clinical laboratory testing. The insured employee/individual is given a Lab Card (TM) which is similar to the pharmaceutical card that is currently utilized by nearly fifty million Americans to purchase prescription drugs. When a physician orders a laboratory test for a patient who is a card holder, the patient can present the card to the physician and ask to be referred to LabOne or choose any other available options. The card contains an explanation of the benefit and instructions on how to access LabOne. The physician can choose to collect the specimen and forward it to LabOne, or may send the patient to a conveniently located LabOne Patient Service Center where the specimen will be drawn by a phlabotomist and sent to LabOne.

This concept was tested in the Monterey School district of Northern California. Within six months, and with limited distribution of educational materials, utilization is approaching 50%. The Lab Card (TM) continues to gain acceptance as card holders become aware of the savings and convenience it affords. We have commenced nation wide marketing of the Lab Card (TM) and have been successful in providing our product to a number of self-insured employers and insurance carriers.

This innovation exemplifies the efficacy of providing consumer choice. It lends testimony to the Congress that it is pursuing the right track as it seeks to infuse patient choice into the market place through Medicare.

Direct Billing Legislation

Finally, Mr. Chairman, the Congress should address one additional method which, aside from changing the Medicare program, will inject substantial additional competition into the private clinical laboratory market. Direct billing for laboratory services, already a success in Medicare, will eliminate the unnecessary and costly role of the middle man. It is endorsed by the entire industry and its principles are contained in H.R. 1461, the Direct Billing Act , introduced by Congressmen Fred Upton and Sherrod Brown. HR 1461 requires laboratories to directly bill the person receiving diagnostic services, subject to certain exceptions outlined in the legislation.

This legislation largely impacts the private market, with some spill over impact on the Medicare market. Physicians will be taken completely out of the pricing loop, eliminating the practice of cost shifting. This change will likely result in some reduction of redundant utilization of laboratory testing for Medicare and non-Medicare patient alike, and over time, true price competition in the field. We support this legislation and urge the Committee to look at it very closely.

It is important to note, however that, by itself, direct billing is not a panacea for the immediate lowering of laboratory costs. As a matter of fact there will be a windfall as some entities reap all or portions of the mark ups now gleaned by the physicians.

That is where the competitive incentives we have suggested above come into play. Coupled with a very appropriate and modest reduction in Medicare fee schedules to eliminate the reverse cost shift, direct billing can level the playing field by bringing educated payers and informed buyers to the same table with a full range of sellers to compete head-to-head based on quality, service and price.

In conclusion Mr. Chairman, let me be clear about my purpose in responding to your very kind invitation to appear before this Committee.

I did not come to indict the laboratory industry. It is an industry I love and respect. It has treated me and the American public very well as I have endeavored to serve within it.

I did come, however, to shine some light on a complex set of policies and pricing practices... some directed by government, some archaic remnants of an outdated private market... which result in companies being trapped in a "gilded cage" of dependency on inflated Medicare fee schedules as the protective shield for deep discounts to physicians in return for the opportunity to access more and more of those same physicians' Medicare patients at those same inflated Medicare fees.

Mr. Chairman, you and the subcommittee have the opportunity to break that cycle of dependency. Your actions, as you address Medicare costs and health care reform generally can put us on the path to true competition in clinical laboratory services and reduction in costs to Medicare beneficiaries and private patients alike.

If you will:

- Adopt modest reductions in the Medicare fee schedule such as the 18% reduction over three years we have proposed and
- Extend the current MEI update freeze an additional three years and
- Enact direct billing for clinical laboratory services in the private payer market

you will have reduced Medicare outlays by more than $7 billion over seven years, have injected real and serious competition in the laboratory market place and have created the climate for true patient choice for laboratory services.

These steps will go a long way toward fulfilling your mandate from the American people and we welcome the opportunity to work with you, your colleagues and your staffs to achieve these goals.

Thank you very much.

Mr. ENSIGN. Thank you.
Mr. Salton.

STATEMENT OF ALVIN M. SALTON, PRESIDENT AND DIRECTOR, COMMUNITY MEDICAL LABORATORIES, METUCHEN, NEW JERSEY; ON BEHALF OF AMERICAN ASSOCIATION OF BIOANALYSTS

Mr. SALTON. Thank you, Mr. Chairman and good morning. My name is Al Salton, and I am president and director of Community Medical Laboratories in Metuchen, New Jersey, and I am appearing on behalf of the American Association of Bioanalysts.

Our organization represents the owners, directors, and managers of independent community laboratories across America. We appreciate the difficult task your Subcommittee faces this year and are prepared to work with you to identify and implement Medicare reform proposals.

The laboratory community has already made a disproportionate contribution to the Medicare reform and deficit reduction efforts. While physician and hospital groups complain about the reduction in their expected Medicare inflation adjustments, these pale in comparison to the real cuts we have been forced to absorb.

Labs now receive substantially less for most tests than they did 15 years ago. Charts, submitted with my statement, demonstrate how labs have taken real cuts while most other providers have received increases. Most recently, the 1993 Deficit Reduction Act reduced our fee schedule by another 14 percent over 3 years. We have struggled with the first two installments and still must absorb another 5 percent decrease within the next 12 months. Laboratories simply cannot sustain any further reductions.

In light of previous reductions, there are two proposals that would have a devastating impact on our ability to continue to provide quality laboratory services. The first is reinstating the 20-percent copayment. Reinstating the laboratory copayment is not practical or wise. As the owner of a small, independent laboratory I can tell you that collecting these fees would be an administrative nightmare. It will result in seniors receiving bills for ridiculously small amounts of money, impose unbearable financial burdens on laboratories, and create additional redtape.

In many instances, the cost of collecting these payments will exceed the amounts to be collected. These burdens are the reason laboratory copayment was eliminated in 1984. Reinstatement of copayment is equivalent to at least a 15-percent reduction in our reimbursement rate.

Further, copayment merely shifts costs to senior citizens without controlling utilization. Studies by the Rand Institute, the OTA, and CBO have indicated that seniors will get those tests ordered by their doctors regardless of whether a copayment exists.

The second proposal to which we strongly object is called competitive bidding. Under this proposal the government would select the lowest bidding laboratory in each area of the country to provide all Medicare laboratory services. Regardless of the level of the bids submitted, the government would be required to reduce lab payments to ensure at least a 10-percent savings. The few experiments that have been done in this area have had very unfortunate con-

sequences and most have been canceled because of quality problems.

Poor quality does not save money. This proposal will irrevocably alter the existing market, disadvantage rural and underserved areas, and in the long run eliminate rather than encourage competition.

Large national chains are in the position to underbid contracts for one or more years to drive community laboratories out of business. Once the large labs are established as government-sanctioned monopolies, we expect their bids will rise and there will no longer be any competition on either price or quality.

When copayment and competitive bidding are combined with the OBRA 1993 cuts their impact is indisputable. No provider, large or small, is in a position to absorb these radical reductions.

However, we are prepared to work with the Subcommittee on additional steps to control Medicare expenditures. We have long supported direct billing which has been proven to control utilization within the Medicare Program and at the State level. There is strong evidence that extending Medicare billing to all payers will further reduce Medicare costs.

In conclusion, we urge the Subcommittee to look at the real problems that are driving up Medicare costs. Laboratory expenditures only comprise a very small part of the Medicare budget and, in recent years, the overall amount spent on these services has declined. Further implementation of copayment rates, either through fee schedule reductions or implementation of copayment and competitive bidding, are not justified and will destroy an entire segment of the health care industry.

I appreciate the opportunity to appear before you today and would be pleased to answer any questions.

Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF ALVIN M. SALTON
AMERICAN ASSOCIATION OF BIOANALYSTS

Good Afternoon. My name is Al Salton. I am President and Director of Community Medical Laboratory In Metuchen, New Jersey and I am appearing on behalf of the American Association of Bioanalysts. Our organization represents the owners, directors, and managers of independent community laboratories across America.

We appreciate the difficult task your Committee faces this year and are prepared to work with you to identify and implement Medicare reform proposals. At the same time, it is extremely important the Committee understand the extent to which the laboratory community has already made a disproportionate contribution to the Medicare reform and deficit reduction efforts.

While physician and hospital groups complain about the reduction in their expected Medicare inflation adjustments, these pale in comparison to the real cuts we have been forced to absorb. Labs now receive substantially less for most tests than they did fifteen years ago. These charts demonstrate how labs have taken real cuts while most other providers have received increases. Most recently, the 1993 Deficit Reduction Act ["OBRA 93"], reduced our fee schedule by another 14 percent over three years. We are struggling with the first two installments of OBRA 93 and must absorb another 5 percent decrease within the next twelve months. These changes have contributed to an overall reduction of 11 percent in Medicare spending for independent and physician laboratory services in the last two years. Laboratories simply cannot sustain any further reductions.

In light of previous reductions, there are two proposals that would have a devastating impact on our ability to continue to provide quality laboratory services. The first is reinstating the 20 percent copayment.

Reinstating laboratory copayment is not practical or wise. As the owner of a small independent laboratory I can tell you that collecting these fees will be an administrative nightmare for laboratories and senior citizens. It will result in seniors receiving bills for ridiculously small amounts of money, impose unbearable financial burdens on laboratories and create additional redtape. In many cases the cost of collecting these payments will exceed the amount to be collected. These burdens are the reason laboratory copayment was eliminated in 1984. Reinstatement of copayment is equivalent to at least a 15 percent reduction in our reimbursement rate.

Further, copayment will merely shift costs to senior citizens without controlling utilization. Seniors will receive bills, which they may not be able to afford, from providers they've never seen. This will create much confusion but will not control costs. Studies by the Rand Institute, the OTA and the CBO have indicated that seniors will get those tests ordered by their doctors regardless of whether a copayment exists.

The second proposal to which we strongly object is called competitive bidding. Under this proposal, the government would select the lowest bidding laboratory in each area of the country to provide all Medicare laboratory services. Regardless of the level of bids submitted, the government would be required to reduce lab payments to ensure at least a 10 percent savings. Issues of quality and service would be irrelevant to this bidding process.

The few experiments that have been done in this area have had very unfortunate consequences. For example, a young woman who recently died of cervical cancer testified last year before the Judiciary Committee about the abysmal quality of the competitively bid laboratory services offered by her HMO. This lab failed to detect her cancer despite numerous tests over a three year period. This is not an isolated example. When the Air Force used competitive bidding for screening Pap smears, the laboratory performed so inadequately that the project was cancelled and more than 700,000 specimens had to be retested. Poor quality does not save money.

This proposal will irrevocably alter the existing market, disadvantage rural and underserved areas and, in the long run, eliminate rather than encourage competition. Large national chains are in a position to underbid contracts for one or more years in order to drive community laboratories out of business. Once the large labs are established as government

sanctioned monopolies, we expect their bids will rise and there will no longer be any competition on either price or quality.

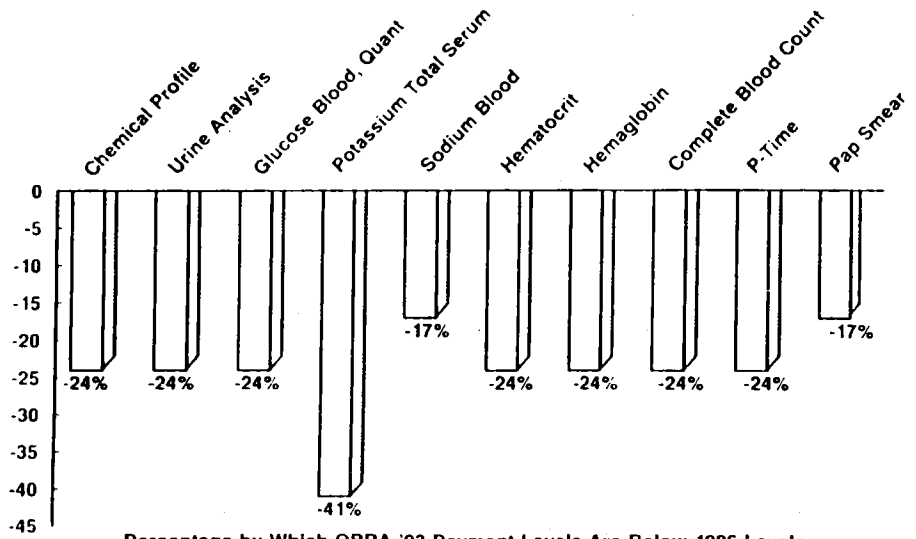
When copayment and competitive bidding are combined with the OBRA '93 cuts, their impact is indisputable. OBRA 93 mandates a 14 percent reduction, coinsurance is tantamount to a 15 to 20 percent cut, and competitive bidding would decrease laboratory payments by another 10 percent. Combined, the total level of cuts in less than three years would be more than 40 percent. No provider, large or small, is in a position to absorb these radical reductions.

While we object to the copayment and competitive bidding proposals, we are prepared to work with the Committee on additional steps to control Medicare expenditures. We have long supported direct billing, which has been proven to control utilization within the Medicare program and at the state level. There is strong evidence that extending direct billing to all payors will further reduce Medicare costs.

In conclusion, we urge the Committee to look at the real problems that are driving up Medicare costs. Laboratory expenditures only comprise a very small part of the Medicare budget and, in recent years, the overall amount spent on these services has declined. Further reductions in laboratory payment rates either through fee schedule reductions or implementation of copayment and competitive bidding are not justified and will destroy an entire segment of the healthcare industry.

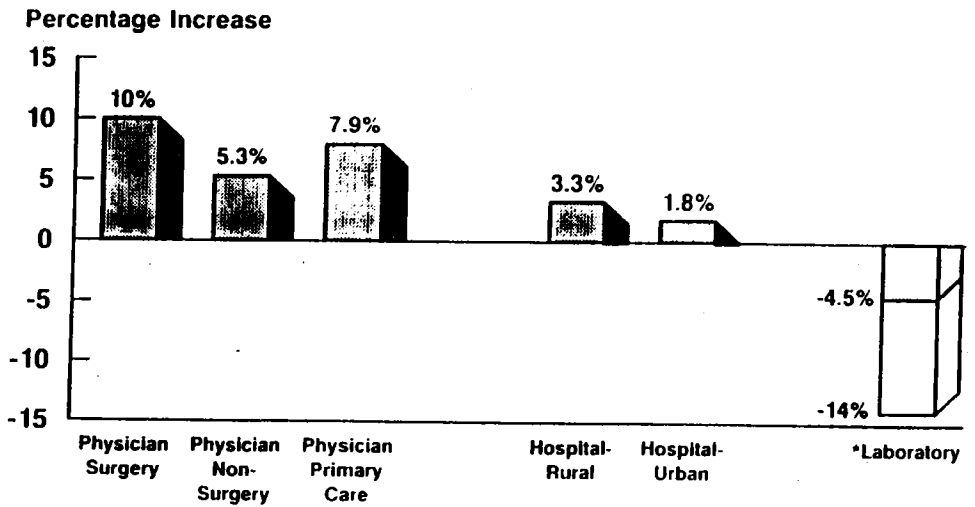
I appreciate the opportunity to appear before you today and would be pleased to answer any questions. Thank you.

Laboratories Have Suffered Real Cuts in Reimbursement Levels Since 1986



Based on Test Reimbursement Levels in Oregon Assumes a 3% CPI Update in 1996

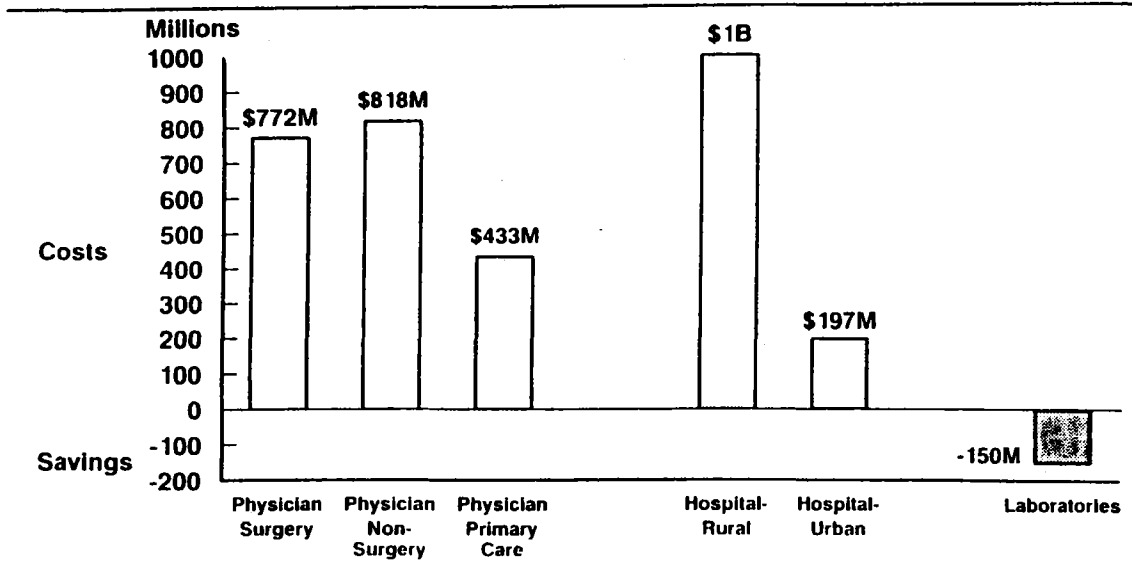
Changes in Medicare Reimbursement Rates - FY 1994



Source: HHS Office of the Actuary, Administration Estimates

* 14% Reduction Over 3 Years. 1994 Reduction Is 4 5%.

Costs Associated with Changes in Reimbursement Rates - 1994



Source: HHS Office of the Actuary, Administration Estimates

The Proposed Policy Changes Would Radically Cut Laboratory Payments

Act	Reduction
OBRA '93	14%
Competitive Bidding	10%
Coinsurance	15%
Total Cuts	39%

Mr. ENSIGN. Thank you.
Mr. Rapp.

STATEMENT OF RICHARD J. RAPP, SENIOR VICE PRESIDENT, APRIA HEALTHCARE, COSTA MESA, CALIFORNIA; ON BEHALF OF HOME OXYGEN SERVICES COALITION

Mr. RAPP. Mr. Chairman and Members of the Subcommittee, I am Dick Rapp, senior vice president of Apria Health Care. Apria provides comprehensive, integrated home care services, including home respiratory therapy to 350 branches serving patients in 48 States. Apria, headquartered in Costa Mesa, employs 2,400 people in over 100 locations in California alone, and provides home care services to 120,000 patients in that State.

The Home Oxygen Services Coalition was organized to represent the interest of home medical equipment manufacturers and service providers that bring oxygen therapy to the individuals in their homes. Lung-related diseases are the single largest cause of physical handicaps in the Nation today. Nearly 15 million Americans have been diagnosed with chronic obstructive pulmonary disease known as COPD, which accounts for 20 million physician office visits a year and has become the fastest rising cause of death.

By providing services in their homes, we enable patients to lead productive lives or, if they are more seriously ill, to convalesce at home rather than at an institution. Our respiratory therapists and technicians typically check on patients and equipment regularly and are available 24 hours a day, 7 days a week. In addition to delivering equipment and training patients, we also refill oxygen tanks and supply patients with masks, the canulous tubing, and other disposable items.

Therapeutic services and technical support account for nearly 75 percent of the cost of providing home oxygen therapy to patients with COPD and are vital to the delivery of high-quality care in the home. Today I want to describe this important health care service and underscore some fundamental principles about the services we provide.

You may have heard statements that home care costs have been rising at the rate of more than 30 percent a year. Those are not the cost increases of home oxygen services. Our services are reimbursed under Medicare part B, rather than part A which has far fewer cost controls. The utilization of oxygen services increases as new patients are diagnosed with COPD and are treated with oxygen therapy under the physician's prescription.

Home oxygen therapy is subject to some of the strictest utilization controls of any Medicare benefit. It has three built-in controls against overuse or excessive costs. Number one, each patient must have a physician's prescription. Number two, each patient must pass an independent blood-gas test verifying that oxygen levels are deficient. Three, each patient must pay 20 percent of the cost of the therapy.

Home oxygen therapy is provided on a prospective cost basis. The same amount is paid regardless how much service each patient requires, where they live, or the complexities of their circumstances. Moreover, in the past 9 years, Congress and HCFA have approved

18 separate restrictions or cutbacks in the reimbursement for this therapy.

Not only are our costs under control, but you have been fine-tuning them at a frequency of two times a year, despite the fact that the home oxygen benefit represents less than 1 percent of the Medicare budget in 1992.

I want to now turn to a proposed solution, competitive bidding, which we feel should be rejected. Competitive bidding for home medical equipment has been tried and rejected in Ohio, Connecticut, Montana, and South Dakota. Among the reasons the States cited for dropping it are, loss of freedom of choice for the beneficiary; actual reduction in competition between the providers; reduced access to provider support of the patient; and the difficulty in cost of the program administration.

Any competitive bidding program would require HCFA to build a new bureaucracy to administer it, probably at far greater cost than could ever be recouped in savings. The regional medical carriers that issue reimbursements to providers do not have the resources or the administrative structure to implement this concept.

Try to imagine an elderly patient in California who has a problem with a competitive bidding winner who refuses to come to his or her home for an emergency call. And that elderly patient has to call the regional carrier in Tennessee to register a complaint.

The trauma and anxiety of such a situation would be enough to send the patient to the emergency room and then we would have gained little.

In conclusion, Mr. Chairman, competitive bidding is not competition. Competitive bidding just sounds good. Competitive bidding would be synonymous with more bureaucracy and less patient choice or support without any evidence of savings to the program. We would welcome any opportunity to work with you as you fashion new market-based solutions for the delivery of medical care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF
RICHARD J. RAPP
SENIOR VICE PRESIDENT OF APRIA HEALTHCARE
ON BEHALF OF THE
HOME OXYGEN SERVICES COALITION
BEFORE THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
JULY 25, 1995

Mr. Chairman, members of the Committee, on behalf of the Home Oxygen Services Coalition, I thank you for the opportunity to testify. I am Dick Rapp, Senior Vice President of Apria Healthcare.

Apria Healthcare, a recently merged company between Homedco Group and Abbey Healthcare, provides comprehensive integrated homecare services including home respiratory therapy, home infusion, home medical equipment, women's healthcare, contract nursing services, and coordinated care through 350 branches serving patients in 48 states. Apria Healthcare, headquartered in Costa Mesa, California, employs 2,415 people in 120 branches in California, and we provide homecare services to 120,000 patients in the state.

The Home Oxygen Services Coalition (HOSC) was organized to represent the interests of home medical equipment manufacturers and service providers that bring oxygen therapy to individuals in their homes. Apria Healthcare's Chairman, Jeremy M. Jones, who serves as Chairman of the Home Oxygen Services Coalition, asked me to express his regrets that he could not be with you today.

We agree with you that Medicare is in need of substantial restructuring and market based incentives are the most effective way to control costs and assure long term quality of care. Until we get there, we also must address both the cost and utilization of services for the great majority of Medicare beneficiaries who will continue to be served on a fee reimbursement basis. We believe the current structure for reimbursement of home oxygen services offers a model for utilization and cost controls that can be applied to other parts of Medicare.

Today I want to describe this important health care service and underscore some fundamental principles about the services we provide:

- You may have heard statements that home care costs have been rising at a rate of more than 30 percent a year -- those are not cost increases for home oxygen services. Our services are reimbursed under Medicare Part B, and the utilization of these services increases only as new patients are diagnosed with chronic obstructive pulmonary disease (COPD) and are treated with oxygen therapy as prescribed by their physicians.

- Home oxygen therapy is subject to some of the strictest utilization controls of any Medicare benefit. It has three built-in controls against overuse or excessive costs. In addition to having (1) a physician's prescription, each patient must pass (2) an independent arterial blood gas test, and (3) must pay 20 percent of the cost of the therapy.

- Home oxygen therapy is provided on a capitated basis -- the same amount is paid regardless of how much service each patient requires, where they live, or the complexities of their circumstances. Moreover, in the past nine years, Congress and the Health Care Financing Administration have approved 18 separate restrictions or cutbacks in the reimbursement for this therapy -- not only are our costs under

control, you have been fine tuning them at a frequency of two times a year.

Let me tell you about the patients we serve. Lung related diseases are the single largest cause of physical handicaps in the nation today. Nearly 15 million Americans have been diagnosed with chronic obstructive pulmonary disease which alone accounts for 20 million physician office visits a year and has become the fastest rising cause of death. COPD is an insidious disease, which most often is irreversible and is complicated by aging. COPD diseases, including chronic bronchitis and emphysema, make it more difficult to breathe and rid the body of carbon dioxide. Over time, the ability to breathe is so impaired that adequate levels of oxygen cannot be maintained in the blood. We provide the equipment and services to these individuals who are in need of this life sustaining therapy.

By providing services in their homes, our patients can continue to lead productive lives, or if they are more seriously ill, to live and convalesce at home rather than in an institution. Our industry supports their needs at home 24 hours a day, and facilitates their travel all over the country by car, train, or airplane.

Public opinion polls suggest that an overwhelming number of patients prefer home care. Not only is it far more desirable, it almost always is more cost-effective than caring for them in institutional settings.

A 1991 Lewin-ICF economic analysis focused on the effect of home oxygen services on the cost of care for patients suffering from COPD. Lewin-ICF determined that $520 per patient per episode would be saved if a COPD patient was to receive care in the home rather than in the hospital.

After a physician prescribes oxygen therapy, the oxygen provider consults with the physician and the patient to develop a plan of care which reflects the patient's needs. Those needs will influence the choice between one or more of three oxygen systems that can be provided. The following systems are the most frequently prescribed:

- Oxygen concentrators are designed primarily for home use. However, as many as 70 percent of patients are semi-ambulatory and require a portable system to meet their needs. These electrically-powered devices separate oxygen from room air, producing a rich concentration of oxygen.

- Gaseous oxygen is stored under high pressure in heavy, stationary tanks which must be replaced at regular intervals by the oxygen providers, sometimes with little advance notice.

- Liquid oxygen is stored in large reservoir containers at temperatures of minus 297 degrees Fahrenheit. Liquid oxygen reservoirs must be refilled regularly. Liquid oxygen also includes a small, portable container that can be filled from a stationary unit, allowing for greater patient mobility.

Commonly, a physician will prescribe that a patient use a concentrator for in-home use and a portable oxygen unit which will allow travel away from home for short periods of time -- whether to a physician's office, grocery market, or other activities necessary to daily living, including vacation travel. This ambulatory activity often is prescribed to further maintain the health of the patient.

After oxygen equipment is placed in the home, it is important to ensure that patients comply with the prescribed regimen. As oxygen providers, we monitor compliance, continually reinforcing and reeducating patients as necessary. Even with monitoring and training, approximately 20 percent of all

costly hospitalizations of the elderly result from a failure to follow prescribed therapy.

Therapeutic services and technical support account for nearly three-fourths of the cost of providing home oxygen therapy for patients with COPD and are vital to the delivery of high quality care in the home. Our respiratory therapists or equipment technicians typically check on patients and equipment regularly and are available in case of emergency 24 hours a day, seven days a week. As a provider, we also supply patients with masks, cannulas, tubing, and other disposable items on an as-needed basis, and deliver or refill oxygen tanks. We also service concentrators at appropriate intervals to ensure that oxygen continues to flow at the level prescribed by the physician. If we do our job well, patients never experience a problem or interruption.

The home oxygen benefit has been one of the most frequently reviewed and modified programs under Medicare despite its relatively small size. According to 1992 data contained in the 1994 Green Book, the home oxygen benefit represented only 0.85% of the total Medicare budget. Congress enacted broad reforms to the home oxygen benefit, which they put into effect only six years ago in 1989. Responding to concerns about utilization and cost controls, this "six-point plan" provided a number of changes which have strengthened and improved the quality of care and brought further discipline to the cost of the program. Among these changes, Congress mandated:

- That home oxygen services be reimbursed on a capitated basis -- a fixed fee would be paid regardless of the oxygen modality that was chosen by the physician, the liter flow requirements of the patient (one to four liters per minute) or the number of service visits required by the patient.

- That each COPD patient must undergo and pass a strict arterial blood gas test administered by an independent laboratory to determine the oxygen retention capability of the patient. Medicare will reimburse for oxygen therapy only if the test demonstrates a clinical need objectively.

These changes, when combined with the requirement for the physician's prescription and the 20 percent copayment by the patient, support our contention that this therapeutic benefit is one of the most tightly controlled in the Medicare program. Add to this the 18 reductions in reimbursement for home oxygen therapy that Congress and HCFA have adopted in the past nine years and you begin to appreciate how closely this program has been monitored.

The reimbursement cuts, along with other programs, have had a major impact on the way we provide these services. These Medicare changes have forced us to become more efficient. We now deliver more services, and better services, for less money. This is why we would encourage this committee to use the home oxygen benefit as a model for utilization and cost controls that could be applied to other areas of Medicare.

At the same time, I want to discourage any effort to adopt an attractively phrased, quick-fix solution such as the often-rejected proposals for competitive bidding. Competitive bidding continues to surface in every budget reconciliation and Medicare reform debate for only one reason -- the title. Who can reject a proposal that contains the words "competitive" and "bidding" in the title? Here are a few reasons why we believe you should reject it:

- The concept is only a title -- there is no carefully developed proposal to implement competitive bidding for home oxygen services.

- Competitive bidding, as managed by HCFA, will result in limiting or eliminating patient choice of a home oxygen services provider.

- Competitive bidding for certain selected home medical equipment items has been tried or considered and abandoned in Ohio, Connecticut,

Montana, and South Dakota. Among the reasons cited for dropping it -- loss of freedom of choice for recipients, an actual reduction in competition between providers, and reduced access to provider support of the patient, and difficulty of administration.

- Any detailed proposal would disclose the need for Medicare to build a new bureaucracy to administer it -- probably at far greater cost than could ever be recouped. The regional medical carriers that issue reimbursements to providers do not have the resources or the administrative structure to implement this concept. Try to imagine a patient in California who has a problem with a competitive bidding winner that refuses to come to his or her home for an emergency call and has to call the regional carrier in Tennessee to register a complaint.

Our company, and the other companies in our industry, compete for business every day with managed care plans and a broad range of other entities that offer home oxygen benefits to insured patients or plan subscribers. However, competitive bidding is not competition. Competitive bidding would be synonymous with more bureaucracy and less patient choice or support without any evidence of savings to the program.

Again, I want to underscore the fact that in a fee reimbursement structure which Medicare operates today, and will continue to operate for years to come, the capitated payment and utilization controls that we operate under give Medicare the best value for the money.

This committee, and the Congress, have embarked upon a challenging course to make Medicare work better and be more cost effective, while meeting the medical needs of our growing population of senior citizens.

The members of the Home Oxygen Services Coalition are proud of the record they have established of providing high quality, cost-effective services to patients suffering from COPD.

A large portion of our business is provided to market-based health care delivery systems, and we would welcome an opportunity to work with you as you fashion new, market-based solutions to the delivery of medical care. We also have had years of experience in providing Medicare beneficiaries with home respiratory services, and we would offer that experience to you for the period of transition to a new system to demonstrate the cost-effectiveness of the home oxygen benefit because it is based on a capitated, utilization controlled system.

Thank you for giving us the opportunity to appear before you today.

Mr. ENSIGN. Thank you, Mr. Rapp.
Mr. Liken.

STATEMENT OF JIM LIKEN, PRESIDENT, LIKEN HOME MEDICAL, INC., PITTSBURGH, PENNSYLVANIA; AND MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

Mr. LIKEN. Thank you, Mr. Chairman and Members of the Subcommittee. I am Jim Liken and I am president of Liken Home Medical in Pittsburgh, Pennsylvania. I represent NAMES, the National Association for Medical Equipment Services, the only national association representing HME, the home medical equipment services industry, exclusively, and 1,800 companies specifically.

This hearing is the first step in addressing one of the most pressing issues faced by Congress—how to set the direction for the Medicare Program, while trying to reduce the Federal deficit?

This will include a delicate balance of maintaining quality of care and expanding its access, while reducing costs. We understand this Subcommittee's key role in seeking ways to restructure the Medicare Program. We would support a radical restructuring of the entire system. This could include a consolidation of Medicare part A and part B in order to provide incentives for patients to choose the best quality, most cost-effective level of care. We also think the focus should be on the consumer, the present and the future Medicare beneficiary who needs and deserves patient choices.

HME makes a significant difference by avoiding more costly care, providing speedier hospital discharge, and ensuring that the individual continues to live as independently as possible.

HME providers furnish a continuum of care. Our responsibilities do not end when equipment and supplies are delivered in the home and consumers are trained in their use, they just begin. The HME services industry is routinely oncall 7 days a week, 24 hours a day to provide the support services needed.

The service aspect of our industry cannot be appreciated enough. In April 1995, NAMES conducted a survey of our longstanding members to obtain information on Medicare fees paid on selected items over the preceding 10 years. The results show that Medicare payment amounts for the selected items have remained relatively unchanged during the previous 10 years.

For example, in 1985 oxygen concentrators were reimbursed by Medicare at the average rate of $302.50, compared to the 1995 monthly payment amount for oxygen therapy of $303.54. This current payment also covers all the supplies and oxygen contents used by the patient which were reimbursed separately 10 years earlier. Semielectric beds were reimbursed at $118.23 in 1985, and $137.96 in 1995.

The 1995 payment is also reduced 25 percent in the fourth month and capped or stopped completely after 15 months of rental. These examples are exemplified by the charts shown, as well as the complete survey which is attached to my written testimony.

The HME services industry has received 18 cuts in the last 9 years. We must remember that HME outlays represents approximately 2 percent of the total outlay for Medicare expenditures. I submit to you that any growth in Medicare expenditures for home

medical equipment services is not due to rising prices for the services, but utilization rates that reflect why HME is the solution and not the problem.

NAMES recommends enacting the following additional solutions which we believe will potentially save the Medicare Program millions of dollars.

First is accountability measures. The industry needs standards of service that are reflected throughout both the public and private health insurance industry. Second, consistent monitoring of the HCFA common procedure coding system. Congress could eliminate problems that have occurred because HCFA's system of codes have simply failed to keep up with technology.

Third, Congress could also require HCFA to set an optional 5-day response, electronic preauthorization system for rehab assisted technology for equipment costing more than $1,000.

Fourth, HCFA should allow the beneficiary the ability to upgrade to his or her equipment of choice.

And, finally, NAMES is working to enact strict legislation creating an environment that discourages fraudulent providers from participating in the health care system and encourages quality and cost-effective care.

In developing new ways to pay for the Federal deficit one dubious proposal, competitive bidding for HME services is continuously under consideration. Competitive bidding for certain selected HME items under Medicare has been tried previously and subsequently abandoned.

States including Montana, Ohio, and South Dakota found competitive bidding to impair freedom of choice for recipients, to render the States incapable of utilizing the expertise of all vendors, and to impede competition and patient access. A competitive bidding program is extremely complicated. At this time HCFA has no plan for administering such a program.

All evidence suggests it is virtually impossible to design and administer a competitive bidding process without damaging our marketplace. HME providers do more than just deliver home medical equipment to Medicare beneficiaries. The high level of home care services must be encouraged and not destroyed. We look forward to working with you to be futuristic in reforming our system and to save substantial money and to provide more cost-effective care in the home.

I will be glad to answer any questions.

Thank you.

[The prepared statement and attachments follow:]



Testimony

of the

National Association for

Medical Equipment Services

on

Medicare and Budget Reconciliation Issues

Hearing

of

Wednesday, July 19, 1995

Before

the

Ways and Means

Subcommittee on Health

The National Association for Medical Equipment Services (NAMES), the only national association representing the home medical equipment (HME) services industry exclusively, is pleased to testify today before this Subcommittee regarding Medicare and Budget Reconciliation Issues. I am Jim Liken, President of Liken Home Medical, Inc. in Pittsburgh, Pennsylvania and a Member of the NAMES Board of Directors.

Today is the first step in addressing one of the most pressing issues faced by Congress: how to set the direction for the Medicare program while trying to reduce the federal deficit. This will include a delicate balance of maintaining quality of care and expanding its access, while reducing costs. Toward that goal, this testimony addresses the role of HME services and rehab/assistive technology in ensuring quality, affordable health care for all Americans as well as Medicare expenditures. I will discuss significant policies which will help to eliminate fraudulent health care providers from the Medicare program and will potentially save the federal government millions of dollars. I also will present evidence that competitive bidding is not the way to save the Medicare program money.

The Role of Quality HME Services

NAMES members comprise approximately 1,800 HME companies which provide quality, cost-effective HME services and rehabilitation/assistive technology to patients in their homes. According to physician prescription, HME providers furnish an extremely wide array of HME and related services to patients in their home, ranging from more "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, and intravenous antibiotic therapies; apnea monitors and ventilators; and specialized rehabilitation equipment customized for the unique needs of people with disabilities. Many of these consumers are Medicare beneficiaries.

HME can make the difference by avoiding more costly care, providing a speedier hospital

discharge and ensuring that the individual continues to live as independently as possible. HME providers furnish a continuum of care. Responsibilities do not end when equipment and supplies are delivered to the home and consumers are trained in their use -- they just begin. The increasing sophistication of equipment that is available at home today means the HME services industry is routinely "on call" seven days each week, 24 hours per day to provide the support services needed.

The HME marketplace today reflects the growing number of patients as well as their needs and expectations for quality services. Home care using HME services and rehabilitation/assistive technology can ensure the continued provision of high quality health care in a setting that the vast majority of consumers and their families prefer. And, that care can save our nation's health financing system millions of dollars.

HME Expenditures

As you know, NAMES testified before this Subcommittee in February of this year regarding the growth in Medicare expenditures. NAMES agreed that Medicare expenditures for home care services have grown. However, we submitted that this is not the problem, but a solution in itself. In an era of increasing cost consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve and foster the very benefit that provides home care services in the most cost-effective and yet compassionate fashion.

HME reimbursement has been essentially level for the past ten years. In April of 1995, NAMES conducted a survey of our longstanding members to obtain information on Medicare fees paid on selected items over the preceding ten years. HME services providers across the country were asked to provide actual Medicare payment information on the following HME items: oxygen concentrators; portable oxygen add-ons; commodes; standard wheelchairs; total electric beds; and semi-electric beds. In addition to the Medicare payment amount, HME services providers were to provide a copy of an actual Medicare Payment Remittance Advice Notice sent to the provider by the Medicare carrier making the payment, as confirmation of the Medicare payment amount reported as received. The results show that Medicare payment amounts for the selected HME items have remained relatively unchanged during the previous ten years. For example, in 1985, oxygen concentrators were reimbursed by Medicare at the average rate of $302.50. Currently in 1995 oxygen concentrators are reimbursed by Medicare at the average rate of $303.54. Standard wheelchairs were reimbursed by Medicare at the average rate of $32.45. In 1995 Medicare reimburses on average only $47.11. We have attached a copy of the entire survey to our testimony (Appendix A).

The HME services industry has received 18 cuts in the last nine years (Appendix B). We must remember that HME outlays represent approximately only 2% of the total outlay for Medicare expenditures. I submit to you that any growth in Medicare expenditures for home medical equipment services is not due to rising prices for HME services but utilization rates that reflect why HME is the solution and not the problem. And, that care in the home can save our nation's health financing system millions of dollars.

We understand this Committee's key role in seeking ways to restructure the Medicare program. We at NAMES would support a radical restructuring of the entire system. This could include a consolidation of Medicare Part A and Part B, in order to provide incentives for patients to choose the best quality, most cost-effective level of care.

Fraud and Abuse

NAMES takes seriously its mission to promote access to quality HME services and rehab/assistive technology and has devoted significant resources for several years to combat fraud and abuse. The industry has worked assiduously with the Administration and Congress to help eliminate the few unethical providers who damage the reputation of an otherwise upstanding industry.

One of NAMES' efforts consisted of working during the 102nd Congress with Rep. Ben Cardin (D-MD), who introduced H.R. 2534, the "Ethics and Treatment of Home Medical Equipment Act of 1991." This legislation, which was co-sponsored by 112 Members of Congress, remains the most far-reaching of all subsequent HME bills introduced in Congress to date. Many provisions and concepts in H.R. 2534 were incorporated into legislation that passed the 102nd Congress in 1992, but were vetoed by President Bush. In the 103rd Congress, NAMES helped Congress enact into law, the Social Security Act Amendments of 1994 (H.R. 5252 & S. 1668), which incorporated many of the ethics provisions contained in H.R. 2534.

Recently, NAMES took a serious look at the specific problems with the provision of HME services and rehab/assistive technology in the Medicare program. The following reflects our solutions to those problems which we believe will potentially save the Medicare program millions of dollars.

- **Accountability Measures--The Need for Standards.** NAMES has advocated for years that there must be stronger accreditation, certification and licensure requirements, including on-site inspections. Despite the work of NAMES and HME providers to create a higher level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding type or frequency of services that should be rendered, record-keeping practices, emergency care, patient education, home safety assessments or infection control practices.

- **Consistent Monitoring of the HCFA Common Procedure Coding System (HCPCS) Codes.** The HCPCS codes are currently updated on a yearly basis only. One of the possible abusive areas in HME is in questionable coding practices. By legislatively mandating HCFA to prospectively change the coding system quarterly, Congress could eliminate problems that have occurred in similar situations with support surfaces.

  Further, the Office of Inspector General is currently expending significant resources in an attempt to prove that providers abused the system by filing lymphedema pump claims under "high-priced codes"; in fact, HCFA's system of codes simply failed to keep up with technology.

  NAMES also would advocate that Congress create a **Manufacturer and Provider Advisory Committee** to assist HCFA in setting the HCPCS Codes and recommend appropriate descriptors to help identify emerging technology.

- **Optional Electronic Preauthorization.** Assistive technology and special wheelchair systems require building and delivery prior to claims submittal. HCFA has no set time period for claim adjudicating and guaranteed payment. We have received information which suggests that some providers may be submitting claims and paperwork indicating the equipment has been delivered, when in fact they have not even begun constructing the equipment. Providers will do this in order to get advanced assurance of Medicare coverage and payment for costly, complex equipment that has been prescribed by the physician.

  By requiring HCFA to set up an optional 5-day response electronic preauthorization system for rehab/assistive technology for equipment costing over $1,000, Congress could avoid any incentives to engage in this practice, by reassuring the provider that their services will not go unpaid.

- **Equipment Upgrades.** Currently, a Medicare beneficiary with a prescription who wishes to purchase certain pieces of equipment may be unable to do so. For instance, a beneficiary who has a prescription for a full-electric hospital bed to meet his/her physical needs is prohibited by Medicare to purchase the bed. Although Medicare will pay for the rental of a semi-electric bed, a full-electric bed is deemed medically unnecessary, even as originally prescribed by the physician. In essence, regardless of the patient's medical needs or a physician's prescription, Medicare makes the final medical need and payment decisions.

  Currently, when a beneficiary needs an item of medical equipment the provider will bill Medicare for the item and Medicare may deny payment and instead substitute another item that costs Medicare less. In addition Medicare denies the beneficiary the ability to "upgrade" to his/her equipment of choice. NAMES strongly supports legislative efforts to allow equipment upgrades for Medicare beneficiaries.

NAMES also is working with the Coalition of Associations United Against Fraud and Abuse to enact strict legislation creating an environment that discourages fraudulent providers from participating in the health care system and encourages quality and cost-effective health care. We have attached a summary of the Coalition's proposal (Appendix C). NAMES highly endorses this proposal as a way to potentially save billions of Medicare dollars.

By enacting the suggested provisions, Congress could potentially save the Medicare program money that could be used to reduce the federal deficit.

Competitive Bidding

As an HME services provider and business owner, I recognize the need to balance the federal deficit. But in the rush to develop new ways to pay for such reform, one dubious proposal, competitive bidding for HME services, is continuously under consideration.

Congress should consider the fact that competitive bidding for certain selected HME items under Medicaid has been tried previously and subsequently abandoned in a number of states. States found competitive bidding to impair freedom of choice for recipients, to render the States incapable of utilizing the expertise of all vendors, and to impede competition and access.

- Ohio Medicaid officials concluded that competitive bidding was unworkable after issuing a request for purchase.

- Montana abandoned competitive bidding because the program was found to deny access to beneficiaries and impair the ability of the State to tap the expertise of all providers.

- South Dakota backed away from a decision to implement competitive bidding after deciding it could reduce Medicaid costs in other, more effective, ways.

A competitive bidding program is extremely complicated. At this time, the Health Care Financing Administration (HCFA) has no plan for administering such a program. Such an endeavor would require HCFA to invest in a significant new bureaucracy and ultimately could cost more to create and operate the bureaucracy than would be saved from competitively bidding the products and services.

Competition and competitive bidding are not synonymous. True competition compares service and price. Competitive bidding looks only for the lowest price. It does not address issues of service, choice, or quality. Winner-take-all competitive bidding may even destroy competition by driving many HME companies out of business.

Competitive bidding compromises quality, access and choice. Medicare patients do not seek HME such as oxygen therapy as a matter of discretion. When service is interrupted, consumers must receive prompt service or be forced to enter the hospital. Quality home medical equipment service companies maintain 24-hour, seven day a week patient support so that service is never interrupted. That level of service would be improbable to maintain in a competitive bidding environment. Patients with emergencies end up entering the hospital at additional Medicare program costs. In fact, service has been shown to decrease significantly in areas where HME providers are forced to competitively bid.

The worst result for Medicare beneficiaries would be to establish a structure that would permit low bidders to offer inferior quality at below market prices, without providing the level and quality of support and service that is essential to basic patient care.

In short, all evidence suggests it is virtually impossible to design and administer a competitive bidding process without damaging the market, compromising quality and leading to higher prices in the long run. With policymakers now considering various mechanisms to reform Medicare by moving more beneficiaries into managed care, it is illogical to create a new scheme at this time just for HME services that removes the entire concept of competition out of the marketplace altogether.

Conclusion

In closing, NAMES recognizes the difficulties faced by Congress and this Committee in developing a responsible legislative package that will reduce the Federal deficit and still address America's critical health care needs. At the same time, NAMES submits that enacting legislation which does not work is counterproductive to our common goals of allowing people to be discharged sooner from an institution and permitting people with severe disabilities to lead productive lives. Such obviously cost-effective and compassionate means of providing health care in the home should be encouraged and fostered where possible and clinically appropriate.

HME providers do much more than just deliver home medical equipment to Medicare beneficiaries and others. This high level of home care services must be encouraged -- not destroyed. HME services providers are willing to do our part to assist Congress in reducing Medicare expenditures, but the budget cannot be balanced through repetitive consideration of proposals such as competitive bidding that have been rejected time and time again. However the budget can be balanced by following the industry suggestions presented here today.

I will be pleased to answer any questions you may have. Thank you for allowing me to testify.



NAMES
National Association for
Medical Equipment Services

NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

SURVEY

MEDICARE PAYMENT FOR SELECTED HOME MEDICAL EQUIPMENT ITEMS

1985 - 1995

(Released - July 17, 1995)

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I. Introduction

Early in 1995, former National Association for Medical Equipment Services (NAMES) Chairman of the Board (1993 - 1994) Richard Doherty, correctly forecast that the impending Congressional debate on Medicare reform would invariably include a discussion of adjusting yet again the payment amounts received by Medicare providers. Since 1985, Congress has acted on seven different occasions to reduce or limit the growth of home medical equipment (HME) services Medicare fees. These actions include a rebasing of HME fees in 1990 (OBRA 1990), a freeze of Medicare allowables in 1986 and 1988, payment deductions in 1989 and 1990 (Gramm-Rudman-Hollings), limitations on Consumer Price Index (CPI) updates to the HME fees (OBRA 1990) and changing the payment methodology calculation to lower fees (OBRA 1993). On its own initiative, the Health Care Financing Administration (HCFA) has acted at least twice to lower HME fees, including a fee rebasing in 1986 (Inflation Index Charge Application) and a change in payment methodology in 1987 (Lowest Charge Level Reduction).

Congress and HCFA took each of the preceding measures to limit growth in individual HME item Medicare payments presumably to slow and/or reverse the aggregate increases in Medicare expenditures for HME. Given the continuing presumption that Medicare HME fees are too high, Mr. Doherty questioned the effectiveness of these fee limiting initiatives to control Medicare outlays. Using his own company's experience (Comprehensive Home Health Company, Avon, Massachusetts), he conducted a survey on selected HME items to determine the actual impact these Congressional and Administrative actions have had on his Medicare payment amounts over the last decade. The results showed that, in the majority of cases, HME fees have remained relatively flat or, in some cases, actually decreased.

Based on his company's experience, Mr. Doherty concluded that the perception of high individual payments was incorrect and that increased fee amounts were not the cause of an aggregate increase in Medicare payments for HME over the last decade. Mr. Doherty requested that NAMES repeat this survey on a national basis, and the Association undertook such an effort in April of 1995. The results NAMES obtained mirrored Mr. Doherty's. An explanation of those results and how the survey was conducted are described in the following report.

II. Methodology

A. HME Item Selection

i. Items Selected Based on Provider Experience

For purposes of the survey, NAMES selected a variety of items that represent a reasonable cross section of the majority of items placed with Medicare beneficiaries by an average HME services provider. The items are:

Oxygen Therapy and Oxygen Concentrators - Oxygen therapy is medically necessary oxygen administered via liquid oxygen, compressed gas or oxygen concentrators. Effective as of 1989, the statutory payment methodology for oxygen therapy is modality neutral. One monthly fee amount is made in payment of approved oxygen therapy, regardless of the administration method. Prior to 1989, Medicare paid separate amounts for liquid oxygen equipment, gas equipment and concentrators. In addition, prior to 1989, Medicare paid for the actual liquid or gas contents used in the equipment on a per pound or per cubic foot basis. Even patients using an oxygen concentrator as their primary delivery modality must have a gas or liquid oxygen back up system. Many also use a portable system, which is explained below. Since 1989, there is no additional or separate Medicare payment for the contents used in a back up or portable system.

Portable Oxygen - Medicare pays a minimal monthly "add-on" for the additional equipment needed to provide portable oxygen to those patients with an accepted medical necessity. Portable oxygen can be delivered either by a compressed gas system -- small "E" size tanks, not refillable by the patient and replaced when empty -- or by a liquid oxygen system -- a small portable liquid oxygen unit, refilled by the patient from a stationary liquid reservoir as needed. This add-on is not for the contents, but for the equipment. Since 1989, any content payment is considered included in the monthly allowable payment for the stationary unit.

Commodes - A bedside commode is covered and paid for by Medicare for patients whose medical condition confines them to their bedroom or otherwise makes them incapable of using regular toilet facilities.

Standard Wheelchairs - A wheelchair is covered if the patient's condition is such that without the wheelchair the patient would otherwise be bed confined.

Full Electric Hospital Beds - A full electric bed contains an electric motor with a hand-held controller permitting the patient to adjust the angle of elevation of the head and foot. Additionally the patient can adjust the bed height as needed for transfer into and out of the hospital bed. Since 1994, the Medicare carriers have considered electric bed variable height adjustment as a non-covered "convenience" feature, not medically necessary under any circumstance. When such beds are billed, they are automatically down-coded by the carrier (reduced to the next least expensive covered item) to the semi-electric bed payment amount. (Although the carrier's do not pay for full electric beds, HCFA still maintains billing codes and publishes annual Medicare fees for full electric beds. Providers are required to truthfully bill the equipment placed with the beneficiary, even in the face of the automatic downcode. Differences in prices cannot be charged to patients when the claim is taken on an assigned basis when the item is downcoded, as opposed to an outright denial of Medicare coverage which makes the beneficiary liable for the item.)

Semi-Electric Hospital Beds - A semi-electric hospital bed contains an electric motor with a hand held controller permitting the patient to adjust the angle of elevation of the head and foot. Changes in the bed height as needed for transfer of the patient to and from the bed is accomplished by means of a handcrank located at the foot of the bed on the under carriage.

ii. Selected Items Compared With HCFA Payment Experience

Based on HCFA provided information for 1991 on the "top 100" HME items in terms of aggregate Medicare payments, the amount paid in allowed charges by HCFA for oxygen therapy delivered via the oxygen concentrator modality only ranked 1, 2, 3 and 4 ($378.8 million), portable gaseous oxygen systems ranked 11 ($39.6 million), commodes ranked 22 ($14.1 million), standard wheelchairs ranked 17($20.6 million), full electric hospital beds ranked 9 ($45.7 million) and semi-electric hospital beds ranked 5 ($54.2 million). (See HCFA Request for Proposal - Durable Medical Equipment Regional Carriers, Attachment J.10, May 14, 1992.)

B. Methodology

i. The Survey Instrument

NAMES developed a questionnaire for each of the selected HME items. Respondents were asked to indicate the state being reported, since each state has a separate fee schedule for HME. This is a holdover from the pre-regional carrier, pre-"national" fee schedule era when each state had a separate Part B Medicare claims processing contractor (carrier) for durable medical equipment claims.

(Each state still maintains a separate Medicare carrier for physician claims.) On the survey document, respondents were asked to indicate the Medicare carrier in 1985 and any change in the carrier through 1995. For each year, the respondents were asked to provide a paid Medicare amount for the selected item. Respondents were asked to attach to the survey a Payment Remittance Advice Notice as received from the carrier to verify the reported payment amounts for each of the ten years, 1985 through 1995.

ii. The Respondents

NAMES used its membership database to identify HME services providers in business at least ten years, from which NAMES chose HME services providers with at least ten years of ongoing NAMES membership. Accounting for several database updates over the last ten years, we were able to identify 242 potential members fitting this criteria across the country. A general mailing to this group resulted in the return of 51 usable responses. Further refinements resulted in usable state-by-state information as shown on the following table.

Table 1 - Number of Respondents and Number of States Represented, By Category

Oxygen Concentrators -	46 responses representing 21 states
Portable Oxygen -	39 responses representing 17 states
Commodes -	24 responses representing 8 states
Standard Wheelchairs -	18 responses representing 11 states
Full Electric Beds -	18 responses representing 6 states
Semi-Electric Beds -	31 responses representing 13 states

iii. Data Manipulation

Information from the various respondents was collated by item. Responses not verified by an attached Payment Remittance Advice Notice were not included. HCFA Common Procedure Coding System (HCPCS) codes were compared for the reported payment amounts as shown on the Remittance Advice to assure that like items were being reported and considered. Not every respondent was able to provide a payment amount in each of the ten years for a selected item. In computing the average yearly price, this lack of data was accounted for so as not to artificially deflate the derived yearly average payment amounts. For full electric beds, no received payment amounts for 1994 and 1995 were reported. The average of HCFA's computed fee schedule amounts was substituted for this missing data. For comparative purposes, the Consumer Price Index (CPI) for All Urban Consumers for Medical Care (U.S. city average) from 1982 to 1994 was obtained from the United States Department of Labor, Bureau of Labor Statistics. The derived average for 1985 was

used as a base year and the Medical Care CPI for each year was applied to that base average amount to establish the average "market price" for the HME items.

III. Results

The data spread sheets for each of the items are attached. In summary, the results are as follows:

Oxygen Concentrators - In 1985, the average Medicare monthly payment was $302.50. After a high of $318.39 in 1989, the average Medicare payment fell to a low of $280.18 in 1990. In 1995, the average Medicare payment is $303.54, or $1.04 more than Medicare's average payment ten years ago.

If oxygen concentrator payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $596.91. Medicare is therefore paying $294.37 below an estimated market price for oxygen concentrators. **This represents a 50% decrease in equipment payment over the last ten years.** The decrease in the payment made to the provider by Medicare is even greater if amounts received for content usage in back up or portable systems is added to the monthly amount paid the provider during the years 1985 through 1988.

Portable Oxygen Add-On - In 1985, the average Medicare monthly payment was $46.25. After a high of $50.30 in 1990, the average Medicare payment fell to a low of $45.99 in 1994. In 1995, the average Medicare payment is $46.98, or $.73 more than Medicare's average payment ten years ago.

If portable oxygen add-on payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $91.27. Medicare is therefore paying $44.92 below an estimated market price for portable oxygen add-on services. This **represents a 49% decrease over the last ten years.** The decrease in the payment made to the provider by Medicare is even greater if amounts received for portable content usage is added to the monthly amount paid the provider during the years 1985 through 1988.

Commodes - In 1985, the average Medicare payment was $80.26. In 1995, the average Medicare payment is $94.08, or $13.82 more than Medicare's average payment ten years ago.

If commode payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $158.38. Medicare is therefore paying $64.30 below an estimated market price for commodes. **This represents a 41% decrease over the last ten years.**

Standard Wheelchairs - In 1985, the average Medicare monthly rental payment was $32.45. In 1995, the average Medicare payment is $47.11, or $14.66 more than Medicare's average payment ten years ago.

If standard wheelchair payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $67.29. Medicare is therefore paying $20.18 below an estimated market price for standard wheelchairs. **This represents a 30% decrease over the last ten years.**

Total Electric Beds - In 1985, the average Medicare monthly rental payment was $135.60. After a high of $182.05 in 1990, the average Medicare payment fell to $160.32 in 1993. Since 1994, Medicare carriers automatically downcode full electric beds to semi electric beds. HCFA still computes a total electric fee, however, which in 1995 was an average of $166.57.

If total electric bed payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $267.56. Medicare would therefore be paying $100.99 below an estimated market price for total electric beds and, in downcoding and paying the average semi-electric bed payment amount, is actually paying $129.60 less. **This represents a 48% decrease over the last ten years.**

Semi-Electric Beds - In 1985, the average Medicare monthly rental payment was $118.23. After a high of $154.61 in 1990, the average Medicare payment fell to $126.76 in 1992. In 1995, the Medicare average payment is 137.96 or $19.73 more than ten years ago.

If semi-electric bed payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $233.29. Medicare is therefore paying $95.33 below an estimated market price for semi-electric beds. **This represents a 41% decrease over the last ten years.**

IV. Conclusion

Over the last ten years, Congress and HCFA have undertaken a variety of pricing control measures to reduce the outlays in Part B Medicare for home medical equipment and services. Their collective efforts have, at several different times, arrested the growth of allowed payment amounts (allowed charges) for HME to Medicare. Medicare payment amounts for the items selected in the survey have remained relatively unchanged over the preceding ten years. On average, Part B Medicare pays 43% less for HME than does a current free market consumer. Any increase in the amounts expended by Medicare do not appear to be caused by runaway increases in the prices Medicare is charged for HME. With the passage of the fee setting methodologies for HME in 1987 (the so-called "Six-Point Plan" contained in the Omnibus Reconciliation Act of 1987), increases based on submitted charges were removed from Medicare's calculation of HME fees. Any connection of market forces to fee inflation was thereby broken. There must be other factors in play to account for the perceived increases in Part B Medicare expenditures for HME.

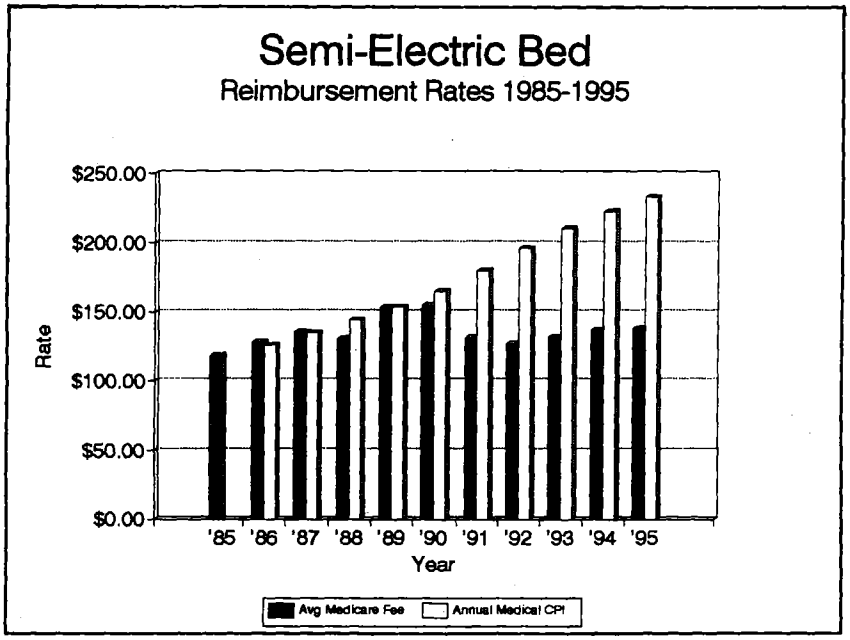
According to the U.S. House Committee on Ways and Means' 1994 Green Book – Overview of Entitlement Programs, the number of Part B Medicare enrollees is expected to rise from 22 million in 1985 to 31 million in 1995, an increase of 9 million. Over the same period the annual amount spent by Medicare Part B per enrollee is expected to rise from $733 to $1,806. Given the survey results, this per enrollee increase is not a result of rising HME prices. Yet, given the overall increase in eligible beneficiaries, a potentially valid assumption is that more individuals are receiving HME, driving up utilization and thereby increasing outlays. Given the improvements in HME technology that have made many more medical treatment options in the home setting available than ever before, this would be a plausible assumption. A survey by NAMES in 1991 ("Coming Home", A Nationwide Survey By NAMES, 1991) showed that a majority of individuals preferred to receive medical treatment in their own homes if that option were available. Finally, given the built-in disincentive in the Part A Medicare payment methodology to unnecessarily extend a patient's hospitalization, efforts to keep HME fees artificially low by using a fee setting methodology not responsive to market forces may actually contribute to increasing HME utilization.

V. Recommendation

Based on the survey's findings and the factors described above, NAMES recommends that any contemplated legislative or administrative changes to achieve further reductions in HME payment amounts in 1995 not occur. This survey is evidence that lowered prices do not control the increase in aggregate Part B Medicare outlays.

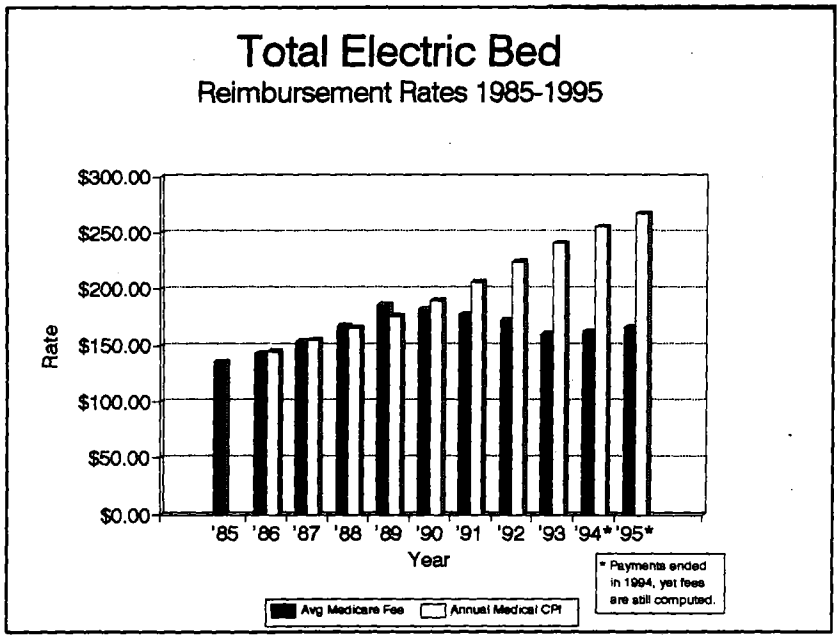
VI. **Charts and Graphs**

The charts and graphs for the collected data appear on the following pages.



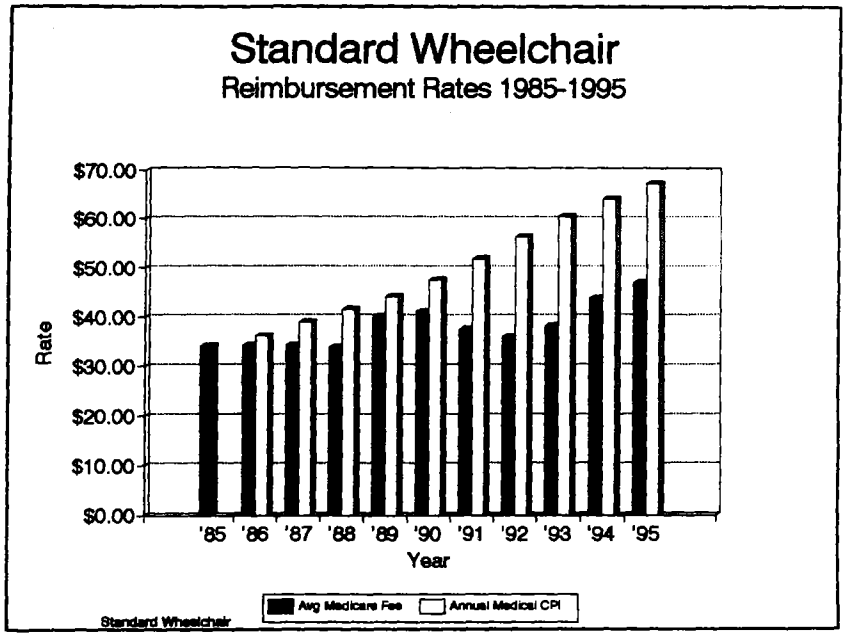
	'85	'86	'87	'88	'89	'90
Medicare Avg	$118.23	$129.28	$135.66	$130.75	$153.38	$154.61
Medical CPI		$125.68	$135.10	$144.02	$153.38	$165.19

	'91	'92	'93	'94	'95
Medicare Avg	$131.47	$126.76	$131.93	$136.69	$137.96
Medical CPI	$180.06	$195.72	$210.21	$222.61	$233.29



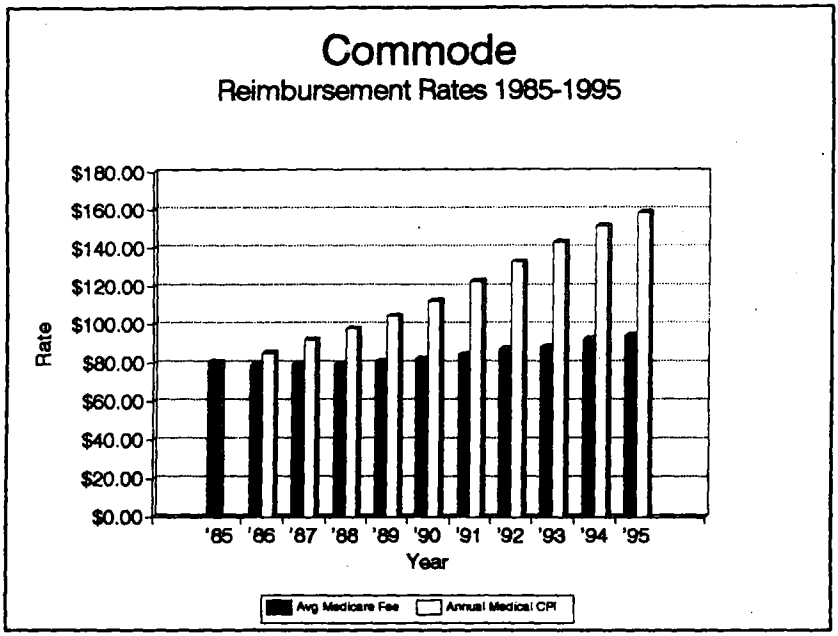
	'85	'86	'87	'88	'89	'90
Medicare Avg	$135.60	$142.76	$153.39	$167.32	$185.48	$182.05
Medical CPI		$144.14	$154.95	$165.17	$175.91	$189.46

	'91	'92	'93	'94*	'95*
Medicare Avg	$177.70	$171.94	$160.32	$162.51	$166.57
Medical CPI	$206.51	$224.47	$241.06	$255.31	$267.56



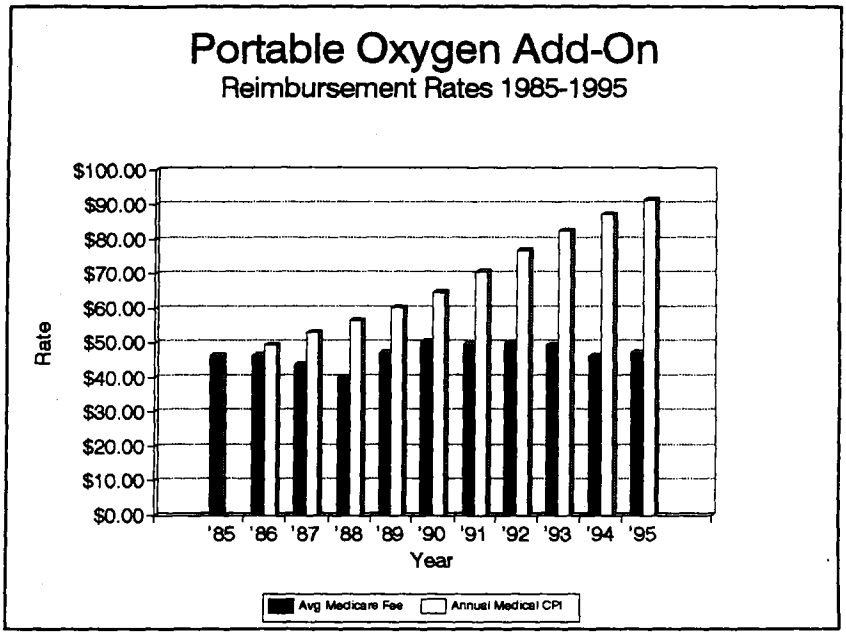
	'85	'86	'87	'88	'89	'90
Medicare Avg	$32.45	$32.57	$32.66	$32.10	$38.14	$39.16
Medical CPI		$36.25	$38.97	$41.54	$44.24	$47.65

	'91	'92	'93	'94	'95
Medicare Avg	$35.69	$34.25	$36.37	$41.90	$47.11
Medical CPI	$51.99	$56.45	$60.69	$64.21	$67.29



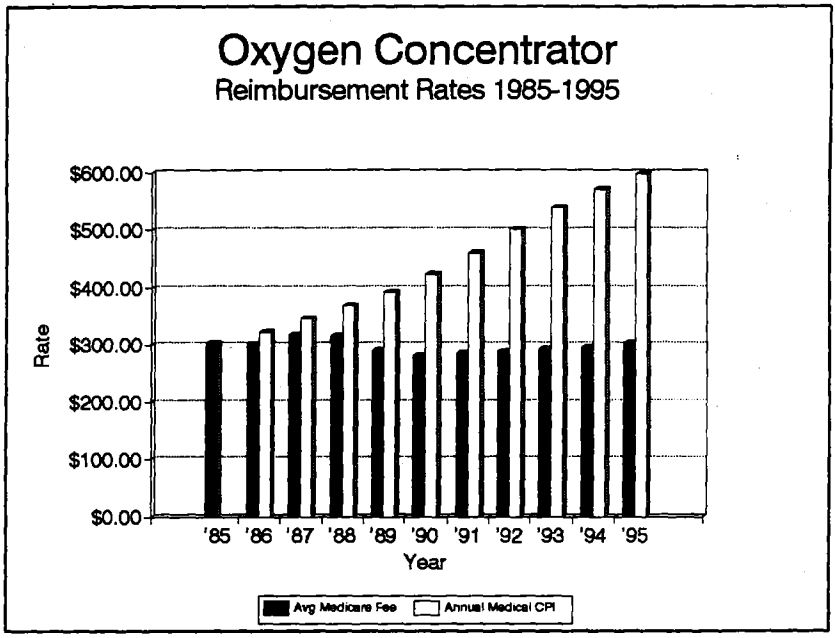
	'85	'86	'87	'88	'89	'90
Medicare Avg	$80.26	$79.06	$79.31	$79.33	$80.73	$81.69
Medical CPI		$85.32	$91.72	$97.77	$104.13	$112.14

	'91	'92	'93	'94	'95
Medicare Avg	$84.31	$86.79	$88.42	$92.15	$94.08
Medical CPI	$122.24	$132.87	$142.70	$151.12	$158.36



	'85	'86	'87	'88	'89	'90
Medicare Avg	$46.25	$46.21	$43.46	$39.86	$47.02	$50.30
Medical CPI		$49.17	$52.85	$56.34	$60.00	$64.62

	'91	'92	'93	'94	'95
Medicare Avg	$49.47	$49.79	$49.16	$45.99	$46.96
Medical CPI	$70.44	$76.57	$82.23	$87.09	$91.27



	'85	'86	'87	'88	'89	'90
Medicare Avg	$302.50	$300.91	$318.39	$316.23	$289.66	$280.18
Medical CPI		$321.56	$345.68	$368.49	$392.44	$422.66

	'91	'92	'93	'94	'95
Medicare Avg	$285.70	$288.73	$292.79	$295.89	$303.54
Medical CPI	$460.70	$500.78	$537.84	$569.57	$596.91

APPENDIX B



NAMES
National Association for
Medical Equipment Services

SUMMARY OF HME SERVICES INDUSTRY CUTS/FREEZES

o 1985	Least Costly Systems Payment Reduction;
o 1986	Inflation Index Charges/Freeze;
o 1986	Concentrator Equivalency Limits/Freeze;
o 1986-1988	Gramm-Rudman-Hollings Cuts;
o 1987	Lowest Charge Level Reduction;
o 1987	OBRA '87 mandated the establishment of fee schedules;
o 1988	Inherent Reasonableness/Freeze;
o 1989	OBRA '89 eliminated inflation updates for DME, reduced payments for seat-life chairs and TENS by 15%, and directed that motorized wheelchairs be treated as routinely purchased items;
o 1989	Six-Point Plan;
o 1989	PRN Cuts;
o 1986-1990	Freezes;
o 1990	OBRA '90 established ceiling and floors to the HME fee schedules to make payments more uniform, prohibited suppliers from distributing completed or partially completed CMNs; and
o 1991-1993	CPI Cuts.

Coalition of Health Associations United Against Fraud and Abuse

APPENDIX C

The Coalition is made up of organizations that represent health care providers and suppliers who want to work with Congress and the Administration to help eliminate fraud and abuse.

The Coalition believes that existing fraud and abuse statutes must:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;
- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;
- Protect Federal health care programs from unnecessary cost, utilization, and the failure to deliver appropriate levels of care;
- Be appropriate for the changing health care market; and
- Separate willful from technical violations.

The Coalition further urges Congress to adopt the following proposals to help eliminate health care fraud and abuse.

I. **Tools of Enforcement**

Federal Regulators should have the ability to prosecute fraudulent health care providers and suppliers.

A. **Establish a new health care fraud statute in the criminal code.** Providing penalties of up to ten years in prison, or fines, or both for willfully and knowingly executing a scheme to defraud a health plan in connection with the delivery of health care benefits, as well as for obtaining money or property under false pretenses from a health plan will help as a deterrent to fraud.

B. **Provide for the creation of an Anti-fraud and Abuse Collection Account.** An account subject to the congressional appropriations process will provide the Office of the Inspector General and the Federal Bureau of Investigation with the resources necessary to prosecute fraudulent providers and suppliers, and to provide guidance to those who seek to comply with the law.

C. **Clarify Antikickback Statute.** The current antikickback statue is vague and not focused on fraudulent activity. This provision would ensure that the antikickback law applies to those who *intentionally* defraud the government by codifying the Hanlester Network VS. Shalala decision. In this case, the court ruled that "knowingly and willfully" committing a fraudulent act should be the basis of federal prosecution. In addition, there is a clarification to the longstanding issue that an action is illegal,if a "significant or substantial reason" for making a payment is to induce referrals.

D. **Additional Enforcement Tools.** In addition to criminal prosecution, regulators are given the following enforcement tools to punish those found to commit a health care fraud offense:

1. **Exclusion from Federal and State Health Care Programs.** Mandatory exclusion from Medicare and state health care programs to those convicted of a health care felony. Increase existing permissive exclusion and apply it to an officer in an entity that has been convicted of a health care offense, if that officer is found to have a "reason to know" that the crime was committed; and

2. **Expansion and increase in civil monetary penalties.** Expanding penalties will serve as an appropriate deterrent.

II. **Health Care Fraud and Abuse Guidance**

It is the belief of the coalition that the vast majority of providers and suppliers seek to comply with the complex laws of Medicare and Medicaid. We further believe that much of the "noncompliance" can be resolved with education and guidance. The following provides mechanisms for further guidance to health care providers on the scope and applicability of the anti-fraud statutes.

A. **Safe Harbors.** Updates existing safe harbors and creates new ones.

B. **Fraud Alerts.** Establishes a formal process for the request and issuance of special fraud alerts.

C. **Advisory Opinions.** Advisory opinions assist providers and others engaged in the delivery of health care to ensure that they remain in compliance with health care statutes and regulations.

III. **Medicare Claims Process**

The General Accounting Office (GAO) in its report entitled "Medicare Claims _ Commercial Technology Could Save Billions Lost to Billing Abuse" (May 1995) stated "Flawed payment policies, weak billing controls, and inconsistent program management have all contributed to Medicare's vulnerability to waste, fraud, and abuse." The following provisions will improve that process.

A. **Medicare Transaction System (MTS).** Downgrade the priority or terminate the development of the Medicare Transaction System.

B. **Commercial Automatic Date Processing Equipment (ADPE).** Require Medicare carriers to acquire commercially made Commercial Automatic Data Processing Equipment.

C. **Reduce number of Medicare Carriers to ten.** Upon implementation of the ADPE, HCFA should be required to study and report to Congress on reducing its 32 Medicare Part B carriers to 10 such as the Durable Medical Equipment Regional Carriers (DMERCs) that were reduced to four. This will help to foster better communication between HCFA and the Regional Carriers.

D. **Contractor/Provider Relationships.** Prohibit Medicare carriers and intermediaries from reviewing claims of provider organizations when the Medicare contractor has an investment in that organization;

E. **Study Fraud and Abuse Under Managed Care.** The rise in managed care brings new forms of fraud and abuse. For example, the government and beneficiaries may be defrauded through withholding necessary services. The Institute of Medicine should undertake a study on the types of fraud that it may encounter under managed care and to begin ways to detect and combat such fraud.

Mr. ENSIGN. Thank you, gentlemen.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

And thank you, gentlemen, for your testimony.

Mr. Rapp, in your testimony you talk about how previous reimbursement cuts and other changes in Medicare reimbursement—such as going to a capitated rate for home oxygen services—has forced you to become more efficient in the delivery of services. As a result, you really now deliver more services at less cost to your patients.

Can you talk a little bit about how that process worked and how you became more efficient? Were there technological advances that were a part of that, or differences in delivery?

Mr. RAPP. I think for our company it has been a matter of consolidation of the industry. As the inefficient providers found difficulty competing over the last 10 years, our company has acquired those companies and we have built them into our system. So as we have gotten larger we have been able to gain leverage that way.

We have forced ourselves to push the limits of efficiency in terms of delivery and caring for the patient without jeopardizing the quality that is constantly monitored by physicians and the medical community. If that quality is not there and a patient complains to their physician, they will find another supplier and that is just the real process of the marketplace.

And that is how we have been able to do it.

Mr. MCCRERY. So even though you have delivered the services at less cost, you still deliver quality to your patients?

Mr. RAPP. As long as there is the continuing pressure of competition in the marketplace, I think that almost any marketplace you look at there is dozens of suppliers. The differentiating factor is normally service. Then you really have to respond to those market forces.

Mr. MCCRERY. Mr. Liken, you had a comment?

Mr. LIKEN. I would like to mention that about 96 percent of our membership base is small business, companies that are doing a few hundred thousand dollars a year in revenue up to a few million dollars a year in revenues. And all of them in order to survive in the recent years have continued to compete vigorously on the quality issues and had to become much, much more efficient and they have done it.

Our industry is highly competitive but largely small business companies are providing the services.

Mr. MCCRERY. Thank you.

Mr. Chairman, I think this is a good example of how we can exact some savings in the Medicare Program without diminishing the quality of the benefits to beneficiaries in the program. The example that Mr. Rapp has given us and that Mr. Liken has expounded on is a good one, I think, for the entire industry.

There is an interesting interplay between Mr. Hood and Mr. Salton on a related subject. One of you says, Gee, I think we can deliver good quality services at a lower reimbursement rate if you do not mess us up with some other things. The other one says you have done us too bad already and you have cut us as much as we can be cut.

Is it not true, Mr. Salton, though in your industry you have seen some technological advances that have allowed you to deliver some services at lower cost and, if that is the case, then why should we not see a reduction in some of the reimbursement rates?

Mr. SALTON. Well, the technological changes are only part of the overhead that is related to the laboratory industry. The laboratory industry is a very labor-intensive industry and labor is our highest cost item. Yes, the technology changes have kept the increases to a minimum as far as fee increases.

However, in order to maintain the quality and the service that we now provide, to further reduce the reimbursement would be detrimental to the industry, as a whole.

Mr. MCCRERY. Mr. Hood, do you want to comment on that? I know the Chairman has some questions.

Mr. HOOD. Yes. The baseline for Medicare was set fairly high to begin with and the laboratory industry's prices are not the result of a free market.

It is a very perverse market. Medicare does subsidize, in most laboratories, the private marketplace. For example, a laboratory charges a very low price to a doctor which the doctor can then mark up and make a handsome profit from. In exchange, the doctor gives the Medicare business to the clinical lab because the doctor then has to, by statute, allow that clinical lab to bill the Medicare work.

And, obviously laboratories would not do that unless Medicare work had some profit in it.

Mr. MCCRERY. Thank you.

Mr. ENSIGN. Thank you and I want to thank the entire panel for your testimony. I just want to follow up on my colleague from Louisiana, and his line of questioning.

That has to do with the whole idea of technology and what competition can do in the marketplace because I think that it does illustrate some of the efficiencies that we are trying to introduce into the Medicare system to achieve some of the $270 billion in cost savings, not in spending cuts, but in cost savings that we are trying to achieve.

The main lab that I am familiar with in our area is a lab called Associated Pathologies Laboratories in Las Vegas. I have toured the lab a couple of different times and they also were the primary veterinary laboratory in Las Vegas. There used to be two labs in Las Vegas and they provided—APL provided such great service they actually ended up outcompeting the other lab, and they are the only lab now in town and their prices have remained very, very low.

Over the years, I have seen exactly—and remember now we are not talking about Medicare setting rates. We are talking about total free market where the veterinarian is paying the costs. You know the number of tests that you get on a basic panel have increased dramatically over the years and the costs have not.

And primarily, Mr. Hood, I think that you would agree with me that has primarily been due to technology allowing labor to be saved.

Mr. HOOD. That is correct.

Mr. ENSIGN. I mean even just the bench models that you can buy for a small practice, the costs have come down dramatically per test on those, and computer technology I think is what is driving most of the cost reductions and some of the huge pieces of equipment that you have to buy. They are a large cost in the capital equipment that you have to buy for these, but the massive amounts of tests that you can run through these seem to be making each person that you have working in those facilities much more efficient instead of taking a pipette and doing all of the individual tests. Now they run them through these big computer analyzing machines and it seems that they have saved a tremendous amount of money.

So I would question—and I would not mind a little colloquy between the two of you to discuss why one thinks the technology in the future cannot save more money in Medicare and why one does. Why is one more efficient than the other one not? This seems like a little market at play here.

Mr. HOOD. It is not only a question of efficiencies, it is also a question of how the Medicare fee schedule works with the other payers.

You have, as you know, third-party payers and their lab test costs are marked up by the doctor in most States, except in New York, California, and a few other States. So the only attractive marker left for the laboratories, primarily, is the Medicare work. And so they offer discounted prices to the doctor to achieve the Medicare reimbursement. And you can see Medicare rates are lucrative. For example, a chemistry profile at $15, $16, $17 as a Medicare reimbursement rate, but yet, you can see laboratories all over the marketplace charging doctors $5 or $6 for private sector business, which is probably below their costs. But it is a very perverse market and if clinical labs then get the Medicare work by statute, they can mark up their direct-billed charges to the higher Medicare fee schedule rate which has a lot of profit in it.

Mr. ENSIGN. Mr. Salton, you have about 1 minute, as we have to take a vote, but go ahead.

Mr. SALTON. I think the laboratory industry is really segmented into different markets. You have the hospital market and the physician market and then the independent community laboratory. Now, these are totally different than what would be a large laboratory that receives only mail-in specimens. When you have a laboratory in a community which operates such as mine, I have been in business now for 38 years and I have seen where the reimbursements have not increased tremendously at all in certain procedures over 38 years. There are certain tests that we are now receiving the same reimbursement as we charged 38 years ago.

So I do not think that the fees have increased that dramatically especially even for the multitest profiles as you mentioned.

Mr. ENSIGN. But would you not agree that one of the reasons for that is that the computer technology has brought the costs down so that when adjusted for inflation your costs have actually been dropping, your prices have actually been dropping?

Mr. SALTON. When you think about it, I would say, yes, for the reason that technology has increased our output and in addition,

I think that you will find that laboratories generally are not contributing to the high cost of medicine.

Mr. ENSIGN. I hate to interrupt but I only have 1 minute to make the vote.

This Subcommittee will stand in recess and this panel is excused. I am sorry to cut you short, thank you.

[Recess.]

Mr. ENSIGN. I call the Subcommittee back to order.

Our next panel will be Philip Cryer, president-elect, American Diabetes Association; and Doris Derelian, president, American Dietetic Association.

Mr. Cryer, we will start with you.

STATEMENT OF PHILIP E. CRYER, M.D., PRESIDENT-ELECT, AMERICAN DIABETES ASSOCIATION

Dr. CRYER. Thank you, Mr. Chairman and Members of the Subcommittee, I am Philip Cryer and I teach and do diabetes-related research at Washington University in St. Louis, and I am here today in my role as president-elect of the American Diabetes Association.

Diabetes is a truly devastating disease among older Americans. Because the prevalence of diabetes increases with age, approximately one-half of the 14 million Americans with the disease are over 55. And 19 percent of the Medicare population has diabetes but approximately 27 percent of the Medicare budget, a staggering $28.6 billion in 1992, is spent on the treatment of diabetes, particularly its long-term complications including heart attacks, strokes, gangrene of the legs, blindness, and kidney failure.

Clearly, if the prevalance of diabetes and its complications can be reduced, substantial cost savings to Medicare can be realized.

Medicare does not adequately cover diabetes self-management training which according to the Bush administration's report, "Health Goals 2000," is so widely accepted as standard that denying it would be unethical.

The fact is that as diabetes progresses over time its management becomes progressively more dependent upon the patient. I know of no other chronic disease in which the person who suffers from the disease must become so responsible for its management. Effective management requires the patient to control his or her diet, exercise regularly, if possible, and measure his or her own blood sugar level several times a day, and often inject insulin in doses based on those measurements.

Thorough self-management training empowers the patient to become expert in the management of his or her diabetes. It is really the informed person with diabetes who successfully manages the disease.

It is unfair that Medicare covers self-management training only in hospitals and selected rural health clinics. The overwhelming majority of people with diabetes only visit these providers when seriously ill.

My written testimony documents how providing self-management training in quality outpatient settings can help Medicare reduce costs substantially. Legislation introduced in Congress to require Medicare coverage of this necessary training, H.R. 1073, currently

has over 100 cosponsors including 4 Members of this Subcommittee. We encourage all Members of the Subcommittee and the Full Committee to cosponsor this important legislation.

Medicare also fails to provide coverage for almost all of the drugs, supplies, and equipment a person with diabetes needs to stay healthy. There is no coverage for oral medications, insulins, syringes, insulin pumps or, except for those using insulin, blood glucose meters and test strips.

These are essential for people with diabetes to avoid the costly and deadly complications of the disease. If unable to afford them, a person with diabetes is likely to be a frequent visitor to the most expensive health facility of all—their local hospital emergency room.

Indeed, Medicare discriminates against people with diabetes and increases costs by focusing on acute, rather than preventive care. The Speaker of the House has emphasized the importance of providing diabetes self-management training and preventive care. Last year, on Good Morning America, Speaker Gingrich noted,

> We do not today pay for training you as a diabetic how to take care of yourself. We will pay to put you in the hospital and to amputate your leg when you fail to take care of yourself, but literally the government bias today is to not pay for the preventive and educational experience that will lower your costs.

How much could we save from the billions spent on diabetes each year by Medicare? Again, quoting Speaker Gingrich in a speech to the Seniors Coalition last April,

> I had a doctor approach me 1 year ago who is a specialist in diabetes who believes we can save $10 billion per year in diabetes alone, just by having more preventive care so people take care of themselves so they do not go blind, they do not have their legs amputated, they do not end up on disability.

We agree with the Speaker wholeheartedly, by providing comprehensive coverage for the critically needed diabetes training, drugs, supplies, and equipment we may be able to save as much as $10 billion each year in Medicare spending.

As you look for ways to save money, it is important to note that the effort to move the Medicare population toward managed care has serious implications for Medicare recipients with diabetes. The managed care community has been slow to empower people with diabetes. New studies cited in my written testimony documents substandard care being received by people with diabetes in one of California's largest HMOs. It is critical that any move to enroll Medicare recipients into a managed care environment ensures comprehensive provision of self-management training, supplies, and care along with the requirement for regular analysis of the care people with diabetes receive.

Finally, it is critical that by ensuring all people with diabetes have access to comprehensive coverage you can help Medicare avoid paying the extensive costs associated with the full-blown complications later in life.

Mr. Chairman, we have presented substantial evidence from numerous studies which show that we can improve diabetes care and save Medicare billions of dollars in the process. The American Diabetes Association is committed to helping you attain this important goal.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF PHILIP E. CRYER, M.D.
AMERICAN DIABETES ASSOCIATION

Chairman Thomas, Ranking Member Stark, and members of the subcommittee, I am Philip Cryer, MD, President-elect of the American Diabetes Association. I appreciate the opportunity to testify before you today on the American Diabetes Association's recommendations for Medicare reform. You have an extremely difficult task before you, but I am confident that we can provide constructive ideas for your efforts.

Before I begin my formal presentation, I would like to relate a quote of House Speaker Newt Gingrich. On July 27, 1994, as Minority Whip, Mr. Gingrich stated on Good Morning America that

> [W]e don't today pay for training you, as a diabetic, how to take care of yourself. We will pay to put you in the hospital [and to] amputate your leg when you fail to take care of yourself. But literally, the government bias today is to not pay for the preventive and educational experience that will lower your costs.[1]

The American Diabetes Association whole-heartedly agrees with Speaker Gingrich in this matter. As the American Diabetes Association's President-elect, I am here today to describe to you how to remove that "government bias" and expand coverage of diabetes-related supplies and education while simultaneously saving the U.S. Treasury billions of dollars. But in order to understand how this can be done, it is important to have a general understanding of the disease.

Diabetes is a disease that affects the body's ability to convert blood sugar into energy. There are two forms of diabetes, type I, known as insulin-dependent diabetes, and type II, known as non-insulin dependent diabetes. Type I is what the public usually equates with diabetes. This may be due to the peculiarities of this form of the disease. Type I usually strikes children and young adults and is characterized by the body's inability to produce insulin. Since the body does not produce insulin, multiple daily injections of insulin are required in order to survive. Type I diabetes develops rapidly, usually over the span of several weeks and has severe and recognizable symptoms. For these reasons, nearly everyone with type I diabetes has been diagnosed with the disease. Roughly 5% of the nearly 14 million people with diabetes have type I.

Type II diabetes is the far more prevalent form of the disease. It is different in many ways from type I. For example, type II diabetes usually strikes individuals who are over age forty. While most individuals with type II are able to produce insulin, their body is not able to use it effectively. While insulin injections may be required in advanced stages, type II can often be regulated through modification of diet, exercise and oral drugs. Type II diabetes develops over an extended period of time, sometimes a span of many years. The clearly identifiable warning signs typified by type I diabetes are not necessarily associated with type II. Because of this, more than 6 million Americans have undiagnosed type II diabetes, and are usually diagnosed through one of the resulting complications of diabetes, if they are diagnosed at all.

Despite these major differences, both type I and type II diabetes can be effectively managed by the afflicted individual. The medical research which led to the development of insulin in 1921 has enabled millions of individuals with type I diabetes to live long and productive lives. Medical research has also resulted in, and continues to result in, effective treatment regimens for the many millions of Americans with type II, enabling them to live longer, healthier lives. But one of the central paradoxes of diabetes hinges on the fact that because one can live for many years with the disease, its consequences are severely under-appreciated by the general public and health care professionals.

One of the commonalities of type I and type II diabetes is that both are characterized by elevated blood sugar levels. These elevated blood sugar levels, when left untreated by an outside agent such as insulin or oral medication, are the primary cause of the complications of

diabetes. Because both types of diabetes obstruct the body's ability to produce or use insulin, which converts blood sugar into energy, nearly *all* individuals with diabetes must rely on an outside mechanism to regulate their blood sugar levels.

Elevated blood sugar levels are found in all people with diabetes, particularly in those who remain undiagnosed or who do not manage their condition properly. And in the 13 million Americans with type II diabetes, elevated blood sugar levels can be sustained for extended periods of time, with an insidiously silent effect on their health. This is a reason why so many millions of Americans remain undiagnosed. These elevated blood sugar levels cause substantial long-term damage to the body's blood vessel system. Damage to this network of vessels, in turn, causes extensive damage to many of the body's essential organ systems. This damage to major organ systems is what we refer to when we talk about the complications of diabetes.

The complications resulting from elevated blood sugar levels are staggering. Each year the complications of diabetes result in the deaths of more than 160,000 Americans. That is equivalent to the combined populations of Olean, New York; Wauconda, Illinois; Papillion, Nebraska; Windsor Locks, Connecticut; Bastrop, Louisiana; Lamont, California; Allen, Texas; Union City, California; Franklin, Wisconsin; and Grambling, Louisiana.[2] And because diabetes is a disease that one can have for many years, the effect of elevated blood sugar levels are devastating in the individual and in the aggregate. Many hundreds of thousands of Americans suffer from these complications of diabetes:

Blindness -- Elevated blood sugar levels cause extensive damage to the tiny blood vessels in the human eye. Consequently, diabetes is the leading cause of blindness in people ages 25-74. The Centers for Disease Control and Prevention estimate that approximately 27,000 people go blind each year because of diabetes.[3] *This is roughly equivalent to the combined populations of Corning and Olean, New York.*[4]

Amputations -- High blood sugar levels cause extensive damage to the circulatory system in lower body extremities. Consequently, the risk of a leg amputation is 27.7 times greater for a person with diabetes than the general U.S. population. Approximately 54,000 people lose their leg or foot each year because of their diabetes.[5] *This is roughly equivalent to the population of Monroe, Louisiana.*[6]

Heart disease -- Above average blood sugar levels cause major damage to the blood vessels of the human heart. Therefore, people with diabetes are approximately 2 to 4 times more likely to have heart disease than individuals without diabetes. It is estimated that more than 77,000 people die each year from heart disease caused by their diabetes.[7] *This is roughly equivalent to the population of Visalia, California.*[8]

Stroke -- Strokes are caused by ruptures in the tiny blood vessels of the brain. These vessels can be extensively damaged by elevated blood sugar levels. Therefore, people with diabetes are 5 times more likely to suffer a stroke than individuals who do not have diabetes. It is estimated that nearly 11,000 people die each year from stroke caused by their diabetes.[9] *This is roughly equivalent to the population of Papillion, Nebraska.*[10]

Kidney disease -- Elevated blood sugar levels also cause damage to the blood vessels of the human kidney. Consequently, each year diabetes accounts for nearly 1/3 of all cases of kidney failure requiring a transplant or dialysis. Last year, nearly 13,000 people initiated treatment for kidney failure because of their diabetes.[11] *This is roughly equivalent to the population of Windsor Locks, Connecticut.*[12]

THE BURDEN OF DIABETES AMONG SENIOR CITIZENS

Diabetes is a truly devastating disease among those Americans over age 65. Because diabetes prevalence increases with age, approximately 50% of all cases of the disease occur in people over age 55. By ages 65-74, nearly 17% of the US white population, 25% of African Americans and 33% of Hispanics have diabetes.[13] This number will continue to increase as the population growth rate of African Americans and Hispanics outpaces that of white Americans.

However, despite the fact that 19% of the Medicare population has diabetes, approximately 27% of the Medicare budget is used in treating diabetes and its resultant complications. This represents $28.6 billion spent each year by Medicare for treatment of diabetes among those Americans over age 65. It is clear that if the prevalence of diabetes and diabetes-related complications can be reduced, substantial cost savings in Medicare can be realized.[14]

DIABETES CONTROL AND COMPLICATIONS TRIAL (DCCT)

Fortunately, recent medical research has found that the costly complications of diabetes can be reduced through routine medical care. The Diabetes Control and Complications Trial (DCCT), a clinical trial funded by the National Institutes of Health, was a landmark examination of diabetes-related complications.

The ten-year study, the results of which were published in the *New England Journal of Medicine* sought to demonstrate that keeping one's blood glucose levels as close to normal as possible prevented the onset of diabetes-related complications. The results of this study were better than almost anyone had imagined. This intensive treatment strategy, better known as "tight control," was found to reduce kidney disease by 56%, blindness by 60% and microvascular nerve disease, a leading cause of lower-extremity amputation, by 61%.[15] The DCCT proved conclusively that through close blood glucose monitoring, tight control of blood glucose levels can greatly reduce diabetes-related complications and decrease the cost of care. The results of the DCCT have tremendous implications not only for Medicare, but for the entire U.S. health care system and all Americans with diabetes. Diabetes is responsible for 1 in every 7 health care dollars spent, consuming over $100 billion annually.[16] If applied universally among all Americans with diabetes, the results of the DCCT imply that tens of billions of dollars could be saved every year through normalization of blood glucose levels.

DIABETES SELF-MANAGEMENT TRAINING

It is a widely accepted standard of medical care that people with diabetes must have diabetes self-management training on an on-going, as-needed basis. According to the American Diabetes Association's *Standards of Medical Care*, the authoritative reference guide on the treatment and care of people with diabetes

> [C]ontinuing patient education for self-management is an integral component of diabetes treatment. This is particularly so for diabetes; successful management of diabetes is greatly dependent on the patient's own efforts. Therefore, all people with diabetes must have access to affordable patient education services.[17]

And according to *Healthy People 2000*, the national health promotion and disease prevention report prepared under the direction of the Bush Administration

> Patient education is generally considered an integral aspect of patient management and a mainstay of patient self-care. It is so widely accepted as standard diabetes management that a rigorous study design that denies education to a control group would be unethical.[18]

However, despite the overwhelming recognition of the necessity of diabetes education, Medicare does not currently reimburse for the outpatient training people with diabetes must receive in order to control their disease. Unless the training is received during an inpatient hospital stay, a hospital outpatient visit or in selected rural settings, a person with diabetes who relies on Medicare cannot receive diabetes self-management training. The result of this short-sighted policy is that millions of people with diabetes are denied access to the education they need to stay healthy and avoid diabetes complications.

Given the Medicare restrictions on training, it is estimated that very few people with diabetes who rely on Medicare as their health insurance have received the education necessary to care for their disease. In fact, a recent study found that just 35% of all people with all types of diabetes have actually attended a diabetes management program. These statistics have grave implications not only for Medicare, but for the U.S. health care system in general.[19]

Studies conclusively prove that providing coverage for diabetes self-management training not only keeps people healthy, it saves money by helping people with diabetes avoid complications and hospitalizations. For example:

State of Maine -- The State of Maine and the CDC sponsored a diabetes self-management training program in 30 hospitals and health centers, following 1,488 patients over 3 years. *Result:* A 32% reduction in hospital admissions with a savings of $293 per participant, or $3 saved for every $1 spent on diabetes self-management training.[20]

Los Angeles, California -- As reported in the *New England Journal of Medicine*, an integrated system of diabetes self-management training and care resulted in a 73% reduction in hospitalization and 78% reduction in average length of stay for 6,000 people with diabetes. *Result:* An estimated savings of $2,319 per patient each year.[21]

Atlanta, Georgia -- An intensive diabetes self-management training and care program was implemented in a county hospital setting. The study included 12,950 individuals with diabetes, of which 10,500 were treated, evaluated and followed up. *Result:* Severe ketoacidosis was reduced by 65% and lower extremity amputations were reduced by 49%. Savings were estimated to be $437,500 per year.[22]

According to *Diabetes Outpatient Education: The Evidence of Cost Savings*, published jointly by the American Association of Diabetes Educators, American Diabetes Association, American Dietetic Association, Centers for Disease Control and the National Diabetes Advisory Board,

> [L]ack of reimbursement is probably the most significant impediment to the development of diabetes outpatient education programs. It is simpler to receive reimbursement for inpatient care and bury the costs of education; but it is far more expensive and far less effective.[23]

The American Diabetes Association has worked for years to alter the current government bias inherent in Medicare's refusal to provide coverage for diabetes self-management training. Earlier this year, Representative Elizabeth Furse introduced H.R. 1073, the Medicare Diabetes Outpatient Self-Management Training Act of 1995. This legislation would require Medicare to reimburse for diabetes self-management training provided in a quality outpatient care setting. The American Diabetes Association is pleased to note that several members of this subcommittee are among the 98 cosponsors of this legislation, including Representatives Nancy Johnson, Jim McDermott, Ben Cardin, and John Lewis. We thank them for supporting this important legislation and strongly encourage all members of the subcommittee, as well as the full committee, to cosponsor this important legislation.

One of the most important elements for the Medicare type II population, provided for under H.R. 1073, will be access to nutrition therapy. Nutrition therapy will empower people with diabetes on Medicare to monitor what they eat and understand how their diet impacts their diabetes. According to the American Diabetes Association's *Standards of Medical Care*, nutrition therapy is a vital component for the care of diabetes.[24]

If enacted into law, H.R. 1073 will save Medicare billions of dollars annually from the avoidance of costly complications and hospitalizations. However, despite the importance of providing coverage for diabetes self-management training, it will not be fully effective unless it is coupled with other structural changes for people with diabetes in the Medicare program. As with expanding coverage for education, these changes will also save Medicare billions.

COVERAGE FOR PRESCRIPTION DRUGS & INSULIN, SYRINGES, SUPPLIES, EQUIPMENT, AND RELATED PREVENTION SERVICES

The regulation of blood glucose monitoring is a complicated process. In order for people with diabetes to be healthy, it is vital to teach them how to care for themselves, as the self-management training bill would help achieve. However, it is also of vital importance to provide people with diabetes a means to purchase the tools necessary to control their disease. This needs to occur through comprehensive coverage of prescription drugs and insulin, syringes, supplies and equipment.

Currently, Medicare reimburses only for blood-glucose monitoring strips and meters for those individuals using insulin to manage their disease. Medicare does not cover insulin, syringes, insulin pumps, oral agents, blood glucose meters or blood glucose testing strips (for those not using insulin) and other necessary supplies. These items, however, are necessary for people with diabetes to stay healthy and avoid complications. By providing comprehensive coverage of these supplies, Medicare will save billions of dollars.

The current government bias in supply coverage results in a situation where people are not able to take appropriate care of themselves. This leads to individuals with diabetes seeking care in the most expensive and overutilized location of all, the hospital emergency room. A recent study conducted in a major urban hospital found that 43% of patients with diabetes were hospitalized with diabetic ketoacidosis, a life-threatening condition caused by excessively high blood glucose levels, because the patients could not afford insulin. The study also found that over 95% of the hospitalized patients with diabetes were admitted through the emergency room.[25] Although this study focused on people of all ages with diabetes, the ramifications for the Medicare system are quite clear: inappropriate coverage for diabetes-related supplies and services results in increased hospitalizations, physician utilization and expenditures.

A comprehensive care package for people with diabetes will also save Medicare money by keeping people out of the hospital. For example, under current reimbursement guidelines, Medicare will reimburse 100% of the costs associated with the dialysis required for kidney failure. As noted earlier, diabetes accounts for nearly 1/3 of all cases of kidney failure requiring a transplant or dialysis. Last year nearly 13,000 people initiated treatment for kidney failure because of their diabetes. This treatment averages $38,000 per participant, per year. However, if Medicare covered the necessary prescription, medical and dietary interventions, at an estimated annual cost of roughly $1,200, most of these dialysis interventions could be prevented.[26]

Preventing blindness caused by diabetes provides another example of how a comprehensive care package will save taxpayers' money. Diabetes is the leading cause of new cases of blindess in working age adults. Yet, it is estimated that 40% of people with type II diabetes are not receiving appropriate eye care for the treatment of diabetic retinopathy. Researchers conclude that the application of quality standards for screenings of diabetic eye disease among people with diabetes would result in a net savings of $472.1 million a year, even if all costs are borne directly by the federal government.[27]

Clearly, expanding Medicare coverage for prescription drugs & insulin, syringes, supplies, equipment and related prevention services can save Medicare many billions of dollars. Even Speaker Gingrich has acknowledged this fact during a speech to the Seniors Coalition on April 28, 1995

> I had a doctor approach me a year ago who's a specialist in diabetes who believes we can save $10 billion [per year] in diabetes alone just by having more preventive care so people take care of themselves, so they don't go blind, they don't have their legs amputated, they don't end up on disability. That is not a cut. That is a genuine improvement.[28]

QUALITY CARE FROM A DIABETES CARE TEAM

The role of a diabetes care team in the treatment of a patient's diabetes is another vital component of diabetes care and cannot be over-emphasized. A patient's diabetes care can only be monitored effectively through the use of a well-educated diabetes team.

A person with diabetes must be acutely aware of many complications, including heart attack, stroke, kidney failure, amputations and blindness. By utilizing a diabetes care team, adjustments can be made in the individual's regimen which can prevent the long-term consequences of poor diabetes control. Only through the use of a team approach (which includes consultations with a nurse educator, dietitian, endocrinologist, and other specialists as needed) can a patient's medical history be analyzed, necessary tests be conducted and appropriately analyzed, and a diabetes management plan be established and adjusted.

Claresa Levetan, MD, a diabetes expert at the Washington Hospital Center, recently analyzed the effectiveness of providing a diabetes care team approach in the treatment of hospitalized patients with diabetes. Published in the July 1995 edition of the *American Journal of Medicine*, Levetan's study compared the length of hospitalization between patients who received care from a diabetes care team and those patients who received care solely by a general internist. The results of the study were astounding: those patients with diabetes that utilized the health care team approach reduced their hospital stay by 56% or 5 days.[29] Considering that 1.6 million diabetes-related hospitalizations occur each year among those individuals over age 65, a diabetes care team approach translates into billions of dollars in potential cost savings.[30]

MANAGED CARE

Managed care is here to stay for the treatment of disease. A managed care environment has the as-yet unfulfilled potential to provide an opportunity for the empowerment of all people with diabetes to care for themselves.

The managed care industry should be acutely aware of the need to manage diabetes more aggressively. In its March 1995 issue, *The Genesis Report/MCx Managed Care Strategic Briefing*, a managed care journal, reported the need for HMOs to begin to control the costs of diabetes by reducing the risks of complications. Upon completion of an in-depth analysis of the DCCT, the journal concluded that in order to reduce the costs associated with diabetes-related complications it is time to "radically redefine" the approach to diabetes treatment by applying a "detailed management plan" to the disease. The report says a new technique known as "disease management may be the ideal approach to treat diabetes. Treating diabetes is expensive. The risk of complications are extensive [but] diabetes can be controlled which reduces both cost and complications."[31]

Despite this realization, the managed care community has been slow to empower people with diabetes.

A recent study investigating diabetes care in a managed care setting shows that intensive diabetes management has so far failed to take hold. This analysis of hundreds of charts for patients with diabetes among one of the largest HMOs in California suggest that the patients

in this particular HMO are receiving grossly substandard care. Among the most disturbing elements of this study were the discoveries that only 8% of people with diabetes attended a self-management training class, only 5% were referred to an endocrinologist, and only 10% were directed to a dietitian.

When analyzing the procedures performed, even more startling trends emerge. Of the people with diabetes included in the study, 96% did not receive a primary care eye exam, 56% of the patients did not have the necessary blood work performed, 78% were not referred to an ophthalmologist, 94% did not receive a foot exam, and 71% did not have their cholesterol measured. It is noteworthy that the average age of the patient in this survey was 52, just 13 years shy of Medicare eligibility.[32]

It is critically important that health maintenance organizations that serve people with diabetes guarantee a level of care at least comparable to the American Diabetes Association *Standards of Medical Care*. Because of the long-term development of type II diabetes and the fact that diabetes prevalence increases with age, the federal government has a vested interest in ensuring that people with diabetes enrolled in health maintenance organizations receive proper care. Without the necessary and appropriate care, people with diabetes will enter into the Medicare system just as the long-term complications of the disease begin to emerge. By ensuring that health maintenance organizations provide comprehensive care, Congress can help Medicare avoid having to pay the extensive costs associated with complications.

GENERAL POPULATION

It is important to recognize that every improvement we recommend for the Medicare program can be incorporated into reform of the private insurance and Medicaid populations. For all the same reasons which apply to Medicare, the federal government has a vested interest in ensuring that all people with diabetes have access to the supplies and services they need to stay healthy and avoid costly complications and hospitalizations. While the American Diabetes Association understands that this subcommittee can only address Medicare Part A during this hearing, it is important to recognize the potential cost savings to the federal treasury if all people with diabetes received the treatments necessary to effectively manage their disease.

In Wisconsin, a study of the insurance benefits provided to individuals in accordance with state law resulted in some remarkable conclusions. The Office of the Commissioner of Insurance studied the costs of a standard benefits package for diabetes care similar to what we are are recommending today. The insurance commissioner found that directing the private insurance community to offer a comprehensive diabetes benefit did not increase claims filed, did not increase disbursements by the insurer, did not increase costs when compared to other benefits and did not increase premiums.[33] These conclusions are critical for you to consider when contemplating broad based insurance reforms for the private sector.

CONCLUSION

Mr. Chairman and members of the Subcommittee, the task of reforming the Medicare program is daunting. However, when it comes to diabetes, there is a way to save the system money while simultaneously expanding coverage and improving health. Because of the results of the DCCT and the many other studies in the field, we know this can be accomplished by providing comprehensive coverage of diabetes outpatient self-management training, supplies and prescription coverage and guaranteed care by a diabetes team. As Speaker Gingrich has noted, this approach could save $10 billion each year for the Medicare program alone.

Congress has a golden opportunity to dramatically improve the lives of the millions of Americans with diabetes who rely on Medicare for their health insurance. The American Diabetes Association wants to assist in this effort and looks forward to working with you. I will be pleased to answer any questions you may have at this time.

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Mr. ENSIGN. Thank you, Dr. Cryer.
Ms. Derelian.

STATEMENT OF DORIS DERELIAN, PH.D., PRESIDENT, AMERICAN DIETETIC ASSOCIATION

Ms. DERELIAN. Thank you, Mr. Chairman.

Good afternoon, it is nice to be here. I am Doris Derelian, I am president of the American Dietetic Association, the world's largest organization of food and nutrition professionals in the country.

We recognize what it takes to modify and reform the Medicare as you are confronting it on a daily basis here, and in a broader perspective. Dietitians have a concern that this reform gives us an opportunity to truly rethink the way that we pay for medical nutrition therapy. No matter what the disease you have heard about here, whether it is cancer or diabetes or heart disease, things that you have heard about in the last, even few minutes, all of those diseases have an underlying nutritional element or component to them.

Unfortunately, when Medicare was established 30 years ago, our understanding of the intervention of medical nutrition therapy was very limited. We had limited outcome data, we had limited knowledge about the interaction of cellular functioning in disease related to nutritional status. So what happened was we considered room and board, that is those payments for inpatient services to include the delivery of food to the patient's room and that is covered under whatever is reasonable and usual in inpatient services.

What has happened, however, in 30 years, is that we have recognized that intervention, medical treatment for patients with chronic and acute illness, requires and needs nutrition intervention. To do that we need to modify the system to include specific recognition of that part of treatment.

Let me give you an example. We have two women, Mrs. Jones and Mrs. Adams. They are both 75, they both live alone, they both break their hips. Both of them are going to go to the hospital, there is no question that they are going to go to the hospital for treatment. And that hip fracture is going to be taken care of and they are going to be delivered back to their homes after that acute stage is over.

Any disease that requires bed rest and significant time in bed, both as an inpatient and at home, is going to create something that we call pressure ulcers or they are better known as bed sores. A bed sore is a very expensive illness to treat and Medicare pays, once that bed sore has been acquired by the patient, pays for all of it.

And a bed sore, I am not sure if you realize, is an illness that results from very deep, very profound injury to soft tissue. The difference between Mrs. Jones, who does not eat regularly, who does not have access to food or if she does she is not preparing it—after all she has a broken hip and has probably been relatively infirm leading up to it—she is at great risk for the full complications of that bed sore.

In fact, there is a good chance that she is going to be rehospitalized, she is going to require the intensive Medicare payment for the treatment of that bed sore.

Mrs. Adams, on the other hand, could have access to reimbursed meals, parenteral or enteral feeding, which of course now is not covered. If the underlying tissue, the underlying muscle that is being stressed by the illness and bed rest, is healthy then we can prevent or in fact cause a much more limited bed sore. In fact, the estimate is that we would save between $10,000 and $12,000 per pressure ulcer treatment if we simply, on the front end, provided medical nutrition therapy for these patients.

We are not the only ones to have recognized this. In the guidelines that you heard about from the Health Care Policy Research Group they, in their guidelines, have included for pressure ulcers intervention in nutrition.

So even thought it is in the guidelines, it is still not recognized for coverage.

There is some suggestion that just from broken hips alone that the pressure ulcer paycheck at the end of the year is about $84 million. Just that one item would be a substantial reduction if we paid attention to the way that nutrition intervenes in this problem. And that might be on the short term. We have medium term gains when we are looking at reimbursement for medical nutrition therapy in the treatment of diabetes to get blood glucose levels to normal so that patients do not have these highly expensive episodes.

And, over the long term, savings can be realized in reimbursing and paying for cholesterol reduction treatment as intervention.

I guess what I am trying to say is that nutrition therapy is not high-tech. It is specialized, it requires an expertise but it is not high-tech so it has not received, we think, the attention in the total set of modalities that could contribute to success in treating the patient and in saving health care dollars.

We recognize that reform is the movement, and we think we have a good chance of having you look at a real reform in this area.

Thank you, very much.

[The prepared statement follows:]

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The American Dietetic Association

on Medicare and Budget Reconciliation Issues

submitted to the Health Subcommittee

of the House Ways and Means Committee

July 25, 1995

Good morning, Mr. Chairman and members of the Subcommittee. I am Doris Derelian, PhD, MS, RD, President of The American Dietetic Association.

The American Dietetic Association (ADA) is the world's largest organization of food and nutrition professionals with 66,500 members who serve the public through the promotion of optimal nutrition, health and well-being. Over 80 percent of all registered dietitians work in health care delivery, including hospitals and HMOs, long-term care facilities, and clinics and physicians' offices. ADA appreciates the opportunity to share its views with the Subcommittee on ways to reform the Medicare program to achieve cost savings that enable Congress to meet budget resolution targets.

Dietetics professionals appreciate the monumental task that Congress faces in reforming the Medicare program. Finding creative ways to cut costs while providing good health care is a daunting challenge. Dietitians believe that attention to services that reduce long-term medical costs is essential in meeting this challenge. One such service is medical nutrition therapy, which, according to ADA's internal analysis of case studies, has been shown to save an average of over $8,000 per case. When medical nutrition therapy is applied to the disease or condition, it saves money by reducing the length of hospital stay, decreasing complications, decreasing the need for costly medication, and lessening the need for high technology treatment.

Medical nutrition therapy is defined as the assessment of patient nutritional status followed by appropriate therapy, ranging from diet modification to administration of specialized therapies such as intravenous or tube feedings. It is a medically necessary and cost-effective way of treating and controlling many diseases and medical conditions, including AIDS, cancer, kidney disease, diabetes, severe burns, pediatric failure to thrive and surgical wounds. Medical nutrition therapy addresses an individual's nutrient status, which is key to the body's healing process. For example, someone who has suffered extreme tissue damage as a result of severe burns requires extremely large quantities of calories and nutrients to heal.

Findings both from randomized controlled clinical trials and from case studies show that medical nutrition therapy can save health care dollars and improve outcomes when provided to patients with diseases or injuries that place them at high risk of malnutrition -- being inadequately nourished. Almost 17 million patients each year are treated for illnesses or injuries that stem from or place them at risk of malnutrition. Whether in hospitals, long-term care institutions, or scattered throughout the community, medical professionals recognize that medical nutrition therapy is a key factor in improving outcomes and speeding recovery for at least 40 percent of hospital patients in the U.S. who are malnourished based on clinical nutrition evaluations (Roubenoff, Roubenoff, Preto & Balke, "Malnutrition among hospitalized patients: A problem of physician awareness," *Archives of Internal Medicine*, 1987).

Based on clinical research and experience, medical professionals (physicians, dietitians and nurses) identify a range of specific medical nutrition therapies necessary to treat illness and injury that involve:

- Assessment of the nutritional status of patients with a condition, illness or injury that appropriately requires medical nutrition therapy as part of the treatment. The assessment includes review and analysis of medical and diet history, blood chemistry lab values, and anthropometric measurements to determine nutritional status and identify treatment modalities.
- Therapy ranges from diet modification to administration of specialized nutrition therapies such as intravenous medical nutritional products as determined necessary to manage a condition or treat illness or injury.

An internal analysis of nearly 2,400 case studies submitted by ADA members shows that on average more than $8,000 per patient can be saved with the intervention of medical nutrition therapy. Case studies show that, for diseases and conditions in which medical nutrition therapy is appropriate, the average annual or one-time savings per case include:

- For **cancer**, $10,535 savings per case because specialized nutrition therapy enhances effectiveness of chemotherapy and radiation therapy;
- for **heart disease**, $9,134 savings per case because medical nutrition therapy reduces the need for drugs and other artery-clearing procedures and/or surgery;
- for **type I diabetes** (insulin-dependent), $9,049 savings per case because diabetic complications that result in hospitalization are reduced;
- for **type II diabetes** (non insulin-dependent), $1,994 savings per case because medical nutrition therapy reduces or eliminates the need for insulin or oral agents;
- for **kidney disease**, $18,467 savings per case by postponing the need for dialysis;
- for **high cholesterol**, $2,709 savings per case by reducing the need for drugs;
- for **hypertension**, $4,075 savings per case by reducing drug use and preventing complications such as stroke; and
- for a variety of other conditions -- such as **burns and surgery** -- requiring tube or intravenous feedings, $7,051 saving per case by transitioning the patient to less invasive and less expensive nutrient sources.

A survey of 2,337 patient records at 19 hospitals indicates that early nutritional interventions and regular clinical nutrition services reduce hospital stays for malnourished and at-risk patients. The reduced hospital days translate into $8,200 per bed per year average cost savings according to *Cutting Hospital Costs with Clinical Nutrition Services*, a new report by the Nutritional Care Management Institute (NCMI) of Tucker, Georgia.

A report in the July 1995 issue of *The American Journal of Medicine* highlights a study which found that the use of a diabetes team, led by an endocrinologist working with a nurse diabetes educator and dietitian, resulted in a 56 percent reduction in length of hospital stays among patients hospitalized with a primary diagnosis of diabetes compared with patients treated by an internist alone. Currently, hospital care of diabetic patients costs an estimated $65 billion a year. The potential 5-day reduction in hospitalization found by this study translates into billions of dollars per year in potential health care savings.

The evidence is clear. Medical nutrition therapy is an appropriate means for cutting costs. Yet, the Medicare program is inconsistent in utilizing this important service. Currently, *no* policy or approach exists for covering the costs of medical nutrition therapy.

In inpatient settings, dietitians' services must be covered by DRG payments. Yet, when DRGs were implemented in 1983, medical nutrition therapy was only a small piece of treatment and was hidden within general and administrative or overhead costs. As a consequence, hospitals, for the most part, today view medical nutrition therapy as uncovered by DRGs because there has never been an explicit accounting for the cost of medical nutrition therapy. However, as data more clearly show savings and as dietitians approach hospital administrators with this data, medical nutrition therapy becomes more essential to efficient Medicare inpatient care.

In outpatient settings, Medicare coverage for nutrition services is practically non-existent. Medicare technically covers outpatient diabetes education -- which is primarily medical nutrition therapy for

those with diabetes. However, recent collection of claims data by ADA in this area reveals problems with obtaining reimbursement, primarily because no clear-cut coverage policy and code for billing exist. Yet, a study last year by the International Diabetes Center in Minneapolis, MN, showed that persons with type II diabetes can better control their blood sugar levels, weight and cholesterol with medical nutrition therapy.

Even if Congress takes an incremental approach such as the one proposed in H.R. 1073 -- providing for Medicare coverage of self-management training (which includes medical nutrition therapy) for diabetes patients -- dietitians believe this is a vital step in the process of reforming the Medicare program. ADA is appreciative of the bread support which this measure has garnered -- including many members of this Subcommittee.

Dietitians are one of the most highly trained allied health professionals. Other allied health professionals -- such as occupational or physical therapists -- receive consistent medical reimbursement under the Medicare program. Dietitians should be named in the list of those allied health professionals who receive reimbursement. Yet, to date, that has not occurred.

Dietitians are extensively trained and educated in the science of nutrition and its application to disease prevention and treatment. In practice, the dietitian integrates and applies the principles derived from the sciences of nutrition, biochemistry, physiology, food management and behavior to achieve and maintain health. The dietitian has become a fundamental team member in effective health care delivery with the rapid advance of the science of nutrition and its correlation with disease prevention and treatment.

As part of an interdisciplinary treatment team (physicians, nurses, dietitians, and other health professionals), dietitians educate treatment team members in the science of nutrition; assess the patient's blood chemistry, anthropometric measurements, medical history, and diet history to determine nutrition status; and, with the interdisciplinary treatment team, develop, administer and evaluate the patient's response to nutrition therapies.

Mr. Chairman, the growing evidence of the vital importance of medical nutrition therapy in treating many diseases and conditions is being recognized throughout the health care community. While coverage by private health insurance plans varies from plan to plan, managed care programs such as Cigna, Harvard Community Health Plan, Health Insurance Plan of Greater New York, and US Healthcare are contracting with dietitians to provide both medical nutrition therapy and preventive services for their subscribers. Medical nutrition therapy may also be covered in some states under some policies -- especially managed care products -- offered by insurers such as Aetna, Blue Cross/Blue Shield, Humana, John Hancock, MetraHealth, Mutual of Omaha, Provident, Principal Mutual, and Prudential. And, even more significantly, the annual call letter for the Federal Employee Health Benefit Program includes "cost effective, medically necessary services (such as medical foods and nutrition therapy)" as a specifically encouraged service under Fee for Service Plans. As others have said, shouldn't our seniors have the same services through Medicare that are available to federal workers?

The American Dietetic Association with its 66,500 members stands ready to work with the Subcommittee in the development of Medicare reform proposals. We appreciate the support and interest of this Subcommittee on this issue.

Thank you.

Mr. ENSIGN. Thank you, both, excellent testimony.

A couple of questions because both of you talked about savings to Medicare and the whole system. Let us say that we enacted what you both would want us to enact and we were able to save Medicare money over, say, the next 7 years. Would you classify those savings as cuts?

Dr. CRYER. I would not.

Ms. DERELIAN. I would not either.

Mr. ENSIGN. OK. Thank you, I just wanted to get that on the record.

Second, when we are talking about preventive care, because prevention makes so much sense and it seems intuitive it you can spend money up front. My aunt is a diabetic and she also has systemic lupus, but watching what she has gone through over the years and the education that has taken place with her and some of the diets, there is no question of the benefits that I have seen her go through, through using the diet to help manage her disease and some of the preventive measures that have gone on there.

Prevention makes sense, obviously. But when you are in discussions with some people, they say that there are studies that suggest that prevention may save money in the short term but in the longer term, it does not save you any money. I find that hard to believe, and I would like to hear both of your comments on that.

Dr. CRYER. I am afraid that I do not really follow that argument because the bulk of evidence would suggest that preventive measures reduce costs.

Mr. ENSIGN. I think the reason and the logic follows something like this. You do preventive care and people will live longer and therefore consume more medical costs over their lifetime.

Like somebody with diabetes. The worse the care the shorter time they are going to live. Now, granted they will consume more during that shorter period of time but over the longer period of time they were going to consume that certain amount of medical spending over a longer period of time.

Now, it is obviously the wrong thing to do from a moral standpoint, but I am just pointing out some of the other arguments that you do hear in this whole discussion.

Ms. DERELIAN. The other possibility is that we know that a huge percentage of Medicare costs come in the last year of life and since everybody dies and they get sick before they do, it may be that you are compounding data that suggests that the most expensive element, that variable called the last year of life for everybody whether they had a chronic illness or whatever, is bringing that value up.

But if we could keep them healthy, keep their chronic disease under control for a longer period of time—if you were looking at that period—they would be living healthier and productive lives. Certainly for diabetics the more productive we can keep these people the more we can keep them in the work force, the more we can have them productive people there is a cost savings. And then you add that last year of life for every American and I read a statistic that said in 2005, 79 million Americans will be over 55 which means that everybody is moving in that direction in this country.

Mr. ENSIGN. But we all are.

Ms. DERELIAN. Yes.

Mr. ENSIGN. I want to bring up something that you talked about Dr. Derelian on bed sores, I think it illustrates one of the major problems with the whole Medicare system and the way it was set up in the first place.

That is that from the Federal level, the Federal Government has difficulty responding to what is happening technologically in the marketplace. Basically, when new guidelines come out they have difficulty, HCFA, as one agency, responding with new regulations that are timely that can save the government money.

And obviously if we can bring in more market forces to where it is not just HCFA determining who is getting paid for this particular service, but it is providers or HMOs or coordinated care, whatever term you want to put to it, or medical savings accounts or whatever it is, if there are more forces determining who is going to get this nutritional therapy than just HCFA, I think you will see a much faster response time. Your comments?

Ms. DERELIAN. One comment is that there is some data that suggests that when people present with a chronic illness or even an acute illness that has medical nutrition therapy associated with it and they go for counseling services, wherever that may be from, when they walk through the door and they find out that there is no reimbursement for this service under any circumstances, we know for a fact that the person backs away from the service. They back away from it because of the degree to which there is a prevention element to it. There are so many other things that they have to accommodate, particularly in diabetes. They have to have syringes and their insulin. And those things are all handled in some way differently from the way they get nutrition services.

So there is this problem of having the patient trying to make a decision about the value of this service and then not having any guidance about how to go about getting it or any level of reimbursement recognition.

I do believe that HMOs are beginning to change their attitudes about nutrition services. Now that they are obligated to take in subscribers from very well to very sick, they are beginning to find out that if they do preventive nutrition services, that ultimately they will save money in this group down here to be able to pay for these new people that they now have to take in that are more costly. So we are getting some transformation within the health HMOs.

Mr. ENSIGN. The other part of that is that HMOs are a fairly new phenomenon and so some of that is probably short-term thinking. I think that as that market evolves, Dr. Cryer, you mention in your written testimony that HMOs have been slow to respond to diabetes and I think that as this market evolves more you will see these companies taking a long-term outlook that they are going to be there providing this service and it is better for them to spend this money up front. And not just hope that these diabetics are going to shift to someone else's HMOs because they know that those diabetics are going to be shifting to their HMOs as well.

Dr. CRYER. I agree with the premise of competition. I also agree that there is some verbal evidence that the HMOs are beginning to see the benefit of preventive treatment. But on the other hand, as detailed in the written testimony, I think we have to be concerned about the actual performance of HMOs and in one large

HMO there were several things that by the ADA standard were clearly substandard. And notably that 96 percent of the patients did not have their eyes examined. And that is fundamentally important.

Early stages of diabetic proliferal retinopathy are treatable, 90 percent of blindness can be prevented but we have to look and find it. So I think we have to link concept and performance and assure that there is an emphasis on preventive care and that there is a mechanism to ensure high-quality care.

Ms. DERELIAN. Whether we like it or not the Medicare model is the model that is utilized by everybody to determine what services have enough value to be considered by the governing structure to be part of therapy.

Things that are paid for by Medicare are generally viewed as being the sanctified, appropriate, and usual treatments. When there is an exclusion in Medicare, most of the community of other payers simply does not want to acknowledge it.

Mr. ENSIGN. Very good point.

Does Medicare adequately fund parenteral nutrition?

Ms. DERELIAN. Not at all.

Mr. ENSIGN. OK. And that is, more than any other field is widely acknowledged in the medical profession, even in the veterinary profession that that is something that there is no question you have cost savings there. Because they heal faster, they get out of the hospital faster, and their course of treatment is much quicker.

Ms. DERELIAN. Thank you for acknowledging that. That is something that we have had great difficulty in getting recognition for.

Mr. ENSIGN. And I just had not only my own experience and practice but also a good friend of mine was at the National Hospital Center having cancer therapy and then the chemotherapy——

Dr. DERELIAN. And what is so interesting about that, one of the most interesting is because we do not have a separate code. We have no way to track, and you have seen it personally. We have no tracking system. Because when reimbursement to that provider is given, there is no separate coding for the way that parental or enteral feeding was accomplished, so we have no way to follow it, no way to demonstrate without common data what you have just acknowledged with testimonial data.

Mr. ENSIGN. Thank you both very much. It was excellent testimony and I appreciate you both taking your time to be down here.

Dr. DERELIAN. Thank you.

Mr. ENSIGN. This Subcommittee will stand in recess until 1 o'clock.

[Whereupon, at 12:35 p.m., the Subcommittee was in recess, to reconvene at 1 p.m., the same day.]

Mr. CHRISTENSEN [presiding]. We are going to get started here.

I am going to have Congressman Payne introduce a couple of his constituents first. I want to also make a comment that Mrs. Johnson and Mr. McDermott are in an Ethics Committee meeting now. I wanted to confer to the panel that Mr. McDermott wanted to extend a personal welcome to Mr. Jaffe from Harborview Medical Center. That must be up in the great State of Washington. Is that correct?

Mr. JAFFE. Correct.

Mr. CHRISTENSEN. Mr. McDermott welcomes you, and we welcome you.

Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman.

I wanted to welcome all of the witnesses who are here for this panel and to say that we appreciate very much the fact that you are here, and a special welcome, too, to my own two constituents who are part of this panel.

On the far right, your left as you are sitting on the panel, is Bud Thompson. Bud is administrator of the Franklin Memorial Hospital in Rocky Mount, Virginia. This is a very successful rural hospital in our district. In addition to that job and many other things that Bud does, he is also chairman of the Virginia Hospital Association's Task Force on Small and Rural Hospitals. Bud, we are pleased that you are here with us today.

We also have Dr. Bob Cantrell with us today. Dr. Cantrell is the acting vice president and provost of the University of Virginia Health Sciences Center. The University of Virginia Health Sciences Center, if not the finest, we think is certainly one of the finest in the United States, and we are very proud of it. It is not only a very large health center, it is also extremely important to our area in terms of its employment, where almost 6,000 people are employed with the Health Sciences Center.

Dr. Cantrell, thank you very much for being here. Bud Thompson, thank you very much for being here.

Thank you, Mr. Chairman, for giving me this opportunity.

Mr. CHRISTENSEN. Thank you, Mr. Payne.

The Health Care Subcommittee would be pleased to hear testimony of this panel, the last panel of the day. We will start from my left to the right and start with Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. Thank you very much, Mr. Chairman.

I am Larry Gage, president of NAPH, the National Association of Public Hospitals. NAPH's members include over 100 metropolitan area safety net hospitals which provide more than 90 percent of their services to Medicare, Medicaid, and low-income uninsured and underinsured patients.

They also provide many costly preventive, primary, and tertiary services to their entire communities, not just the poor and the elderly. These services include maintaining a wide variety of round-the-clock standby care, such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and manmade disasters.

I am very pleased to have this opportunity to testify today on the subject of Medicare reform generally and those aspects of the Medicare Program that directly affect America's essential providers. I am also pleased to be joined by David Jaffe, who is one of the members of NAPH.

With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are as concerned as you are with rising health costs.

Last week, we saw press reports that the Subcommittee may be considering unveiling a far-reaching proposal that would, among other steps, greatly accelerate enrollment of the elderly into managed care plans.

Let me say at the outset that NAPH is pleased that Members of the Subcommittee's Republican leadership are considering health system reform. We would prefer to see reform apply to all Americans. We agree with the need to bring the Medicare Program in line with trends that are affecting the rest of the health industry.

However, we have a number of general and specific concerns about how such a proposal would fit into the forthcoming budget reconciliation debate which we would like to share with you.

Let me summarize my prepared testimony by commenting in just three major areas. First, on this the 30th anniversary of final congressional passage of Medicare and Medicaid, we are seriously concerned with the ability to implement any positive reforms in the context of a $45 billion-plus budget reduction in Medicare and Medicaid.

We accept the fact that Americans want less government, fewer regulations, more competition, and ultimately a balanced Federal budget. However, we disagree that the Americans want to meet these goals by decimating our Nation's health and social infrastructure and eliminating any semblance of a safety net for the poor and disenfranchised.

We recognize that the long-term stability of Medicare is important and that both Medicare and Medicaid, after 30 years, are ripe for reform. We further agree that major reductions in the rate of growth are both inevitable and necessary, perhaps even on the order of $55 billion for Medicaid as proposed by President Clinton and $160 billion for Medicare as suggested by AHA president Dick Davidson in his testimony last week. We have suggested some ways in which these reductions could be equitably achieved. But we agree with Mr. Davidson that all stakeholders must share in the pain.

This brings me to my second point. While we support health reforms such as those included in the draft circulated by some Members of this Subcommittee last week, we are concerned that they ignore the uninsured and the inadequately insured. Even modest reforms that do not address all of the populations in need of health coverage are likely to make matters worse for those individuals and families they leave out.

Essential providers such as NAPH member hospitals have traditionally been the sole source of critical health care for these individuals, and they will continue to play this role in the future. A full 33 percent of our inpatients fall into self-pay or other categories, and 47 percent of our outpatients. As you well know, this is often a euphemism for no pay. And with 90 percent of our patients either uninsured or covered by Medicare and Medicaid, there will be simply nowhere to shift the costs to make up this deficit.

My prepared testimony does include a number of specific proposals for preserving and protecting safety net providers in the context of the forthcoming debate over deficit reduction.

In conclusion, my third and final point specifically addresses the issue of managed care for the elderly and the poor. While we sup-

port the concept of managed care generally, based on recent experiences in Tennessee, Florida, and other States, we are concerned about the ability of the managed care industry to meet even current needs, let alone accommodate a significantly expanded Medicare population. And without an adequate managed care infrastructure in place, only the cost containment goals of this proposal are likely to be achieved through restricted choice and capped premiums, while the hoped-for improvements in prevention, primary care, and health status are unlikely to occur.

I have addressed a number of specific concerns in my prepared testimony about moving too rapidly into managed care or relying too heavily on it to contain costs. I have also expressed the view that, done properly, managed care can result in genuine improvements in health status and expansion of access for some of our most vulnerable patient populations, and I provided a number of specific comments on the draft specifications that were informally circulated last week.

I would be happy to answer any questions you may have at the appropriate time.

[The prepared statement follows:]

Statement of Larry S. Gage
President
National Association of Public Hospitals

before the
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C.

July 25, 1995

I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $17 billion, these hospitals provide more than 90 percent of their services to Medicare, Medicaid and low income uninsured and underinsured patients. They also provide many preventive, primary and costly tertiary services to their entire communities, not just the poor and elderly. These services include maintaining a wide variety of round-the-clock standby care such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

In just the last two years, NAPH members have been at the forefront of the response to community-wide crises that have included fires, floods, earthquakes, deadly new viruses, measles epidemics, environmental spills, air crashes, and urban riots. At the same time, their preventive and primary care services have been essential to meeting the day-to-day health needs of many millions of urban residents with restricted access to "mainstream" health services. In other words, these essential health systems -- which rely on Medicaid, Medicare and direct state and local governmental subsidies for over three quarters of their operating revenues -- already serve as a "national health system" by default in most of our nation's urban areas.

I am pleased to have this opportunity to testify before the Subcommittee on Medicare reform generally, and those aspects of the Medicare program that directly affect America's essential providers in particular. With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are as concerned as you are with rising health costs. Although in general, the hospital industry has not been the cause of recent growth in the Medicare program, we recognize that in the process of controlling costs, it may be necessary for some public hospitals to close, merge, downsize or consolidate. Already, many safety net hospitals are moving ahead rapidly to become more efficient and effective providers of care, through managed care and other means. At the same time, those Medicare hospital payments that are most vital to essential providers -- such as disproportionate share hospital payments and medical education adjustments -- have remained stable, with little growth, in recent years.

Last week we saw press reports that the Committee may be considering unveiling a far-reaching proposal that would greatly accelerate enrollment of the elderly into managed care plans, as well as give wealthier retirees other options such as medical savings accounts. This proposal would provide both carrots and sticks for the elderly. As we read it, the proposal would combine incentives and potential new benefits for those beneficiaries who choose managed care plans with fiscal penalties that would be levied against those who elect to remain in the current system.

Let me state at the outset that NAPH is pleased that members of the Committee's Republican leadership are again considering health system reforms. While we would prefer to see reform apply to all Americans, we agree with the need to bring the Medicare program in line with the trends that are affecting the rest of the health industry. We would very much like to work with the Committee to begin to consider genuine health care reform once again. However, we have a number of general and specific concerns about how such a proposal would fit into the forthcoming budget reconciliation debate, which we would like to share with you at this time.

Our comments on the budget and legislative proposals before you today can be summarized in three major areas:

- First, we are seriously concerned about the ability to implement any positive reforms, whether in managed care or other areas, in the context of the $450+ billion in Medicare and Medicaid budget reductions mandated by the Congressional budget resolution. While we accept the fact that Americans want less government, fewer regulations, more marketplace competition, and ultimately, a balanced federal budget, we disagree that Americans want to meet those goals by decimating our nation's health and social infrastructure and eliminating any semblance of a safety net for the poor and disenfranchised.

- Second, while we support health reforms such as are included in your proposed new legislation, we are concerned that they ignore the uninsured and the inadequately insured. Even modest reforms that do not address all of the populations in need of health coverage are likely to make matters worse for those individuals and families they leave out, even if they are of benefit to some.

- Third, while we support the concept of managed care generally, based on recent experiences in Tennessee, Florida and other states, we are concerned about the ability of the managed care industry to meet even current needs, let alone accommodate a significantly expanded Medicare population. And without an adequate managed care infrastructure in place, only the cost containment goals of your proposal are likely to be achieved, through restricted choice and capped premiums, while the hoped-for improvements in prevention, primary care and health status simply will not occur.

In the remainder of my prepared testimony, I will address each of these comments in greater detail.

THE MEDICARE AND MEDICAID BUDGET TARGETS CANNOT BE ACHIEVED WITHOUT DESTROYING THE PROGRAMS

On this, the 30th anniversary of the establishment of Medicare and Medicaid, it is important to pause and recognize the unsurpassed contribution that these landmark initiatives have made to the health of America's elderly, disabled and indigent. From our vantage point on the front lines of providing care to these vulnerable populations, NAPH members are daily witnesses to the positive impact that these programs have had on their beneficiaries.

Despite rhetoric to the contrary, these programs have achieved their results for the most part efficiently and economically. Medicare in particular has seen provider payments capped at a growth rate less than inflation for most of the last decade. And current projections for growth in the Medicaid program are largely due to demand for long term care and the growth in the number of recipients, with the poor elderly being a major factor on both fronts.

For these reasons, it is simply impossible for most analysts to imagine reducing spending in these two programs by almost half a trillion dollars over the next seven years without destroying both programs and disenfranchising tens of millions of elderly and low income Americans. Surely, it is impossible to contemplate implementing positive reforms such as are envisioned in the Committee's new proposal in the face of such reductions.

We recognize that the long term stability of the Medicare program is important, and that both Medicare and Medicaid, after thirty years, are ripe for reform. We further agree that major reductions in the rate of growth are both inevitable and necessary -- perhaps even on the order of $55 billion for Medicaid, as proposed by President Clinton, and $160 billion for Medicare, as suggested by American Hospital Association President Dick Davidson in his testimony last week. NAPH has already suggested some ways and some areas in which reductions could be equitably

achieved, but we strongly agree with Mr. Davidson that all stakeholders must share in the pain. And in particular, we ask that in enacting reductions, the Committee be attentive to the ability of our nation's safety net providers to continue to care for America's 41 million uninsured.

IF MAJOR BUDGET REDUCTIONS ARE REQUIRED, IT IS ESSENTIAL THAT AMERICA'S HEALTH SAFETY NET BE PRESERVED AND STRENGTHENED, NOT FURTHER WEAKENED

Essential providers such as NAPH member hospitals have traditionally been the sole source of critical health care for these individuals, and they will continue to play this role in the future. In addition to the 55 percent of NAPH members' gross revenues that come from Medicare and Medicaid, a full 33 percent fall in the "self pay/other" category. On the outpatient side, the situation is even more burdensome, with "self pay/other" patients making up 47 percent of our gross revenues. Unlike most other hospitals, "self pay/other" patients for safety net institutions are essentially "no pay" patients -- they simply do not have the means to cover their bills, and our hospitals do not recover the bulk of this revenue. The impact of reduced support for such patients due to budget reductions and health system reform is already graphically evident in metropolitan areas as diverse as Los Angeles, Memphis, Washington D.C., New York, New Orleans, Milwaukee, and Boston, where safety net hospitals are proposing to close, eliminate many essential services, or merge with or be purchased by private organizations or entities. And while some of these actions may turn out to be effective survival strategies, the issue of potential reduced access to care for the inner city poor, elderly and otherwise disenfranchised patients is one that must be addressed in each case.

Further reductions of the magnitude contemplated in the Congressional budget resolution will simply accelerate the spread of this trend into most American cities, and many underserved rural areas as well. To take just one example, NAPH's preliminary analysis of the impact of the proposed Medicare budget reductions shows that, under one scenario, our 100 member hospitals would lose $313 million in the year 2002, or 12 percent of our members' Medicare revenues.

In addition to affecting access to care, the potential economic impact of a severely crippled safety net hospital system is also likely to be great. These hospitals are major employers in their often economically-depressed communities, and they throw off significant ancillary economic activity for local businesses. Moreover, they provide unparalleled egalitarian educational opportunities within their urban communities. The inevitable indirect economic impact of cutbacks in Medicare should therefore also be seriously considered as you move to structure specific reform plans.

For all of these reasons, major reductions in future Medicare and Medicaid spending will actually require your increased attention to the needs of essential safety net providers, in order to protect and strengthen the foundation and infrastructure of our health system.

Let me now turn from the overall impact of the reduced spending targets outlined in the budget resolution to some observations about specific parts of the Medicare program that particularly affect essential hospital providers.

- Medicare DSH funding has been and will continue to be an essential piece of the patchwork funding that enables our hospitals to provide critical health services to the elderly, disabled and poor -- services that simply are not readily available elsewhere. DSH payments also help to underwrite the high-cost specialty services (such as burn care, level-I trauma care and neonatal intensive care) on which the entire community relies. For this reason, if DSH funding is to be reduced by 25%, as specified in your proposal, it is essential that the remaining amounts be more narrowly targeted on the highest volume providers of care to low income elderly patients.

- Although this subcommittee obviously does not have jurisdiction over Medicaid, it is also important to keep in mind that any changes made to the Medicaid program will directly impact Medicare DSH. The Medicare DSH formula is based in part on the number of days provided by a hospital to Medicaid patients, meaning that if Medicaid eligibility is sharply cut back (either through a loss of the Medicaid entitlement or through other means), Medicare DSH payments will be immediately reduced without a single change in the law.

- In addition, there are certain issues related to the calculation of Medicare DSH payments that need to be addressed. For example, as more states received waivers and Medicaid moves more and more patients into managed care, the Medicare DSH formula should be clarified to ensure that Medicaid managed care days are included in the equation for calculating Medicare DSH payments, even in states which have replaced their Medicaid programs under a waiver.

- With respect to medical education payments, again this source of support is virtually irreplaceable for major teaching hospitals in the current context. Eighty-five percent percent of NAPH members are teaching hospitals. As with DSH payments, the problems generated for public teaching hospitals by reduced medical education payments will affect their ability to cover the costs of caring for low income and uninsured patients.

WITH RESPECT TO MANAGED CARE, WE MUST BE CAREFUL NOT TO OVERPROMISE AND OVEREXPAND, BEYOND THE CAPACITY OF OUR HEALTH SYSTEM TO RESPOND

The term "managed care" is now so ubiquitous that it dominates the field of vision in both the private and public sectors of the our health industry. More than just a helpful tool, managed care has become a preoccupation -- perhaps even an obsession -- for private insurers, employers, and individuals, as well as for legislators and bureaucrats at every level of government. Yet it is an obsession that obscures the need for greater scrutiny of the managed care industry, in order to avoid potentially irreversible damage to the future viability, quality and ethical standards of health care providers, as well as to the good health of many millions of Americans.

In other words, before we continue this headlong rush into uncharted territory, we need to pause and take stock, to make sure our moral compass is working properly. We need to ask (and answer) some tough questions in the heat of the current debate, which I believe represents nothing less than a struggle for the reputation, ethics, values, even the soul, of the managed care industry.

The dilemma is essentially a simple one: what is "managed health care" and should it primarily benefit payers or patients? Is it largely designed as a blunt instrument for containing health costs -- as many policymakers in Washington and dozens of state capitols believe? Or -- as many managed care advocates would like to believe -- is it something else: a genuine health care delivery reform that shifts the historic emphasis from acute and episodic intervention to the prevention and maintenance of wellness?

This is not an idle question. If managed care is primarily the former -- a way to contain costs -- then we may be wasting our time worrying about ethics. As indicated by the recent publicity over the failure of some HMOs to pay for emergency services, if the bottom line is all that counts the patient and the provider will both suffer (this is true whether the bottom line is Medicare savings or higher dividends for shareholders). Of course, we would all like to believe that effective managed care plans can BOTH restrain costs and improve wellness. But the plain fact is, in the public sector at least, MOST managed care activities have been carried out in the name of short term cost containment rather than genuine health system reform.

There are perhaps several ironies here. The first, of course, is that there is increasing evidence that managed care is not much more effective over time in holding down health costs

than the fee for service system it is rapidly supplanting. Only the most highly organized and self-contained plans -- staff and group model HMOs -- have any measurable track record over time in holding down costs. For most other plans, after a brief initial flurry of savings -- often driven more by the arbitrary demands of payers than any inherent efficiencies in most organizations -- costs seem to rise at about the same rate as the industry as a whole.

A second irony is that the major underlying reasons for cost increases in the American health industry have little or nothing to do with either managed care or fee for service medicine. Rather, they depend on such factors as the large and ever-growing numbers of uninsured, continuing advances in expensive technology on both the outpatient and inpatient fronts, and the fact that no one yet has effectively cured most Americans from demanding the most and the best no matter what health plan they enroll in. (It cannot escape the Committee's notice that the so-called "point of service" managed care plans -- the most costly and least controllable -- are the plans that usually score highest in consumer satisfaction among HMOs.)

The third, and perhaps greatest, irony is that the steps which clearly could reduce health costs over time -- prevention, wellness and public health services -- are the last services added and the first ones on the chopping block when the primary goals are short term cost containment and profit-taking.

Certainly, there is no disagreement about the importance of preventive measures aimed at improving both individual and community-wide health status. Preventive health can minimize both the potential for excessive care in the fee for service environment and the potential for providing too few services in the managed care environment. Moreover, the assignment of patients to primary care gatekeepers who are able and willing to manage the full continuum of a patient's care, also improve a patient's health, and thus hold down long term health costs, even if more services are needed in the short run. But these features must be fully integrated into HMOs, not just grafted onto the surface. Of course, many managed care organizations and employers do try to emphasize wellness and prevention, or at least pay lip service. The problem is, we cannot demonstrate that these services will reduce health costs overnight. In fact, in the short run their effective use is likely to increase services and costs, especially for low income elderly patients historically deprived of such services.

Ultimately, of course, if "managed care" is seen only as a tool for cutting costs, the result will be a health system that is neither "managed" nor "care". We all know that there are more than a few dirty little secrets about the explosive growth in Medicaid managed care over the last several years. I will agree that some managed care organizations have developed elegant, sophisticated MIS and case management systems that emphasize prevention and wellness. Some plans may also have adequate and well-rounded networks of providers that are reasonably reimbursed even as they are given rational incentives to change wasteful practice patterns. However, many other organizations have simply grown too fast to take the time to develop such systems or incentives. Rather, they devote their efforts to enrolling mostly people who are young or healthy (or both), invest as creatively as possible the enormous cash flow generated by capitated payments, ratchet down payments to providers wherever they can, keep support staff to a minimum, erect subtle and not-so-subtle barriers to access, and pray no one needs a liver transplant before they can cut a deal to sell out.

Now it may sound from these statements that I am cynical -- perhaps even that I oppose managed care. But nothing could be farther from the truth. I belong to an HMO. NAPH has been working rapidly to help both public and private health systems develop or expand managed care capacity all over the country. Together with my associate, Bill von Oehsen, I have even published a new book -- a 1000 page "How To" manual for Medicaid Managed Care and State Health Reform. Managed care is not problematic in itself -- especially for the poor and disenfranchised. Done properly, managed care can result in genuine improvements in health status and expansion of access for some of our most vulnerable patient populations. It is just that,

done poorly, implemented too rapidly, or for the wrong reasons, it could be a setback, not an improvement, both for patients and for entire communities.

We need only look at the TennCare Medicaid debacle to see some of the problems we face when cost becomes the only issue. With TennCare, the state of Tennessee dumped all Medicaid and many uninsured patients overnight into ill-prepared managed care plans with inadequate provider networks, only to pay them premiums that were originally found to be 40% below acknowledged actuarial soundness. As recently as last month, TennCare rates were determined by Governor Sundquist's own TennCare Roundtable to remain 10-20% below costs. And in fairness to the Governor, who was not responsible for developing TennCare, he and his staff have now publicly committed themselves to implementing needed reforms.

I do not believe it is inevitable that TennCare represents the future of managed care -- but if we hope to expand such programs to include a substantial proportion of Medicare beneficiaries, we must act quickly, together, to set tough standards for equity, fairness, access, quality and fiscal integrity in managed care plans.

Finally, let me conclude my prepared statement with some specific observations about the managed care proposal introduced by the Committee:

- In addition to financial solvency and capital adequacy standards for health plans, it is essential that your proposal include assurances of actuarial soundness for plan premiums. Failure to do so will mean that managed care will be little more than a cruel hoax on most elderly patients, either limiting them to plans with severely reduced choice or requiring high out of pocket payments that will be beyond the reach of most lower income elderly.

- For example, as Medicare managed care expands, it will become increasingly urgent to reevaluate the AAPCC -- adjusted average per capita cost -- system used to pay HMOs. Currently, the AAPCC calculation is all-inclusive, incorporating direct and indirect medical education payments as well as DSH payments. Yet there is no requirement that the risk contractors pass these payments along to the providers for whom they are intended, or even that the HMOs have contracts with teaching or DSH hospitals. The problem has been noted by both ProPAC and the PPRC.

- It is also essential that any program of enhanced choices for the elderly take into account and coordinate carefully with the Medicaid programs (including residual programs in waivered states) so as to permit the widest possible range of choices for low income elderly patients as well as others. In that respect, we strongly endorse your proposal to adjust MediChoice rates for demographic and risk factors, provided there is also a requirement that such adjustments also are reflected in provider payments and contracting requirements to ensure that access is maintained for higher cost patients who reside in underserved areas.

- While the proposal would appear to require plans to agree to serve all beneficiaries on a "first come first served" basis, we know now from experiences in several states that plans have many sophisticated ways to avoid such obligations and protections and redline the poorest and sickest patients from their marketing plans. Tough criminal and civil liability standards must be included to ensure that all elderly, including the low income elderly, have a true choice.

- In general, managed care organizations (MCOs) have typically refused to recognize the higher costs incurred by teaching hospitals in negotiating rates, in both the Medicaid and Medicare context. For these reasons, NAPH urges you again to retain separate IME, DME and DSH programs, with payments flowing directly from the government to hospitals (or other non-hospital ambulatory teaching sites).

NAPH looks forward to assisting the Committee and Congress as a whole to work together on a bipartisan basis to develop rational Medicare reforms that will achieve real cost savings without placing the health care safety net in serious jeopardy.

I would be pleased to answer any questions you may have at this time.

Mr. HOUGHTON [presiding]. Thank you, Mr. Gage.

I am sorry that we have sort of shifted the baton here. I was not here to hear your earlier comments, but I certainly appreciate your being here and everyone else.

Mr. Jaffe, would you like to make a comment or two?

STATEMENT OF DAVID E. JAFFE, CHIEF EXECUTIVE OFFICER, HARBORVIEW MEDICAL CENTER, SEATTLE, WASHINGTON

Mr. JAFFE. Thank you.

Mr. Chairman and Members of the Subcommittee, my name is David Jaffe and I am the chief executive officer of Harborview Medical Center, in Seattle, Washington. I want to thank you for allowing me to appear here today.

I am here to tell you candidly without any sugar-coating what will be the real impact of proposed Medicaid and Medicare cuts on Harborview Medical Center and the people we serve within a four-State region.

Harborview is a King County owned facility managed by the University of Washington's School of Medicine. The management contract between the county and the university has existed since 1967.

With a handful of exceptions, every employee working at Harborview is a University of Washington employee. Harborview is the only level I trauma center in the State of Washington and, along with its regional burn center, serves patients from Washington, Alaska, Montana, and Idaho, referred to as the WAMI region. This region represents approximately one-quarter of the land mass of the United States. These critical emergent care programs serve as models across the country, as does the Medic One Emergency Response Program for which Harborview was the first home.

In terms of its payer mix and sources of revenue, Harborview has approximately 48 percent of its patients reimbursed through Medicaid, one of the highest percentages in the country, 19 percent through Medicare, 25 percent through private insurance, with approximately 9 percent being no pay at all.

Harborview's longstanding and unwavering mission has been to care for all persons, regardless of ability to pay. It has been and continues to be at the forefront of providing care to the underserved. It is important to note that that Harborview receives no operating support from King County.

Harborview is central to the unique role of the University of Washington's School of Medicine. The School of Medicine is the only medical school in the WAMI region. This is a regional program which trains, places, and supports retention of providers in the four States.

Harborview is one of the pivotal patient care teaching and research institutions in this valuable regional partnership. The salaries of the full-time faculty are mostly supported through the services provided by them at Harborview. The faculty is complemented by 123 residents in general and specialty fields. This is an integral part of the University of Washington's educational training and research programs. The School of Medicine, with Harborview being one of its primary focuses, maintains one of the largest National Institutes of Health supported research programs.

The impact of the proposed Medicare and Medicaid cuts on Harborview will be devastating. It is estimated that over the 7-year period, Harborview will lose approximately $125 million in Medicaid reimbursement and approximately $60 million in Medicare reimbursement. Harborview has been able to operate at a very slim margin and has been extremely effective in bringing down its costs by substantially reducing its length of stay and work force, and by implementing other efficiencies.

Recognizing that there is still room to reduce costs further through increased efficiencies, these increases in efficiencies would only make a mere dent in the $185 million. It is not by chance that we must depend on Medicaid and Medicare to provide many of the services needed by our patients. Trauma and burn, for instance, are not limited to people with insurance, and they are not by personal choice. They are the result of accidents, a car running a stoplight, a boiler in a ship exploding. The proposed cuts will severely limit our ability to provide these services.

The impact of these reductions are exacerbated by the disproportionate cuts being proposed for medical education. The primary purpose for our residency programs are education and training. Nonetheless, Harborview's ability to provide level I trauma services depends on having advanced house staff available 24 hours a day in the hospital. A substantial part of the cost of those staff is paid by Medicare. Also, the indirect part of medical education payments reimburses us for our disproportionate percentage of services provided to sicker and poorer patients.

Congress is faced with a difficult task. It must reduce the growth in expenditures and ensure that the Medicare Trust Fund has sufficient funds for the foreseeable future. It must ensure that the policy goals of the country are responsibly met.

We are not opposed to a number of the policies now being discussed. For instance, Medicare risk contracts are growing rapidly in our area, and we are participants in this process. There are strategies that can be expected to restrain the growth of health care costs. We need to look at these options and select policies that meet the Nation's needs and do not harm our basic and important services.

I would like to suggest a number of actions that Congress could take to decrease the impact of services like ours in the short run. Number one, cuts in Medicare should be less in areas of the country that are lower cost and more efficient. The Northwest has long treated patients more efficiently with shorter lengths of stay and fewer hospitalizations. This is a result of continually improving the way services are provided. Proportionate cuts would inappropriately punish providers who are doing a good job.

Number two, disproportionate share payments through Medicare and Medicaid should be continued. These policies have recognized for years that certain hospitals care for sicker and poorer patients. For Medicare, these payments should continue outside of risk capitation. For Medicaid, if it is block granted, States should be required to continue disproportionate share payments for a transitional period.

Number three, if reductions to growth rates must be made, they should be proportionally applied to all parts of the program. Dis-

proportionate cuts in medical education will severely impact service provided to people served by Harborview and similar institutions.

Number four, the education payments that Medicare pays to hospitals should be separated from risk contract payments. Managed care entities do not necessarily use the education funds for provider education and for caring for the sickest and poorest patients. To ensure that these funds are used for their intended purposes and not as a windfall, the funds should be separated from the managed care payments, put in a special fund, and distributed to the institutions that actually provide the education and services.

Number five, if reductions in growth are made in the Medicare and Medicaid Programs, those reductions should be accompanied by clear thinking, deliberation, and congressional direction about other sources of support for needed services. We cannot survive simultaneous deep cuts in all of the Federal programs that affect us without other sources of funds.

I appreciate the opportunity to speak to you today. I hope this has been helpful, and I would be pleased to respond to any questions you may have.

Thank you.

[The prepared statement follows:]

STATEMENT OF DAVID E. JAFFE
HARBORVIEW MEDICAL CENTER
SEATTLE, WASHINGTON

Mr. Chairman, Members of the Subcommittee, thank you for allowing me to appear today.

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In terms of its payer mix and sources of revenue, Harborview has approximately 48% of its patients reimbursed through Medicaid (one of the highest percentages in the country), 19% through Medicare, 25% through private insurance, with approximately 9% being no-pay. Harborview's long-standing and unwavering mission has been to care for all persons regardless of ability to pay. It has been and continues to be at the forefront of providing care to the underserved. It is important to note that Harborview receives no operating support from King County.

Harborview is central to the unique role of the University of Washington's School of Medicine (UWSOM). The UWSOM is the only medical school in the WAMI Region. This is a regional program which trains, places, and supports retention of providers in the four states. Harborview is one of the pivotal patient care, teaching, and research institutions in this valuable regional partnership. The salaries of the full-time faculty are mostly supported through the services provided by them at Harborview. The faculty is complemented by 123 residents in general and specialty fields. This is an integral part of the University of Washington's educational, training, and research programs. The School of Medicine, with Harborview being one of the primary focuses, maintains one of the largest National Institutes of Health supported research programs.

The impact of the proposed Medicare and Medicaid cuts on Harborview will be devastating. It is estimated that over the seven year period, Harborview will lose approximately $125 million in Medicaid reimbursement and approximately $60 million in Medicare reimbursement. Harborview has been able to operate at a very slim margin and has been extremely effective in bringing down its costs by substantially reducing its length of stay and work force, and by implementing other efficiencies. Recognizing that there is still room to reduce costs further through increased efficiencies, these increases in efficiencies would only make a mere dent in the $185 million. It is not by chance that we must depend on Medicaid and Medicare to provide many of the services needed by our patients. Trauma and burns for instance, are not limited to people with insurance, and they usually are not personal choice. They are the result of accidents -- a car running a stop light, a boiler in a ship exploding. The proposed cuts will severely limit our ability to provide these services.

The impact of these reductions are exacerbated by the disproportionate cuts being proposed for medical education. The primary purpose for our residency programs are education and training. Nonetheless, Harborview's ability to provide Level I trauma services depends on having advanced house staff available 24 hours a day in the hospital. A substantial part of the cost of those staff is paid by Medicare. Also, the indirect part of medical education payments reimburses us for our disproportionate percentage of services provided to sicker and poorer patients.

Harborview's problems, and those of many providers of basic services, cannot be solved by caring only for those with insurance, or moving facilities to communities that are more wealthy or charging the insured more. Our hospital is full so we cannot just increase our volumes. We have been under revenue restrictions for years and must justify every dollar we spend. We have to date been successful in doing this while operating in one of the most competitive and efficient health care markets in the nation.

Our community has been very supportive of Harborview and the important mission we fulfill. Washington State has also been supportive in its reimbursement to Harborview, recognizing the critical regional role we play and our commitment to the underserved. Washington State, however, will not be able to pick up the slack resulting from the proposed cuts in federal funding. The state has already proposed the elimination of a $40 million program for the medically indigent, many of whom are seen at Harborview.

Congress is faced with a difficult task. It must reduce the growth in expenditures and ensure that the Medicare trust fund has sufficient funds for the foreseeable future. But, Congress must understand the impact of the policy choices it makes when it reduces these funds. It must ensure that the policy goals of the country are responsibly met.

We are not opposed to a number of the policies now being discussed. For instance, Medicare risk contracts are growing rapidly in our area, and we are participants in this process. There are strategies that can be expected to restrain the growth of health care costs. We need to look at these options and select policies that meet the nation's needs and do not harm our basic and important services.

I would like to suggest a number of actions that Congress could take to decrease the impact on services like ours in the short run.

1. Cuts in Medicare should be less in areas of the country that are lower cost and more efficient. The Northwest has long treated patients more efficiently with shorter lengths of stay and fewer hospitalizations. This is a result of continually improving the way services are provided. Proportionate cuts would inappropriately punish providers who are doing a good job.

2. Disproportionate share payments through Medicare and Medicaid should be continued. These policies have recognized for years that certain hospitals care for sicker and poorer patients. For Medicare, these payments should continue outside of risk capitation. For Medicaid, if it is block granted states should be required to continue disproportionate share payments for a transitional period.

3. If reductions to growth rates must be made, they should be proportionally applied to all parts of the program. Disproportionate cuts in medical education will severely impact services provided to people served by Harborview and similar institutions.

4. The education payments that Medicare pays to hospitals should be separated from risk contract payments. Managed care entities do not necessarily use the education funds for provider education and for caring for the sickest and poorest patients. To ensure that these funds are used for their intended purposes and not as a windfall, the funds should be separated from the managed care payments, put in a special fund, and distributed to the institutions that actually provide the education and services.

5. If reductions in growth are made in the Medicare and Medicaid programs, those reductions should be accompanied by clear thinking, deliberation, and Congressional direction about other sources of support for needed services. We cannot survive simultaneous deep cuts in all of the federal programs that affect us without other sources of funds.

I appreciate the opportunity to speak to you today. I hope this has been helpful and I would be pleased to respond to any questions you may have.

Respectfully,
David E. Jaffe

Mr. HOUGHTON. Thank you, Mr. Jaffe.

Now, Mr. Duckett, would you like to make your presentation.

STATEMENT OF GREGORY M. DUCKETT, SENIOR VICE PRESIDENT AND CORPORATE COUNSEL, BAPTIST MEMORIAL HEALTH CARE SYSTEM, MEMPHIS, TENNESSEE

Mr. DUCKETT. Thank you, Mr. Chairman.

I am Greg Duckett, senior vice president and corporate counsel for the Baptist Memorial Health Care System in Memphis, Tennessee.

The Baptist Memorial Health Care System is a diversified not-for-profit health care delivery system comprised of 33 health care corporations, 16 of which are freestanding acute care hospitals located in Tennessee, Arkansas, and Mississippi.

I am pleased to have this opportunity to appear before you not just because of the importance of the issue that is before this Subcommittee, but also because approximately 30 years ago the late Dr. Frank C. Groner, then-president of Baptist Memorial Hospital, appeared before Congress to express concerns about a program that was under consideration at that time. He stated that the program would grow out of control. That program was Medicare. A number of the concerns that he raised then are confronting us now.

Congress earlier this year established its framework for addressing many of the problems that confront our Nation in its budget resolution. As part of that resolution, a goal of $270 billion in savings would be achieved in the Medicare Program over the next 7 years. While I understand the need, no, let me say it is imperative that we get our house in order when it comes to our financial stability and viability, Medicare reform must be accomplished in a way to ensure that the benefits that are provided to the elderly are done so without punishing those who are directly involved with the responsible and humane task of providing those services.

In looking at the current guidelines established by Congress, I would be remiss to the people that we and other health care providers serve if I did not say that the level of cuts outlined in the budget resolution are too large and would take effect much too soon.

The future approaches that we take to control cost in the health care system must take into consideration the lessons learned from the past. We must reorganize both the priorities that are covered under the Medicare Program, as well as the incentives to those hospitals, physicians, and patients who utilize the resources.

With incentives, like the society that the health care system is a part of, we have evolved around incentives. That is to say that a number of the problems that we are discussing today grew out of an incentive taken to an extreme or an incentive whose usefulness no longer exists. Our system is honestly broken. It is broken financially, as well as in terms of the mechanics of the operation.

But as we seek to fix it, we cannot engage in a blame game. In terms of expectations, from the consumers, many providers heard the comment "I want the best, it doesn't matter what it costs." That is a direct byproduct of our third-party payment system. In terms of the incentives to the providers, we have all experienced the different reimbursement schemes under Medicare ranging from

charge-based reimbursement, to cost-based reimbursement and, last, to fixed-based reimbursement.

It basically has evolved from a mentality of more is better, meaning the more I as a provider can do, the more I will be rewarded or the better I will be rewarded financially, to underfix rate reimbursement to the less I can do, the quicker, as a hospital provider, I can get the patient out of the system, the better off I will be financially.

This historical perspective of reimbursement points to what is needed to reach any goal of reducing cost in the health care system and, in particular, the Medicare Program. To control cost of the Medicare Program, we must restructure the health care delivery system and set expectations that will provide proper incentives for us to move from a sick care system to one that is centered on wellness, one that will utilize coordination of care.

There are four interrelated factors that make up the cornerstones of American medicine. First, the quality of medical care, the cost of care, patient access to care, and the choice of providers. You cannot substantially alter one without having an impact on the other three. To solve the Medicare problem, we must look at all four.

The private health market has already recognized the benefits of more competition and are already bringing their health care costs under control. In Memphis, there is the business coalition known as the Memphis Business Group on Health. This coalition is made up of the larger employers in the city of Memphis.

Through published requests for proposals, these companies have been able to hold their health care costs down. Those proposals have included a variety of plans, ranging from fee-for-service plans through health maintenance organizations. The goal or the purpose of the business group is working. It is controlling cost in the Memphis market. We are expanding that through the development of our integrated delivery system to our rural and other health care settings for which we provide care.

The key is to provide every legitimate effort in reducing health care costs through coordinated delivery of services. But if we are unable to achieve the level of savings designed, I think two things should be taken into consideration. First, as we move beyond those levels of cuts, we must look at an independent commission, as has been advocated by other members that have appeared before this panel before me, to look at a constructive way of further reforming the Medicare Program.

Third, we should always look at creating a mechanism to provide for shared sacrifices. Just as there should be shared responsibilities among all providers and beneficiaries, there should be shared financial sacrifices that cover the entire spectrum.

In conclusion, let me say that a vital Medicare Program is essential to the elderly and it must be adequately funded. And if we look at addressing these problems in a thoughtful, logical manner, I think the end product will not only serve the good of the Medicare Program and other beneficiaries, but society as a whole.

Thank you.

[The prepared statement follows:]

REMARKS TO
HOUSE WAYS AND MEANS COMMITTEE
Subcommittee on Health
July 25, 1995
Gregory M. Duckett
Baptist Memorial Health Care System
899 Madison Avenue
Memphis, TN 38146

Mr. Chairman, I am Greg Duckett, Senior Vice President and Corporate Counsel for Baptist Memorial Health Care System in Memphis, Tennessee. The Baptist Memorial Health Care System is a diversified health care delivery system comprised of thirty three health care corporations, sixteen of which are freestanding acute care hospitals located in Tennessee, Arkansas and Mississippi. I am pleased to have this opportunity to appear before you, not just because of the importance of the issue that is before this committee, but also because about 30 years ago the late Dr. Frank C. Groner, then president for Baptist Memorial Hospital appeared before Congress to express concerns about a program that was under consideration at that time by Congress. He stated that the program would grow out of control. That program is Medicare. A number of the concerns that he raised then are confronting us. Medicare as well as our basic health care system has gone astray, in terms of its cost and the fundamentals of the system. Given the medical and financial realities of the Medicare program it is imperative that it be reformed.

Congress earlier this year established its framework for addressing many of the problems that confront our nation in its budget resolution. As part of that resolution, a goal of $270 billion in savings would be achieved in the Medicare program over the next seven years and $175 billion in Medicaid. While I understand the need, no, *the imperative* is that we get our house in order when it comes to our financial stability and viability. Medicare reform *must* be accomplished in a way to insure that benefits are provided to the elderly without punishing those directly involved and responsible for the humane and necessary task of providing that care. In looking at the current guidelines established by Congress, I would be remiss to the people that we and other health care providers serve if I didn't say that the level of cuts as outlined in the budget resolution are too large and take effect too soon.

Today's health care delivery system has evolved from a single compassionate function of tending to the health needs of individuals into a complex system of entities designed to reach a variety of needs in many different environments. Our future approaches that we take to control the cost of the health care system must take into consideration the lessons learned from the past. We must take into account the actuarial realities that the sheer size of the Medicare population will demand in the years ahead. These realities must bring about a significant and fundamental change in the way Medicare benefits are provided and funded. These changes may initially seem at odds with the traditional American expectation of unlimited medical care for the elderly. But none the less, if we are to provide this vital coverage to our senior citizens, we *must* reorganize both the priorities covered under the Medicare program and the incentives to those hospitals, physicians and patients who utilize those significant resources.

In terms of incentives the health care delivery system, like the society that it is a part of, evolved around incentives. That is to say a number of the problems that we are discussing today grew out of an incentive taken to an extreme or incentives whose usefulness no longer exist. Historically the Government has been the largest provider of incentives to the health care system.

To responsibly address the needs of Medicare I believe that it is important that we realize that the system is broke. Our health care system today is too expensive. As we seek to fix it, however, we can't afford to engage in a blame game.

The health care system that we have today exists because of the incentives and expectations that have been placed on our industry. In terms of expectation, from the consumer, we heard, "I want the best. Whatever it takes to get me well, I want it, because money is no object, I have insurance." Not many if any patients would say, "I can only

party payment system. The patient wanted and demanded the latest and best in technology. It is as though "high tech" equals high quality outcome.

In terms of incentives, we have all seen the impact of different reimbursement schemes. We started with Charge Based Reimbursement. Then we went to Cost Based Reimbursement and lastly Fixed Based Reimbursement (Per diems). It basically went from a "more is better" mentality to a "less is better". This means that as a provider, in order for me to succeed, I had to bill more. It moved under the fixed reimbursement to one of the less provided and the quicker a discharge was made the greater the financial success of the provider. All of these approaches were intended to hold down cost but they did not work. Not only did cost continue to rise during this period but it also created the infamous peril of cost shifting. Additionally, during the fixed reimbursement period, hospitals operated under incentives to limit the patients stay in terms of days in the hospital, but physician providers didn't. This divergence of incentives made failure inevitable.

This historical perspective of reimbursement points to what is needed to realistically and meaningfully reach any goal in reducing the cost of the health care system and particularly the Medicare Program.

To control the cost of the Medicare Program and reform our health care delivery system we must create a new paradigm. *We must restructure the health care delivery system to one that sets expectations and provides the proper incentives to move us from sick care to well care through the use of coordinated care.* This can only be achieved if all components of the reimbursement process and the delivery process work in conjunction with one another.

If as a nation we have limited resources to spend on health care, we must question everything that we do. We must begin to ask the tough question of "Does this add value to the outcome for the patient?" This is not a question to be answered in a vacuum. It deserves the input from all stakeholders, because if we are to be successful, it will take all of us working together.

Over the last two years, a lot has been said about changing the health care delivery system. There are four interrelated factors which make up the cornerstones of American medicine: The quality of medical care, the cost of care, patient access to care and the choice of providers. You cannot substantially alter one without having an impact on the other three. To solve the Medicare problem we must look at all four component parts. We need competition to bring down costs, data to track and ensure quality, planned uniformity to guarantee access and consumer choice to allow successful providers to be rewarded and further allow individual means and desires to be expressed.

You can change the incentives from a system driven and rewarded largely by volume to a competitive and capitated system driven by efficiency. That we must do. We must change in order to eliminate unnecessary and defensive medical costs and yet do so without damaging the quality of care.

The private health care market has already recognized the benefits of more competition and are already bringing their health care costs under control. In Memphis, there is the business coalition known as The Memphis Business Group on Health. This coalition is made up of the largest employers in the city of Memphis. Through published request for proposals these companies have been able to hold their health care cost down. Those proposals have included various types of plans for the employee to choose from: ranging from the traditional fee-for-service plan to a health maintenance organization plan. The efforts of groups like the Memphis Business Group on Health and the Washington Business Group on Health are already bringing their health care costs under control. They have recognized the power of group purchasing, data driven quality assurance and competitive bidding.

We must bring the Medicare program in line with the progress that is being made in the private sector. Progress that is based on financial and actuarial choices which reward those institutions who can deliver appropriate and efficient medical care. Also in the private sector, choices are being made by employers who now, more than ever, understand the mechanics involved in the delivery of quality care, and by consumers making choices about their own health care coverage, and using their own ability to help pay for some of those choices.

We must recognize also, that because of this relative new and dynamic progress in the private sector, there are no longer segments of the marketplace that will tolerate and accommodate the historical cost shifting of underfunded federal and state programs by struggling providers.

Progress in controlling costs in the competitive private sector has taught us: First, that each successful program is a team effort. An effort comprised of purchasers, insurers, providers and consumers working together toward a common end. It is the recognition of the needs of the other team members that begins the real process of managing care. One group does not long benefit at the expense of another, they have learned through education and experience to share the responsibilities, and the discipline needed to make it work. Second, the benefits of a successful program are based on the sharing of actuarial data, as well as goals and objectives. There must be accurate and timely data on the medical needs of the population and the efficiency of the providers serving those needs. In the private sector the most successful managed care partnerships are "data driven" in just such a way. We have learned that feedback is critical all along the continuum of care. Expectations must be compared to results, over and over again in a never ending search for a better way to provide quality care.

Restructuring the delivery system around the principles of managed care will curtail and contain the growth in our health care system. To the extent that sufficient savings are not derived to meet established guidelines, two things are essential before any further reductions are attempted. First, an Independent Commission should be established to comprehensively review the Medicare program to determine further reform for the program. For too long the approach to cutting the Medicare Program has been to cut reimbursement. If the goal of this congress is to ensure the long term viability of the Hospital Insurance Trust Fund, a number of tough issues must be addressed. Issues that desire more than being a political football. Actuarially, the numbers are staggering when we look at what is projected to happen to per capita earnings and the number of people eligible for the program. These dynamics must be dealt with first before they become crises and in an apolitical manner. Given our current structure the independent commission appears to be the best approach. Secondly, to the extent that there must be financial sacrifices, they must be shared. Every participant in the health care delivery process should share in whatever cuts are made in the program.

The Medicare population is dynamic. It is a population that changes year to year, that is aging year to year and one that is increasing in size each year as well. It is essential that Medicare have the funding necessary to make these changes and at the same time help educate this population on their own responsibilities to hold down the cost of care. It does not stop there, however. Congress must review measures previously enacted to insure that the purpose still exists that led to the enactment of the provision. Specifically as we work more closely with other providers concepts such as self-referral and anti-trust and anti-kickback must also be reviewed to insure that no unnecessary cost is passed throughout the system. Anything short of such unduly ties the hand of the providers. Additionally, each aspect of the Medicare program must be evaluated to insure that nothing inhibits the development of a complete continuum of care. We at BMHCS like other providers are working to develop what is called an Integrated Delivery System. This is basically a network of providers to insure the entire continuum of care. It is difficult to achieve this if at the same time Congress is looking at issuing a moratorium on different aspects of care, i.e., long term hospitals. We recently developed a long term hospital and are finding it to be a logical and necessary step in the continuum of care. Just as home health, outpatient services and entities are key components in delivering health care, long

term hospitals can under the proper circumstances be a key component. Also regulations related to reimbursement should not be changed haphazardly. As we hear of different proposals we are optimistic that change will continue to envelope progressive measures that are centered on the proper incentives. It is a bit disconcerting when we hear things like reducing or eliminating Medicare bad debt payments. As emphases are placed on fiscal responsibility and shared sacrifice, it is important to realize that this responsibility could have an adverse effect on a segment of our population that can't financially afford it, and thereby increase bad debt ratios to hospitals. This could have a detrimental effect on a number of hospital providers.

A viable Medicare program is essential to the elderly and an adequately funded program is essential to the providers of care. We in the BMHCS urge you to structure the means by which this care can be professionally and appropriately managed. Thank you.

Mr. CHRISTENSEN [presiding]. Thank you, Mr. Duckett.

Mr. Cantrell, the Subcommittee would be pleased to hear your testimony.

STATEMENT OF ROBERT W. CANTRELL, M.D., ACTING VICE PRESIDENT AND PROVOST, HEALTH SERVICES CENTER, UNIVERSITY OF VIRGINIA, CHARLOTTESVILLE, VIRGINIA

Dr. CANTRELL. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity today to share with you the impact of reductions in Medicare funding on rural academic health centers.

I am Robert W. Cantrell, M.D., acting vice president and provost of UVA, the University of Virginia Health Sciences Center in Charlottesville, Virginia.

I would like to address three areas of impact, clinical income, graduate medical education funding, and the economic impact beyond the institution. The University of Virginia Health Sciences Center is an academic health center located in rural central Virginia. The university has 556 medical students, 475 nursing students, and 678 residents in training.

The Health Sciences Center also includes a medical center providing all levels of care from primary through quaternary to the citizens of Virginia, the mid-Atlantic region, and beyond. We are a level I trauma center, the only burn center in our region, and we offer all levels of critical care, preventive services, and hospice care. We take our primary care into the community and rural counties.

Our Health Sciences Center's total budget approaches $600 million annually. The University of Virginia turns no patients away. Slightly less than one-half of our patients are medically indigent. These include approximately 20 percent of our patient population who are covered by Medicaid, and one-third of our patients who are on Medicare. We provided in excess of $35 million in uncompensated care last year. We do not begrudge providing so much free care, but if this amount were to grow or the reimbursements from paying patients, the majority whom are on Medicare, were to drop, the financial viability of our institution would be jeopardized.

More than three-quarters of our budget, roughly $460 million, comes from clinical income. One-third of our clinical income derives from Medicare, yielding an income of about $150 million annually. To reduce this figure by 10 percent would impact the University of Virginia by $15 million.

To put this in perspective, a 4-percent profit margin for medical centers is necessary to maintain financial viability. Our hospital revenues last year were about $375 million. Four percent equals $15 million. A 10-percent cut in Medicare revenues could create an operating loss leaving us with no money for capital equipment, improvements, clinical program development, depreciation, and no reserve to sustain us through more draconian reductions.

Added to these considerations is the impact of managed care. Medicare reduction would cause a precipitous cut in clinical income, but equally serious is the specter of Medicare cuts in the funding of graduate medical education. The UVA has 678 residents in training. We agree that too many specialists are being trained, and we are taking steps to train more primary care physicians.

In the last year alone, we have increased our number of generalists in training from 29 to 39 percent. Reductions in Medicare educational funding would have a serious severely deleterious effect on this initiative.

Virginia enacted legislation in 1992 to promote the training of generalist physicians. Under this initiative, we have placed students in primary care doctors' offices for the purpose of exposing them to careers in generalist medicine. Our hope is that many will choose family medicine for their future practice in one of Virginia's medically underserved communities. Fourteen of the seventeen counties which make up Virginia's Fifth Congressional District where UVA is located are medically underserved, according to Health and Human Services guidelines.

Medicare funding of graduate medical education compensates for teaching. Teaching hospitals are more costly than hospitals which do not train students or residents, for several reasons. Just two are that young doctors in training are less cost-effective practitioners and teaching them is time consuming for the faculty. Academic medical centers care for the sickest patients with the most complex and serious problems, especially the elderly and the indigent. As a result, our costs are higher, frequently over DRG allowances, and we are not adequately reimbursed for this care.

The Congress has provided payments for both direct and indirect graduate medical education costs. For the 7.7-percent figure now used for the indirect costs, which amounts to $25 million for the University of Virginia, reduced to 3 percent, as some have proposed, the UVA's amount would fall to $10 million, a reduction of $15 million per year. This could result in an operating loss. Should both graduate medical education payments and Medicare payments for care be reduced as proposed, we would experience a negative balance of $15 million. This would fore us to curtail some needed programs and services and probably lay off upward of 600 employees.

This brings me to my final point, the impact of reduced Medicare funding on the local and regional economy. The Health Sciences Center employs nearly 6,800 faculty and staff. We are the largest single employer in central Virginia. Medicare funding directly benefits those who are ill, but the money paid for their health care does not remain in a vault in the medical center. The largest segment of health care costs is salaries. Health care professionals buy food, clothes, cars, homes, and they pay taxes on their income. Based on the traditional multiplier effect of lost jobs in the economy, the economic loss of 600 jobs would probably be in the neighborhood of $30 to $40 million.

I appreciate the dilemma that you as elected officials have in trying to reduce the budget deficit. We have cut costs and we intend to continue these efforts. We cannot, however, absorb substantial reductions in Federal funding and still sustain our mission.

I pray that God will be with you as you deliberate on this and other pressing questions that face this Nation.

Thank you.

[The prepared statement follows:]

TESTIMONY OF ROBERT W. CANTRELL, M.D.
UNIVERSITY OF VIRGINIA HEALTH SCIENCES CENTER

Mr. Chairman and members of the Committee:

Thank you for the opportunity to share with you comments on the impact of reductions in Medicare funding on rural academic health centers. I am Robert W. Cantrell, M.D., Acting Vice President and Provost of the University of Virginia Health Sciences Center, in Charlottesville, Virginia. The views I relate today are my own, but I suspect that they hold true as well for similar rurally based academic medical institutions such as the University of Iowa or Pennsylvania State University. Indeed, many of the proposed Medicare funding reductions would impact significantly on all of this nation's academic health centers. These centers are already under siege by managed care and private sector market pressures, by constraints on research funding, and by state funding cuts.

I would like to address three areas of impact: clinical income, graduate medical education funding, both direct and indirect, and the economic impact beyond the institution.

The University of Virginia Health Sciences Center (UVA) is an academic health center located in Charlottesville, in rural central Virginia. The University has a School of Medicine which enrolls 556 medical students, a School of Nursing with an enrollment of 475, and graduate medical education programs at University Hospital and at associated regional hospitals which train 678 residents across the spectrum of medical fields. The University's Health Sciences Center also includes a comprehensive Medical Center providing all levels of care, from primary through quaternary, to the citizens of the Commonwealth of Virginia and the mid-Atlantic region and beyond. We are a Level I trauma center with helicopter and fixed-wing aircraft to transport patients from throughout the region. We are the only burn center in the region. Our services include adult critical care, intensive care for high-risk newborns and children, and heart and liver transplants. We have a comprehensive cancer center which offers particular expertise in cancers of the bone, breast, head and neck, lung, gynecologic system, gastrointestinal tract, and prostate. Our Women's Center has one of the first menopause clinics in the country, where women can receive gynecological and endocrinological care and mammography, all in one visit to a single place. In addition, we take our primary and secondary care services out into the community and to nearby rural counties — we operate a number of satellite clinics, are allied with several community-based practices, and offer mental health services through a rural outreach program. We also provide wellness and preventive medicine services through our Institute of Quality Health and home health care through our Continuum program. Our newest initiative, opening just this week, is a hospice and palliative care unit which has a cooperative relationship with the community-based regional hospice.

The University of Virginia turns no patient away. Slightly less than half of the patients we see are classified as medically indigent. These include approximately 20 percent of our total patient population who are covered by Medicaid. Fully one third of our patients are covered by Medicare.

The University's physicians and hospital together provided in excess of $35 million in uncompensated care last year. We are not complaining about providing so much free care — serving the medically needy who lack the means to pay is one of the reasons we exist. However, if this dollar figure were to grow, or if the compensation we receive from our paying patients — the majority of whom are on Medicare — were to drop, the financial viability of our institution would be seriously affected.

Were the University not here or were our ability compromised to provide care to all who need it, patients would be forced to travel hundreds of miles to receive the services they require. Since the most needy — medically and financially speaking — would be least able to travel, they would, in effect, be denied care.

The University of Virginia Health Sciences Center employs nearly 6800 faculty and staff and has an annual budget which approaches $600 million. We are the largest single

employer in central Virginia. Less than seven percent of our budget comes directly from the Commonwealth of Virginia to support health professional education. We receive more than $73 million annually from research grants, most of these awarded by the National Institutes of Health; it is worth mentioning that, since there is talk in these halls of reducing the NIH budget by ten percent, such an action would immediately cut our academic health center's research income by more than $7 million annually.

More than three quarters of the University of Virginia Health Sciences Center's budget — roughly $460 million —comes from clinical income. These are the dollars we earn from patient care. Approximately one third of our clinical income derives from Medicare patients. This yields us a Medicare income of about $150 million annually. To reduce this figure by ten percent would impact the University of Virginia by $15 million.

To put this in a simple financial perspective for our hospital operations: a four percent profit margin for medical centers is necessary to maintain long term financial viability. Our hospital revenues last year were about $375 million. Four percent would equal $15 million. A ten percent reduction in Medicare revenues could create an operating loss, leaving us with no money for capital equipment or improvements, no money for clinical program development, no money for depreciation, and no reserves to support us through difficult times or more draconian reductions. We must add into all of these considerations the impact of managed care, with many for-profit HMOs entering the area and skimming off as much as 30 cents from each health care dollar for profit and administrative expenses, then negotiating deep discounts in physician reimbursements and hospital payments.

These threats to our financial viability have not gone unheeded. We have already taken steps to operate responsibly on a leaner budget, in leaner times. As a result of a hiring freeze instituted in August 1993, the number of full-time equivalent employees in our hospital and clinics has fallent by 600, from about 4,800 to 4,200, resulting in savings of $20 million. A program of value improvement has yielded efficiencies of cost without compromising quality. For example, physicians, nurses, and administrators worked together to trim $8000 off the charge for coronary artery bypass grafting, reducing our total charge for this frequently performed procedure to approximately $28,000, which compares to a national average of $40,000. Similarly, charges for total hip replacements were nearly $14,000 at our institution in 1993 but now average $9,600, with uncomplicated cases in March 1995 being charged only $7,800 (the national average is $15,000).

While Medicare payment reductions would cause us to experience a disastrous cut in our clinical income, we also face the equally ominous specter of Medicare cuts in the direct and indirect funding of graduate medical education. As I pointed out earlier, the University of Virginia has 678 residents in training.at University Hospital and affiliated institutions. We agree that too many specialists and subspecialists are being trained — some of our specialty training programs are in a steady state or downsizing — and we are taking steps to train more primary care physicians, particularly family practitioners, general internists, and general pediatricians. In the last year alone, we have increased our number of generalists-in-training from 29 percent to 39 percent, and that number will grow. Reduction in Medicare educational funding would have a severely deleterious effect on this initiative.

The Commonwealth of Virginia wisely enacted legislation in 1992 to promote the training of generalist physicians, especially those equipped to practice in rural sites. In 1994, the Commonwealth apppropriated funds for this "Generalist Initiative" involving the state's medical schools. With the help of these funds, we are able to place medical students in primary care doctors' offices and reimburse the physicians for their time spent in teaching, all for the purpose of exposing these young men and women to and interesting them in careers in generalist medicine. In most instances, they not only practice with but live with their physician preceptors, so that they experience the day-to-day lives of these physicians, many of whom practice in rural settings

Our hope is that some of our students will find in their rural preceptorship experience a model for their future practice, in one of Virginia's many medically underserved rural communities. This is important, since fourteen of the seventeen counties which make up Virginia's Fifth Congressional District, in which the University of Virginia is located, are medically underserved according to Health and Human Services guidelines.

Note that I mentioned the Generalist Initiative funds are given to compensate private practitioners for the time they spend teaching medical students in their practice. This goes to the heart of the reason for Medicare funding of graduate medical education: compensation for teaching. Teaching hospitals — hospitals which serve as training sites for medical students and residents — are more costly than hospitals which do not have students or residents. There are several reasons why this is so:

- These young students and doctors-in-training are still learning how to become efficient, cost-effective practitioners. The faculty must take time to educate the trainees under their supervision and cannot practice as efficiently as private practitioners.
- Academic medical centers care for the sickest patients with the most complex and serious problems (especially the elderly), compounded by the indigent patients who do not exercise good preventive habits or seek care until their conditions are far advanced. Since Diagnosis Related Group (DRG) payments are uniformly applied and it is frequently difficult to indicate the more serious problems under a given diagnosis, the acuity of these patients is not adequately accounted for. As a result, our costs are higher, frequently over DRG allowances, and not adequately reimbursed.
- Much new technology is developed and applied in teaching institutions. The guidelines for using this new technology, along with the added precautions which must be applied, force our costs higher.

The Congress in its wisdom has recognized these facts in the past. In addition to providing payment for direct graduate medical education (DGME), Congress has passed legislation supplying indirect medical education (IME) costs to permit financial viability of teaching hospitals. It may be appropriate now for Congress to enact legislation requiring all for-profit medical insurance companies and managed care organizations to pay a share of these DGME and IME costs, since these entities are the beneficiaries of the education and training physicians receive at the nation's academic health centers. Medicare educational costs could then be reduced by the amount of this contribution.

It would be unwise, however, in my view, to reduce the DGME and reduce residents' salaries. Many, if not most,of these young men and women have substantial personal debt — in the $50,000 to $100,000 range — because of the high cost of medical education. Likewise, it would be unwise to reduce the IME payments. Were the 7.7 percent figure now used (which amounts to $25 million for the University of Virginia) reduced to 3.0 percent, as some have proposed, UVA's amount would fall to $10 million, a reduction of fully $15 million per year. Again, this could result in an operating loss. Should both IME payments and Medicare payments for care be reduced as proposed, we would experience a negative balance of $15 million. This would force us to curtail some programs and services and probably lay off upwards of 600 employees.

This brings me to my final point: the impact on the local and regional economy beyond the institution of reduced Medicare funding. It is important to realize that, although Medicare funding directly benefits those Medicare recipients who are ill, the money paid for their health care does not remain in a vault in the medical center. By far the largest segment of health care costs are personnel costs. These health care professionals use their wages to buy food, clothes, cars, and homes, and they pay taxes on their incomes. Based on the traditional multiplier effects of lost jobs in the economy, the economic loss would probably be in the neighborhood of $30 to $40 million.

I appreciate the dilemma that you as elected officials have in trying to reduce the budget deficit while not visiting severe privations on the citizens. As I indicated, we at the

University of Virginia have also responded to market forces to cut costs and increase the value of our services. We intend to continue these efforts. However, we cannot absorb substantial reductions in federal funding and still sustain our mission.

I am grateful for this opportunity to share with you information on the impact of the proposed cuts on an area with which I am quite familiar. I suspect that what I have shared with you is true for other academic health centers across America. Certainly it is true for our fellow rural academic health centers. I pray that God will be with you as you deliberate on this and other pressing questions facing this great nation. Thank you.

Mr. CHRISTENSEN. Thank you, Dr. Cantrell.

Mr. Thompson, the Subcommittee would be pleased to hear your testimony.

STATEMENT OF RAYBURN A. THOMPSON, JR., CHIEF EXECUTIVE OFFICER, FRANKLIN MEMORIAL HOSPITAL, ROCKY MOUNT, VIRGINIA

Mr. THOMPSON. Good afternoon. I am Bud Thompson, chief executive officer of Franklin Memorial Hospital in Rocky Mount, Virginia.

Franklin Memorial Hospital is a 37-bed facility providing a broad array of health care services, including acute inpatient are, home-based care and a variety of other outpatient services. Franklin Memorial is an affiliate of the Carilion Health System based in Roanoke, Virginia.

I am here to discuss the impact of Medicare cutbacks on Franklin Memorial. Medicare beneficiaries account for 63 percent of our inpatient days, amounting to 52 percent of our inpatient revenue.

Franklin Memorial has historically done an excellent job of balancing access to health care and providing a high-quality service with fiscal prudence. Based on the fiscal year 1994 Medicare cost report, Franklin Memorial had a PPS inpatient margin of 4.6 percent. This was achieved through the appropriate use of resources and proper utilization review management. However, the future does not seem as bright. Based on a Lewin-VHI model assuming a $250 billion reduction in Medicare spending over the next 7 years that they could project could result in a $94 billion PPS hospital payment reduction, Franklin Memorial would experience a negative margin of 11.77 percent in fiscal year 2000, rebounding to a negative 3.85 percent in fiscal year 2002. This loss may be compounded due to an increase in rate of growth of the Medicare population as a result of Franklin County becoming an established retirement community.

This negative trend will be complicated by rapidly increasing intolerance for cost shifting in the commercial market. Managed care is moving into southwest Virginia at a dramatic rate. A little over 1 year ago, there were no HMOs in our part of the State. There are now at least nine HMOs wanting to do business in our market. Based on interviews with these HMOs and major employers in the area, it is anticipated that as much as 60 percent of the commercial insurance market will be covered by an HMO within the next 4 to 6 years.

The projected Medicare reimbursement declines, coupled with an unwillingness of the commercial market to accept a cost shift, will pose significant fiscal pressures for Franklin Memorial. Though we expect to ratchet more costs out of Franklin Memorial through a reengineering effort, these reductions will not cover the Medicare revenue shortfall.

The Medicare revenue shortfall will force Franklin Memorial to consider eliminating or certainly scaling back servicers that now benefit Medicare beneficiaries, as well as other patients. A prime example of this is the support that we provide to the Free Clinic of Franklin County. Approximately 50 percent of the funding for this clinic is provided by the hospital.

According to census data, approximately 23 percent of the 65 and older population of Franklin County live below the poverty level. Despite coverage through Medicare and sometimes Medicaid, this population has difficulty financially accessing certain health care services. The Free Clinic of Franklin County helps meet the financial access for these residents.

Other examples could include eliminating or scaling back a variety of outpatient oriented services designed to give easy access to residents of Franklin County to, in the most dramatic cases, eliminating inpatient care services at Franklin Memorial. These decisions affect the 65 and older population most significantly due to mobility issues.

Though I understand this Subcommittee does not have oversight of the Medicaid Program, I would like to point out that the funding issues of Medicaid also exacerbate the fiscal stress of Franklin Memorial. 11.4 percent of Franklin Memorial inpatients are covered by Medicaid. Medicaid reimbursement is not adequate to cover the cost of care for these patients and, therefore, cost shifting is necessary.

I will close by summarizing the four principles presented by Dick Davidson, president of the American Hospital Association, to this Subcommittee last week.

First, change the delivery system to encourage more use of coordinated care, cooperating groups of hospitals, doctors and others who knit the fragmented delivery system together for patients and have powerful incentives to control costs.

Second, change the process by which Medicare benefits and funding decisions are made.

Third, make sure all stakeholders absorb spending reductions.

Fourth, ensure access to high-quality health are for our most vulnerable populations, the elderly, poor, and disabled.

Thank you for the opportunity to discuss the Medicare funding issue with you.

Thank you.

Mr. HOUGHTON. Thank you, Mr. Thompson.

I do not have any questions at the moment.

Mr. Payne, would you like to inquire?

Mr. PAYNE. Just very briefly. I again want to thank all of the panelists for being here. I apologize for the vote. In fact, we were coming in and out as you were testifying.

I just wanted to touch on something that Bud Thompson has just said and to make sure I understand this. You were saying that should the Medicare cuts occur as anticipated at a $250 billion level over the 7-year period, that it would make the margins of Franklin Memorial Hospital a negative of 11.7 percent in the year 2000.

Mr. THOMPSON. That is what I said, assuming $94 billion of that $250 billion reduction was directed toward hospitals.

Mr. STARK. Would the gentleman yield?

Mr. PAYNE. I yield.

Mr. STARK. Could he also inquire, would he consider inquiring, if you crank in the additional $180 billion in Medicaid cuts—I do not know how that would affect the gentleman's hospital in Rocky

Mount—but I wonder if you have taken that additional cut into consideration.

Mr. PAYNE. Is that part of that calculation?

Mr. THOMPSON. That is not part of this.

Mr. PAYNE. In addition to that, you mentioned that 11.5 percent of your business is Medicaid business, and the cuts in Medicaid then would affect that part, as well, which would further reduce your profit margin from a negative of 11.7 percent to an even greater deficit?

Mr. THOMPSON. I would suspect so.

Mr. PAYNE. You mentioned that one of the things that you could do immediately in order to respond to that would be to stop supporting the free clinic. As I and people in that area know, that is a very valuable service that is being provided in the area that is generally deemed to be medically underserved—more than 40 percent of the older population live below the poverty level there. So if you would stop doing that, then the impact to the Treasury likely would be that there would be more people who would be looking at Medicaid in order to pay their bills, is that correct?

Mr. THOMPSON. I would think that would be a possibility.

Mr. PAYNE. So their impacts are not even measured as you look at what is going on within your institution. There would be additional impacts, peripheral impacts that would occur.

Dr. Cantrell, you were speaking of the impact that would occur to the University of Virginia Medical Center from two sources, one from the reduction in terms of the payment of fees generally, which would amount to perhaps as much as $10 million, as you have stated, a 10-percent reduction, coupled with the reduction in the GME and IME funds I believe you said of an additional $15 million.

Dr. CANTRELL. That is correct.

Mr. PAYNE. So the two combined would suggest that there would be $25 million less that would be flowing to the University of Virginia's revenue stream than is flowing in today, if there was a 10-percent reduction in terms of the payment, and, two, if the 7.7 percent were reduced to 3 percent, if those two things happen.

Dr. CANTRELL. The Medicare amount of money is $150 million, so a 10-percent reduction would be $15 million for that, and 15 percent for graduate medical education funding, so the total would be $30 million. In addition to that, we have $73 million in research grants, most of them through the National Institutes of Health, and there is talk of a 10-percent reduction in that budget. If that happened, that would be another $7 billion hit on top, so the total could be as high as $37 million, and that is before any negative impact of managed care.

Mr. PAYNE. In addition to that, the State of Virginia at this time is funding less and less in terms of the needs of the University of Virginia Health Sciences Center.

Dr. CANTRELL. They fund only 7 percent of our educational costs through direct appropriations.

Mr. PAYNE. So there is then a combination of effects that are all occurring at the same time which will have an extremely negative impact on the University of Virginia, and many other institutions like the University of Virginia Health Sciences Center.

Dr. CANTRELL. Yes, sir, and I think these things apply uniformally to academic health centers across the country.

Mr. PAYNE. Thank you very much, Dr. Cantrell.

Thank you, Mr. Chairman.

Mr. HOUGHTON. Thank you, Mr. Payne.

Mr. Stark, would you like to inquire?

Mr. STARK. Thank you, Mr. Chairman.

I am sorry that I missed most of the presentations by the witnesses. I had a chance earlier today to summarize some of your testimony.

I wondered, Mr. Jaffe, if you could elaborate. As I understand it, your hospital is the only level I trauma center for four States in the Pacific Northwest.

Mr. JAFFE. Correct.

Mr. STARK. What happens to you with these cuts, whether it is Medicare or Medicaid, and also what happens to service in that area?

Mr. JAFFE. Suffice it to say that if the cuts go forward as proposed, and I had mentioned that the impact on Harborview over the 7-year period will be approximately $185 million. That is such a humongous cut, that to say that services will be seriously affected I believe is a gross understatement.

The losers in this, if this plan were to go forward, would be the entire region, which is one-quarter of the land mass of the United States. It is staggering, when you look at that, but that in fact is the case. We would not be able to continue to provide the level of service that we are providing now.

Mr. STARK. What does that mean, a level I trauma center? What does that mean when I hurt my leg at Sun Valley, which I would surely do if I went.

Mr. JAFFE. A level I trauma center means that you have to be fully equipped on a 24-hour basis to handle the most severely injured trauma and burn cases imaginable. Those would be terrible automobile accidents, gunshot wounds, victims of a ship boiler explosion, devastating fires, those types of things. Residents staff our emergency room and trauma departments and burn services 24 hours a day in all the specialty services to provide for that care. It is a very expensive operation. It is a very needed operation.

Mr. STARK. Is it something that the private system would want to pick up and make money on in this new proscribed or proposed competitive arena that we are trying to create?

Mr. JAFFE. I seriously doubt that. Harborview and the Pacific Northwest really has served as a model for trauma care throughout the country, and the way we provide the care, having only one level I and a series of level IIIs and level IVs throughout the region, is a very economical way to provide this type of care and has been used as a model by other trauma centers across the country. So I think what we have is extremely valuable. It has taken us a long time to get there, and I do not see anybody else wanting to get into that business.

Mr. STARK. Larry Gage, can you fill us in? If we move away from guaranteeing benefits and just guarantee a specific amount of dollars, my guess is that most of your member hospitals serve a very high percentage of people with no insurance at all. It does not mat-

ter whether the general public gets a voucher or not, there is now 40 million uninsured, and I imagine that is due to go up by about 7 million with the Medicaid cuts that are proposed. What happens to the members of the Public Hospital Association? What do you see as the fallout, say taking a 25-percent cut in your revenue stream by the seventh year? What do you project?

Mr. GAGE. Mr. Chairman, unfortunately, for better or for worse—former Chairman, old habits die hard, I am sorry—we are already seeing an impact from reductions that have occurred through another State, States that have reduced their Medicaid spending, States that through Medicaid waivers have ended programs to pay a disproportionate share of teaching payments under Medicaid, like the State of Tennessee.

We have seen States like California, where there have been very serious and persistent recession, loss of jobs, significant impact on Los Angeles County, for example, where I think only yesterday the Board of Supervisors was debating a proposal to close Los Angeles USC Medical Center, which is the very largest public hospital in the country with hundreds of thousands of uncompensated inpatient and outpatient services every year.

So we are already seeing this impact. The impact of a further 20 to 25 percent, I think my testimony noted that one of the configurations under a $270 billion Medicare reduction would be a reduction for just these 100 hospitals of about $313 million in the seventh year.

You are not going to see a system that is the same system that we have today. You are going to see a system that has dramatically restricted access for many different kinds of services that, as David Jaffe just pointed out, benefit the entire community, and not just the poor. You are going to see doors shut for the uninsured. You are going to see hospitals closing down or going out of business. The Oakland Highland Hospital has been teetering on the brink for the last couple of years, and reductions of this magnitude could push that county over.

Mr. STARK. Mr. Chairman, if you would indulge me, I would like to inquire a little further of Mr. Duckett and what is happening in Tennessee with managed care.

Mr. HOUGHTON. Go right ahead.

Mr. STARK. I did not hear your testimony, Mr. Duckett, but I presume your Medicaid Program has been sort of turned on end in a State that I do not imagine had a huge percentage of people in managed care plans 2 or 3 years ago, unlike my district, where 60, 70 or 80 percent of the people in my community are in either HMOs or managed care plans.

What can you tell us will happen to public hospitals there with the advent of a new plant, but now arguably with less money coming in? A lot of your seniors get Medicaid as their copayment and a way to pay their premium. I am not sure what happens to them. I am not sure what your Governor, our former colleague, will do. Can you make any predictions or any warnings about what would be different in a State that is already converted, as it were, to a competitive system?

Mr. DUCKETT. Mr. Stark, I would love to make some projections, as well as recommendations to Congress as you consider this most important issue.

First and foremost, having been a part of a community that is not really advanced in managed care when we look to implementing programs, the first word of advice I would provide to Congress is to go slow, because one of the most detrimental impacts that we have seen not just on public hospitals in the urban community, but all of the hospitals, Baptist being one of them, is that the rate by which we move into the program known as TennCare has caused some tremendous problems in terms of adequacy of networks to ensure that adequate health care is available to the entire population being served by the program.

So as we move toward managed care, as it is shared and as it is a part of my official comments, it is extremely important that we put the right incentives in place, coupled with an opportunity for sufficient time to be allowed to develop sufficient networks of providers so that vulnerable populations and nonvulnerable populations do in fact have legitimate access to care.

One of the biggest fallouts that we are having in the State of Tennessee, above and beyond or in addition to whether or not the program is adequately funded, is the tension that is developed between some of the managed care organizations and the providers, and that does not serve the end goal of providing quality health care to the public.

Mr. STARK. Are the beneficiaries confused? Do they need time also to learn? In other words, Kaiser-Permanente is 50 years old, and one-half of the people of my county belong to it, so it is something you grow up knowing about. You can get an argument of whether some people like it or some people do not. But in an area where suddenly being assigned to a doctor or if community clinics close, for example, as has happened in our area when managed care has taken over some of the Medicaid services, do the patients need time to adjust, to learn where to go, how to use the system effectively?

Mr. DUCKETT. Most definitely they do. We are creatures of habit, by and large, and unfortunately our program in the State of Tennessee did not provide for an adequate educational transitional period, as a result of which there was some duplication and unnecessary cost absorbed by a number of providers.

If, for nothing else, when you look at a number of the hospital providers, if individuals were accustomed to coming to emergency rooms as their primary care point of access into the health care system, that continued for a period of time, and as a result of which there were some unnecessary costs in terms of triage and in masking sure that there were no medical emergencies, and had the beneficiaries in this case then afforded additional educational opportunities, some of that could very well have been avoided.

Mr. STARK. I would love to go on, but I think suffice to say that your recommendation to us is that we could make changes, but do it carefully.

Mr. DUCKETT. Most definitely.

Mr. STARK. Do not rush into it, give the system a chance to adjust to its inertia and make the changes without harming a lot of people. That is what I am hearing, and I appreciate that.

Mr. DUCKETT. Yes, sir.

Mr. STARK. Thank you, Mr. Chairman.

Mr. HOUGHTON. Thanks very much, Mr. Stark.

I would like to ask a question or two. I was not intimately involved in this process, but there have been clarion calls for help ever since OBRA was enacted in 1993 in the market basket concept.

Mr. Thompson, I think you mentioned that you think you might have to close the free clinic. That is too bad, because I am sure that is important. But that really is not sort of the thrust of Medicare here.

Mr. Jaffe, maybe you could sort of work me through the arithmetic. How do you arrive at losing $125 million in Medicaid reimbursement? Since we really have not discussed Medicaid or had any sort of general guidelines, we really do not even know where we are going now, and some of the projections as far as Medicare, the same thing. I think we are generally talking about reducing it by about one-half the growth rate. But where these figures come from, I do not know what is going to happen outside this building 1 minute from now, and so maybe you could work through the arithmetic and give me some sort of a sense of this.

Mr. JAFFE. First of all, recognizing that Harborview has approximately 48 percent of its patients on Medicaid, that is one of the highest percentage payer mix in the country. In addition to that, we have 9 percent of our patients in the totally nopay category.

Mr. HOUGHTON. Right. I see that arithmetic. You have got it down here on the page.

Mr. JAFFE. We estimate that on the disproportionate share cuts for Medicaid alone over the 7 years, we would stand to lose approximately $25 million.

Mr. HOUGHTON. Give me sort of the general philosophy upon which you base that arithmetic, and also maybe you could move into Medicare after that.

Mr. JAFFE. I do not have all the specific numbers in detail with me. We would be happy to provide that to staff. Harborview, because of the types of patients it treats and the high number of uninsured that we treat and the indigent, we are provided with disproportionate share moneys that flow through the Medicaid Program, and we have estimated, based on the proposal, that this is the number that we would be impacted by. Again, I do not have the detail and the specifics on that with me here today, but could provide that to you.

We also have as part of the number, moneys we receive through the Medicaid Program for direct medical education. Those amount on the Medicaid side to about $8 million, and those moneys stand at risk under the new proposal.

[The following was subsequently received:]

Assumptions and Methodology Used in the Calculations of the Impact of Proposed Medicare and Medicaid Cuts for Harborview Medical Center

The estimated impact of the proposed Medicare and Medicaid cuts on Harborview Medical Center (HMC) over the seven year period totals $185 million. The following assumptions were utilized by the National Association of Public Hospitals (NAPH), and were utilized in the calculation of the impact on HMC. The figures calculated by HMC were further reduced by 50 percent to reflect a very conservative estimate of the impact.

Medicare ($60 million):

- Assumed 7-year total Medicare reductions of $250 billion of which $94 billion will come directly out of PPS hospital payments.

- Based upon Medicare inpatient operating payment levels from the 1994 cost report.

- Payment levels were rolled forward to estimate Medicare payments through the year 2002 under the current law assuming no changes in patient volume.

- The current proportions of Indirect Medical Education, Direct Medical Education, and Disproportionate Share funding to the current total Medicare funding were applied to the 7-year total estimate.

Medicaid ($125 million):

- Assumed current structure of the health care system remains constant to the year 2002 (i.e., HMC's 1993 percent share of Medicaid acute care spending is similar to what will exist in 2002. This will most likely not be the case given current trends in the environment and/or given the proposed radical restructuring of the Medicaid program and the effect of the magnitude of the proposed overall reductions. Specifically, some hospitals may close, resulting in a shift of an even greater number of Medicaid patients to HMC).

- Assumed Medicaid cuts will be borne proportionally in all areas of the Medicaid program.

• Long term care portion (36% of Medicaid expenditures) may not be cut as severely as the acute care portion.

• Assumed states would make dollar-for-dollar reductions in their Medicaid spending to correspond to the federal savings.

• The current proportions of Direct Medical Education and Disproportionate Share funding to the current total Medicaid funding were applied to the 7-year total estimate.

Mr. HOUGHTON. I would be interested, but I do not know whether you gentlemen would, in seeing some of the breakdown here, because I think maybe if we could take and prototype what you are doing, it would help us.

I had a fling or two in business myself and it all depended on what your assumptions were of where you wanted to end up. I am sure you have been very honest here, and I would be very interested in seeing this. I think we all believe in Medicare and Medicaid. We all think that this is an extraordinarily important program which was started 30 years ago, today or sometime this week.

We are all wrestling with the concept of how we can try to save the trust fund or save certain amounts of money. There are a variety of different ways of skinning this cat, and the thing we do not want to do is to ruin the system or hurt the people who are the basic recipients.

Mr. JAFFE. Sure.

Mr. HOUGHTON. Let me just ask you a question, if you could just bear with me. There was a health care system called Laurel Health Care in Wellsboro, Pennsylvania, right across the border from where I live, and this hospital was extremely concerned about just the issues we are talking about and strung out the figure, extrapolated some things, and all of a sudden found that they were going to go belly up.

They got a consultant who said the first thing you have got to do is to stop thinking of yourself as a hospital, do not think of those four brick walls and surgical services and things like that, think of yourselves in different ways. So in refiguring their mission—and it went out in terms of Meals on Wheels and in terms of a whole variety of different services in the community—they were able to think through where their position was going to be if some of the general assumptions of Medicare were adopted here.

I do not know whether that makes any sense at all, but we are constantly trying to do that and adapt and not hurt the program and not hurt the recipients. Maybe you would like to make a comment.

Mr. JAFFE. I agree wholeheartedly with you. In Harborview's case, given that we are the only level I trauma center in a four-State region, it is kind of difficult to back away from that mission. We do fulfill that mission extraordinarily well. As I said before, we re regarded as a model trauma center throughout the country and emulated by other systems. The care that we provide in that system is done economically, as economically as possible in delivering that type of very, very sophisticated care.

We are going out and relooking at the way we do things. We have been exceptionally proactive in reducing our costs. Our length of stay has dramatically dropped over the 1½ years. Our work force has also decreased. We have implemented a whole array of efficiencies of the hospital, and we still can do more. We are very confident that there is more room to become more efficient and save more money.

The problem is that when you are dealing with the magnitude of the numbers of $185 million, that the money that you could save from greater efficiencies is just a mere dent in that overall picture. But I agree with you in terms that we need to be part of the solu-

tion here. In the body of my testimony, I identify a number of ways that we see are ways, very responsible ways of saving money, of helping to save the program.

But they are, for instance, going ahead and taking a block grant and universally applying it across the country to States like Washington—this is an example—and Oregon, which have a wonderful record of bringing down their costs. You do not do that to States like ours and give us a double hit, when there are other States across the country who have not been as successful, and provide the same rate of reduction to them. That is just one example.

Mr. HOUGHTON. Those suggestions that you have were rather interesting. The worry that I have had—and maybe you gentlemen share this—is that as the system moves more toward the managed care and to the HMOs, those people—and I believe in the profit system, I came out of the profit system—those people who are going to be running the HMOs may not tip their hat to the education and the training. Therefore, I think what you did is you had suggested that certain funds be separated from those HMO payments. Would you like to elaborate just 1 second on that? That was point number four. Maybe I am misstating it.

Mr. JAFFE. Let me first say that the University of Washington School of Medicine turns out approximately 50 percent of its residents in primary care. That is a very important statement, because academic medical centers are oftentimes regarded as just spinning out specialists or turning out specialists, and we need fewer specialists is the argument, and we really need to focus more on primary care. There has been an overwhelming commitment on the part of the University of Washington toward that, and our residents go out into that four-State region and beyond and practice primary care, which is all part of the managed care system.

The academic mission is one that, if not supported, will be seriously jeopardized. In our State, being the only medical school in the four-State region, this would be incredibly damaging. The moneys that the medical school would lose just related to Harborview in terms of indirect medical education through Medicare are $23 million over the 7-year period. On the direct side, it would be $3 million, and that is just at the Harborview site.

You cannot provide the residents to staff a level I trauma center 24 hours a day without supporting the academic mission through those people. What my recommendation suggested is why include a cost for medical education embodied in a capitated rate for those that are not really providing the educational service, but better spend that money on the academic medical center which is fulfilling that goal and doing it extraordinarily well.

Mr. HOUGHTON. Thank you very much.

Mr. Payne, would you like to inquire again?

Mr. PAYNE. Let me just follow up on that. I know that Dr. Cantrell and I had a conversation about that same subject in terms of how the indirect medical expenses ought to be properly allocated, knowing that there are some needs to look at and visit the Medicare Program in terms of the rate of growth, and so forth.

Dr. Cantrell, perhaps if you could speak to that briefly, it might be useful for the Subcommittee.

Dr. CANTRELL. As I pointed out in my testimony, academic health centers are by their very nature less efficient than private centers, simply because the faculty who could be spending a lot of time seeing patients have to decrease the numbers in order to do teaching.

Now, it does seem somewhat inequitable to me that the burden of this teaching and this graduate medical education funding should fall necessarily on the Medicare Program. There are a number of for-profit managed care concerns and for-profit insurance companies who contribute nothing to the educational program, and these managed care programs, these HMOs do benefit from the training and education of these young men and women who are going into the health care profession.

It seems to me that it would be only appropriate that they should make some contribution to this educational fund, and for the amount of that contribution you could reduce the Medicare payments and that would then help in what it is that you gentlemen are trying to do with the Medicare budget. I just think that is equitable and fair.

So that would be one suggestion that we would offer to look at who benefits from this—and I am not talking about the patients in terms of benefits, I am talking about the companies that are in this for profit—it seems to me that they could affords to take some of their profits and pour that into the education of these academic health centers where the medical residents and students are being trained. That was one of the things that Congressman Payne and I discussed.

In alluding to what one of the other people said, I will acknowledge that there has been some fat in the system in the academic health centers. At the University of Virginia, since 1993, through attrition and a hiring freeze, we have reduced the number of people in the medical center alone by 600 FTEs, saving in the process $15 million. I am not certain that we can reduce those numbers very much more without seriously affecting the programs.

On the other hand, we do have critical pathways that we are utilizing for our high-volume procedures, such as coronary artery bypass surgery, which just a few years ago, in 1993, as a matter of fact, the cost of the total package was in the high $30,000 range and it is now $28,000. We have reduced that by $8,000 in that timeframe, compared to a national average of $40,000. On total hip replacements, which were in excess of $13,000 in 1993 at the University of Virginia, and without compromising quality, I might add, but just looking at economies and the physicians, the nurses, the administrators worked together on this, we have reduced the average cost of our total hip replacements this year to $9,600. And for the uncomplicated hip replacements in March of this year, they were $7,800.

So there can be some savings in the system. But the market forces are already forcing that, you see. But in order for us to remain viable and compete in a managed care market, we have had to reduce our costs, which most academic centers have been in excess of what a private medical center would have. In Virginia, we have reduced at the University of Virginia, which was the fourth highest in the State 2 years ago, is now 55th in terms of cost. So

there are savings in the system, but as one of the other people testifying today said, we should divide the cost of the care and the educational cost.

Mr. PAYNE. Thank you.

Mr. Chairman, may I make one other comment? You began questioning the remarks of Mr. Thompson as related to the free clinic. I think the point is that in a rural hospital, a large percentage of the revenues is Medicare business—in Mr. Thompson's case is 52 percent of his gross revenues, and we have hospitals that have as much as 70 percent of their gross revenues as Medicare business—and as this portion of the business is compensated in a different way and that is reduced, when you have such a high percentage of your revenue in that category, you really have two options. You can either, as you suggest, do some creative things and try to find new ways to generate revenue, you can reduce cost, or you can do both or some combination thereof.

I think with these hospitals that have such a high percentage of Medicare business as they are currently operating in rural areas, that there will be a number of responses. The worst responses in some of our areas is that the hospitals simply will not be able to make it because they will not be able to cut costs enough. I think what Mr. Thompson was saying is he did not know what they might be able to do to respond, but one of the things is that they are now engaging in subsidizing the availability of service for those who are indigent in the Franklin County and Rocky Mountain area.

So while you might say, Well, the Medicare cuts were made and they really did not affect the hospital greatly or they did not affect the care of those Medicare patients, I think if you look at the county, you see that a facility like that is no longer there, and they provided a tremendous service. In think in Groveton, we have a lesser health care service than we would have had had these decisions not been made. I think that was a point that Mr. Thompson was making in his testimony.

Thank you.

Mr. HOUGHTON. Anything more?

Mr. Stark, please.

Mr. STARK. Mr. Chairman, I just wanted to add with particular reference to the hospitals that these gentlemen represent. We are talking in aggregate figures of possibly having 23 percent less spending in 2002 than is anticipated. They anticipate in round numbers of the hospitals of the country getting $200 billion. So we are talking about $46 billion.

Now, you could average that over all the hospitals. But what we have before us are those people who are already receiving a lot of supplements because they have a huge number of uncompensated patients, and a huge number of high-cost payments in terms of teaching. If they were the average hospital, maybe they are only going to have a cut of between 1 and 2 percent in revenue, which perhaps you and I would agree that just efficiencies and planning ahead could resolve.

But where they already get I think a 16-percent bonus for disproportionate share because of high uncompensated care and high Medicaid patients where they have trauma centers that may not be

compensated, they have got all of the expensive end of that average and there are a small number. That is why it may be difficult in inner-city New York as compared, say, to outside of Manhattan, where they would have the same problem. Hospitals in suburban New York probably would not have quite the burden that these hospitals represent.

So I presume what they are doing, Mr. Jaffe, is taking an average cut and saying if my revenues were reduced from what I anticipate the baseline would be, that is where he comes up with that. Now, it could be that the final bill will take more out of the doctors than out of the hospitals, or more out of home health care. But all they have estimated on now is the averages of what the present baseline would take them to, and you can get some pretty frighteningly large size cuts if you follow that line.

Hopefully, the Subcommittee will be able in whatever the final product to take that into account and say we cannot just do it across the board, we never have for good reason, because we are hearing from people like this today who have special needs that probably make good policy to find a way to compensate.

I agree with Dr. Cantrell, I have always agreed. I have never been able to figure out why Medicare got hung with paying for medical education. I know why historically, but there was no reason. They kind of got to the end of the bill and they said, Oh, my gosh, how are we going to pay medical schools?, and they tacked it on Medicare. You and I would probably agree that it ought to be spread. It is a socially desirable thing and more people ought to pay their way. But we are stuck with 30 years of a tradition that that is how medical schools get funded.

If we are going to change that drastically, we ought not to leave them without a way to continue, and that is something I think we are going to have to resolve here, and I hope these gentlemen will give us some help as we do it. My experience with them is they have been very straightforward and not alarmists, and we are going to need their advice as we go through this, free advice.

I thank the Chairman for indulging me.

Mr. HOUGHTON. Thank you, Mr. Stark.

Would you like to make any comments about that? I have one more question to ask Mr. Duckett, but please go ahead.

Mr. DUCKETT. I would like to make a comment on graduate medical education, and particularly as we look at managed care and competition. I think the comments of some of my other colleagues on the panel are most important, because if we are going to a process where I must competitively bid for the services of another individual, if I have graduate medical education expenses as part of my overhead, then I have got to pass that cost on to the people that I seek to do business with.

So I wholeheartedly support and encourage Congress to look at ways to come up with a uniform mechanism whereby the cost of graduate medical education between those institutions that are providing it are addressed so as not to disadvantage some of the historical quality providers, as we move into this wave of managed care, because there is some fixed overhead associated, as the record will show.

Mr. HOUGHTON. Does anybody have any other comments here? It is not speak now, but forever hold your peace, because there will be other chances. But we really do want your input here. Any other comments on what Mr. Duckett has said, Mr. Stark or Mr. Payne?

All right. Well, I would like to ask one final question. I am fascinated by your reference to Dr. Groner, Mr. Duckett, and his apprehension about how this thing was going to get out of control, the Medicare Program. Of course, indeed it did.

But then you mentioned sort of creating a new paradigm. That always bothers me, that word. Maybe you could elaborate a little bit on what you think is important here. Again, we are all struggling with the resolution.

Mr. DUCKETT. The paradigms that are referenced in my prepared remarks is that when we look at the reimbursement or really what has gotten us to this point in terms of the cost component of health care, there were certain factors that came into play; namely those factors where the incentives were in place at the time.

I think some earlier individuals that testified before this Subcommittee indicated that the Medicare Program has basically become the standard by which a number of people structure their health care plans around, and as a result of which we went through the three distinct paradigms of charge-base reimbursement, then we moved to cost-base reimbursement, and then we ended up with fixed-based reimbursement.

Those are for me the paradigms of the past, because basically we had a situation where, in order to make money in the health care system, I had to provide more services in order to increase my margins. Then we got to a point where we had to provide less service under the fixed per diem reimbursement, less services while the person is in the hospital, get the person out as quickly as possible to maximize my revenue opportunities.

What I think is important as we move to the future, we have got to bring the stakeholders together to come up with an equation that will basically allow us to say what is the appropriate level of care necessary to address the health care needs of the people.

Mr. HOUGHTON. But it is not only the goals of what are the appropriate levels of care, it is the incentives that I think that you emphasized. I happen to agree with you, although I cannot break it down any further than this. But I think if we avoid the incentives as we restructure the program so that it is not a program by government fiat, but a program through basic incentives and competitive pressures, then I think we will be missing a big bet.

Mr. DUCKETT. In essence, I agree with that statement.

Mr. HOUGHTON. Good. Any other comments, words of wisdom, thoughts?

Thank you very much, gentlemen. We certainly appreciate this.

[Whereupon, at 2:30 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF CHIEF MASTER SERGEANT JAMES D. STATON, USAF (RET.)
EXECUTIVE DIRECTOR
AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished committee members, now that the budget resolution has passed in Congress and it is clear that there will have to be changes in the Medicare system, we are hopeful that a proposal that the Department of Defense is pushing, and we wholeheartedly endorse, will become law. I am speaking, again, of **Medicare subvention.** I am testifying on behalf of the Air Force Sergeants Association's 160,000-plus members. AFSA represents the millions of enlisted (noncommissioned) active duty and retired Air Force, Air National Guard and Air Force Reserve members, and their families. Many of our members have served their nation, entered their retirement years, and are now among those receiving care through the Medicare system. We are grateful for this additional opportunity to have AFSA's views heard on this subject.

As we have stated before, AFSA members understand the challenge that faces this committee in finding ways to control costs within the Medicare program. The overall costs and fees for service become especially significant for our members because of the lower enlisted military retirement pay. Large medical bills can wipe out the typically lower savings of this group of retirees.

That is why we once again urge the committee to support subvention: The transfer of funds from the Department of Health and Human Services (HHS) to reimburse the Department of Defense (DOD) for care received by Medicare-eligibles either in TRICARE or at Military Treatment Facilities (MTF) (on-base medical care facilities). The question is not spending HHS dollars versus DOD dollars; the real possibility is to save *taxpayer and beneficiary* dollars through this simple transfer of funds. Two bills have been introduced in the House that provide for some form of subvention: H.R. 580, sponsored by Representative Joel Hefley, and Representative Randy Cunningham's H.R. 861.

The necessity for subvention is clear: Even today, military members are told at every re-enlistment that in retirement, they and their families will have free health care for life. Enlisted retirees, because of their lower rates of pay, rely on this as part of a deferred compensation package. However, that promise has been broken over time. In fact, at age 65, they are, in most cases, prohibited from formally participating in military health care programs altogether. They are still officially able to use MTFs on a "space-available" basis. However, because of a lack of funds, space has become less and less available. Therefore, Medicare becomes their only option, and it is one that they are unable to comfortably afford because of their lower rates of retirement pay.

This policy is discriminatory and changes the rules for retirement after-the-fact. It is wrong for the government to treat those who secured this era of relative peace in such a fashion.

There has been a great deal of discussion in Congress of ways to incorporate managed care ideas into the Medicare system. AFSA believes DOD has a program that will best serve the needs of both the Medicare system and a number of beneficiaries.

The specific method for incorporating Medicare-eligible military retirees into a managed care system is by allowing them to enroll or remain in the TRICARE program after age 65. This three-part system, DOD's health care plan of the future, is currently available only to under-65 military retirees and their dependents, and active duty family members. TRICARE includes an HMO option, TRICARE Prime. Prime's enrollment fee and cost-shares also provide lower-cost care than traditional "fee-for-service" care associated with Medicare Part B insurance.

As I said earlier, the lower retirement income of <u>enlisted</u> military retirees and their survivors magnifies the issue of health care costs. The TRICARE program promises to offer enrollees much lower costs than current fee-for-service insurance programs. Additionally, military retirees would be allowed to stay in the Military Health Services System (MHSS) for life, as they were promised when they chose to serve their nation. At the same time, costs for their care would be reduced.

Another advantage in cost-savings would be that HHS would spend fewer dollars for the care it buys at MTFs than it does from civilian providers. Savings on-base are derived through the military's "utilization management" system, which is preventive in nature.

Medical resources are used in the most efficient way possible, and care is coordinated so that more serious treatment problems are headed off, thereby holding down costs. Put another way, the right treatment is given in the right place at the right time. Also, the cost of physicians is significantly tempered by the military rank structure.

Finally, MTFs already have an infrastructure in place, so the basic care components are there. The results, when comparing MTFs to civilian providers, are savings in costs, overhead and mark-up fees.

AFSA feels that Medicare subvention would make on-base care more likely for our older retirees and, at the same time, save program costs by reducing the level of Medicare expenditures for military retirees.

According to the Office of the Assistant Secretary of Defense for Health Affairs, one of the principle blocks to getting Medicare subvention enacted is a difference of opinion between DOD and HCFA regarding its cost and effectiveness in providing treatment to this group of beneficiaries. Ostensibly, however, it comes down to a budget "ownership" discussion. HCFA argues that care for Medicare-eligibles should not come out of its budget, because it believes care is already being provided for free at Military Treatment Facilities. But again, the reality is that fewer and fewer Medicare-eligible military retirees obtain "space-available" care, because the downsizing of the military has meant a dramatic reduction in the number of MTFs and fewer and fewer doctors to handle patient traffic.

The dollars needed to cover the cost of health care, whether paid out of DOD's or HCFA's account, come from citizens, either in taxes or program co-payments and/or enrollment fees. The greatest concern for both taxpayers and beneficiaries is getting the most value for their dollar. Retirees do not care which agency receives their premiums and enrollment fees, and taxpayers want to support their government fairly and wisely. TRICARE promises to offer lower-cost care to its beneficiaries than they are currently paying.

In recent weeks, DOD has stated that it believes it can provide care to Medicare-eligible military retirees for 93 percent of the Average Adjusted Per Capita Cost. Mr. Chairman, we are asking you to use your position of influence to bring all parties together and make subvention a reality for the substantial number of affected retirees.

We believe that through subvention the government would work for the best interests of its citizens and prevent, in this case, the opposing interests of government agencies from interfering with the needs of retirees.

Mr. Chairman, again, thank you for this latest opportunity to express our ideas on ways to lower the costs associated with the Medicare system. As you are determining how best to serve the interests of Medicare beneficiaries, we hope you will give our thoughts serious consideration. Approving ways to keep all retirees in the MHSS is not only cost-effective, it also keeps the promises made to retirees that they would have lifetime, affordable care as a result of their service.

The men and women of the Air Force Sergeants Association wish you well as you work to accomplish your important mission. As always, we are available to assist you in matters of mutual concern.

STATEMENT OF AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 37,000 member professional association of respiratory care practitioners (RCPs), welcomes the opportunity to submit written testimony on the House Ways and Means Committee's July 20, 1995 hearing on *"Saving Medicare and Budget Reconciliation Issues"*.

Respiratory care is an allied health specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and patients of all ages who require the use of a ventilator to breathe—all often cared for by the respiratory care practitioner.

The AARC shares the Congress' concern at the increasing costs of the Medicare program and the affect that this program has on the entire budget of the United States. We believe that, unless fundamental changes are made to the Medicare program, the cost escalation will continue until the entire health care system reaches crisis proportions.

The reevaluation of the Medicare program which Congress has undertaken poses many complexities. While the Medicare program has provided critical health services to American seniors for the last 30 years, the time has come to take a fundamental look at the basic tenets of the program. The respiratory care profession is specifically concerned that the Medicare program has not kept pace with the advancements in respiratory care medicine and technology. The program's coverage policy for respiratory therapy services was developed nearly 25 years ago, and has changed little since that time.

Respiratory care medicine has advanced well beyond the type of services that were only delivered in the hospital setting. Yet, Medicare has not updated and tracked these medical and technological developments and incorporated them into coverage policy. We believe Congress has an opportunity, as it begins to scrutinize the Medicare program, to rectify the imbalance in the current coverage policy with the reality of respiratory medicine.

We believe it is of significant importance that Congress must consider the direction that the private health care market is taking in terms of a strong movement towards managed care. Medicare must keep pace, and has until this point in time not kept pace, with the direction of the private sector. The premise of managed care is to provide the most appropriate care in the most appropriate care site. A survey by the AARC showed that a majority of managed care plans provide respiratory care services outside of the hospital setting (such as home, nursing home, outpatient, rehabilitation facilities, etc.) when deemed necessary. These plans have the flexibility of providing needed respiratory therapy services where appropriate. Yet under the Medicare program, a patient needing respiratory therapy services will be denied alternate care coverage for the services simply because of the coverage rigidity of the current system. Present Medicare policy must adhere to a strict list of benefits which prescribe precisely where respiratory therapy services must be provided. Patients in need of respiratory therapy services remain in the hospital because Medicare coverage policy deems that this is the only appropriate place to provide those services.

As advocates of the respiratory care community, the AARC and its members are acutely aware of the medical and clinical advances in the provision of respiratory care medicine, which now permits the pulmonary-restricted patient other pathways to receive the necessary evaluation, care, and treatment of their illnesses and diseases. For example, outpatient pulmonary rehabilitation has given many chronic lung diseased patients the ability to continue to lead productive lives at home. Pulmonary rehabilitation programs have greatly reduced hospital admissions, readmissions, and emergency room visits for asthmatics.

As another example, a ventilator-dependent patient who, twenty years ago, may never have survived or, at very best, be left totally hospitalized, can now be cared for in a less acute care site such as a nursing home or even in the home. Many of these patients can be fully or partially weaned from the ventilator and lead productive lives provided they have access to respiratory therapy.

For the last two decades, Medicare program has strictly interpreted a regulation that permits only respiratory therapists employed in a hospital with which there is a transfer agreement in place to provide Medicare-covered extended care respiratory therapy services in the nursing home. The restrictive nature of the rule ties the hands of a nursing home facility in its ability to seek out other qualified respiratory therapy practitioners. Even respiratory care practitioners who could be employed directly within the nursing home would be considered unreimbursable by the Medicare program. This is yet another example of an antiquated Medicare policy.

The AARC is well aware of the increasing concern Congress and the Health Care Financing Administration has in ensuring that only appropriate therapy services be provided and reimbursed in the home, the nursing home, and via the DME benefit. We share the concern that overutilization and outright fraud and abuse in Medicare is undermining not only the integrity of the program, but wasting tens of millions of dollars of taxpayers' money. We recognize that as we ask Congress to increase the access of Medicare beneficiaries to respiratory therapy outside of the hospital setting that the program does not incur the same overutilization errors that have plagued other therapy providers. In order to advert potential overutilization of respiratory therapy services outside of the hospital, we would urge Congress to require the use of Clinical Practice Guidelines as a requirement for any covered respiratory therapy service. For several years, the AARC has been developing Clinical Practice Guidelines (CPGs) for numerous respiratory care procedures. These Guidelines have been rigorously peer-reviewed, endorsed by key pulmonary physician organizations, and are becoming widely implemented across the health care delivery sites. Guideline development is an ongoing process and new guidelines are in various stages of review.

Again, we would urge Congress to remove the restrictions placed on the provision of respiratory care services to Medicare patients in alternate care sites with the caveat that services be rendered under the parameters of Clinical Practice Guidelines.

We hope this testimony will illustrate the need for change in the Medicare program to provide the flexibility to Medicare beneficiaries by providing them the ability to receive appropriate respiratory therapy services in the most appropriate setting.

STATEMENT OF AMERICAN ASSOCIATION OF DIABETES EDUCATORS

Testimony to the House Ways and Means Subcommittee on Health
July 25, 1995

Chairman Thomas, Ranking Member Stark, and members of the subcommittee, the American Association of Diabetes Educators would like to respectfully submit this written testimony in regard to Medicare reform. We hope, with the reinforcement of the testimony given today by our colleagues from The American Diabetes Association and the American Dietetic Association, that we convey that there is a way to reform Medicare which will ultimately save lives, and in the process save billions of dollars annually in health care expenses.

We would like to take a moment to address specifically the purpose and effects of diabetes education. The role of the diabetes educator is to integrate diabetes education and treatment into the overall care a person with diabetes receives. The diabetes educator must collaborate with all of the patient's management team.[1] The objective of diabetes education is to provide individuals with diabetes the management skills necessary to care for themselves. This is accomplished through planned learning experiences that include counseling, behavior modification, and individual classroom teaching designed to influence knowledge, health behaviors and to manage health outcomes.[2]

What does this mean in terms of Medicare reform? Diabetes is an enormously common and costly disease in the United States, afflicting 16 million Americans. In 1992, twenty-seven percent of the entire Medicare budget was attributed to costs for

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[1] American Association of Diabetes Educators. The scope of practice and the standards of practice for diabetes educators. Diabetes Educ 1992;18(1):52-56.

[2] National standards for diabetes patient education and American Diabetes Association review criteria. Diabetes Care 1986:9.

diabetes related illness. In total, $105 billion was spent in 1992 caring for people with diabetes.[3] But through studies funded by NIH and CDC, we have scientific proof that the most serious, and expensive, complications of the disease are preventable. Most of the 50,000 diabetic related amputations, 90 percent of the cases of diabetes related blindness, and more than half of the kidney failure resulting in dialysis can be delayed or prevented.

The scope and magnitude of diabetes in America can be appreciated if one looks at a list of the major debilitating conditions for which diabetes is the leading cause. Each year, almost 40,000 cases of adult blindness are due to uncontrolled diabetes; 54,000 amputations are due to uncontrolled diabetes; 13,000 people with diabetes begin kidney dialysis at cost of more than $35,000 per year; people with diabetes are two times more likely to die of heart disease, and; infants of women with uncontrolled diabetes have three times greater risk of being born with a birth defect and have over twice the risk of dying during pregnancy.[4]

Studies have proven that among the diabetic population, proper education and care dramatically reduce the risk of severe health problems like heart disease, stroke, gangrene, foot ulcers and amputations. And yet Medicare currently does not provide for these preventative measures. The AADE emphasizes that to reduce costs and to assure good health for people with diabetes, the Medicare system must direct its resources to early intervention and patient education. Diabetes care must focus on health maintenance and disease prevention rather than acute care treatment. Two recently introduced pieces of legislation, HR 1073 and HR 1074, take important steps in that direction.

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[3] Levetan, R., American Diabetes Association. Talk to Speaker Gingrich's Congressional Health Resource Group, June 22, 1995.

[4] American Association of Diabetes Educators, White Paper on Health Care Reform, 1994.

The American Association of Diabetes Educators commends and gives its thanks to subcommittee members Johnson, McDermott, Cardin and Lewis, for their cosponsorship of Representative Elizabeth Furse's bill, HR 1073, the Medicare Diabetes Outpatient Self-Management Training Act of 1995. We strongly encourage the remainder of the subcommittee, and the full committee, to lend their cosponsorship to this important legislation.

The cost savings offered by HR 1073 is significant. This legislation would expand reimbursement for diabetes education and substantially expand the provision of self-management training services outside the hospital setting. Given the ability to pay for these services, people with diabetes would have access to the educational and medical tools they would need to prevent or postpone more costly medical procedures necessary when the disease has progressed untreated. The cost of the treatment and supplies is low. Medicare would pay $35 for a patient's consultation with a diabetes educator and the cost of the patient's supplies and medications. For a visit that could cost as little as $50, a $1,500 dollar a day hospitalization could possibly be avoided later.[5]

The burden these expenses place on the current Medicare system extend throughout the nation's health care system. The United States of America has the most technologically sophisticated health care in the world. However, the very people who need it the most are often excluded because they are denied access to coverage due to a pre-existing condition. When these people's disease progresses untreated, the costs are often absorbed by the already over-burdened system. Additionally, our health system

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[5] Levetan, R., American Diabetes Association. Talk to Speaker Gingrich's Congressional Health Resource Group, June 22, 1995.

must have a strong public health component to assess the impact of diabetes, to promote policies that translate into preventive health care and to assure access to health care for the diverse population.

Providing diabetes education reimbursement and establishing a proactive health care system will help to address the immediate and profound expenses associated with this disease. Research has proven that the complications associated with diabetes can be delayed or avoided through the control of blood glucose. But additional research funding is needed until a prevention or cure for diabetes is found.

Medicare reform must be proactive rather than reactive. A proactive system focuses its resources on health promotion and disease prevention rather than acute care. It empowers the people with diabetes to take responsibility for their own disease management with the help of a multidisciplinary health care team. Essential to this personal responsibility is an integrated public and private health care system that ensures affordable access to preventive care and education for all, regardless of pre-existing conditions.

STATEMENT OF AMERICAN ASSOCIATION OF EYE AND EAR HOSPITALS

Background

- Congress enacted a Medicare payment adjustment for ambulatory surgery performed in qualified eye and ear hospitals in 1987 and extended the adjustment in 1990. The adjustment expired on December 31, 1994.

- This effort was designed to offset the impact of Medicare payment reductions on these specialty institutions and to recognize the need to maintain access to these unique services by Medicare beneficiaries. The disproportionate impact of reductions in Medicare payments for outpatient surgery in eye and ear specialty hospitals is based, in part, on the fact that outpatient revenues generally account for 50 percent or more of their total operating revenues.

- Eye and ear specialty hospitals are major referral centers. They offer some of the most innovative teaching programs in the country and routinely treat the most severely ill eye and ear patients. Eye and ear specialty hospitals have led the way as providers of first-class, high-quality, cost-effective outpatient health care services. The mission of these specialty institutions requires them to maintain leading edge technologies that enable them to provide highly specialized services that are not available in general hospitals.

- Under current law, qualified eye and ear hospitals are paid the lesser of their costs or charges or a blended rate of 75 percent hospital-specific costs and 25 percent of the ambulatory surgical center rate. Other acute care hospitals receive a blended rate of 42 percent hospital-specific costs and 58 percent of the ambulatory surgical center rate. Currently 11 hospitals across the country receive the adjustment.

Explanation

- When the adjustment—and the 1990 extension—was enacted, Congress expected that a Medicare prospective payment system for outpatient surgery would be ready for implementation. Despite efforts underway by HCFA, no viable methodology is adaptable at this point in time. Extension of the adjustment for another five years or at least until a prospective payment system for outpatient surgery and services is implemented is critical.

Mr. Chairman and Members of the Subcommittee, I appreciate this opportunity to submit testimony on behalf of the ***American Association of Eye and Ear Hospitals*** on the matter of Medicare outpatient payment reform in general, and specifically on our proposal to extend the Medicare outpatient payment adjustment for approved ambulatory surgical procedures performed at qualified eye and ear hospitals.

The American Association of Eye and Ear Hospitals is comprised of the premier centers for specialized eye and ear procedures in the world. Association members are major referral centers, offer some of the most innovative teaching programs in the country, and routinely treat the most severely ill eye and ear patients. The mission of these specialty institutions requires them to maintain leading edge technologies that enable them to provide highly specialized services that are not available in general acute care hospitals.

Eye and ear specialty hospitals have led the way as providers of first-class, high-quality, cost-effective outpatient health care services. As evidence of the level of excellent care provided by Association members, for the past five years the ***U.S. News and World Report*** has selected many of our members as being among "America's Best Hospitals" in the specialties of ophthalmology and otolaryngology.

This year, AAEEH members comprised eight of the top 17 ophthalmology facilities in the nation. Wilmer Eye Institute at Johns Hopkins University received the top ranking — a distinction which has continued for five of the last six years. Bascom Palmer Eye Institute was ranked second, followed by Wills Eye Hospital. Massachusetts Eye and Ear Infirmary was ranked fourth; former AAEEH member Doheny Eye Institute was ranked twelfth; Manhattan Eye, Ear and Throat Hostal was ranked eleventh; New York Eye and Ear Infirmary was ranked thirteenth; and University of Illinois Hospital and Clinics weighed in at seventeenth.

In the specialty of otolaryngology, AAEEH members comprised four of the top 40 facilities in the nation. Johns Hopkins was ranked first; Massachusetts Eye and Ear Infirmary was ranked second; Manhattan Eye, Ear and Throat Hospital was ranked 21st; and, the University of Illinois Hospital and Clinics was ranked 23rd.

The selection was based on reputational scores from physician surveys conducted over the past three years. These hospitals were recommended by at least 3 percent of the specialists in the field who were surveyed. From a universe of 1,631 major medical centers, only 128 were selected as the nation's best.

BACKGROUND

In 1987, Congress recognized the unique services eye and ear specialty hospitals provide — especially to Medicare beneficiaries — and moved to preserve access to these services by granting qualified eye and ear specialty hospitals a special Medicare payment adjustment for outpatient surgery and services they deliver. Congress extended the payment adjustment in 1990 until December 31, 1994, when it expired.

Under this Medicare Part B provision, qualified eye and ear hospitals are paid the lesser of their costs or charges or a blended rate of 75 percent hospital-specific costs and 25 percent of the ambulatory surgical center rate. Other hospitals receive a blended rate of 42 percent hospital-specific costs and 58 percent of the ambulatory surgical center rate. Currently, 11 eye and ear specialty hospitals qualify to receive the payment adjustment.

DISCUSSION

The proportion of total Medicare Part B medical and surgical services rendered on a hospital outpatient basis has increase over time as a result of shifting from an inpatient hospital setting to an outpatient hospital setting, due, for the most part, to advances in medical technology and the implementation of the inpatient prospective payment system (PPS). In the past decade, diagnostic and surgical technological innovations, such as laser surgery for cataracts, enabled more procedures to be performed on an ambulatory basis.

In addition, Medicare's PPS policies provided direct financial incentives to reduce admissions and lengths of stay and to provide services, where clinically appropriate, in other less expensive settings, such as the hospital outpatient department and freestanding ambulatory surgical centers (ASCs). Eye and ear specialty hospitals responded to these incentives like no other class of hospitals.

When the adjustment — and the 1990 extension — was enacted, Congress anticipated that a Medicare prospective payment system for hospital ambulatory surgery and services would be ready for implementation. Despite efforts underway by the research community and the Health Care Financing Administration (HCFA) to develop a methodology for such a system, no viable approach is adaptable at this point in time. This delay makes the re-instatement and retroactive application of the current payment adjustment for eye and ear specialty hospitals imperative.

The AAEEH — like HCFA — believes that the Medicare outpatient payment system is in need of reform for a number of important reasons. The current system does not reward efficiency — 93 percent of costs is the payment ceiling for both the most efficient and the least efficient hospitals. In addition, the Medicare program requirements for coding, billing and reimbursement are too complex. Moreover, hospitals are frustrated by the continual revision of those requirements. As a result, the administrative expense required for outpatient services is perceived to be high.

Finally, the current Medicare outpatient system is too complicated — the system has roughly a dozen different ways of determining payment. Subsequently, hospitals cannot determine what they will be paid or should be paid for delivering services. This limits the ability of hospitals to manage the costs of these services.

The AAEEH has offered to provide input to HCFA on its outpatient PPS plan as it is being developed. Most recently, we have asked the chief financial officers at each member facility to provide the Association with input on a number of matters in which we feel we can make a contribution to HCFA's proposal, especially in terms of evaluating possible grouping techniques, the framework for expenditure controls via volume performance standards, the design of possible payment adjustments, i.e., teaching, specialty care, and bundling.

While these constructive discussions between HCFA, the AAEEH and other hospital associations are proceeding, no specific outpatient PPS plan has been completed, nor is a plan ready for implementation. This delay — though judicious in order to assure the development of an equitable, workable plan — makes it all the more important for Congress to re-instate retroactively until December 31, 1994 the Medicare payment adjustment for qualified eye and ear

specialty hospitals and to extend it for another five years or at least until an outpatient PPS system is in place. In the meantime, the AAEEH will continue to work with HCFA on this very important initiative.

In its April, 1989 report to Congress, the Prospective Payment Assessment Commission (ProPAC) recommended that Medicare payment for ambulatory surgical procedures performed in eye and ear specialty hospitals be the same as it is for other hospitals. According to ProPAC's analysis, eye and ear specialty hospitals' costs are comparable to those of other hospitals within their peer group (i.e., urban teaching hospitals).

ProPAC did, however, conclude that eye and ear specialty hospitals are potentially more vulnerable to changes in Medicare outpatient surgery payments than other types of hospitals even though they may have comparable costs. According to ProPAC, there are three compelling factors which demonstrate the potential vulnerability of eye and ear specialty hospitals to changes in Medicare outpatient payment policy. First, eye and ear specialty hospitals' relative proportion of outpatient services versus other services is high; second, the majority of eye and ear specialty hospitals' cases are in the payment groups that sustain the greatest reductions under current Medicare payment policies, and, finally, eye and ear specialty hospitals' proportion of Medicare utilization is higher than other acute care hospitals.

Under the FY96 first concurrent budget resolution, this Committee has been instructed to recommend policy initiatives to reduce the growth in Medicare payments by $270 billion over the next seven years. The vast majority of these cuts will come from payments to hospitals. And, a large portion of *these* savings will probably be achieved by cutting payments to hospitals for outpatient surgery and services provided under Medicare Part B.

According to the Health Care Financing Administration, Part B spending is expected to grow at a rate of more than 13 percent in FY95, with growth rates between 11.5 percent and 13.5 percent for the rest of the decade. Growth rates for outpatient hospital spending are expected to exceed 14 percent over the next five years, the fastest growing portion of Part B spending. Given these trends, Congress is expected to severely cut back on Medicare Part B spending.

Unlike other institutions, eye and ear specialty hospitals have less flexibility to respond to shortfalls in Medicare payments because most of their patients are Medicare beneficiaries -- outpatient revenues generally account for 50 percent or more of their total operating revenues. There is little, if any, margin of error since these facilities have a very limited ability to recover losses from other sources.

Clearly, further outpatient payment reductions will cause irreparable harm to eye and ear hospitals, harm that its unavoidable even given prudent management decisions by hospitals and efficiency initiatives on factors within their control. The combined effects of Medicare payment reductions and the reality of losing the 75%/25% payment adjustments could indeed threaten the very existence of the nation's eye and ear specialty hospitals.

The AAEEH understands the need for cost-effective hospital operations — we have led the way in that regard. At the same time, we want to make sure that we are able to continue to provide the highest quality of health care possible for the Medicare beneficiaries we have served over the years. Extending the current Medicare payment adjustment for qualified eye and ear specialty hospitals will greatly assist our institutions in fulfilling our missions to provide this specialized care.

POSITION

As you consider proposals and alternatives to reform the Medicare program, we urge you to give serious consideration to the role of the eye and ear specialty hospital and the benefits of hospital outpatient service care. We know what those benefits are and so do our patients. Our cost saving and quality care techniques are real, quantifiable and, we believe, have merit for your consideration.

Because eye and ear specialty hospitals are particularly vulnerable to changes in Medicare outpatient payment policy and because they represent premier centers of excellence in their medical specialty the American Association of Eye and Ear Hospitals requests your support for legislation that will re-instate the Medicare outpatient payment adjustment that qualified eye and ear specialty hospitals received as of December 31, 1994, and extend that adjustment for five years or at least until Congress implements an equitable prospective payment

system for ambulatory surgery and services that adequately recognizes the unique characteristics of these institutions.

CONCLUSION

The American Association of Eye and Ear Hospitals and its member institutions appreciate this opportunity to share with you and Members of the Subcommittee our thoughts on Medicare outpatient payment reform and our proposal to re-instate retroactively the Medicare outpatient payment adjustment for qualified eye and ear specialty hospitals.

We respectfully request that as you contemplate changes in the Medicare program that you give serious consideration to our positions. We are confident that you will agree that our proposal is a credible way to protect one of the elements of the nation's health care delivery system that is the best that American medicine has to offer.

The AAEEH looks forward to working with the Members of the Subcommittee and their staff on these very important matters. Thank you.

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
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The American Federation of Home Health Agencies, a national association representing Medicare participating home health agencies, believes that Congress has a somewhat schizophrenic attitude towards the Medicare home health benefit. On one hand, Congress tells us that they understand why home care has grown and they are enthusiastic in support of the benefit... but at the same time there is a conflicting current that says, in effect, "home health is growing fast so we must shoot it."

CONGRESS SHOULD BE PRAISED FOR CREATING A SUCCESSFUL HOME HEALTH BENEFIT

Congress and the Clinton Administration have expressed concern about the recent growth of the Medicare home health benefit. Rather than regard this growth as a problem that must be attacked with imposition of bundling, beneficiary copayments or other artificial utilization controls, Congress should build on the great success of the home care benefit.

Hospital prospective payment (PPS), passed by Congress in 1982, has worked just as Congress intended it to work. It has resulted in the discharge of Medicare beneficiaries to the home and other outpatient settings more quickly and in a poorer state of health.

The growth of Medicare home care stems from a variety of factors, primarily:

1. Reimbursement changes, noted above, leading to the early discharge of Medicare patients from hospitals;

2. Technological advances which have given home health agencies the ability to provide all health services short of surgery in the home;

3. The aging of the American population, as well as an increase in the average age of home health recipients, which is now approximately 79 years of age;

4. Strong family and patient preference for cost-effective family-oriented home care services; and

5. A 1988 Federal court decision (Duggan v. Bowen) that reversed restrictive Federal policies which denied home health services to a number of otherwise eligible beneficiaries on the claim that they were in effect "too sick" for home care.

In addition to the overall growth of the home health benefit, per patient utilization of Medicare home health services has increased, from an average of 23 visits in 1980 to 53 in 1993. There are considerable state and regional variations in utilization patterns, as indicated by attachment #2.

No doubt there are home health agencies which have engaged in what could be considered "overutilization." Home health utilization must be appropriate; it is and should continue to be the duty of The Health Care Financing Administration (HCFA) and its intermediaries to ensure that the number and type of visits provided are appropriate.

Some in Congress and in the home health industry, however, may jump to the conclusion that "too many" visits are being provided in the high utilization states rather than perhaps "too few" visits are being provided in the states ranked near the bottom in utilization. We do not have a definitive explanation for the variation but we do have strong indications that there are legitimate reasons for the regional variations and that there is a correlation between utilization and outcomes.

I. Two articles in the Fall 1994 issue of the Health Care Financing Review, published by HCFA, indicate the following:

(A) Greater per patient utilization of home care may be associated with better patient outcomes, as indicated in a comparison of Medicare HMO patients with Medicare patients receiving services from fee-for-service home health agencies. Fee-for-service agencies provided significantly more visits and demonstrated significantly superior outcomes for beneficiaries. ("Home Health Care Outcomes Under Capitated and Fee-for-service Payment," Shaughnessy, Schlenker, Hittle, p. 187-p. 221);

(B) Higher utilization of Medicare home health services is directly related to:

- o the number of medical conditions and diagnoses a patient has ever had;
- o patients who have three to five deficiencies in activities of daily living (ADL);
- o beneficiaries who live alone;
- o racial minority status;
- o low income, as indicated by Medicaid eligibility, which in turn is related to poorer health status and higher morbidity; and
- o the number of nursing beds in the community -- home health utilization is higher in communities with fewer nursing home beds.
("A Profile of Home Health Users in 1992," Mauser, Miller, Fall 1994, p. 17- p. 33)

II. According to a September 30, 1994, study (Patient, Agency, and Area Characteristics Associated with Regional Variation in the Use of Medicare Home Health Services) prepared by Mathematica Policy Research, Inc., a research firm which frequently contracts with HCFA: "Resolution of the 1988 Duggan v. Bowen lawsuit led HCFA to clarify home health regulations in mid-1989... (T)here is anecdotal evidence that a substantial number of agencies have not attempted to make use of these clarifications because they still operate under the specter of the high denial rates of the mid-1980s." (p. 8).

The foregoing would indicate that many home health agencies may still be self limiting the number of visits provided, out of fear of denials. If providers self limit and do not exercise Medicare appeals rights on behalf of beneficiaries or on their own behalf, the number of visits per patient may well be artificially low compared to areas where home care providers and physicians (1) have adopted practice patterns which encompass revised and more expansive HCFA coverage criteria, and (2) vigorously exercise their appeals rights.

The Mathematica report tends to confirm a number of Mauser's and Miller's conclusions, noted in I.(B) above, with respect to the factors which are found in conjunction with high home health utilization in some states and areas of the country. Among the correlations Mathematica found are the following:

- o Home health beneficiaries in the South Central regions are "more likely than average to have primary diagnoses... of diabetes or hypertension and other cerebrovascular conditions,... were also much more likely to have a secondary diagnosis of incontinence... (I)ncontinent patients are more likely to develop dicubitus ulcers... that are difficult to heal and, if catheterized, are more likely to develop frequent urinary tract infections... (and) were... somewhat more likely than average to have a secondary diagnosis of malnutrition or dehydration, an indication of poor health status." (p. 34).

- o The percentage of elderly living in poverty is highest in the South Central region, and "Low income is often associated with poor health and may increase the use of home health care." (p. 37).

- o Racial minorities, a significant percentage of the population in most high utilization regions, are more likely to use home health services and to receive more visits than non-minority patients. (p. 34).

Mathematica also corroborates the link between the number of nursing home beds in a community and home health utilization, stating: "...(I)f nursing home beds are scarce, beneficiaries are more likely to use home health care (either while awaiting nursing home placement or instead of nursing home placement). Similarly, if hospitals have very high occupancy rates, they may be inclined to discharge patients sooner and with greater posthospital home health needs than otherwise." (p. 7).

Mathematica adds: "In addition, alternative providers (such as nursing homes) may be unwilling to serve a particular type of patient (for example, ventilator-dependent patients or patients with dementia) if they do not perceive themselves as adequately compensated for caring for that type of patient or if they do not have the specialized resources the patient needs. Care for some of these patients may then fall to home health agencies, if the patients also have skilled needs." (p. 7).

Home Care Is Cost-Effective Even For High-Utilization Beneficiaries

Home health care is cost effective even for the most frequent users of services -- those beneficiaries who receive more than 150 visits per year. According to Mauser and Miller, for this category of patients, the average number of visits received in 1992 was 250 and the average total reimbursement was $12,276.00. (p. 2).

We would contend that this is a great cost effective bargain for the American taxpayer. A patient requiring 250 visits a year is a very sick patient. If such a beneficiary is unable to get vital services in the home, he or she will end up in an institutional setting at a much greater cost to the Medicare program and the American taxpayer. Hospitals and skilled nursing facilities could not begin to provide substitute care at anywhere near the home health agency's level of cost effectiveness.

A COPAYMENT ON COST REIMBURSED MEDICARE HOME HEALTH SERVICES BURDENS BENEFICIARIES AND PRODUCES LITTLE BUT ILLUSORY SAVINGS

Imposition of a copayment on the Medicare home health benefit may at first glance appear to furnish an easy and fair source of revenue. Congress may look at other Medicare benefits like hospital and skilled nursing facility services, see a requirement for cost sharing that has saved the program money, and assume the same would be true if a copayment were applied to the home health benefit.

A copayment cannot be applied soundly in the context of a cost reimbursement system since all reasonable and allowable expenses incurred by a home health agency in the process of furnishing services to Medicare patients, including those associated with the copayment, are costs that accrue to the Medicare program.

A copayment imposed on the current Medicare home health reimbursement structure will have perverse unintended consequences. The most cost effective providers will be disproportionately disadvantaged. This will occur because copayments are likely to be based on average costs per visit, the model that has been incorporated into numerous deficit reduction and health care reform bills.

To illustrate the perverse impact, if the average skilled nursing visit cost is $80.00, a 20 percent copayment would be $16.00. This copayment amount would represent 27 percent of the per visit costs of an extremely efficient home health agency which provides a skilled nursing visit for $60.00, but only 16 percent for a high cost agency which provides a skilled nursing visit for $100.00. The lower an agency's cost, the greater the copayment burden. This situation will no doubt serve as an incentive for providers to allow their costs to move up to the cost limits.

In addition, the savings projected by beneficiary copayments are little more than illusory when applied to a cost reimbursed benefit. In scoring a home health copayment, it would appear that the Congressional Budget Office (CBO) failed to take into account provider behavioral changes that inevitably will occur if a copayment is imposed on the current reimbursement system. These changes, which are totally predictable, would result in new expenses for the Medicare program in the form of reasonable costs incurred by home health agencies. Among these are:

- hiring of new staff to perform the copayment billing and collection function;
- purchase or lease of new equipment, software, and supplies to assist in performing the collection function; and
- the interest cost of loans secured to allow the home care agency to continue operating while attempting to collect copayments from beneficiaries, third party payers, the Medicare program, and other Federal and state programs.

CBO scoring must also take into account the replacement value of home health care. Patients not receiving medically necessary services at home will end up utilizing more costly hospital and nursing home services at a greater cost to the American taxpayer.

In addition to imposing an enormous administrative burden, the cost of which will accrue to Medicare, copayments will represent small amounts and will cost more to collect than the amount of the copayments.

Truth in scoring demands that the above-mentioned factors be taken into consideration by Congress, CBO, and the Administration.

BUNDLING OF MEDICARE PAYMENTS IS ANTICOMPETITIVE AND DENIES PATIENT CHOICE

Senate and House Budget Committee documents propose bundling post-acute care services, including up to 60 days of home health care as well as all post-hospital SNF and rehabilitation services, onto the hospital DRG payment. Such a change in Medicare benefit and payment policy would make hospitals responsible for these services, supposedly correct the incentive hospitals currently have for discharging patients early to other settings, and save significant sums of money for the Medicare program. AFHHA has serious doubts about the validity of many of the assumptions underlying the bundling proposal. In addition, we are concerned about the negative consequences for Medicare patients and the freestanding home health industry that would result from adoption of such a scheme.

Among our concerns are the following:

- Medicare DRGs, designed for inpatient hospital care reimbursement, are not an accurate indicator of the need for post-hospital services.
- Only a small percentage of Medicare hospital DRG admissions are associated with post-hospital services.
- Many hospitals, especially rural facilities, will not be able or willing to assume the financial responsibility of arranging for post-hospital service, especially for an indefinite period of time.
- Contrary to Congressional budget committee claims, bundling will not lead hospitals to retain patients longer, but rather will extend current incentives for limiting inpatient care to post-hospital services.
- The bundling proposal is monopolistic and anti-competitive, and would have the effect of enfranchising hospital systems as the sole deliverers of post-hospital services.
- Bundling is anti-small business, and would lead to the destruction of a large percentage of the post-hospital infrastructure that currently provides home health, SNF, and rehab services in the community.
- Bundling is anti-patient freedom-of-choice, locking beneficiaries into the providers and modalities of care dictated by the discharging hospital.
- Bundling forces all Medicare beneficiaries who happen to be hospitalized into managed care whether or not they wish to be in a Medicare managed care system.
- Contrary to Congressional claims that bundling would take health care decisions out of the hands of government bureaucrats and turn such decisions over to health professionals, in reality bundling would have an opposite effect. It would take health care decisions out of the hands of physicians and other health care professionals and turn them over to hospital financial managers.

Many of the above points are the very arguments that Republicans used so successfully against President Clinton's health care reform bill last year. Republicans charged that the President's plan was anti-competitive and would deprive consumers of freedom of choice of provider. The same charges can be leveled against the post-hospital bundling proposal. It is significant that House Speaker Newt Gingrich has stated on a number of occasions that he opposes forcing Medicare beneficiaries into managed care against their will. Post-hospital bundling would not appear to be consistent with this position.

PPS FOR HOME HEALTH CAN BE ENACTED TODAY

AFHHA advocates the application of market-based principles to the Medicare home health benefit, as a means of reducing inefficiency, providing incentives for cost-effectiveness, and reducing the cost of the program for taxpayers. Specifically, we have proposed replacing the current retrospective cost-based reimbursement system -- a system inherently devoid of incentives to providers to reduce costs and increase efficiency -- with a prospective payment system (PPS). Home health is still one of the few services not reimbursed prospectively by Medicare. There is widespread agreement among experts that the prospective system used for hospitals has resulted in significant program savings over the last decade and that similar savings could be achieved in home health.

In recent years Congress has twice indicated its desire to move the home health benefit off of the current antiquated reimbursement system. In 1987, it mandated a PPS demonstration which is still in progress and just now entering its second phase. In 1990, Congress directed HCFA to develop an alternative reimbursement approach for the home health benefit by October 1993. Although HCFA failed to meet this deadline, it has recently promised Congress a proposal by 1997. AFHHA believes we cannot afford to wait until 1997.

We have expended considerable time and resources in conducting expert actuarial analyses of HCFA's home health care cost data and formulating a legislative proposal that replaces the cost-based system with PPS. This proposal was incorporated into the Penny-Kasich and Kerrey-Brown deficit reduction amendments in 1993. It was also a part of two subsequent Republican budget resolutions. AFHHA believes the proposal has as much merit today as it did in 1993; indeed, the factors commending its adoption are far stronger today than they were in 1993.

The proposal would replace the current retrospective cost-based reimbursement methodology with a standard payment rate, prospectively determined, for each visit for each type of service. This PPS model is designed to promote the cost-effective delivery of quality services to Medicare patients and to reduce unnecessary regulatory burdens on agencies such as fiscal intermediary micromanagement of agency business decisions and practices.

The standard payment rate system, like the hospital inpatient prospective payment system, would be more effective than the current cost-based system in controlling costs. Because payment is made for the actual costs of services (up to a limit) the current retrospective system is inherently devoid of incentives to minimize costs. The standard payment rate system, utilizing fixed payment amounts, would give providers incentives to maximize efficiency and minimize costs. The benefit to Medicare would be program savings.

Further, under the proposal many of the administrative burdens that are part of the cost-reporting system would be reduced. Providers would still be required to make reports to HCFA through the fiscal intermediaries, but the reporting would be simplified.

Under the proposal an individual's eligibility for home health services under Medicare and patients' access to services would not be changed in any way. Neither would the proposal affect quality of care or utilization of the benefit.

Specifically, the proposal would:

* establish the base per visit rate for each type of visit at 93 percent of the mean of the labor-related and nonlabor costs of that type of visit, adjusted by the area wage index;

* update the per visit payment rates annually based on the home health marketbasket increase;

* as under present law, provide for an add-on for certain non-routine medical supplies identifiable as services to an individual patient (other than medical equipment, orthotics, and prosthetics) associated with skilled nursing visits;

* provide for the development by the Secretary of a system whereby an actuarially sound random sample (not more than 5 percent) of home health agencies is required to file full cost reports each year for the purpose of enabling Congress and HCFA to compare the actual costs of agencies with the standard payment rates;

* provide for the development by the Secretary through regulation of a simplified cost report for the same purpose stated above for the remaining 95 percent of home health agencies;

* provide for exceptions and adjustments to the payment rates (waiver) as the Secretary deems appropriate to take into account the special circumstances of only those home health agencies whose actual costs significantly exceed the standard payment rate amounts for reasons beyond the control of the agency.

While the government and the taxpayer realize genuine program savings, those HHAs who work to reduce their costs and promote efficiencies will be rewarded. Unlike the current system, the prospective payment system will foster efficiency by eliminating needless and time-consuming reporting and regulatory burdens. Even those agencies whose costs are above the payment rates -- and there will be some, just as there are already agencies with costs above the caps -- will be advantaged by being liberated from these burdens.

In addition to developing this proposal, AFHHA continues to work with other national and state home health associations, including through the "PPS Workgroup," on the development of a joint industry proposal that address Congress' concerns and ensures the benefit makes sense for beneficiaries, providers, and the Medicare Trust Fund.

KEEPING MEDICARE AFFORDABLE
RECOMMENDATIONS OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE

Introduction

Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in the knowledge that health care services will be accessible to them. The American Society of Internal Medicine, representing the nation's largest medical specialty and the principal providers of medical care to Medicare beneficiaries, is committed to preserving this contract with older Americans. However, in the face of changing demographics, burgeoning costs and the need to restrain overall federal spending, the Medicare program--as well as all those affected by its policies--is facing an unprecedented challenge.

If no action is taken, the hospital side of Medicare will go broke in less than a decade, the supplemental medical insurance portion of Medicare will consume increasing amounts of the federal budget and beneficiaries may face increasing difficulty in obtaining needed health care. This is clearly not a viable option.

Policymakers could continue with the historical approach to attempting to reign in Medicare's costs--enacting cuts in provider payments and imposing increasing regulatory rules on the program as part of massive year-end budget reconciliation measures. This, of course, does not address the underlying reasons for increasing costs under the program and will only serve to exacerbate many of the growing problems in Medicare.

The third option is to reform the Medicare program so that its financing is placed on a sound basis and to introduce the kind of marketplace incentives that have enjoyed success in the private sector in holding down the growth of health care costs. ASIM strongly believes that this is the only option that Congress should consider.

ASIM recognizes the urgent need for reforming the Medicare program and restraining growth in spending under other federal health care programs. *Ideally*, these changes should be made in the context of other health system reforms. Medical liability reform, insurance market reform, measures to broaden and protect choice of plan and physician, and ensuring due process for patients and providers in health plan operations and clinical decisions are important system-wide reforms that will foster an environment in which changes in Medicare will have a positive impact. Nevertheless, these recommendations are ASIM's response to policymakers calls for proposals to address the need for fundamental changes in the Medicare program so that it may continue to be a reliable source of medical care for the nation's elderly well into the new century.

The recommendations propose both immediate changes that can be made in Medicare financing and the current Medicare risk contracting program as well as longer term reforms to expand beneficiaries' insurance options through enactment of a defined federal contribution program.

Changing the Medicare Financing System

Last December, a report on entitlement reform options was issued by staff from the Bipartisan Commission on Entitlement and Tax Reform (hereinafter referred to as the Commission). That report identified a number of measures that could be enacted in the existing Medicare program to stem the imbalance in funding. Among those improvements ASIM supports are:

1. Increasing the eligibility age for Medicare to align it with eligibility for Social Security. It would make sense, both financially and administratively, to couple the eligibility age for Social Security with that for Medicare. However, such a change must come in concert with insurance market reforms and other measures to assist those elderly under 67 with chronic, but not disabling, illnesses in maintaining insurance coverage.

2. Increasing the amount contributed by upper income beneficiaries to financing the Medicare system. The Commission staff proposed reducing the Part B premium subsidy and creating a new Part A premium indexed according to growth in program costs. ASIM believes this premium should instead be indexed to income. This would avoid imposing an excessive burden on those with modest means while concomitantly calling for appropriate contributions from those with greater ability to finance their health care.

3. applying the Part B coinsurance to home health services. Current law requires no cost sharing by beneficiaries for these services. Home health care has been among the fastest growing parts of the Medicare budget and cost sharing has been demonstrated effective in stemming overutilization of services.

4. including in taxable income the value of health insurance benefits beyond a set value of insurance premium. Today, employers and workers benefit from a system that gives preferential tax treatment to high cost health plans. Placing a limit on the tax deductibility of such health insurance will promote the purchase of cost-effective but moderately priced health plans and would bring in significant revenue into the health care financing system.

5. limiting disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients. The Commission staff report cited studies showing that DSH payments, intended to compensate hospitals for services provided to low income individuals, have been used by some states for purposes beyond its original intent. Without harming those hospitals truly in need of these payments, the formula should be changed--e.g. elimination of DSH payments for hospitals whose disproportionate share index is below the 80th percentile--to avoid inappropriate uses of federal payments.

In accord with ASIM's longstanding policy that Medicare trust fund reserves should be augmented through a combination of expenditure reductions, program efficiencies and revenue increases, ASIM also supports:

6. increasing federal excise taxes on alcohol and tobacco if the revenues from changes identified above prove inadequate to finance an appropriate level of benefits. Not only would these additional revenues help to support the program but they would discourage certain behaviors that result in increased public and personal health costs.

ASIM believes it is time to rethink Medicare funding of graduate medical education, not simply as a device to reduce federal spending, but in order to respond to the changing health care delivery environment and to ensure that all components of the health care system that benefit from highly trained physicians contribute to the cost of their education. To those ends, ASIM supports:

7. creation of a national all-payer funding pool for GME. All payers and health plans should contribute a percentage of their premiums to a financing pool for graduate medical education. Until now, no one has asked health plans and insurers to help support the cost of training this nation's physicians. However, given Medicare's financial condition, the federal government can no longer be viewed as a major source of funding for the future supply of doctors.

8. creation of a private sector physician workforce planning initiative. The American Medical Association has proposed that a taskforce be established with participation of both public and private sectors to offer recommendations to Congress about the physician workforce supply and the future of GME. If the all-payer GME pool is established, such a task force will be necessary to advise how the funds in the all-payer pool would be distributed.

9. increasing the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the weighting factor for others. Currently, direct medical education payments are based on hospital-specific, per resident costs multiplied by the number of residents. Proposals have been offered in past Congresses to reimburse hospitals more for primary care residents than for specialty residents in order to encourage training of more primary care physicians. The need for more primary care physicians has grown with the increase in the elderly population as well as with the desire of health plans for physicians to manage the care of their enrollees. Alterations in the financing of medical education will encourage changes in training programs to meet those needs.

10. decreasing the number of funded residency positions to 110 percent of U. S. medical school graduates. The Physician Payment Review Commission has recommended that the number of funded residency positions in the United States be reduced in order to respond to the fact that the country is facing, in general, an excess of physicians. By taking this action, the U. S. would cut the oversupply of

physicians while at the same time--if the other steps are taken--increase the proportion of primary care physicians relative to the population.

Instilling Market-based Incentives in the Medicare Program

The Medicare risk contracting program was intended to encourage health plans to control utilization of services and, subsequently, costs. Because of flaws in the formula for paying risk contracting plans and because healthier beneficiaries are more likely to enroll in these health plans than other beneficiaries, the risk contracting program has not been as successful at reducing Medicare spending as originally anticipated.

Again, steps can be taken to improve this existing mechanism designed to enhance market competition until more substantial reforms are implemented. These include:

1. changing the adjusted average per capita cost (AAPCC) formula used to pay health plans. The current AAPCC is based on historical, fee-for-service costs in an area resulting in overgenerous payments to health plans in high cost areas and modest payments to health plans in regions where health care costs have been kept relatively low. The AAPCC should reward cost effective health plans in areas with historically low utilization rates instead of penalizing such plans with less generous AAPCC payments.

2. applying risk adjustments--such as severity of illness--in setting payments to risk contracting plans. This change should be coupled with other reforms in the AAPCC to avoid driving away from the program managed care plans that might attract more seriously ill patients and to make regional plan payments more equitable.

3. broadening managed care choices for beneficiaries to include HMOs with point-of-service and preferred provider organizations (PPOs), instead of limiting participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers. Under the current risk contracting program, beneficiaries have a limited range of health plans from which to choose and are precluded from taking advantage of the numerous managed care products that have arisen in recent years in the private market.

4. requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them. In order for beneficiaries to make fully informed choices about their health plan, they should be provided sufficient data that will enable them to compare these plans on costs, physicians and other providers, quality and benefits.

5. giving beneficiaries one opportunity per enrollment year to disenroll from a plan within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days, he or she should be required to wait until the next open enrollment period. Under current law, beneficiaries may disenroll from a health plan with only a 30 days notice. This makes it difficult for many risk contracting plans to anticipate costs for a health plan year. It is also contrary to most enrollment policies effective in the private sector which call for enrollment or disenrollment during a particular "open season". Asking beneficiaries to stay with a plan until the next open season once they have been in a plan for two months would offer additional stability to a risk contracting plan without limiting too severely beneficiaries' ability to change their minds about managed care. Such a requirement would make Medicare more consistent with the private sector in which workers are required to make an annual selection of a health plan and to stay with that plan for an entire year. Limiting the disenrollment opportunity to one per year would also prevent cases in which people jump from plan to plan every so often prior to the 60 day deadline. Medicare patients should accept the same degree of responsibility in choosing a health plan that is expected from those under 65.

6. mandating reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program. With improvements in the risk contracting program, it is reasonable to expect that those who choose to remain with the higher cost fee-for-service side of Medicare should bear a portion of those higher expenditures.

Medicare Vouchers

Making changes in the existing fee-for-service Medicare program and improvements in the current risk contract program will help to stabilize the program for the short term. However, to achieve a system that relies on competition to control costs and broaden beneficiary choices, that instills individual responsibility for the appropriate use of scarce medical resources and that assures the long term survival of Medicare, major restructuring of the program will be required. One way to do this is for the government to offer beneficiaries the opportunity to take a defined government contribution--or voucher--and purchase private insurance coverage with those funds.

ASIM supports creation of a voucher system and believes that the following elements are necessary to any voucher program designed for Medicare to ensure that beneficiaries have access to the widest range of cost-effective, high quality health plans, physicians and providers.

1. Medicare beneficiaries should be given the option of staying in the current Medicare program or using a voucher to buy any private health plan that meets certain conditions of participation.

If a plan purchased with a voucher becomes insolvent, or ceases operation in a beneficiary's area, beneficiaries should be able to enroll in another plan. When the annual enrollment period occurs, beneficiaries should be able to return to the traditional Medicare program at that time.

Transition to a voucher program should be done gradually to account for the fact that some areas of the country may not have the degree of managed care penetration necessary to make competition among health plans work. Retaining traditional Medicare would provide reassurance to beneficiaries while serving as a spur to voucher plans to make their products attractive enough to encourage enrollment by Medicare recipients.

2. Under a voucher program, beneficiaries should have access to a variety of plans ranging from indemnity models to staff model HMOs. All voucher plans that restrict enrollees to the use of network providers should be required to offer at a nominal cost an optional rider that would provide point-of-service access to non-network physicians for those enrollees. Enrollees should be able to select from among a network plan's panel of physicians an internal medicine subspecialist as their primary care physician and plans should be prohibited from discriminating against physicians in their selection processes based on a physician's patient population.

Under the present Medicare system, beneficiaries are entitled to receive all covered benefits from any provider of their choice. A voucher system could undermine this basic premise of the program. If the voucher is inadequately funded, some beneficiaries may be compelled to select a plan that limits the physicians and providers they may see for services. Adequate choice of physician and health plan can be promoted by offering beneficiaries a wide menu of plans and by establishing the federal contribution at a level that does not force patients to choose the cheapest plan available, as discussed below. By requiring voucher plans that use a network of physicians to offer enrollees the opportunity to buy a point-of-service rider, enrollees who want the flexibility to go outside the network will be able to select this option while those beneficiaries who wish to choose a closed-panel HMO may do so. In addition, a POS rider requirement for all health plans with restricted provider networks might ameliorate adverse risk selection arising from the tendency of very ill beneficiaries in an area to gravitate toward traditional Medicare and/or one plan with point-of-service.

3. Beneficiaries should have the option of using their government contribution--e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to purchase coverage through a health plan. The MSA would:

a) be coupled with a catastrophic health insurance policy purchased through a purchasing group to help preserve community rating;

b) be comprised of a fund from which a beneficiary could pay deductible medical expenses and would be coupled with purchase of catastrophic health insurance to cover expenses that, in the aggregate, exceed the catastrophic insurance deductible;

c) permit accumulation of unspent balances within the fund;

d) allow state and federally tax exempt distribution of funds only for medical expenses, health insurance premiums and/or long term care.

Since 1987, ASIM has supported the concept of medical savings accounts and the idea of integrating medical savings accounts into an overall health system in which people could choose among a variety of health plans, including medical savings accounts. These accounts are useful as part of a continuum of health care coverage options, particularly for their impact in enhancing consumers' awareness of the costs of health care.

ASIM feels strongly, however, that MSAs should not be used as the sole source of health care coverage but should be established in concert with a catastrophic health insurance policy. Furthermore, ASIM agrees with the concerns of some MSA critics that these accounts would adversely affect community rating of insurance and diminish the potential for widening insurance coverage. Ways to ameliorate these effects include ensuring that money in an MSA be used only for health care, including long term care, and making MSAs available for purchase only through purchasing groups to address problems with community rating.

Because MSAs appeal to so many patients and physicians, ASIM believes efforts should be made to include them in the menu of coverage options available to beneficiaries. To make medical savings accounts a reality under the Medicare program, however, will require many more provisions than the outline provided above. ASIM intends to develop additional policy concerning implementation of MSAs in the months ahead.

4. Voucher plans should be required to accept all applicants during an open enrollment period to minimize adverse risk selection. Beneficiaries should be allowed one opportunity per enrollment year to disenroll from a plan within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days, he or she should be required to wait until the next open enrollment period. Beneficiaries should be explicitly informed of this requirement by the health plan and should be required to sign a written acknowledgement of the conditions of enrollment.

A reinsurance mechanism should be available to those plans subject to adverse risk selection or to a sudden influx of voucher enrollees whose previous plan has gone bankrupt.

Another set of problems related to choice of physician and plan has to do with the response of health plans to those beneficiaries holding vouchers. To avoid circumstances in which health plans sought to avoid covering the very ill, all plans should be required to enroll any beneficiary with a voucher who seeks entrance into the plan. On the other hand, mandated acceptance and the ability of beneficiaries--under current Medicare risk contract rules--to enroll and disenroll outside of any prescribed enrollment period leaves plans vulnerable to unanticipated costs. In such a scenario, beneficiaries' right to choice of plan/physician conflicts with health plans' needs to maintain their cost and utilization control. The Congressional Budget Office has suggested that an annual enrollment period with a point-of-service policy "would permit Medicare enrollees to go to providers outside [a managed care plan's] panel when they wanted to and yet it need not increase benefit costs for either the [the plan] or Medicare." To avoid circumstances in which beneficiaries enroll in and disenroll from plans multiple times using the 60 day window, there should only be one opportunity during an enrollment year to disenroll from a plan within two months, after which the beneficiary would have to wait for the next open enrollment period. For such changes to work, beneficiaries must be given enough information at the outset to understand that, in signing up for a managed care plan, they must remain with that plan until the next open enrollment period once they have been in a plan over two months. This puts the burden of education on the managed care plan and the decision in the hands of the beneficiary. In addition, such an approach would make managed care more palatable to both beneficiaries and physicians.

5. The defined contribution--or voucher--should be set at a level that would produce incentives for beneficiaries to consider cost in choosing a health plan without forcing them into the cheapest plans that are most restrictive of choice of physician. The voucher should not be set at the cost of the lowest priced plan in a region.

The voucher amount should be adjusted according to age, sex, disability status, institutional status, and Medicaid-buy in status and applied by region. Once the regionally adjusted voucher amount was established, HHS or HCFA would accept applications from health plans to participate in the voucher program.

If the voucher is set too high it will have little impact on controlling Medicare costs. Set too low and beneficiaries choosing the voucher option may find their choice of plan and, ultimately choice of physician, quite limited. In addition, for a segment of the Medicare population, a voucher will

not cover what a health plan would spend on treating them. This would seem to call for some type of adjustment in the value of the voucher through mechanisms that are reasonably simple and inexpensive to administer. Otherwise, health plans might attempt to discourage certain beneficiaries from selecting that plan by adopting discriminatory policies or marketing strategies.

A voucher set at some national average would fail to reflect the appropriate regional differences in costs of health care delivery. Setting a regional voucher amount is a more accurate way for the voucher to reflect local health care costs, would be less likely to drive people into restrictive health plans and would ensure that there would be at least one plan in a region that could serve Medicare beneficiaries for the price of the voucher. Any process used to set the voucher amount in which plans submit their premiums to the government and the government then sets the voucher on some portion of those premiums must ensure that the resulting voucher is not so low as to make it worthless to most beneficiaries.

> 6. The voucher should be updated on a regular basis to keep pace with the costs of providing services to beneficiaries. In the event that spending under the voucher program exceeds estimated savings goals or targets, the voucher should not be subject to arbitrary caps. Mechanisms to keep spending within designated limits or to recoup excess expenditures, such as a "look back sequester", should be rejected. Instead, an independent board or commission should be established that would involve all participants in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If spending is greater than projected due to development of valuable new technologies or increased patient utilization of services deemed medically necessary, there should be a commitment to increasing the amount of funds devoted to the voucher program in order to ensure vouchers retain sufficient purchasing power and to assure appropriate medical outcomes.

The way in which the voucher is updated will determine to a large extent how much purchasing power the voucher continues to give beneficiaries. Given too great an increase and the voucher will be ineffective in controlling health costs. Given too little, and the voucher may drive some beneficiaries into lower quality, more restrictive health plans. There is also always a risk that the voucher update could fall victim to budget politics and be "frozen" or "capped" at some point to meet deficit reduction targets.

If spending under a voucher program is higher than anticipated because valuable new technologies or treatments have become available and patients have sought to take advantage of these advances in medicine, it does not make sense to penalize physicians by cutting their payments when costs increase for legitimate reasons. Furthermore, if beneficiaries do not participate in the voucher program in numbers sufficient to keep costs down, physicians should not be held financially responsible for beneficiaries' independent decisions. In addition, across-the-board cuts in physician and provider payments do not target those areas where health care costs have inappropriately increased and penalize caregivers who may in fact have kept their costs down. Arbitrary reductions in payments will serve only to perpetuate inequities in the Medicare payment system and compel physicians to limit their exposure to Medicare patients.

Finally, a cap on spending for the voucher implies a lack of confidence in the ability of the market to control the cost of health plan premiums and may have the unintended consequence of becoming a "floor" rather than a ceiling. If health plans know that the government's contribution will be capped at a certain percentage rate of growth, this may serve as an incentive to those plans whose rates of growth are lower than that percentage to allow their premiums to rise to meet the government's growth rate.

In the event federal health program costs remain uncontrollable, some entity – such as a commission or board – should be established separate from any government financing office to involve all parties in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If beneficiaries are to be assured of getting all the necessary care they need when they need it, the voucher amount should keep pace with the costs of providing services. If the value of the voucher is allowed to erode over time, beneficiaries may lose access to many high quality health plans offering comprehensive services or they may be forced to pay increasing amounts out-of-pocket to maintain a certain level of service. This would be especially detrimental for those beneficiaries of low and moderate-income who may be unable to bear an increasing financial burden. If the market is unable to deliver health care to patients within a predetermined cap, this should not be used as an excuse to diminish the government's commitment to Medicare beneficiaries.

7. A reassessment of the voucher program should be required after five years. This reevaluation should be undertaken by an agency or commission not responsible for funding Medicare.

Given the untried nature of a voucher program for Medicare, there should be an evaluation of the program relatively early in its life. If the voucher program does not seem to be living up to its expectations, Congress and the administration should not merely tinker at the edges to provide short term fixes but should step back, take a hard look at the program and even consider starting all over again.

8. Beneficiaries opting for the voucher program should be provided incentives that encourage their selection of an economically priced plan but that do not force enrollees into those plans that are most restrictive of choice of physician and that impose the strictest limits on access to services. Incentives should come in the form of additional benefits or services provided by the health plan and not in the form of a cash rebate. With rules in place to ensure that all beneficiaries have access through voucher plans to the full range of Medicare covered benefits and services, beneficiaries should pay the difference between the voucher amount and any premium charged by a plan that exceeds the voucher amount.

Some analysts contend that beneficiaries should be provided incentives to select a health plan that costs less than the federal contribution amount, or voucher. These incentives typically fall into two categories--cash rebates or additional services. Giving beneficiaries a cash rebate if their premium is less than the voucher amount would remove funds from the health care system that ought to be providing for health care services. Instead, any excess value should be returned to the beneficiary in the form of additional benefits such as coverage of additional services, providing coverage for long term care or creating a health care spending account. There is also debate over whether beneficiaries should bear the full cost of a health plan more expensive than the voucher to encourage enrollees to select more economical health plans. Although there is concern that such an incentive might drive beneficiaries to select plans of lesser quality or that don't cover the full range of benefits, this is less of a problems if all plans offer the full range of Medicare-covered services.

9. Reasonable cost sharing under voucher plans -- both fee for service and managed care -- should be imposed to assure consumer cost consciousness in utilization of services. Lower cost sharing should be imposed on clinically-proven preventive services so that people are not unduly discouraged from obtaining beneficial care. Preventive services should be subject only to copayments, not deductibles. Copayments for preventive services should be set lower than those for other services.

To avoid unjustified restrictions on choice of physician, POS voucher plans should not impose unreasonable coinsurance on services provided by out-of-network physicians. To prevent beneficiaries who seek out-of-network care from being subject to unexpected out-of-pocket costs, POS plans and physicians should be required to establish their own conversion factors to be used against an improved resource based relative value scale (RBRVS). This would determine the rates the POS plan would pay and the fees the physicians would charge for their services. Plans and physicians would be required to supply enrollees in the POS plan with information based on these conversion factors to enable enrollees to determine in advance how much they would pay in going out of the plan's network of physicians.

As an incentive to promote greater price consciousness in the traditional Medicare program and to encourage the movement of beneficiaries into the voucher system, those who choose to stay in the traditional Medicare program should be subject to reasonable and non-punitive increases in cost-sharing. As with POS plans, in order to buffer beneficiaries from unexpected costs, a requirement could be imposed under traditional Medicare that physicians must establish their conversion factor for their services each year concomitant with the announcement of Medicare's conversion factor. Enrollees in traditional Medicare would be supplied annually with information comparing the charges of physicians in their area to Medicare's fees based on their respective conversion factors. In this fashion, beneficiaries would know in advance whether or not they would have to pay out-of-pocket for services charged under traditional Medicare.

Beneficiaries should not be subject to charges in excess of Medicare's payment amounts under the following circumstances: in the case of low income beneficiaries; emergency situations; when the beneficiary has little voice in the selection of a physician--e.g. anesthesiologists and radiologists--or in areas of the country where there is no competition for a particular medical specialty (for example, in areas where there may only be one cardiac surgeon).

ASIM believes it is especially important that cost sharing on preventive services be reduced and deductibles on these services be eliminated entirely to avoid discouraging patients from obtaining necessary care. By erecting barriers to cost-effective preventive care--for example, imposition of cost sharing on mammograms--patients may avoid those services and wind up with more serious, and expensive, illnesses in the future.

In addition, ASIM supports limits on the degree to which additional cost sharing can be imposed on those enrolled in managed care plans who use a plan's point-of-service (POS) option to seek care outside the plan's network of physicians. The intent behind POS is to allow beneficiaries greater choice in physician and provider. If the cost sharing imposed on a beneficiary for going outside a health plan's physician network is excessively burdensome, then the promise of greater choice is a hollow one.

Obviously, if beneficiaries are to be encouraged to enter the voucher program, those who opt to stay in traditional Medicare must bear a greater share of the cost of remaining in the more expensive program. Nevertheless, any additional cost sharing should follow the principles stated above so that primary care and preventive services are sheltered from deductibles and are subject to cost sharing at a rate lower than that imposed on other services. Because high deductibles can act as a disincentive for patients to receive needed primary care and preventive services, ASIM does not support replacing the current coinsurance requirements under traditional Medicare with a single high deductible.

ASIM believes that its Competitive Pricing, Informed Choices proposal--issued in 1992--offers a means to instill price competition among physicians, enhance consumer cost consciousness and prevent price gouging by unscrupulous providers. If health plans that pay according to a fee schedule (POS plans, traditional Medicare, etc.) and physicians were required to set and publish the conversion factors they would use each year to determine their charges and fees, this information could be used by beneficiaries to determine what they would pay out-of-pocket, if anything, if they joined a particular health plan or used a particular doctor. Beneficiaries would then be able to decide if the value they derived from a health plan and/or physician in terms of quality and service was worth the price of any additional costs.

While ASIM generally supports cost sharing by patients in order to enhance cost consciousness in the utilization of scarce health care resources, there are situations in which billing beyond Medicare's payment rates or additional cost sharing should not be imposed. These situations arise where beneficiaries' income is simply too low to sustain any additional out-of-pocket financial burden, where they have no opportunity to "shop around" for a physician (e.g. emergency situations), where beneficiaries have but one choice of physician (such as typically occurs during hospitalizations when patients are essentially assigned certain hospital-based doctors to deliver designated services) or where there are so few physicians in a particular specialty within a community that there is no chance for competition among physicians to operate.

10. To qualify as a voucher plan under Medicare, health plans should have to: offer a standard minimum Medicare benefits package that includes preventive services; meet certain utilization review and quality assurance standards; involve participating physicians in development of the plan's utilization review (UR) and quality assurance (QA) and provider selection policies and procedures; disclose their utilization review and quality assurance policies, restrictions on choice, risk arrangements and provider selection criteria; establish due process mechanisms in selection of plan providers; meet certain solvency standards; report certain information -- such as premium costs, out-of-pocket liability, consumer satisfaction and the percentage of premium dollars devoted to administration versus benefits -- to a central data collection entity so that this information can be distributed to beneficiaries and use uniform claims forms and standard billing and claims processing procedures.

Health plans that selectively contract with physicians should be required to offer enrollees the opportunity to buy a rider that provides point-of-service access to non-network physicians, in addition to meeting the foregoing standards.

Health plans should play by the same rules if competition is truly to be effective in controlling costs. Given that the idea behind many Medicare voucher proposals is to enhance competition within the program so as to bring down costs, it would seem equally advisable that health plans should be required to meet certain rules if they wish to participate in the voucher program and market themselves to beneficiaries as Medicare voucher plans.

A uniform minimum benefit policy would assure a basic level of care for all beneficiaries. In addition, it would facilitate beneficiaries' comparison of health plans. If beneficiaries are to have sufficient information to make informed choices with their vouchers, they will need data on a plan's costs, patient out-of-pocket liability, provider panels, and quality. Furthermore, disclosure of UR and selection standards benefits not only the providers involved with a health plan but helps beneficiaries as well by giving them another piece of information on which to compare health plans.

In addition, it is important that physicians have a role in developing and implementing health plan policies and procedures that directly affect clinical decision-making--e.g. benefits coverage criteria, determination of medical necessity, preauthorization of services, quality assurance standards, protocols and processes for selection and deselection of physicians. To leave decisions affecting patient care solely in the hands of health plan administrators whose concerns center largely on cost containment may jeopardize the quality of care given to enrollees and deny patients access to medically necessary services. Furthermore, health plans that involve physicians in development of these policies are far more likely to obtain the cooperation of their network physicians in proper implementation of those policies.

Finally, it is important that voucher plans be required to operate under similar billing and claims processing procedures to avoid unnecessary red tape. All plans that currently operate within the Medicare system must abide by the uniform claims form and billing rules and it would be logical to expect that voucher plans should use a standard format and follow standard claims processing procedures for this new variation of the Medicare program.

The type of standards to which ASIM refers--involvement of physicians in clinical policymaking, providing information to enrollees and prospective enrollees sufficient to enable them to make informed decisions about the plan--are, in fact, those that are being adopted by many well-run health plans in today's marketplace. In a competitive environment, those plans that pursue "patient-friendly" policies such as these are more likely to succeed than others.

> 11. Because Medicare is a federally funded program, the federal government must continue to ensure that health plans are accountable for the care they give to beneficiaries and that they abide by standards set out for Medicare plans. HCFA or another federal agency should be responsible for contracting with health plans; reviewing marketing materials; disseminating to beneficiaries objective data about each plan in a region in a standard format; ensuring health plan compliance with certain standards governing their rules and operations; and ensuring that health plans meet certain quality standards. However, private accreditation agencies should be able to achieve "deemed" status to fulfill the role played by HHS in approving voucher plans. Mechanisms should be available for patients and physicians to pursue grievances against health plans for denial of medically necessary care. Patients and physicians should retain access to fair hearing and judicial review processes at least comparable to those now available under traditional Medicare.

Because vouchers would require more thought and decisionmaking by Medicare recipients, some analysts question whether beneficiaries would find the voucher program truly appealing. Other policymakers argue that the basic premise of the voucher program is simple and that most beneficiaries, given the right kind of information, will be able to make proper decisions about a health plan. While this may indeed be the case for healthy beneficiaries who are mentally alert, the frail and disabled elderly, those who do not speak English very well or those with little education may find the task of sorting through health plan information daunting. To respond to some of these concerns, the voucher program should have an entity with which voucher plans would contract and which would ensure voucher plan adherence to any standards adopted governing such plans.

Given the characteristics of the Medicare population, an ombudsman's office should be created to receive, investigate and resolve complaints against voucher plans as well as to offer guidance to beneficiaries with questions about the voucher program. Finally, beneficiaries and physicians should retain access to the current Medicare appeals process.

ASIM would prefer that the health care industry voluntarily abide by the standards established for a voucher program and, indeed, supports the idea of a private accreditation body responsible for ensuring health plan adherence to voucher program standards. However, the voucher program will be funded by federal dollars and the federal government should not relinquish its responsibility for ensuring that health plans are accountable for the care they deliver to beneficiaries and for seeing that corrective actions are taken when deficiencies are found if a plan wishes to remain in the voucher program. Health plans that accept the government contributions should understand that, if they are going to compete for the business of the federal government through the voucher program, they must accept certain standards and certain reasonable oversight.

12. Self-referral restrictions affecting shared laboratory facilities and group practices should be removed and antitrust reforms enacted to enable physicians and providers to negotiate on an equal footing with health plans and purchasers.

Antitrust reforms and other modifications to statutory restrictions on physicians could improve the functioning of health plans offered under a voucher system and the ability of physicians to deliver services within their context. For example, self-referral restrictions on group practice compensation arrangements not only interfere in the internal affairs of private businesses but lead to confusion over how such practices may distribute revenue from ancillary services without indirectly taking into account the referrals made by physicians. Furthermore, subspecialists--such as oncologists and infectious disease specialists--in many group practices are barred from providing drugs and other services to their patients because of the self-referral laws.

Limitations on the ability of physicians to share information in order to form integrated service networks may impede the goals of voucher advocates who wish to foster competition that reduces the cost of care and increases benefits to attract voucher recipients. Indeed, antitrust laws developed at a time when most physicians and other providers practiced independently of one another now prevent these caregivers from organizing preferred provider organizations, health plans and other delivery networks that would enable physician-directed health care organizations to compete in the marketplace and offer beneficiaries a wider choice of health care options.

Conclusion

ASIM is under no illusion that reforming Medicare will be simple, easy, or quick. Changes of the magnitude required to place the program on sound financial footing and to guarantee that beneficiaries continue to receive the high quality health care to which they have become accustomed and to which they are entitled will require a great deal of thought and debate. For ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared responsibility.

Physicians have a responsibility to deliver care to greater numbers of Medicare patients under health care delivery systems that will increasingly require them to accept financial risk and to be accountable for the cost and quality of their clinical decisions--and to compete within this new system on the basis of cost and quality.

Medicare patients have a responsibility to consider the costs of alternative sources of health care coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive coverage and--for those who can afford to--to contribute more to the financial support of Medicare so that those of lesser means can afford coverage.

Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and introduce positive incentives into the health care system including a limit on the tax deductibility of employer paid insurance and increased taxes on tobacco.

The insurance industry has a responsibility to compete in the new system--not solely on price or risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect beneficiaries who choose private insurance coverage.

And the federal government has a responsibility to assure that the government's contribution remains adequate to guarantee that all beneficiaries can obtain high quality coverage through traditional Medicare and private sector alternatives--and to provide sufficient oversight over the market to protect patients' interests.

STATEMENT OF JAMES L. SCOTT, PRESIDENT
AmHS INSTITUTE

Mr. Chairman and members of the Committee, the AmHS Institute is pleased to submit this statement for the record of the Committee's hearing on the future of the Medicare Program. The AmHS Institute is the public policy center for American Healthcare Systems. AmHS is a national alliance of forty of our nation's premier integrated multi-hospital systems. AmHS and its subsidiaries operate insurance, purchasing, quality assurance and marketing programs that strengthen its shareholders' ability to provide intergrated health care services more effectively and efficiently. These systems own, lease, or manage nearly 400 hospitals and have affiliation agreements with over 600 other hospitals. AmHS shareholders employ over 280,000 people and generate $36 billion in annual revenues.

In our testimony, we will:

- review the environment for reform in both the public and private sectors;
- present an overview of our recommended approach to Medicare reform; and
- describe long-term objectives and specific short-term action steps in five key areas of reform.

Environment for reform

The federal fiscal environment for the Medicare program is simple to describe: the program is in serious trouble. The financial statistics are all-too-familiar to the committee.

- This year, Medicare will spend $178 billion -- 11 percent of total federal spending.
- Under current law, the program is expected to grow by 9.9 percent annually from 1995 - 2002, nearly double the 5.5 percent annual growth rate in the total federal budget.
- Under this scenario, Medicare will grow to 15 percent of total federal spending by the year 2002 -- with no end in growth in sight in the future.

The status of the Medicare Hospital Insurance (HI) Trust Fund presents an equally bleak picture. The most recent report of the Board of Trustees of the Hospital Insurance Trust Fund projects that the Medicare Trust Fund will begin spending more than it receives as revenue starting next year, which begins the process of exhausting the Trust Fund reserves. The Trust Fund could be depleted in just 7 years -- by 2002.

The Congress has responded with a budget target that proposes to lower Medicare growth rates from the baseline growth of 9.9 percent annually to growth of about 6.4 percent per year over the next seven years -- for total Medicare savings of $270 billion below baseline spending projections.

We are opposed to this level of reduction in the rate of growth. The amount of savings needed to keep the Medicare Hospital Insurance Trust Fund solvent for the forseable future is much lower. Spending reductions in the Medicare program should not be used to fund tax cuts. In addition, this level of proposed spending reduction is both politically unrealistic and programatically unattainable.

Having noted our strongly held belief that the budget savings targets for the program are excessive, we will focus our testimony on the need for Medicare program reform and our specific recommendations for achieving that reform.

It is clear that Medicare is an important budget issue, especially at a time when the Congress is seeking to move toward a balanced budget. However, we have reached the practical, political, and policy limits of the traditional approaches to "cutting" Medicare: provider payment reductions, increased beneficiary cost sharing and premiums, and increases and extensions of the coverage of the HI tax.

That approach has been tested repeatedly: such short-term, budget driven "savings" approaches have been tried in budget reconciliation bill after budget reconciliation bill in the past 15 years. And the approach has failed. Despite all the annual short-term "savings" and political pain over this time period, we continue to be confronted by the current budget and trust fund problems.

It is time to step back from this never-ending treadmill of "cuts" and call for Medicare reforms. And to do that, we need to go back to the basics. We believe that the objective should be to restore one of the original concepts of Medicare: Medicare was to offer financial protection to seniors through a health insurance program that mirrored the coverage available in the private sector.

And the Congress succeeded in fulfilling this objective -- in 1965 -- by building Medicare on the then-predominant fee-for-service approach. In today's terminology, Medicare was a variant of a "market-based" plan in 1965.

But it it is now 1995. The private health system has changed dramatically, and Medicare has not kept up to date.

- Managed care arrangements now cover about 63 percent of privately insured employed individuals -- growing nearly 20 percent in just the last year.
- That managed care penetration level among employers is about six times Medicare's managed care enrollment of 10 percent (about 9 percent in Medicare HMOs and managed care plans, and about 1 percent in Medicare Select - a Medigap PPO being demonstrated successfully in 15 states).

If Medicare's design continues to remain stagnant in the midst of a rapidly changing health care market, the program will fall farther and farther behind the plans available to the working population. This increases the risk to the program -- financially, politically, and programmatically -- because Medicare beneficiaries no longer have coverage like that available in the private sector.

If we are to address fundamental reforms, we must shift our thinking from short-term to long-term. The irony is that the more we focus on "guaranteeing" short-term "savings," the less we are able to achieve structural reform and real long-term savings.

In order to meet the nation's commitments to the elderly and disabled in a manner that is financially and politically sustainable, Medicare must be updated to provide beneficiaries the choice of managed care and other arrangements that now are the dominant form of benefits in the private sector. For Medicare, voluntary -- not mandatory -- enrollment is crucial. This requires that we remove current barriers and provide incentives for beneficiaries to enroll in alternative health plans.

We believe that this approach will serve government, beneficiary, and provider interests in a balanced manner:

- The government can achieve real long-term, structural savings in Medicare if it can avoid the more simplistic short-term targets that lock-in short-term "solutions."
- Beneficiaries will benefit from a program that is once again similar to private sector health coverage, as well as from enhanced choices and the stability available from a Medicare program with long-term financial viability.
- Providers will benefit by being able to provide services within a framework that allows them to focus on what they do best -- provide high quality care at an affordable cost.

Recent CBO data highlight the long-term potential for restructuring and managed care in Medicare (CBO, February, 1995).

- For the total population, HMOs reduce overall utilization by an average of 8 percent -- and the most tightly integrated models, the group/staff HMOs, reduce use by nearly 20 percent.
- For the Medicare population, the utilization reduction by group/staff HMOs is potentially greater -- nearly 22 percent.
- The potential Medicare savings depend on assumptions about how much of the population might be in effective HMOs -- the savings range from 2 percent to 20 percent.

AmHS Institute Medicare Reform Proposal

Overall approach

The AmHS Institute believes that Medicare should be restructured so that the program is able to take advantage of the competitive revolution taking place in the private health care market. A reformed Medicare program should provide beneficiaries a choice of health plans, including provided based delivery networks and managed care arrangements, along with incentives to join the plans that are best able to deliver quality benefits at a competitive price.

We would stress, however, the need to proceed in a practical, staged manner. The reality is that this reform will require a transition period. One of the lessons of previous health reform debates is that policy makers should establish a sense of direction of where they are going, but proceed incrementally, testing new ideas, monitoring implementation and results, and making changes and revisions in the future. As a result, the Institute is recommending long-term views about the direction for reform, as well as focusing on specific short-term actions that could be taken this year to begin the process.

Policy makers must also recognize and deal with the interrelationships among many of the health care changes taking place: Medicare restructuring, the rapid movement to a more competitive private market, and Medicaid reforms all call for a reexamination of some current health care arrangements.

- As we move to a more competitive health care system, we must also adapt our mechanisms of public support for "public goods" such as health professions education, and mechanisms for helping providers finance care for the uninsured.
- In addition, for the millions of dual Medicare/Medicaid eligibles, Medicare and Medicaid changes must be linked.

The following reviews the AmHS institute's long-term objectives and short-term action steps in five areas: delivery system and health plan participation options, retiree health plan approaches, payment policies and methodologies, making the market more competitive, and information/enrollment/consumer protection measures.

Options for delivery systems and health plans available to serve beneficiaries

One critical element of Medicare reform is to expand the options under which health plans and delivery systems could participate in Medicare.

Long-term: Medicare should make payments to a wide range of health care plans

under a competitive market model. The existing Medicare system should remain as an option, but it too should be revised to move beyond a pure Fee-for-Service (FFS) approach and pay providers under a variety of arrangements -- FFS, partial capitation, competitively determined prices, and other models.

Short-term: *Medicare should begin to expand the options for delivery system and* health plan participation in two ways. First, the program should begin to expand the definition of health plans qualified to participate on a capitated, full risk-basis for all Medicare benefits. The program should move beyond the traditional health maintenance organizations (HMOs) and competitive medical plans (CMPs) that today are available to beneficiaries. Additional entities could include (subject to meeting appropriate financial and quality standards designed to assure consumer protection):

- Managed care plans such as well defined "point of service" (POS) and "preferred provider organization" (PPO) products; and
- Provider based integrated delivery networks that include physician, hospital, and other services required to serve beneficiaries.

Second, Medicare should begin to reflect the reality that there is not a strict dichotomy in the market between a FFS plan and a fully capitated health plan: instead, there are numerous delivery arrangements between the two, and the program and its beneficiaries should take advantage of them. Medicare should establish alternative payment options within the "traditional" plan for an array of delivery system options on the spectrum between FFS and full risk, full capitation models. These would include:

- traditional FFS Medicare (PPS for hospitals; RBRVS for physicians).
- potentially broader bundles of payments such as those that would combine the hospital and physician payment per admission. This would be a way to encourage hospitals and their admitting physicians to begin to work under the same incentives, without having to leap immediately to fully capitated managed care.
- partial capitation models of various types: Medicare should explore partial capitation arrangements under which Medicare makes capitated payments for a subset of Medicare services.
- risk sharing arrangements that move beyond pure capitation: Medicare could, for example, define risk corridors, sharing in gains and losses. These arrangements could be applied to partial capitation models as well as full capitation models.

As the Congress pursues these strategies, it is vitally important that they be linked with changes in the regulatory standards for health plans, including capitalization and solvency standards. There appears to be a substantial level of effort in the health plan community to try to apply insurance standards to the new provider based integrated

delivery networks that are evolving in the market. That is a very short-sighted approach, because it relys on the old standards for FFS insurance -- a model that is at the heart of the failure of the health system -- to meet financial and coverage needs of the American people. We need to adapt our regulatory structures to keep pace with the changes in the market -- not use an old regulatory structure to stifle a potentially innovative market.

While some level of financial standards should apply to all health plans contracting with Medicare, the measurement and definition of the assets that count toward meeting the standards should take into account differences in types of plan. Insurers require cash assets to purchase services from others, while delivery systems have existing human and physical assets -- hospitals and health professionals that can actually provide the contracted care.

Employer/retiree health plans

Long-term: retired workers should have the option to remain in their employer's retiree health plan so long as that plan meets standards set by Medicare, with Medicare making its defined contribution to the employer much as it would if the individual enrolled in a traditional qualified health plan.

Short-term: Medicare, working with the employer and health plan communities, should develop standards for such arrangements and methodologies for making payments to such plans. Further, the federal government should use the Federal Employees Health Benefit Program (FEHBP) as a model program for this effort, with Medicare making payments to the retiree health plan of federal retirees who are also eligible for Medicare.

Medicare and beneficiary payments

If Medicare is to take advantage of the changes taking place in the market, it needs to revise its current approach for making payments to health plans.

Long-term: Medicare should establish its payments for coverage of the Medicare benefit package based on premium competition in local markets. For example, health plans would establish their premiums for Medicare's defined package of benefits. Medicare would establish its payment at some percentile of those premiums; all of the plans could then compete to attract beneficiaries with additional benefits or lower out-of-pocket costs, but with Medicare's established payment level for that local market. Beneficiaries would then choose among health plans.

Alternatively, Medicare might select those plans with the best bids to serve the Medicare population -- the high cost or low quality losing bidders would not be allowed to serve the Medicare population. This approach could have the greatest potential savings.

Beneficiaries would always have the statutory Medicare benefit package available to them without extra costs (beyond the Part B premium). And beneficiaries could always opt for a richer benefit package by joining a health plan that can provide the additional benefits within the Medicare payment amount or by paying additional amounts for such richer benefits, as is the case today.

Short-term: Medicare should begin to take the steps necessary to develop the capacity to move to this new system, as well as make short-term changes in the existing system.

First, Medicare needs to begin to fund demonstrations on how to develop and move to a market-based model, and test the various approaches that might be envisioned. While the market-based model is much discussed by the experts, policy makers need to examine real-world experience with this system before nationwide implementation.

Second, it is well-known that Medicare's current mechanism for paying health plans, which is based on the "adjusted average per capita cost" (AAPCC), is inherently flawed. However, since it has to be retained pending development of the longer-term, market-based model, temporary changes should be enacted to improve it as much as possible. For example, three changes should be considered:

- the AAPCC should be based on a direct calculation of fee-for-service costs;
- AAPCC rates should be set for Metropolitan Statistical Areas (MSAs) rather than counties; and
- Medicare should establish some type of "payment band" -- a ceiling and floor on AAPCC payment rates -- to bring payments in rural counties up to levels that would allow those communities to begin to develop the health plan infrastructure to serve beneficiaries.

In addition, if the Congress is serious about Medicare restructuring and a move to organized delivery systems and managed care, an investment strategy is called for. Congress should set aside a portion of the savings from other Medicare cuts and allocate them as targeted investments to enhance payment rates and encourage the development and participation of health plans and beneficiaries in areas where Medicare managed care penetration is currently low.

Finally, HCFA should accelerate its work on risk adjusters, and begin to conduct

demonstrations of alternative models of risk adjusters.

Market competition

If Medicare beneficiaries are to make choices in a competitive market, Medicare must take the steps to make sure that the various options operate on a "level playing field."

Long-term: the supplemental market -- whether Medicare supplemental policies (traditional Medigap plans), or comprehensive plans that provide Medicare as well as supplemental benefits -- should be made more competitive, with these products competing for beneficiary enrollment on a more level playing field.

Short term: The Congress has already taken one important step to expand competition and managed care options to beneficiaries through the supplemental market, by extending and evaluating the Medicare Select demonstration nationwide for a period of three years (Medicare Select is a Medigap PPO being demonstrated successfully in 15 states).

In addition, we should begin tests and demonstrations of how best to standardize the rules for participation among the various types of options that are available to beneficiaries. For example, policy makers can begin to examine standardization of underwriting policies, rating rules, and benefit offerings, to make this market more understandable for beneficiaries making choices among health plans. The following should be tested:

- o standardization of medical underwriting policies in local markets. Currently, Medigap products can deny coverage to Medicare beneficiaries after an initial enrollment opportunity; while HMOs that participate in Medicare on a risk basis cannot.
- o standardization of rating rules in local markets. Currently, Medigap products can use "attained age" rating (i.e., charge higher rates as a person ages); while HMOs that participate in Medicare on a risk basis charge all enrollees the same (although HCFA's payment to the health plan varies by age).
- o standardization of benefits supplemental to the basic Medicare benefit package. Currently, Medigap products must fall within one of 10 product categories; while HMOs that participate in Medicare on a risk basis can offer any combination of benefit additions.

Information/enrollment/consumer protection

Finally, if beneficiaries are to make choices in a market, they need information and fair enrollment options.

Long term: a Medicare program in which beneficiaries have a choice of health plans is predicated on timely, accurate information and performance measures that beneficiaries can use to make comparisons among benefits, delivery systems, quality, service, and

price. Moreover, health plans must be available to beneficiaries at specified times so that beneficiaries have the option to change their enrollment -- otherwise, the "choice" model cannot work.

Short-term: HCFA should be required to provide beneficiaries with information on the options available prior to the time of initial Medicare eligibility (which is when the beneficiary makes initial decisions about enrollment in Medicare health plans or Medigap plans). In addition, HCFA should test approaches and models for enhancing enrollment, including the following:

- o models for providing comparative information on performance measures to beneficiaries for all products available to them, including Medigap plans and health plans participating in Medicare. These models could include requiring health plans to provide some type of information on a comparative basis.
- o approaches to coordinated open enrollment in different markets, including options such as coordinated annual periods, as well as various models of "rolling" open enrollment.
- o approaches that would require active marketing in targeted areas, such as inner cities, as a condition of health plan participation in Medicare.

Conclusion

The AmHS Institute recognizes that the challenges confronting the Congress are enormous. But the importance of Medicare for current and future beneficiaries calls for action. We urge that you proceed by adopting specific steps this year to begin the process of restoring Medicare to a program which will continue to provide health benefits like those available to Americans under the age of 65 into the 21st century. We would be pleased to work with the Committee in that effort.

Statement of The College of American Pathologists for The Record of The House Ways and Means Subcommittee on Health Hearing Regarding "Saving Medicare and Budget Reconciliation," July 25, 1995

The College of American Pathologists (CAP) appreciates the opportunity to present its views to the Ways and Means Subcommittee on Health regarding the need to transform the Medicare program into a system that serves the elderly and disabled in a more efficient manner. The College is a national medical society representing nearly 15,000 physicians who are board certified in clinical and/or anatomic pathology. College members practice their specialty in community hospitals, independent clinical laboratories, academic medical centers, and federal and state health facilities.

The College is grateful to the Subcommittee chair, Mr. Thomas, and the chair of the full Committee, Mr. Archer, for their leadership and foresight in holding hearings to solicit the views of health care professionals on transforming the Medicare program. Ideally, Medicare should be a model of efficient interaction between the public and private sectors in serving patients. Instead, the program is failing from a budgetary standpoint due to its financial structure and unrealistic expectations. Rather than deal with these underlying structural problems, Congress and the Executive Branch have historically attempted to deal with the program's financial problems by cutting provider payments and making numerous operational changes that have increased the administrative burden and confusion for everyone involved with the program.

The College believes that the necessity of preserving the solvency of the Medicare trust funds and introducing marketplace efficiency into the program offers unique opportunities for Congress to correct these problems. However, the College is concerned that the desire to reduce the rate of growth in the Medicare program could once again force Congress to resort to short-sighted budget cuts to meet deficit reduction targets rather than taking a careful, comprehensive look at how the Medicare program could be financed more equitably. The College believes that restructuring of the fundamental financing of the Medicare program is a viable way to address these concerns with the program.

RESTRUCTURING THE MEDICARE PROGRAM

Although the Medicare program is clearly a success story in improving the access to health care of the nation's elderly and disabled, the thirtieth birthday of the program is an appropriate time to assess whether it is financially feasible to continue its current financial structure. Increases in the number of beneficiaries, improvements in diagnostic and therapeutic technology, and inefficiencies in the current administration of the program, call for reconsideration of the manner in which program benefits are offered and provided to beneficiaries and financed by the federal government.

The markets for and modes of provision of health care services have changed dramatically in the last thirty years. Proposals that restructure both the beneficiaries' and the governments' responsibilities in administration of the Medicare program may offer the best methods to enhance its long-run fiscal integrity, improve its efficiency, and control costs, while continuing to provide access to needed services. Several such proposals have surfaced in the last few months that would involve Medicare beneficiaries in decision-making about how their health care benefits are provided and financed, similar to the decisions that many others make in the private sector when they choose among health plans, and that would attempt to put the program on a more sound financial footing.

The College supports the following changes to financing and coverage under the Medicare program:

- **Restructure of the government funding of Medicare premiums to give beneficiaries choices in selecting among the traditional government-administered fee-for-service option, enrollment in private-sector administered insurance plans, and establishment of alternative health care financing funds such as Medical**

Savings Accounts to be used to purchase health care coverage as needed. While the government would continue to financially subsidize each of these options, beneficiary choice could, over time, place more of the day-to-day administration of the Medicare program in the private sector and reduce program costs, while allowing the beneficiaries much more choice of health care plans than they have today. As those now in the workplace, who enjoy and expect those choices, reach Medicare age it is appropriate that they continue to have choice and responsibility in determining how their health care dollars are spent.

- **Elimination of the coinsurance for Medicare covered services.** Restructured and adequate funding of health insurance for Medicare beneficiaries should also include elimination of the requirement for payment of coinsurance and purchase of supplemental insurance such as Medigap policies. Currently about three-fourths of beneficiaries purchase Medigap policies to cover the coinsurance and deductibles that the program imposes--in effect, most beneficiaries pay no coinsurance or deductible at time of service provision. Appropriate restructuring of government financing to eliminate the need for a Medigap policy would make the Medicare program more financially sound and simplify its administration both for the government and for the beneficiary.

- **Reduction in the premium subsidy for higher income beneficiaries.** A sliding scale for determining beneficiary premium contribution, with higher income beneficiaries paying more, would reduce the government subsidy of Medicare coverage without reducing access to services.

- **Increase in the Medicare eligibility age.** As the nation's elderly live longer and more productive lives, and continue to have available and to be able to purchase private health insurance, it is appropriate to adjust the age at which Medicare coverage is provided.

- **Elimination of the Medicare balance billing restrictions on covered services.** Integral to proposals to restructure the Medicare program and give choices to beneficiaries is increased responsibility among beneficiaries and the private sector and decreased government tinkering with health care provision. Elimination of current restrictions on physician's charges to Medicare beneficiaries and institution of a system where physicians set their prices, the government sets its payment amounts, and the purchaser chooses, will enhance competition and alleviate much of the confusion about what charges are, what Medicare pays, and what the beneficiary can expect in cost sharing, issues that have plagued the program since its inception. Physicians have long demonstrated their willingness to forego balance billing when the patient's financial situation warrants. In an era of enhanced competition and beneficiary choice and responsibility overly intrusive restrictions on charging patterns are not appropriate.

BENEFICIARY SAFEGUARDS UNDER MANAGED CARE PLANS

The College believes managed care plans should be required to meet a minimum set of standards designed to assure that beneficiaries have continued access to quality care. The College supports legislation establishing standards of operation for managed care plans, requiring full disclosure of those standards to patients and providers, and providing effective options to resolve problems when enrolled in or contracting with managed care plans.

Congress should require that beneficiaries receive easily understood information about plan costs, covered and excluded procedures, and requirements for prior authorization. In order to ensure fairness and that needed medical services are provided, managed care plans should be required to afford due process procedures for physicians seeking participation in plans and timely notice and appeals procedures for physicians who are denied participation. Physician involvement in utilization review and other medical policy development activities should be required.

The College believes that Medicare beneficiaries who opt for a managed care plan alternative should maintain their right to choose their provider. Managed care plans should be required to provide access to out-of-network providers chosen by the patient or by the patient's attending physician. Reimbursement disincentives for patient use of out-of-network providers such as increased cost sharing must be limited to a reasonable amount and beneficiaries must be able to appeal denials of coverage of out-of-network services.

THE MEDICARE RBRVS

The College continues to be concerned about the inappropriate structure of conversion factors and volume performance standards under the Medicare physician services resource-based relative value scale. There are three distinct conversion factors and Medicare Volume Performance Standards (MVPSs) under the RBRVS, one each for surgery services, primary care services, and all other nonsurgery services. Increases in volume and expenditures for surgery, office and other primary care visits, and pathology, radiology and other nonsurgery nonprimary care services are tracked under each respective MVPS and the update to each conversion factor is determined accordingly. Many physicians provide services in each category and the volume of many services in the all other category is determined by physicians who are not directly affected by payment changes for those services because the services are provided by other physicians. Examples of this last phenomenon are pathology, radiology and other diagnostic services ordered by attending physicians but provided by physicians in other specialties. The existence of multiple MVPSs and conversion factors (with different annual conversion factor updates) is divisive among physicians, inaccurate in determination of the source of increases or decreases in volume and expenditures, and inequitable in implementation of updates based on performance.

The College urges Congress to establish a single MVPS and a single conversion factor that is applicable to all physician services paid under the RBRVS.

Ideally, this would be accomplished with a statutory change eliminating the separate standards and conversion factors for 1996. At a minimum, we urge Congress to establish the 1996 updates to the existing three conversion factors in a manner that is consistent with movement toward a single MVPS and conversion factor. A single, equal conversion factor update of 1.1 percent as suggested by the Physician Payment Review Commission and the Administration will not move toward a single MVPS and conversion factor but will continue current distortions. Differential updates to each of the three existing conversion factors that are designed to reduce the differences in those factors are much more appropriate.

COMPETITIVE BIDDING FOR MEDICARE CLINICAL LABORATORY SERVICES

Proposals for competitive bidding of certain Medicare services, such as clinical diagnostic laboratory services, continue to resurface although they have been considered many times by the Congress and rejected for sound reasons. Most recent proposals would require that the competitive bidding process achieve at least a ten percent savings, thus focusing the competition on the lowest price not the best price for quality and access.

The College opposes Medicare competitive bidding for clinical laboratory services.

While competitive bidding is a well established mechanism for purchasing goods and services where quality is readily discerned by visual inspection of the item, it is wholly inappropriate for the purchase of medical services that are tailored to dynamic and highly individual needs. Competitive bidding for medical services, such as clinical diagnostic laboratory services, may result in a reduction in the quality of and access to the services sought, a problem that would not be apparent until harm had been done. Competitive bidding will not promote competition if it drives qualified laboratories out of business and thus decreases competition in an area.

This would be especially probable if a single "winning bidder" is chosen to provide services to Medicare beneficiaries in a given area. The winning bidder may not be immediately accessible to the patient or patient's physician, delays in service provision and patient

diagnosis may occur, and overall quality of services may fall. Forced reduction in bidding prices may achieve immediate budget goals, but such savings are short-sighted and carry a high potential for negative health care outcomes. Eliminating freedom of choice of clinical laboratory services provider through a competitive bidding process would remove a major quality determinant in health care: the ability to seek care from the complete range of health care providers.

The College urges the Congress to again reject competitive bidding for Medicare clinical diagnostic laboratory services and to work with the physician and laboratory community to achieve savings through other means.

COINSURANCE FOR MEDICARE CLINICAL DIAGNOSTIC LABORATORY SERVICES

The College opposes reinstitution of a 20 percent coinsurance for services in the clinical laboratory fee schedule (CLFS).

Since eliminating the coinsurance requirement for clinical diagnostic laboratory services in 1984 Congress has repeatedly rejected proposals to restore it, with good reason. Reimposing coinsurance would place a significant administrative burden on laboratories and a new cost on beneficiaries while doing little to affect utilization of laboratory services. In many instances the cost of billing for coinsurance will exceed the amount collected from the beneficiary.

If coinsurance were reimposed, laboratories would have to produce two claims — one to the Medicare program and one to the patient. On average, laboratories estimate it would cost about five dollars just to produce the additional invoice billing the coinsurance to the patient. In many instances, this cost would be a substantial percentage of the amount collected from the patient and could easily exceed collected amounts. The table below illustrates the approximate coinsurance amount this year for several commonly ordered tests. Once the Omnibus Budget Reconciliation Act of 1993 payment reductions already passed are fully phased in the coinsurance amounts will be even less. For these common tests, the collection costs exceed the coinsurance payments:

	1995 CLFS Amount	Coinsurance
Common Chemistry Panel	$15.65	$3.13
CBC	$11.00	$2.20
Urinalysis	$4.47	$0.89

Past experience with coinsurance suggests that many laboratories will have to write off from 20 to 50 percent of the billed amounts as uncollectible. These collection problems are the very reason that coinsurance was eliminated by Congress as part of Deficit Reduction Act of 1984, with the support of the Health Care Financing Administration and the laboratory industry. In exchange for eliminating the copayment, Congress mandated the current fee schedule methodology which set the fee schedules at 60 percent of then-prevailing charges.

Imposition of coinsurance would shift the costs of the Medicare program to beneficiaries and force them to incur an additional $7 billion in out-of-pocket expenses, a burden that Congress specifically relieved them of in 1984. However, it is unlikely that coinsurance would have any impact on the volume of clinical laboratory services performed. Patients do not decide when to order testing nor do they select the testing laboratory. These decisions are made by the physician. As the Congressional Budget Office noted in a 1990 Report, "Cost-sharing probably would not affect enrollees' use of laboratory services substantially...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing."

The College urges the Congress to again reject reimposition of coinsurance for services in the Medicare clinical laboratory fee schedule.

DIRECT BILLING FOR CLINICAL LABORATORY SERVICES

The College supports legislation which would require that payment for all pathology services, including both anatomic and clinical pathology, be made only to the person or entity which performed or supervised the service--a direct billing requirement--with an exception for referrals between laboratories that are independent of a physician's office.

In order to provide clinical laboratory services as efficiently and cost effectively as possible, the College urges Congress to require that laboratories seek payment directly from the patient or a financially responsible third party, such as the patient's insurer. Medicare already requires laboratories to bill the program directly for clinical diagnostic laboratory testing provided to its beneficiaries. In addition, California, New York and Rhode Island legislatures have each enacted some form of direct billing. Payors in other states, such as Michigan, Connecticut and Pennsylvania, require direct billing as a matter of payment policy.

The Center for Health Policy Studies (CHPS) recently completed an analysis that found that the number of services per person is *28 percent greater in non-direct billing states* than in states where direct billing is required and that *total lab charges per person are 41 percent higher* in non-direct billing states. The Center concluded that if a direct billing requirement were adopted nationwide, *the annual private sector cost savings* attributable to this change would fall in the range of *$2.4 to $3.2 billion*, or *between $12 billion and $16 billion over five years.*

In addition, CHPS found that Medicare utilization also declined in states that require direct billing for other payers, suggesting that Medicare expenditures could also be reduced by enactment of a national direct billing requirement.

The College urges enactment of an all-payer direct billing requirement this year.

PAYMENT FOR MEDICARE PAP SMEARS

All Part B payment for Medicare Pap smears should be in the physician services fee schedule rather than split between two separate fee schedules. To accomplish this, payment for the Medicare screening (technical component) Pap smear should be moved from the clinical laboratory fee schedule to the RBRVS fee schedule.

Medicare covers a Pap smear, in the absence of signs or symptoms of disease, every three years. More frequent coverage is available if certain signs, symptoms or history are present. In either event, payment for the screening portion of the Pap smear (the technical portion) is made through the clinical laboratory fee schedule. Payment for physician interpretation of the Pap smear is made through a separate fee schedule, the RBRVS. Each fee schedule bases payment on a different method and is subject to different payment rules and restrictions. This dichotomy causes considerable confusion among beneficiaries, physicians, laboratories, and even Medicare carriers. Currently there are six billing codes (CPT or HCFA codes) to choose among to report the service, three for the screening service on the clinical laboratory fee schedule and an additional three for the physician interpretation on the RBRVS.

The College believes that payment for the screening (technical) portion of the Pap smear should be moved to the RBRVS as a technical component to the physician service. This would be consistent with the fee schedule convention for other diagnostic services such as mammograms, x-rays and EKGs. In addition, the three technical billing codes now on the clinical laboratory fee schedule could be eliminated and the technical portion reported using a technical component modifier to the RBRVS service, consistent with the method for reporting

other diagnostic services. This would simplify administration of the Pap smear benefit for all concerned.

The College requests that payment for the screening (technical component) Pap smear be moved from the clinical laboratory fee schedule to the RBRVS fee schedule.

CONCLUSION

As fundamental changes in the structure and financing of the Medicare program are considered it is important to realize that measures designed to achieve short-term savings, such as arbitrary cost sharing or experimental competitive bidding projects, will not result in cost-control and may eventually separate the Medicare system and its beneficiaries from the mainstream of American medical care. Instead of stop-gap measures, sound changes in the way the government finances health care for Medicare beneficiaries should be implemented, consistent with the goal of continuing to provide access, choice and quality.

The recommendations discussed above for achievement of those goals would also move the federal government toward cost-containment without overreaching and negatively affecting the health care of Medicare beneficiaries. The College welcomes the opportunity to discuss these proposals further and thanks the Subcommittee for the opportunity of submitting this statement.

STATEMENT OF STANLEY B. BENJAMIN, M.D.
PRESIDENT, DIGESTIVE DISEASE NATIONAL COALITION

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the Digestive Disease National Coalition (DDNC) regarding Medicare reform, specifically, Medicare coverage of colorectal cancer screening.

The DDNC is comprised of 23 national voluntary and professional organizations concerned with a broad range of digestive diseases. The Coalition has as its goal a desire to improve the health care of millions of Americans who suffer from one of the many conditions, both acute and chronic, which effect the digestive tract.

One of the most common, and fatal, digestive disorders is colorectal cancer. Colorectal cancer is the second leading cause of cancer death in the United States with 155,000 new cases reported each year. The death rate from a diagnosis of colorectal cancer approaches 60%. Colorectal cancer accounts for over half (1/2) of the 80,000 ostomy operations (a surgical procedure leaving the a patient with an appliance to collect body wastes) performed each year, resulting in an annual expenditure of $1 billion. Anyone can get colorectal cancer, it is more common than either breast or prostate and cancer, and strikes men and women in almost equal numbers.

Despite these staggering statistics, colorectal cancer screening is not currently reimbursable for Medicare patients, even though advanced detection and prevention strategies have rendered colorectal cancers almost entirely preventable. Mr. Chairman, we know that early detection saves lives and saves health care resources. Diagnosis of colorectal cancer in an early localized stage translates into a 5 year survival rate of 93% for colon cancer and 87% percent for rectal cancer. Early detection not only improves the quality of life for patients but is much more cost effective than providing complex, expensive medical care to individuals in the later stages of the disease.

Every major Federal employee health plan recognizes the importance of colorectal screening procedures and provides coverage for these treatments. However, although the average age at the time of diagnosis is 71, Medicare still does not cover colorectal screening and prevention services.

Mr. Chairman, the DDNC supports HR 922, " The Colon Cancer Screening and Prevention Act", introduced on a bipartisan basis by Congressman Cardin. This important legislation addresses the problem of Medicare reimbursement for colorectal preventive services by extending Medicare coverage to include two colorectal screening tests at annual intervals.

Specifically, HR 922 would enable early detection of colorectal cancers by providing for an annual fecal occult blood test (FOBT). This is a non-invasive procedure, with an average cost of only $5, that helps reduce the risk of death from colorectal cancer by between 33 and 43%. Second, Congressman Cardin's bill includes benefit coverage of a flexible sigmoidoscopy examination, which enables a doctor to inspect the lower part of the colon where 50 to 60% of polyps and cancers occur. Finally, this legislation permits individuals at high risk to receive a screening colonoscopy exam no more than once every two years. This procedure allows examination of the entire colon and, if necessary, biopsy and removal of suspicious polyps, which are the precursors to almost all colon cancers.

The DDNC, in collaboration with the American Cancer Society, the American Nurses Association, the American Medical Association, and several other health care advocacy organizations enthusiastically support Congressman Cardin's bill. I strongly encourage all members of this distinguished subcommittee to incorporate the Medicare screening provisions of HR 922 in your comprehensive Medicare reform legislation. In addition, because the methods utilized for periodic screening and diagnosis vary, depending upon determination of the patient's risk category and current medical knowledge, the DDNC recommends that federal policy be flexible enough to allow the discretion of the health care professional, in consultation with the patient, to make the final decision on the screening technique to be employed. Coverage should reflect that discretion, and should allow for the most appropriate screening method.

Mr. Chairman, I believe it is apparent that providing Medicare coverage for colorectal cancer screening is consistent with this subcommittee's goal of slowing the growth of Medicare spending. By extending Medicare coverage to include testing procedures, the federal government will give America's seniors (the most at-risk segment of the population) a financial incentive to be tested, and in the long run, save Medicare dollars.

Once again, Mr. Chairman, thank you for the opportunity to present the Digestive Disease National Coalition's views on Medicare coverage for colorectal cancer screening. It is our sincere hope that this subcommittee recognizes the medical and economic advantages of colorectal cancer screening and extends Medicare coverage to include these vital procedures. To do less would deprive those who run the greatest risk of developing colorectal cancer the same opportunity to live a disease-free life as any other American.

Statement of the
Health Industry Distributors Association
submitted to
House Ways and Means Committee
Subcommittee on Health
Hearing on
"Medicare Solvency and Budget Reconciliation"
Tuesday, July 25, 1995
Washington, D.C.

I. Introduction

The Health Industry Distributors Association (HIDA) is pleased to submit a statement for the record for the House Ways and Means Committee's Subcommittee on Health Hearing on "Medicare Solvency and Budget Reconciliation," Tuesday, July 25, 1995.

The Health Industry Distributors Association (HIDA) is the national trade association of Home Care companies and health and medical products distribution firms. Created in 1902 by a group of medical products business people, HIDA now represents over 1000 wholesale and retail distributors with approximately 2000 locations. HIDA Home Care members include approximately 500 companies which provide quality Home Care services, supplies and equipment to patients in their homes. Home Care companies provide a wide array of services, including patient education and training on the use of equipment, furnishing of supplies, respiratory therapy visits and 24 hour emergency on-call service. Home medical equipment (HME), supplies and services which Home Care companies provide to patients include canes, crutches, wheelchairs, hospital beds and more intensive services such as home infusion therapy, oxygen, and parenteral and enteral nutrition. HIDA Home Care companies serve a significant number of Medicare beneficiaries.

HIDA commends the House Ways and Means Subcommittee on Health for its efforts to carefully examine the Medicare program to find ways to improve its quality and cost-effectiveness. We share the Subcommittee's concerns regarding the pending insolvency of the Medicare trust funds and are willing to work with Congress to slow down the rate of growth of program expenditures. However, we strongly oppose targeted cuts to home oxygen services, which have taken 18 reductions in reimbursement over the past nine years. We strongly oppose competitive bidding for home medical equipment (HME), including oxygen and parenteral and enteral nutrition (PEN) -- a cut which would be out of proportion with the rest of Medicare and would not achieve the savings or outcomes which Congress anticipates. We are also very alarmed with the negative attention focused on the "growth" of Home Care. Home Care growth is not the problem, but rather a solution to our nation's health care costs. The Home Care infrastructure has allowed countless patients to receive care in the more cost-effective environment of their own homes rather than more expensive institutional settings. We believe that the Home Care infrastructure must be preserved and enhanced to ensure that Medicare beneficiaries receive quality care at the least cost to the federal government.

II. Why HIDA Opposes Competitive Bidding for HME

Although we agree that Medicare needs restructuring, targeting home oxygen services for cuts through a competitive bidding program is not appropriate or necessary. First, Medicare patients do not seek out home oxygen therapy as a matter of discretion. To quality for home oxygen services under the Medicare Part B benefit, a patient who is diagnosed with chronic obstructive pulmonary disease (COPD) must meet very strict utilization criteria, including (1) having a physician's prescription of medical necessity, (2) passing an independent arterial blood gas test, and (3) paying a 20 percent copayment. Home oxygen suppliers receive the same reimbursement from Medicare Part B for each patient receiving home oxygen therapy services regardless of the level of service required. To compete in today's marketplace, howeer, most home care suppliers must provide a very high level of service to patients. Staying competitive has required most home care suppliers to become extremely efficient. This has been a challenge for the industry considering that Congress has made 18 reductions in reimbursement to the home oxygen benefit over the past nine years.

HIDA strongly opposes competitive bidding for HME as a way to achieve Medicare savings and cautions Congress to seriously consider its policy implications on the provision of quality home care services, supplies and equipment to Medicare beneficiaries. The Health Care Financing Administration (HCFA) has not yet begun to develop any specific proposal on how to implement competitive bidding, which is very complex and would require a new and costly bureaucracy to administer.

HIDA Members urge Congress to preserve the competitive, free market system for the Medicare home oxygen benefit. Competitive bidding for HME will only lead to higher prices and a sacrificed quality of service for patients. A winner-takes-all approach could potentially result in a loss of jobs, particularly for small businesses. Instead, Congress should consider the value of home oxygen therapy, which is considerably less expensive for the federal government than caring for the elderly and disabled in more expensive institutional settings.

III. Value of Home Care

Home Care adds significant value to our health care delivery system for a number of reasons. Home Care encourages individuals to take responsibility for their care and to function independently, remaining productive members of society. Home Care keeps families together and prevents disruption by allowing the person needing care to stay at home to receive that care. Studies show that patients prefer receiving care in the security and comfort of their own homes versus institutional settings. Finally, Home Care provides the patient with quality of life advantages over institutional care which results in more positive outcomes, preventing the need for more intensive care and further costs to the health care delivery system.

IV. Factors Contributing To Home Care Growth

Health policymakers should regard the recent improvement of Medicare Home Care as a great success story that Congress should build upon. Congress should not be surprised that the infrastructure to support Home Care has grown because of demographic and historical factors which have increased the use of Home Care versus institutional care. A major factor contributing to the increased utilization of Home

Care is the aging of the American population. According to the 1995 *Health Care Financing Review's Medicare Statistical Supplement*, as a percent of total Medicare enrollees, the 65-69 age group has declined steadily while the 85 years of age or over group has grown steadily. The latter represented 9.9 percent of total enrollment in 1992 compared with only 8.1 percent in 1978. Medicare beneficiaries 85 years and over require a much more intensive level of care than younger beneficiaries.

Another factor contributing to Home Care growth is the 1983 implementation of the Medicare hospital prospective payment system which resulted in patients being released from the hospital quicker with more intensive care needs -- thus needing some place to recover. This change has made Home Care a necessity, not an option. In addition, technological advances such as home infusion therapy have allowed patients to receive therapies and services in their homes which less than a decade ago were only available in institutions. Finally, Home Care has grown because of a strong family preference for Home Care and an increased physician and patient awareness of Home Care.

V. Home Care is Cost-Effective

The growth of Medicare Part B expenditures is not attributable to inappropriate utilization. Appropriate Home Care services decrease costly stays in hospitals and nursing homes, and increase patients' potential to become productive and participatory members of society. As the following summary chart shows, a number of studies show that Home Care is more cost-effective than hospital care:

Monthly Cost of Hospital Versus Home Care Under Selected Conditions

CONDITION	COST OF HOSPITAL CARE	COST OF HOME CARE	DOLLAR SAVINGS	DIFFERENCE
Infant with breathing and feeding problems	$60,970	$20,209	$40,761	66.8%
Nutrition infusions	$23,670	$9,000	$14,670	62%
Antibiotic infusions	$7,290	$2,070	$5,220	71.6%
ALS Patient on mechanical ventilation	$366,852	$136,560	$230,292	62.8%
Patient requiring respiratory support	$24,715	$9,267	$15,488	62.5%
Quadriplegic w/spinal chord injury	$23,862	$13,931	$9,931	41.6%
Person with cerebral palsy	$8,425	$4,867	$3,568	42.3%
Bone Marrow infection	$16,000	$5,000	$11,000	68.6%
Respiratory distress/oxygen dependency	$36,000	$11,500	$24,500	68.0%
Ventilator-dependent children	$15,742	$9,153	$6,589	41.9%
Oxygen-dependent children with a tracheostomy	$12,236	$5,304	$6,932	56.7%
AIDS care	$23,190	$2,820	$20,370	87.8%
Pediatric AIDS	$70,153	$16,461	$53,692	76.5%
Cancer chemotherapy	$10,500	$3,500	$7,000	66.8%
Kidney dialysis	$2,000	$1,200	$800	40.0%

Sources: from Olsten HealthCare, Aetna Life & Casualty Co., National Association for Home Care, 1993, 5th International Conference on Pulmonary Rehabilitation and Home Ventilation, Denver, Colorado, 1995.

As this chart shows, Home Care is considerably more cost-effective than hospital care for a number of different medical conditions. The information in the chart is a compilation of published reports and studies from a number of sources, including those listed above. Clearly, the percentage of the difference in costs between the Home Care and hospital setting -- as high as 87.8 percent -- indicates that Home Care should receive the highest consideration in efforts to lower costs in the health care delivery system.

The following chart shows the cost-effectiveness of Home Care per episode in comparison to hospital inpatient treatment:

COST COMPARISON OF TREATMENT OF HIP FRACTURE, COPD AND PNEUMONIA IN ALS

CONDITION	HOSPITAL INPATIENT TREATMENT	HOME TREATMENT	COST SAVINGS
Hip Fracture Patients	$6,708.14	$4,692.05	$2,016.09 per episode
COPD	$3,547.87	$3097.75	$450.12 per episode
ALS Patient	$3,751.26	$3,491.98	$259.28 per episode

Source: Lewin ICF, "Economic Analysis of Home Medical Equipment Services," May 29, 1991.

There are also a number of studies which have showed states' effectiveness in moving to cost- effective Home Care, including the following:

- GAO Report on Home Care Cost-Effectiveness

The General Accounting Office's (GAO) August 1994 report, Medicaid Long Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO-HEHS 94 167) shows the cost-effectiveness of home and community-based long term care programs implemented in Washington, Oregon and Wisconsin. The GAO study reports that as a result of their shift to home and community-based care, these states have been able to serve more beneficiaries with the Medicaid and state dollars they have available. The study states, "On a per-beneficiary basis, home and community-based care is considerably less expensive than nursing facility care." The report also states that per-user spending for nursing facility care has been rising faster than for home and community-based care.

Washington
The report found that Washington's average monthly expenditure per user for nursing facility care for the aged and disabled averaged $2,023 in 1993 compared with $419 for home and community-based users.

Wisconsin
Wisconsin had a net savings in per-person public expenditures associated with home and community-based care of 16 percent.

Oregon
Oregon saved $227 million between 1981 and 1991 by using home and community-based care and reduced the number of nursing facility beds significantly. Oregon's average monthly expenditure per user for nursing facility care for the aged and disabled averaged $1,657 in 1993 compared with $420 for home and community-based users.

Other Reports

- New York's "Nursing Home Without Walls'" State Senate Report New York's "Nursing Home Without Walls" program takes individuals who are eligible for Medicaid and allows them to be cared for at home if the costs so incurred are 75 percent or less than the cost of comparable nursing Home Care. New York's State Senate studies show the state saved 50% of the cost for these patients which would have been incurred had they been placed in a nursing, home.

- New Mexico Waiver Program New Mexico's waiver program for people with AIDS estimates a savings of $1100 a month for patients who use Home Care rather than skilled nursing facility care. The average patient plan of care costs $1000 a month for Home Care compared to $2,100 a month for skilled nursing facility care. New Mexico reports that only about 47% of patients receiving waiver services are hospitalized in a given year compared to 70% of those not under waiver.

- National Governors Association 1992 Resolution The National Governors Association's 1992 resolution recommended the elimination of the current institutional bias in public programs such as Medicaid. The governors are asking for more flexibility to make greater use of Home Care as the more preferred and cost-effective method of meeting the growing need for long-term care.

VI. HIDA Home Care Recommendations

HIDA Home Care has long advocated that Medicare, while a base for coverage of home health services, supplies, and equipment, should be revise to include therapies, treatments, and equipment which enhance clinical outcomes and quality of life for individuals with both acute and long term care needs. Medicare DMEPOS coverage does not cover many cost-effective home medical services, supplies, and equipment which utilize cost-effective technology. For example, the 1965 Medicare statute's restrictive language prevents beneficiaries from taking advantage of cost-effective home care, such as home infusion therapy.

HIDA Home Care has identified specific ways to improve access to Home Care. These legislative initiatives, which are supported by the Home Care Coalition, recognize and support Home Care as a cost-effective and patient-preferred alternative to institutional care. Legislative initiatives to encourage Home Care that we support include patient choice of provider; caregiver issues; coverage of home infusion therapy services, respiratory therapy services, occupational therapy services; reimbursement issues; and quality assurance mechanisms for the patient receiving Home Care services, supplies and equipment. Specifically, HIDA Home Care supports the following legislative initiatives:

Patient Choice Issues

Patient Choice/Upgrade
Amend the Medicare law to authorize beneficiaries to pay suppliers who agree to take assignment on their claims the balance above the Medicare allowable for the equipment which has functional or other features exceeding those of the item determined by Medicare to be covered. Further amend the Medicare statute to

clearly continue to allow a supplier to submit any claim for payment under assignment for an item the beneficiary chooses to upgrade.

Caregiver Issues

Family Caregiver Tax Credit
Would provide individuals who care for a severely disabled parent, grandparent, spouse or child in their home a $500 tax credit to use for such things as much-needed respite care, basic medical expenses, and special medical equipment to enhance the quality of life.

Caregiver Safety and Well-Being
Require Medicare to take into consideration the safety, health and well-being of the primary caregiver when determining the medical necessity of, and prescribing, appropriate home health services and home medical equipment. Authorize Medicare to pay for specific items and upgrades of otherwise medically necessary HME when, in the clear and documented clinical judgment of the prescribing health care professional, the HME recommended will significantly reduce the risk of injury to the unpaid primary caregiver.

Coverage & Reimbursement Issues

Medicare Coverage for Limited Respiratory therapy services under DME and home health care benefit
Cover limited respiratory therapy under Medicare when the cost will be less than expected cost of hospitalization, up to $900 per patient per year, and in accordance with clinical practice guidelines.

Medicare Coverage for Home Intravenous (IV) Therapy
Cover home IV drug therapy services under Medicare.

Medicare Coverage for Occupational Therapy as Qualifying Benefit
Include occupational therapy services as a qualifying benefit for home health services under Medicare.

Non-Discrimination Against Home Care
Provision would require Secretary to develop a certification form to assist the referring physician and the beneficiary in determining the most appropriate site for the beneficiary to receive care. Purpose is to eliminate any financial or other disincentives for utilization of home care under Medicare. (For example, requiring home care beneficiaries to pay a co-payment for care is a disincentive to use home care when there is no co-payment required for institutional care.) There should be no restriction or arbitrary limits placed on the number of home care visits based on medical necessity.

Physician Reimbursement for Home Care Visits
Medicare should reimburse the physician at a reasonable fee for medically necessary home care visits to a patient in the home and consulting for home care products or services.

Quality Assurance

Certification of Suppliers; Quality Standards
Establish different supplier standards/criteria based on the complexity of the services provided for suppliers to be able to bill Medicare for DMEPOS services. For example, suppliers providing respiratory equipment and related services would have to meet more rigorous standards than suppliers providing only "traditional" HME such as hospital beds and canes. Further, suppliers providing certain "life-supporting" equipment and related services, (*e.g.* parenteral nutrition, IV drug therapy) would be required to meet even higher standards.

Miscellaneous

Home Care Data System
Would provide for a series of data management improvements, including administrative simplification, standard claims processing forms (paper and electronic) for all public and private payors, and standardized home care data management to facilitate communications among providers, payors, *etc.* Would limit the requirement that physicians complete certificate of medical necessity forms to abusive suppliers and overutilized items. Would allow suppliers who take assignment on 90 percent of their Medicare claims to qualify as "participating suppliers" and thereby become eligible to access HCFA's insurance verification system. Many suppliers do not take assignment on all claims because some Medicare fee schedule amounts are too low.

Home Care Council
Establish a national council on home care to make recommendations to Congress, and to develop proposed changes in regulations and policy related to the provision of home care. The national council would make recommendations on simplifying consumer understanding of home care benefits and payments. The Council would include consumers, providers and carriers/fiscal intermediaries. The Council would make recommendations to the Secretary on streamlining procedures for approving coverage criteria and appropriate reimbursement for new technology products.

GAO Study on Personal Assistance Services
Require the General Accounting Office (GAO) to study existing state programs which cover personal assistance services for individuals with disabilities to determine the cost savings associated with providing these services and preventing unnecessary hospitalization. The study would make recommendations on how Medicare could cover such services to achieve program savings.

VII. Fraud and Abuse

HIDA has been very much in the forefront of industry efforts to curb heath care fraud and abuse. We have been actively involved in each stage of HCFA's process to consolidate from 33 carriers to four durable medical equipment regional carriers (DMERCs) to process Medicare DME, prosthetics orthotics and supplies (DMEPOS) claims exclusively. The carrier consolidation process has been extremely successful at reducing the opportunity for fraud and abuse.

CMNs
For years, HIDA has advocated to HCFA and the Hill our recommendation that physicians be required to complete certificates of medical necessity (CMNs) only for those items of durable medical equipment which are overutilized and only for suppliers who have been as being abusive. In other words, we recommend that you create a heavy oversight burden in targeted problem areas. Unfortunately, HCFA has not taken actions to adopt this simple recommendation to reduce overutilization.

Supplier Standards
HIDA has also advocated to HCFA and the Hill our recommendation that the HHS Secretary create quality standards which durable medical equipment prosthetics and orthotics (DMEPOS) suppliers would have to meet to qualify to submit Medicare claims for payment. Currently, suppliers are required to comply only with minimal standards as a prerequisite to receive a supplier number and bill the Medicare program for DMEPOS items. These include honoring warrantees, conducting recalls of faulty equipment, and informing the beneficiary of both of these requirements. In 1994 Congress required the Secretary to develop additional supplier standards; however, HCFA has narrowly interpreted this mandate to include standards that only pertain to requirements that a supplier comply with all applicable

state and federal licensure and regulatory requirements; maintain a physical facility on an appropriate site; and have proof of appropriate liability insurance.

To help rid the industry of the few illegitimate players which tarnish the industry, HIDA has urged HCFA to require all suppliers to comply with standards that will assure Medicare beneficiaries that they will receive a consistent quality of DMEPOS services--that is, standards most beneficiaries currently receive today. Suppliers providing oxygen or other "high technology" products and services should have to meet more rigorous quality standards, and home infusion providers should meet more rigorous quality standards. For example, a Medicare beneficiary receiving home oxygen therapy services should be guaranteed education and training on how to use the equipment, 24 hour emergency on-call service, and the furnishing of supplies. HIDA urges the Subcommittee to seriously consider our certification of suppliers recommendation to improve accountability in the industry.

Home Care Data System
In addition, HIDA Home Care has advocated to Congress a Home Care Data System to improve data management, including administrative simplification, standard claims processing forms (paper and electronic) for all public and private payors, and standardized Home Care data management to facilitate communications among providers and payors. These are just some of our proposals to improve Medicare Part B to prevent fraud and abuse and to improve quality.

VIII. Conclusion - Home Care Is Part of the Solution

As Congress looks to reform the health care system, Home Care is a critical factor. Rather than denounce Home Care for its recent growth, Congress should consider that Home Care has saved the federal government a tremendous amount of money which would have been spent had Medicare beneficiaries received care in more expensive institutional settings. HIDA believes that the answer to Medicare growth is not to cut Medicare Part B by implementing a competitive bidding program for HME (home oxygen, parenteral and enteral nutrition (PEN)). Rather, Congress should revise the Medicare statute to consider cost-effective technologies which Medicare currently does not cover. For example, the 1965 Medicare statute's restrictive language prevents beneficiaries from taking advantage of cost-effective Home Care, such as home infusion therapy and respiratory therapy. These therapies should be covered but currently are not because of the language of the 1965 Medicare statute.

As our population ages and there is more utilization of Home Care because patients prefer Home Care and sophisticated technology allows for Home Care treatment, Medicare must accommodate advances in medical technology to continue the cost-effective use of Home Care versus expensive care in a hospital setting. If access to more Home Care services were provided to patients, hospital costs could be reduced. There is no question that savings could be realized, provided that utilization controls based on medical necessity were also in place. HIDA is concerned that Congress not seek to solve the cost problems by simply limiting the benefits offered to patients without a more global consideration of the most appropriate and cost-effective site of care.

Thank you.

STATEMENT OF HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

This statement augments the Health Industry Manufacturers Asscciation's (HIMA) testimony presented before the Ways and Means Health Subcommittee on July 20, 1995. Our testimony reinforced the importance of restoring Medicare coverage for items and services provided as part of a medical device clinical trial and urged passage of H.R. 1744, the "Advanced Medical Device Access Assurance Act of 1995," introduced by Rep. Bill Thomas (R-CA).

This statement highlights HIMA's position on issues affecting home care technology, competitive bidding, and the need for clarity in the Medicare health care fraud and abuse statute.

HIMA is a Washington, D.C.-based national trade association representing more than 700 manufacturers of medical devices, diagnostic products, and health information systems. HIMA's members manufacture more than 90 percent of the nearly $50 billion in annual domestic sales of health care technology products.

Home Care

Revisions to the Medicare program must recognize the cost effectiveness of home medical equipment and the high degree of patient satisfaction with home care. The following key issues should be a part of Medicare reform to assure a strong, flexible home medical equipment (HME) benefit.

1. Definition of Home Medical Equipment. The Medicare definition of durable medical equipment is no longer consistent with the insurance coverage of many Americans and needs to be brought up to date. A modern, flexible definition of home medical equipment (HME) should be incorporated in statute. Properly drawn, it can address the concerns that have risen about Medicare's current limitations (definition attached).

2. Patient Choice of HME Products. Freedom of choice in medical care has been identified as a prime goal of most Americans in health care reform. Current Medicare policies on HME restrict patient choice. An amendment that allows individuals to "upgrade" or choose additional product features beyond the Medicare approved product at him or her own expense would assure that patient choice remains part of the modern HME benefit. This upgrade option exists only with non-assigned Medicare claims. It should be expanded to include assigned claims so the beneficiary can combine the financial protection of assignment with the flexibility of greater product choice. Enactment of H.R. 1754, introduced by Rep. Sherrod Brown (D-OH), would achieve this goal.

3. Home Infusion Therapy Benefit. HIMA supports the enactment of a Medicare home infusion therapy benefit because it will enhance home care and end the current confusion over Medicare coverage of home infusion. Currently, nutritional therapies are covered under the prosthetic device benefit and other infusion therapies are considered durable medical equipment. No professional services are recognized, even though they are crucial to proper patient care in the home. A comprehensive benefit category should be adopted. Such a benefit would also allow Medicare to be a better prudent purchaser of infusion therapy and help maintain the quality of services rendered

4. Presence of a Caregiver in the Home. Medicare policy forbids consideration of the presence/absence, health, safety and well being of a caregiver in the home. This means that all policy is based on the assumed presence of a capable caregiver in the home. As a result, certain products, such as electric beds, are not covered because they are not needed if a competent caregiver is present in the home. On the other hand, the caregiver may be elderly and not fully able to perform all mechanical functions. Medicare law needs to be changed to permit the Health Care Financing Administration (HCFA) to give consideration to the home environment, including the presence, or absence of, a competent caregiver.

Competitive Bidding

Concern over the burgeoning federal deficit has prompted both the Administration and

Congress to seriously consider the implementation of competitive bidding for clinical laboratory services, durable medical equipment (DME), and parenteral and enteral nutrition (PEN) under Medicare. HIMA opposes the concept of competitive bidding.

Competitive bidding should not be confused with competition in the health care marketplace. In fact, competitive bidding destroys competition by allowing a winner-take-all situation and driving other providers out of business, particularly small providers. Ultimately, this will drive up prices. True competition compares service and price. Competitive bidding looks only for the lowest price. It does not address issues of service, choice or quality. HIMA strongly believes in competition, but competitive bidding is not true competition. In today's marketplace, the diversity of providers brings a wide variety of services to patients, including those in most rural areas. This competitive market holds down prices and motivates companies to enhance the quality of their services.

Both the Administration and Congress endorse the expansion of managed care in the health care market. Competitive bidding is antithetical to the initiatives to expand managed care. The decision to expand managed care options is based on the desire to offer the lowest cost services. In addition, unlike a managed care group, which has a geographically contiguous population, a clearly identified group of beneficiaries, and a case manager for each patient, Medicare has none of these important attributes that are essential to soliciting "bids" for a clearly defined patient group. Furthermore, the lack of a case manager for Medicare patients would preclude Medicare from assuring that patients were getting the equipment and services contracted for by the low bidder. The adoption of competitive bidding would be an invitation to Medicare to create a new bureaucratic oversight structure, but at great cost for little potential return.

The desire to implement competitive bidding also is based on achieving the lowest cost. A structure that permits low bidders to offer inferior quality at below market prices will leave Medicare patients worse off and will cost more in the long run. No competitive bidding program to date has successfully ensured the level and quality of support and service essential to basic patient care.

We object to the use of competitive bidding for these purposes because of its very poor history under other health plans. Prior governmental experience with competitive bidding for lab testing has been poor. As HCFA noted in explaining its concerns about competitive bidding:

> Laboratories might knowingly under price the competition in order to win a Medicare contract, even if they know they will be unable to cover their costs at the bid price. This practice, known as "low balling," has occurred in even limited competitive contracts awarded by the Air Force and by the District of Columbia.

Further, we are concerned that competitive bidding will not ensure quality home medical equipment at reduced payment levels. In fact, it could curtail the access to home medical equipment.

A study by the General Accounting Office (GAO) found no administrative cost savings from its studies of competitive bidding for carrier services in Medicare programs. A 1986 GAO study looked at seven Medicare pilot projects and concluded that four of the seven lost more money than they saved. GAO found that: 1) competitive fixed-price experiments did not demonstrate any clear advantage over the cost contracts already in use to administer the program and 2) frequent use of competitive bidding in contracting could increase Medicare administrative programs, and would increase the risk of poor contractor performance..

In addition, competitive bidding usually reduces competition by eliminating other sources of supply over time. Competitive bidding has been tried for home medical equipment and subsequently abandoned in a number of states, in part due to the problem of implementation. The complexity of dividing the entire nation into multiple and reasonably size service areas is daunting. Additionally, few suppliers provide all possible services that may be needed. Therefore, special care would need to be taken to assure that the full range of services could be

provided by multiple bidders. Rural communities might find competitive bidding particularly adverse to their interest.

There is very little evidence to show that competitive bidding will actually save money when compared to other reimbursement tools. In fact, under the competitive bidding structure for oxygen equipment currently used by the Veterans Administration, there is wide variance in equipment delivery time in order to allow the contractor time to service a large geographic area. Such delays are expensive and burdensome to patients.

Under Medicaid contracts which have used competitive bidding, a number of service-related problems have risen, including inadequate patient education and training on the equipment, poor follow-up services to determine if the patient is properly using the equipment, irregular equipment checks to determine if the equipment is still properly working, and delays in repair or replacement of malfunctioning equipment.

Health Care Fraud and Abuse

HIMA supports strong anti-fraud and abuse legislation. We are pleased that the Committee is considering language that would clarify the discount exemption to the anti-kickback laws. Discounting, as a legitimate marketing practice, actually saves the system money by encouraging competition. HIMA, along with other device and pharmaceutical manufacturers, endorse the attached amendment to clarify current law.

However, there is some concern with expanding the current fraud and abuse statute to private pay plans. The current law is somewhat unclear and should be revised before expanded so that legitimate business practices are not inadvertently prohibited. With this in mind, HIMA supports modifications to the current statute including, but not limited to, advisory opinions, clarification of the "should have known standards," clarification of the intent standard and safe harbor concept, and amending the "one purpose test' to substantial or primary reason for referrals. A coalition known as the Health Industry Initiative (HII) has provided the committee with a complete package of proposed improvements to the current fraud and abuse statute. We hope that the Committee will consider all of HII's suggested changes as it debates fraud and abuse legislation.

Conclusion

Thank you for the opportunity to testify in support of H.R. 1744, "The Advance Medical Device Access Assurance Act of 1995" and provide these written comments on home care, competitive bidding, and health care fraud and abuse.

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PROPOSED REVISED DEFINITION OF DURABLE MEDICAL EQUIPMENT

Definition of home medical equipment: Home medical equipment includes medical devices, products, and delivery support systems which:

a) Can withstand repeated use by multiple users, multiple use by a single user, single use by single user (where medically necessary to insure optimum therapeutic benefit) and

b) Is primarily and customarily used to serve a medical purpose including, but not limited to prevention, treatment, recovery or rehabilitation from an illness or injury, and

c) Generally is not useful to a person in the absence of an illness, injury, or disability arising from genetic or birth defects or the effects of aging, and

d) Is appropriate for use in a home or other residential facility.

EXPLANATION

The definition is changed to rename it from durable medical equipment to "home medical equipment" reflecting current usage within the industry. The definition should be expanded to include the broad spectrum of devices used in the home that are covered by Medicare. The addition of the words "medical devices, products and delivery support systems" picks up items covered under the medical device amendments, products such as mattresses and disposables, and the delivery support systems which are essential to the proper function of a mechanical device such as a cannula within an oxygen concentrator.

Equipment is used in different types of scenarios. The repeated use by multiple users is illustrated by many beneficiaries renting the same wheelchair over time from a home medical equipment supplier's rental fleet. The multiple use by a single user occurs when a patient uses a wheelchair or cane many times, and the item is not subsequently re-rented. By virtue of sanitary requirements, there are products such as disposable intravenous pumps that should be used only once by a single user. Implantable pumps are another example of a single use by a single user.

The medical purpose is broadened to include prevention because of the need to include products that reduce health care costs by preventing illness and injury among the Medicare population. For example, bathroom safety products and wound care have only limited coverage under Medicare. Every year there are 250,000 falls in the bathroom that require hospitalization. Most of these people are over the age of 65. These falls can be prevented by bathroom safety products that are significantly less expensive than the cost of a hip replacement. Wound care is another area in which prevention and early intervention of pressure ulcers also can save money. Under the current Medicare law, preventive uses of these products are not covered.

Birth and genetic defects and aging are added to the definition because Medicare currently doesn't cover home medical equipment users who are in that situation because of these problems. This revised definition is patterned more after the terms used in the "Americans with Disabilities Act". This revised definition will mean that Medicare would reimburse patients for tools that allow them to achieve personal dignity and be independent of requiring assistance with daily living activities.

Finally, other residential facilities are added to broaden the concept of home because these products are appropriately used in these other residential facilities or institutions.

PROPOSAL TO CLARIFY ANTI-KICKBACK LAW PROVISION FOR DISCOUNTS

Legislative Change

Amend 42 U.S.C. Sec. 1320 a-7b(b)(3)(A) to read:

A discount or other reduction in price (including reductions in price applied to combinations of items and/or services, and reductions made available as part of capitation, risk sharing, disease management or similar programs) obtained by a provider of services or other entity under Medicare or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under Medicare or a state health care program. Provided, however, that where an entity which does not report its costs on a cost report separately claims an item or service for payment, and payment by the Medicare program or a state health care program is not based on actual acquisition costs, then a price reduction on the item or service may be properly disclosed and appropriately reflected by providing full and accurate information concerning the price reduction at the time the value of the reduction is known, at the request of the Secretary or a State agency.

Conform Safe Harbor Regulations

The Secretary shall, within sixty days of the enactment hereof, revise the Department's regulations to conform with 42 U.S.C. Sec. 1320a-7(b)(b)(3)(A) as amended by § ____.

Explanation

The Committee is concerned that the "discount" exception to the statute as currently interpreted, and the "discount" safe harbor regulation, have the potential to impede implementation of commercially reasonable and non-abusive marketing practices. One such practice is the combining for discount purposes of various products and/or services supplied by a company to a provider. Another example is the use of disease state management programs, where the manufacturer or supplier shares financial risk with the provider in caring for the patient. A third example involves the provision of discounts based upon purchase volume during a fixed time period. While these arrangements may differ from pure time-of-sale price discounts on a single item or service, they are appropriate in the current health care environment. They are marketplace phenomena developed in response to provider and payor demands for more cost-effective purchasing options. Under these circumstances, the manufacturer or supplier is simply reducing price based on sales volume, creating efficiencies through the breadth of its product line, or developing disease management guidelines and taking some risk for reducing health care costs for patients treated with its products. Similarly, the provider is prudently negotiating arrangements which represent the most cost-effective means of providing quality patient care. The Committee believes that these arrangements are appropriate and create no potential for abuse so long as there is adequate disclosure of the financial parameters of these arrangements so that the Medicare and State health care programs are able to ascertain cost data for purposes of revising payment rates and are able otherwise to evaluate the impact of these arrangements. The Committee believes the manufacturer or supplier providing the discount can meet its disclosure responsibility by informing the buyer of the existence and actual amount of the discount, at the time it is known; similarly, the provider can meet its obligation by providing this information, as may be requested, to the Secretary or state health care agency.

STATEMENT OF MAYO FOUNDATION

Mayo Foundation Principles for Medicare Restructuring

1. The Medicare program will not be viable without major changes (see attachment for major options available). Current Medicare spending growth levels exceed private sector health care growth levels, despite constant ratcheting downward of provider fees. Fundamental changes are needed to bring Medicare in line with the changes taking place in the health care system. These changes must allow continued access to high quality care for senior citizens, and foster a more cost-effective health care system. Regardless of the options chosen, it is important to include the following as essential components in the reform.

2. Patient choice is a fundamental principle that must be enhanced in a more competitive Medicare system. Medicare patients should have the opportunity to choose from the same types of coverage plans that are available in the private market, including HMO, preferred provider organizations/point of service plans, and open panel/fee for service plans. Reforms should not create state or geographic barriers to patient choice of plan or provider, nor restrict access to high value care.

3. If private insurance or vouchers are part of a restructured Medicare system, it is essential that risk adjustment and insurance underwriting requirements be developed to assure that all Medicare beneficiaries have access to adequate insurance coverage.

4. Medicare payments must be more standardized across the nation, decreasing the significant regional payment variations that currently exist. The current system penalizes the efficient providers of health care, and rewards the inefficient. Medicare HMO capitation rates should not include education and disproportionate share payments in the formula, but these payments should be made separately.

5. Funding for education and research should be separated from patient care funding. The Federal Government should create a separate, independent funding pool for these societal benefits, funded by a surcharge on all health plans (including Medicare). Funds should be distributed nationally to teaching hospitals and other organizations incurring the costs of these education and research programs.

LEGISLATIVE OPTIONS FOR MEDICARE

- Modify present government program
  - Increase eligibility age
  - Reduce benefits
  - Increase co-pays
  - Means tested premium increases
  - Further reduce provider payment
- Catastrophic Plan/Medical Savings Accounts
  - $3,000 deductible for all, then catastrophic insurance coverage
  - Can put tax free dollars in "medical savings account" to pay deductible
- Voucher System with private insurers
  - Provider voucher to all seniors (may or may not be means tested)
  - Risk adjust voucher amount
  - Seniors use voucher plus their own dollars to purchase private insurance of choice
  - Government coordinates private insurance offering (similar to Federal Employees Health Plan)
  - Some combination of the above

FULL TESTIMONY
NATIONAL ALLIANCE FOR INFUSION THERAPY

The National Alliance for Infusion Therapy (NAIT) submits this testimony to the Ways and Means Health Subcommittee for the record of the hearings held by the Subcommittee on July 19, 20, and 25 regarding Medicare reform and budget reconciliation issues.

NAIT is a national association of providers and manufacturers who serve patients in need of home infusion therapy and other home care services. Home infusion therapy is life-sustaining treatment for people suffering from a variety of diseases and conditions, including cancer, AIDS, infections, severe pain, gastrointestinal disorders, and many others. Appropriately administered, it is far less expensive than comparable care in an inpatient setting.

We are pleased to discuss Medicare savings and reform proposals as they pertain to home infusion therapy. We believe that the Medicare system must be reformed to reflect more accurately the way health care is delivered today. We further believe that Medicare's management of home infusion therapy is an ideal example of how Medicare has fallen far behind the private sector, to the detriment of its beneficiaries.

There are few areas that are more illogical and self-defeating than Medicare's policies toward infusion therapy. Medicare defines home infusion therapy wrongly, and as a result, cannot cover it in a sensible manner or ensure that its beneficiaries are receiving quality care. We would be thankful if, as a result of this legislative process, Medicare is reformed so that home infusion therapy is defined properly. If that occurs, the program can ensure wise expenditures for home infusion therapy and quality care for its beneficiaries.

To better understand why Medicare's coverage and payment policies for infusion therapy do not work, it would be helpful to explain briefly what infusion therapy is and how it can be dramatically cost effective when properly provided.

Drugs are administered by infusion when other routes of administration are not possible, effective, or desirable, or when a sufficiently rapid therapeutic response is not likely to be achieved. In the case of parenteral and enteral nutrition, nutrient solutions are administered by infusion when the patient cannot ingest enough nutrients orally to maintain adequate weight and strength.

Infusion therapy has been provided in acute inpatient settings for several decades. The first infusion therapies introduced into the home setting during the 1970s were nutritional therapies -- parenteral and enteral nutrition. In the mid-1980s, antibiotic therapy, chemotherapy, pain management, and other therapies were added to the spectrum of infusion therapies that are commonly provided to patients in their homes. Currently, there are over 20 different therapies being offered in the home and other outpatient settings, and Attachment A provides a summary of the most common therapies and the clinical indications for their use. Medicare provides limited coverage of infusion therapy, and the portion of Medicare costs attributable to home infusion therapy is actually small in relation to total home care expenditures and extremely small in relation to the total program, but we still believe that it is an area that warrants serious change.

The use of home infusion therapy grew rapidly in the mid-1980s with the trend to release patients from the hospital at earlier stages of recovery to complete treatment in the home or other outpatient settings. In response to this trend, a new type of home care provider evolved, one that specialized in home infusion therapy and other high-tech home care services. These providers utilized technological developments and advancements in home nursing and pharmacy practice to create a "hospital without walls" concept of home care. Compared to inpatient care, home infusion therapy saves hundreds of dollars per day in hospital "room and board" costs, where patients are properly selected for home treatment. For home infusion therapy to be successful, however, nurses and pharmacists must collaborate with the patient's physician to

carry out a patient-specific plan of care. The activities of these professionals are described in Attachment B.

In many respects, home infusion therapy is a genuine success story, combining the application of clear incentives by the government with the technological advances of the private sector to offer high-tech care to persons in their homes. Medicare, however, does not see it that way. As far as Medicare is concerned, home infusion therapy does not really exist, at least not as the entire clinical community understands it. Rather, Medicare persists in looking at infusion not as the provision of therapy but as the delivery of products and equipment, without the accompaniment of medically necessary professional services. The Health Care Financing Administration (HCFA) has strenuously avoided all efforts to regulate home infusion therapy in a manner that would reflect accurately how it is provided. As a result, we believe that HCFA has missed opportunities to reasonably control expenditures for this benefit without reducing the quality of the care provided to Medicare beneficiaries.

Instead, HCFA has sought to control infusion therapy by grouping it with the delivery of products with which it has little in common. Parenteral and enteral nutrition (PEN) therapies are covered under the prosthetic device benefit of Medicare Part B, while other infusion therapies are covered at carrier discretion under the durable medical equipment benefit, also under Part B. Neither benefit explicitly recognizes the professional services described earlier. HCFA interprets both benefits as only covering drugs or nutrients, supplies, and equipment used in the provision of therapy. Although it is commonly understood, even within HCFA, that it is the nursing and pharmaceutical services that enable patients to receive care in the home at all, Medicare's coverage criteria still do not acknowledge that those services have any role in home infusion therapy.

A natural question arises at this point: What does HCFA gain by defining home infusion therapy simply as the delivery of products? The answer is simple -- short-sighted, short-term cost savings. If HCFA can cling to a product-only definition, then it can advocate for product-only reimbursement, even when it is clear that the products are only one component of therapy. HCFA can then trim the current payment so that not one dollar of reimbursement is applied to the provision of services. At best, this position is simply disingenuous, and at worst, it is dangerous for patients and constitutes a poor basis for the creation of new policies to guide the future.

This has resulted, year after year, in a tug of war between HCFA and home infusion therapy providers over HCFA's proposed cuts in reimbursement. HCFA's proposed cuts have varied over the years, but they would all accomplish the same thing, which is to halt any payment that may possibly reflect the provision of professional services. Each time, we have suggested alternative cuts that we believe make more sense and do not threaten patients, and Congress has generally responded well to our suggestions.

This year, HCFA is again suggesting harmful cuts in the form of competitive bidding. HCFA has been testifying before Congress that it wants the authority to competitively bid for certain services covered under Part B of the Medicare program, including parenteral and enteral nutrition. This is a seriously flawed proposal, and we believe Congress should reject it.

It is clear that HCFA and other advocates of Medicare competitive bidding are trying to convince Congress of its merits by touting the "competitive" nature of the proposal. Unfortunately, the Medicare competitive bidding proposal is nothing like the competitive bidding that occurs in the private sector every day. This is a very important point -- we do not oppose competitive bidding, as it is a way of life outside of the Medicare program. What is being proposed for Medicare, however, will do little more than drive many providers out of business and leave the market to the providers that do not provide good quality services along with the products they deliver. That, we hope you would agree, is not a good result for anyone, including HCFA.

In the private sector, health plans that use the competitive bidding approach to select providers rely on one or more of the following:

- quality standards developed by the health plan, or as an alternative, a requirement that all eligible providers be accredited by the Joint Commission on the Accreditation of Healthcare Organizations;

- a clear and accurate definition of the therapy(ies) in question, so that the providers will know precisely what is expected of them; and

- some means of measuring outcomes, so that the health plan can track the clinical effectiveness of the participating providers.

None of these mechanisms would be in place for the Medicare competitive bidding system. There are no program or quality standards for infusion therapy, because these are Part B therapies, and providers are not subject to Medicare conditions of participation. As noted above, HCFA persists in wrongly defining the very therapies it seeks competitive bids on, so that the winning bid will be limited to the items HCFA recognizes as covered under PEN therapy, and would exclude the professional services that make these therapies available in the home. Finally, there is no outcomes measurement mechanism at all in place for Medicare, so there is no way for the program to ascertain how its beneficiaries are faring under this new, untried system.

This all adds up, in our view, to a recipe for disaster for patients and providers alike. One can only imagine how poorly competitive bidding would work in other areas if the government purposely misdefines what is being bid on. For example, if the Department of Defense put out a bid for a new fighter jet, and explicitly excluded the cost of the engine from the bids it was seeking so as to appear to be "saving" money (at least on paper), the Congress and the public would be rightly indignant about the behavior of the Defense Department. HCFA's competitive bidding proposal warrants the same reaction, for the same reasons. We urge Congress to reject this ill-considered policy.

Recommendations

We understand the need to reform Medicare and find needed cost savings to ensure the solvency of the program. We believe there is a sensible way to achieve this for home infusion therapy without undermining quality and competition, as HCFA's competitive bidding proposal would do.

In short, our proposal is to redefine home infusion therapy under Medicare to include professional services. We are not seeking any reimbursement increase to reflect the more accurate definition. In fact, our proposal will allow HCFA to pay for professional services only when the patient needs them and thus save money. We have described the activities of nurses, pharmacists, and other professionals in caring for patients. However, this level of activity is not the same for every patient. Some patients actually may not need services from their home infusion therapy provider, either because they have access to services through another provider (nursing home, nursing agency) or because they have been on therapy for a long time and have grown proficient in self-administering their treatment. However, Medicare payment for home infusion therapy currently does not vary according to whether the patient is receiving services or not.

This is one of the main differences between Medicare and the private sector as far as coverage and reimbursement for home infusion therapy is concerned. Private insurers directly cover services, and pay for them according to the needs of the patient. Medicare pays the same for every patient, regardless of what the patient needs.

There are several ways to remedy this situation. We submit three options for your consideration:

I. One option is within the context of the broad Medicare reform measures under discussion, where beneficiaries would be given a choice among several alternatives for health care coverage, ranging from the current Medicare fee-for-service system to private sector options such as the use of vouchers and managed care. We would simply request that for all beneficiary options, there should be a standard definition of home infusion therapy that includes clinical services, drugs or nutrients, equipment, and supplies. We support the idea of moving Medicare beneficiaries out of the fee-for-service system into managed care. Even if that happens, however, some will choose to stay with the current system. For them, the definition of home infusion therapy should be the same as for those who choose a managed care option. This will ensure equity for beneficiaries who stay in the fee-for-service segment and will give Medicare the same ability as private-sector insurers to control reimbursement and utilization of home infusion therapy services.

II. If there is no broad-based reform of Medicare, there are still ways to improve the current fee-for-service system. A second option is to make a definitional change within the existing coverage of home infusion therapy. As stated earlier, home infusion therapy is covered under the prosthetic device and durable medical equipment benefits of Medicare Part B. Congress could leave infusion therapy within those coverage niches but expand the definition of the therapies to accurately reflect the clinical services in addition to drugs, nutrients, equipment, and supplies. This would allow the program to develop payment rates that reflect varying levels of service intensity.

III. A third option would be to remove coverage of home infusion therapy from the prosthetic device and durable medical equipment benefits and create a new coverage "niche" for infusion therapy that includes clinical services. Only those infusion therapies that are currently covered by Medicare would be covered, and, as in the second option, payment could be structured so that Medicare only pays for services when patients need them.

Any one of the three options described above, if properly implemented, would decrease total Medicare expenditures for home infusion therapy and bring Medicare in line with private-sector reimbursement of home infusion therapy. By simply acknowledging that the services are integral parts of infusion therapy, HCFA can determine when to pay for them and when not to pay for them and thus control cost in an intelligent manner.

In conclusion, we ask that Congress reject ill-conceived and anti-competitive proposals such as HCFA's competitive bidding system in favor of more progressive reforms. For home infusion therapy, this means recognizing the therapy for what it is: a service-driven, patient-specific approach to home care. In so doing, the Medicare program can realize savings without putting beneficiaries at risk and doing irreparable harm to the market. We appreciate the opportunity to submit testimony to the Subcommittee, and we hope to work with Congress as it undertakes the task of reforming the Medicare program. If members of the Subcommittee or their staff have any questions regarding this testimony, please contact Alan Parver or Jana Sansbury at (202) 347-0066.

ATTACHMENT A
TYPES OF HOME INFUSION THERAPY

Introduction

Drugs are administered by infusion when other routes of administration are not possible, effective or desirable or when a sufficiently rapid therapeutic response is not likely to be achieved. In the case of parenteral or enteral nutrition, nutrient solutions are administered by infusion when the patient cannot ingest enough nutrients orally to maintain adequate weight and strength.

Clinically speaking, drug administration by infusion has advantages and disadvantages. When administered by infusion, the therapeutic agent is completely and reliably delivered to the bloodstream and is therefore immediately available to the body's tissues. In addition, large doses can be administered continuously, thus avoiding tissue damage from potentially irritating drugs. On the other hand, such administration carries with it the risk of systemic infection and venous irritation. Further, certain parenteral drugs can cause a negative reaction if they are incompatible with the patient or if they are administered too rapidly. In such cases, the consequences may be serious and even life-threatening. For these reasons, patients must be carefully screened for their suitability for home infusion therapy.

Typically, most home infusion therapy is administered intravenously (into a vein) but many other routes of administration are feasible, depending on the therapy and other clinical factors. Whatever route is chosen, any infusion requires two basic types of equipment: (1) a vascular access device (usually a catheter) through which the drug or solution enters the bloodstream and (2) an infusion device (usually a pump or a gravity drip system) to move the solution from its container into the delivery system and then into the patient. Technological advances in equipment over the last two decades have played a major role in making infusion therapy possible in the home, and future advances should continue to expand the range of treatment options in the home setting.

Clinical Indications for Home Infusion Therapy

Home infusion therapy is used to treat a variety of medical conditions. A few of the most common are listed below:

- **Infections** of many kinds, including osteomyelitis, cellulitis, endocarditis, respiratory infections, urinary tract infections, gynecologic infections, post-operative infection, cytomegalovirus infection, cystic fibrosis, chorioretinitis, pneumonia and Lyme disease. Such infections can be treated with IV administration of antibiotics.

- **Cancer**, including bronchial/lung, breast, prostate, colon, recto-sigmoid, kidney, ovarian and multiple myeloma. Cancer-related pain is often treated with home infusion therapy as well. Infusion therapy allows precise dosages of chemotherapeutic agents, which can be quite toxic if administered too rapidly.

- **Nutrition-related problems**, such as Crohn's Disease and enteritis, hypoglycemia/malnutrition following GI surgery, intestinal obstruction, short-bowel syndrome, smooth muscle disorders, esophageal cancer, infantile cerebral palsy, and stroke-related conditions such as dysphagia. These patients require IV administration or tube feeding of nutrient formulas.

- **AIDS-related conditions.** AIDS patients suffer from a variety of opportunistic infections and conditions associated with immune deficiency that can be treated with home infusion therapy. Cytomegalovirus infection, chorioretinitis,

pneumonia, anemia, malnutrition and severe pain are the most common. Thus, AIDS patients may receive several infusion therapies, including nutritional therapy.

- **High-risk pregnancy.** Home infusion therapy for these patients usually involves administration of tocolytic drugs such as terbutaline to prevent premature labor.

- **Congestive heart failure.** These patients benefit from IV administration of drugs such as dobutamine to help strengthen cardiac function.

- **Hemophilia.** Hemophiliacs need administration of agents that promote blood clotting (Factor VIII, Anti-Inhibitor Coagulant, Factor IX Complex).

- **Thalassemia.** This condition is caused by an excess of iron in the system and is treated through infusion of drugs such as deferoxamine.

- **Pituitary dwarfism and other growth disorders.** These patients require infusion of human growth hormone to assist in their growth and development.

Types of Home Infusion Therapy

Although a variety of infusion therapies are currently rendered in the home, the most common are antibiotic therapy, chemotherapy, pain management, parenteral nutrition and enteral nutrition. During an episode of illness, most home infusion therapy patients require periodic administration of a single drug or nutrient solution. However, some patients require multiple drugs or therapies concurrently. For example, cancer patients suffering from severe pain and malnutrition may need both pain management and parenteral nutrition; a patient with a serious infection from multiple organisms may need intravenous infusion of multiple antibiotics. Following is a description of the five major home infusion therapies.

Antibiotic Therapy. Administration of antibiotics to treat infections is the infusion therapy most commonly administered in the home. Some of the conditions treated with home antibiotic therapy are listed above. Treatment may last from as little as a few days to several months. Patients who are HIV positive and who have developed serious opportunistic infections often require treatment for significantly longer periods of time.

Chemotherapy. The parenteral administration of anti-neoplastic or anti-cancer drugs is intended to destroy or alter the growth pattern of malignant cancer cells. The type of drug, the frequency of administration and the duration of therapy depend on the type of cancer, the extent to which it has spread and the drug's action and toxicity. Some patients receive chemotherapy once a week for up to six weeks. Others receive it five to ten consecutive days each month. Still others are treated more frequently or for longer time periods. Because the potential dangers of intravenous chemotherapy include life-threatening toxicity, physicians, nurses and pharmacists must monitor chemotherapy patients closely.

Pain Management. Effective pain management using narcotics can alleviate severe pain, thereby decreasing anxiety and enhancing the quality of the patient's life. Chronic and severe pain may be caused by cancer, neurologic, orthopedic or certain AIDS-related conditions. Home pain management enables patients to leave the hospital and receive therapy in the comfort of their homes. It also enables terminally ill patients to spend the last weeks of their life in relative comfort in familiar surroundings with family and loved ones.

The frequency of administration and dosage depend on the medication and the patient's response to the medication. Because the severity of pain typically fluctuates over the course of a day, pumps that allow for continuous infusion of pain medication, as well as bolus "rescue" doses that the patient can self-administer up to a maximum dosage, are often used.

Parenteral Nutrition. Also referred to as intravenous hyperalimentation or total parenteral nutrition, parenteral nutrition enables patients to meet their daily needs for carbohydrates, proteins, vitamins, minerals, trace elements, fats and other nutrients through a surgically inserted venous catheter or other vascular access device. Parenteral nutrition is often recommended for patients with malnutrition resulting from Crohn's disease, short-bowel

syndrome, bowel obstruction, severe burns, malabsorption syndrome, pancreatitis, cancer, ulcerative colitis, and AIDS-related malnutrition. The common element of these indications is that the patient's digestive system does not permit the patient to absorb nutrients sufficient to maintain adequate weight and strength.

Parenteral nutrition formulas are designed to meet a patient's specific nutrient needs; the formulas specified in the physician's prescription are compounded by a pharmacist in a special environment designed to assure sterility. Clinical and laboratory tests are performed to monitor the patient's response to therapy. Parenteral nutrition may be administered continuously throughout the day or cycled over a prescribed number of hours each day (usually overnight). Since an accurate infusion rate is essential, an infusion pump equipped with alarms is used for administration.

Enteral Nutrition. Enteral nutrition involves tube feeding directly into the patient's stomach or intestine. Enteral nutrition therapy is appropriate for patients whose lower gastrointestinal tract functions normally but who are unable or unwilling to swallow, who have a gastric obstruction or who cannot otherwise ingest adequate amounts of food and fluids by mouth. Likely causes include surgery of the gastrointestinal tract, mechanical obstruction or malfunction caused by a malignant or non-malignant disease, a comatose state or Alzheimer's disease.

Most enteral nutrition patients are fed through a nasogastric or smaller feeding tube. The tube is inserted through the nasal passage with the proximal end placed into the patient's stomach or duodenum by a physician or nurse trained in such insertions. Often, enteral nutrition patients needing long-term therapy are fed through gastrostomy or jejunostomy tubes, which are inserted through a surgical incision in the abdominal wall, with the proximal end placed directly into the stomach or jejunum.

Enteral nutrition therapy formulas or solutions ordinarily are premixed by the manufacturer. They may consist of standard dietary ingredients or may be tailored to a patient's specific nutritional requirements. A relatively simple pump is often used to ensure accurate delivery of the formula.

ATTACHMENT B
DESCRIPTION OF PROFESSIONAL SERVICES

The process of admitting a patient to home infusion therapy begins with a telephone call from a physician, hospital discharge planner, home health agency, case manager, or payer. While office personnel or clinical staff can take referral information related to demographic data and insurance information, only a licensed pharmacist or registered nurse can receive orders for treatments and prescriptions.

A physician's treatment plan for the patient is developed; ideally, this should be a collaborative effort between the prescribing physician and the provider's pharmacist and nurse. The treatment plan is patient-specific, and sets forth the physician's therapeutic goals and desired regimen of care for the particular patient. The infusion therapy provider develops a plan of care to carry out the physician's treatment plan. Where patients require multiple therapies, the provider's plan of care can be quite complex and time-consuming to develop.

A clinical nurse specialist conducts an initial patient assessment to determine the patient's suitability for home infusion therapy. Normally, the nurse interviews the patient in person prior to discharge from the hospital, and visits the patient's home as well. The assessment includes an analysis of the home environment for safety and appropriateness for care delivery, a physical and psychosocial assessment, review of the patient's medical condition and current medication, vascular access assessment, and a summary of the patient's treatment prior to the home care admission.

The home infusion staff verifies insurance benefits, and contacts case managers if necessary to discuss service needs and payment. Often, a nurse and/or a pharmacist become involved in these discussions. Obviously, the absence of adequate insurance may cause the patient to decline home infusion therapy; likewise, a provider will be reluctant to accept an uninsured patient who requires costly treatment. However, inadequate or nonexistent insurance does not necessarily preclude a patient from eligibility for home infusion therapy.

Much of the savings from home infusion therapy are attributable to the fact that the patient or his/her caregiver are trained to administer the therapy. Nurses provide most of the patient training and education, although sometimes pharmacists participate. Training is often initiated while the patient is hospitalized, although it can be started after discharge. With some therapies, patients can learn the necessary procedures in one or two training sessions, totalling about 2-4 hours. On the other hand, a parenteral nutrition patient may require several sessions totalling up to 10-12 hours of training. Certain patients may have functional limitations, which diminish their ability to self-administer the therapy and to change equipment and drug delivery systems. The training regimen depends on the patient's response and ability to learn what is required.

Once the patient is trained and admitted into home treatment, the provider attempts to establish a schedule of deliveries, monitoring, and treatment. The preparation of drugs and solutions is performed by a pharmacist (or a trained technician working under the supervision of a pharmacist, if permitted under state law). Sterile admixture is performed under a laminar flow hood or in a Class 100 clean room. The pharmacist verifies the order received from the physician, and the pharmacist is responsible for checking the medical record for pertinent information before dispensing the prescribed medication. Information such as previous allergic reactions, laboratory tests, appropriateness of the treatment for the disease state, and potential drug interactions are evaluated prior to filling the prescription.

The patient is provided with the equipment required to administer the therapy, and a one-week allocation of supplies, including intravenous catheter supplies. Supplies and equipment vary depending on the therapy being provided.

The nurse initiates the prescribed therapy during the initial visit to the patient's home. The patient and/or caregiver subsequently begin to administer the therapy, and perform self-monitoring activities, at prescribed intervals. In the first week of therapy, a nurse may visit the patient daily to ensure that the therapy is being administered properly and to evaluate the patient's therapeutic response to treatment. In addition, the pharmacist and nurse are available 24 hours a day, 7 days a week to all home infusion patients to respond to problems or questions as they arise.

During visits, nurses perform on-going assessments and technical procedures as outlined in the plan of care. They assess the patient's condition, the vascular access device, the drug delivery system, the patient's compliance and response to therapy, their psycho-social adaptation to home care and their satisfaction with the services they have received. Additionally, they perform various procedures related to maintenance of the access device, conduct blood sampling, insert I.V. catheters, and provide further training to the patient and/or caregiver.

Even after the number of actual patient visits may decrease, a nurse and/or pharmacist communicates regularly with the patient regarding progress and problems. During visits and through other communications with the patient, information about the patient's clinical status, treatments provided and the patient's responses to treatment are recorded and communicated to other practitioners, providers, and the primary physician. This information, along with the results of laboratory tests, is reviewed with the physician during periodic reviews of the plan of care to determine if the goals of care are being met and whether the treatment regimen continues to be appropriate. Typically, it is during communications with the physician that changes in medication and treatment orders are received by the provider.

This routine continues until the treatment goals are met and the patient is discharged from service. Often, long-term patients become quite independent and adept at administering the therapy, thus lessening the need for a nurse to visit on a regular basis. These patients still communicate frequently, however, with the nurse and pharmacist by telephone.

STATEMENT OF THE NATIONAL RURAL HEALTH ASSOCIATION TO THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH, PRESENTED BY CHARLOTTE HARDT, MEMBER, BOARD OF TRUSTEES, JULY 20, 1995

Chairman Thomas and Members of the House Ways and Means Subcommittee on Health. I am Charlotte Hardt, Associate Director of the Eastern Washington Area Health Education Center at the Washington State University in Spokane, Washington. I am a member of the Board of Trustees of the National Rural Health Association (NRHA) and the President of the State Association Council of NRHA. The National Rural Health Association appreciates the opportunity to present its views on the potential impact of Medicare on rural health care delivery.

The National Rural Health Association membership is comprised of small, rural hospitals, community and migrant health centers, rural health clinics, primary care physicians, non-physician providers, educators and other rural health advocates.

The National Rural Health Association recognizes the urgent need to reduce the federal deficit. However, as you begin deliberations on Medicare reform, we believe that a more balanced approach must be taken to recognize and address the health care needs of American citizens living in rural and frontier communities.

HEALTH SYSTEMS FINANCING ISSUES

The National Rural Health Association believes that there are two major issues in financing health systems reform that must be considered as you debate Medicare reform. These are: (1) how to finance the overall system and (2) how to pay for services as well as reimbursement focusing on the patient/provider relationship.

Rural providers will not be sustained by abruptly reducing Medicare with draconian cuts. Rural areas, with their disproportionate number of elderly, will suffer inordinately with any decrease in Medicare funding. If cuts must be made, a well timed phase-out over time is preferred.

Achieving savings by reducing disproportionate share reimbursement, dropping hospital payment updates, eliminating sole community provider status, and moving towards a limited capitated rate could put rural providers in financial jeopardy.

Rural hospitals followed the mandate set by the Congress to reduce expensive inpatient services by providing more services that could be performed on an outpatient basis. They did exactly what the Congress sought to the point where now about 55 percent of rural hospitals' Medicare revenue are from outpatient services.

Yet, rural hospitals will find that reductions in outpatient services, let alone reductions in the hospital updates, will substantially erode their financial base, causing vital services to be reduced or eliminated.

MEDICARE HISTORICAL BIASES

It is clear that historical biases in reimbursement to rural providers exist in our current health care system. Medicare pays rural providers up to 40 percent less than their urban counterparts for the same services. Costs for those services in rural communities are generally higher because rural providers cannot take advantage of economies of scale and many other reasons.

If new health systems are based on historical experiences, rural providers and their patients will be put at further risk of losing critical health care resources and services. The rural/urban Medicare differential, reform of the Medicare wage index and adjusting for occupational mix are reimbursement issues that have had a negative impact on delivery of care in rural communities.

Rural providers are paid less than their urban counterparts. This lower reimbursement rate coupled with a lower utilization rate translates into lower Medicare payments on behalf of Medicare beneficiaries. This situation becomes more critical as the trend moves towards greater use of managed care services. As rural hospitals have already driven their costs down in order to compensate for current Medicare discriminatory payments, there is little to no flexibility left in their budgets.

The National Rural Health Association recommends that the wage index reflect the price of labor by reimbursing rural hospitals with a fair occupational mix adjustment.

REIMBURSING PRIMARY CARE PHYSICIANS

Biases exist in the historical payment to rural primary care physicians. The Medicare reimbursement for office visits are substantially lower than the cost of providing the services. Medicare fees simply do not begin to cover the time and material that it takes to serve rural chronically ill elderly residents. NRHA is concerned about the Medicare fee schedule structure in that widely varying geographic schedules would continue the inherent biases in restrictive payment to primary care providers.

Moreover, NRHA is concerned with the reduction in fees below current levels. Ultimately, access problems will arise for rural residents.

The National Rural Health Association believes that higher payments for primary care services can be achieved through reconfiguring the current fee schedule to a single conversion factor. Moreover, NRHA supports 20 percent bonus payments to primary care providers, primary care physicians, nurse practitioners, certified nurse mid-wives and physician assistants who practice in health professions shortage areas.

GRADUATE MEDICAL EDUCATION

Increases in incentives for primary care training for all disciplines are critical to rural areas. It is the hope of the rural constituency that greater emphasis on quality training at rural ambulatory, hospital and non-hospital sites will become a recruitment point for luring primary care physicians and non-physician providers to practice in rural communities.

NRHA supports direct graduate medical education reimbursement to rural ambulatory, hospital and non-hospital sites and paying of local providers for their time to teach. Further, NRHA supports up-weighting direct medical education and indirect medical education payments for primary care residency positions.

LIVING IN ONE RURAL STATE

One pearl of wisdom about rural areas is "if you have seen one rural area, you have seen one rural area." There is incredible diversity in the rural health care delivery system. Take for example Republic, Washington. Republic is a mining and timber community of 1055 people near the Canadian border.

Through the support of a public hospital district tax, Republic supports Ferry County Memorial Hospital, a 25 bed facility, with 11 acute care beds and 4 swing beds; and 14 long term care beds. The hospital recruits providers, pays their malpractice insurance, has emergency room service, obstetrics services (delivers 35-40 babies annually), home health agency, rural health clinic and provides subsidized housing. For the first time in five years, the hospital has realized a one percent profit margin.

Ferry County Memorial Hospital is the last Hill Burton hospital built in the State of Washington. It closed for a short time about six years ago due to a shortage of physicians. Abrupt and heavy Medicare cuts would have devastating consequences on this rural community. The hospital would most likely close. As an employer, the economic impact of the closure, coupled with the layoffs in the timber industry would be disastrous. Losing the hospital would make employees who are already in high risk occupations more vulnerable if an emergency situation should arise.

There would be no base for health care personnel. Physicians, nurse practitioners and physician assistants would leave the Republic community because they would no longer be subsidized by the provider district. Imagine an emergency situation, during ominous weather conditions, where the ambulance must drive between two mountain passes to meet the helicopter to fly a patient to the nearest hospital. In good weather, the nearest facility is a 1.5 hours drive.

Let us look at yet another rural community in Odessa, Washington. This community of 1500 people supports the Odessa Memorial Hospital through heavy property taxes of $4/$1000. This tax district helps to subsidize the 16 bed hospital, with 5 swing beds and 23 long term care bed services, home health services, rural health clinic (serviced by a physician and a physician assistant), and assisted living apartments. As a recruitment effort, the hospital helped to pay off the school loans of a physician before she started to practice in the community.

Odessa Hospital, along with a hospital in Davenport, Washington, which is about 55 miles away, contracted with county commissioners to take on the public health functions of the county. Efficiently utilizing scarce resources to the maximum, the hospital uses the nursing staff to provide the public health and home health services. Odessa Memorial Hospital is surviving on a very narrow margin.

It could be a substantially more viable facility if the Congress would pass an alternative facility law. This would be similar to the model in Montana, the medical assistance facility demonstration program and the model passed by the Washington State legislature. An alternative facility is a facility that is a little less than a hospital, yet more than a clinic. The facility would allow for vertical integration; have short stay beds for observation or short term illness; have a waiver of the hospital staffing requirements; allow emergency room coverage; probably would not have surgery capability, other than for outpatient surgery; would do low risk obstetrics; could be staffed by mid-levels, nurse practitioners, certified nurse mid-wives and physician assistants; and allow Medicare compensation for facility charges such as emergency room charges.

This kind of rural community-based health care system could survive as an integrated entity, without all of the excessive regulatory requirements now burdening some rural hospitals.

MANAGED CARE

Major changes are occurring in the delivery of health care services in many parts of rural America. One of these changes is the development of service delivery networks with a managed care component. In some areas large urban-based managed care networks are expanding into rural areas and contracting with local providers. In other areas, rural-based managed care plans have been organized at the community level.

The Rural Health Policy Board of the NRHA recently developed a white paper on managed care. It found that there are successful models of both urban-based and rural-based managed care models operating in rural areas. Rural managed care plans have the potential to lower the cost of medical care, improve the quality of care and help sustain the local health care system. With managed care plans, premium costs can be lower because the primary care physician acts as a coordinator or gatekeeper in the referral of patients to specialists. Managed care plans also have lower rates of hospitalization, and some offer financial incentives to provide clinical preventive services.

Quality of care may be improved by assigning each patient to a primary care practitioner, thus providing a "medical home" to everyone enrolled in the plan.

Also, since many rural physicians practice in relative isolation, rural managed care plans sometimes facilitate a greater sharing of information among physicians through utilization review and quality assurance activities.

To be effective, however, these activities must be sensitive to the practice environment and unique conditions (e.g., longer hospitals stays because of travel distances and road conditions) prevailing in rural areas. Moreover, rural essential community providers must have a protective status to keep systems in place, or they will be cherrypicked off by well financed managed care organizations.

Now let me give you an example of what recently happened in Colfax, Washington. A California managed care organization came into Colfax selling a Medicare Medigap policy at an incredibly low price. There was a big promotion of the product. Then the rural elderly residents found that they had to travel one hour to four hours to receive this nice, cheap, centralized care. What resulted were calls from the elderly residents to the Colfax Hospital administrator complaining about having to drive such a distance for their health care services.

What makes this so interesting, is that the hospital, nor the providers were ever consulted or invited to participate in the plan. Now the hospital administrator is negotiating with the managed care organization to allow the Colfax community provider hospital organization to be a part of the plan. The consequences, however, are that the cost of the plan to the elderly will rise significantly.

The National Rural Health Association has made a number of recommendations regarding a managed care framework that assures high quality, affordable, and accessible health care to all rural residents. The framework includes state and local determination; consumer choice; strong financial incentives; patient protections; adequate coverage; and provider choice.

ANTITRUST

Antitrust protection is essential if rural areas are going to be able to play on that level field we keep hearing about. The ability of the providers and hospitals to unite with their community to form their own organizations that can negotiate with managed care organizations is crucial to protecting fragile rural systems that have been painstakingly built up by rural folks to take care of their own.

When a community such as Colfax, with its five physicians and small hospital, forms a community provider hospital organization (CPHO) and then is legally challenged by large state-wide managed care organizations who do not want to negotiate with them as a united group, something is wrong. Rural communities are trying to further reduce their extremely low costs by combining management and other services of public health, home health, clinics, hospitals; thereby sharing staff and reducing administrative costs. These kinds of efforts would be undertaken by more rural communities if the specter of antitrust were to be removed.

As you can see, inherent historical biases in reimbursement to all rural providers, coupled with a fragile health care system so dependent on Medicare reimbursement because of the disproportionately high elderly population living in rural and frontier communities, warrants the Congress to judiciously consider any Medicare reform policy changes. Consideration must be given to sustaining and allowing reimbursement for alternative rural health care systems. Policies that shift rural residents, particularly the poor elderly, into managed care plans need special attention in light of the paucity of volume to sustain the providers and the paucity of providers who practice in rural areas.

Rural communities are leading the way in designing innovative rural health care delivery systems that make sense for their unique health care needs. As you begin to craft Medicare reform policy, the National Rural Health Association looks forward to working with you to assure quality health care services for Americans living in rural communities.

STATEMENT OF ROBERT J. SCOTT
SECRETARY/TREASURER
OPPOSE

JULY 20, 1995

STATEMENT OF OPPOSE

My name is Robert J. Scott. I am Secretary/Treasurer of OPPOSE. OPPOSE is a Colorado Corporation formed by teachers, fire fighters, police officers, and other state and local government employees who have elected not to join the Social Security/Medicare system. The purpose of our organization is to assure the continued financial integrity of our members' retirement and health insurance plans by resisting efforts to mandate Social Security or Medicare coverage of public employees. Our members are found in Alaska, California, Colorado, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Ohio and Texas. With respect to the issue of mandatory Social Security and Medicare coverage, the interests of OPPOSE are identical to those of the approximately five million public employees throughout the nation who remain outside the Social Security system.

BACKGROUND

In 1986, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Congress enacted a phase-in of Medicare coverage of state and local government employees who were outside the Medicare system by requiring mandatory coverage of newly hired government employees. In every year since the adoption of COBRA, there have been various legislative proposals to raise revenue by undoing this compromise by forcing immediate coverage of all state and local government workers. It has been estimated that mandatory Medicare would raise about $1.4 billion per year in fiscal years 1996-2000.

MANDATORY MEDICARE COVERAGE SHOULD NOT BE ADOPTED

I. A mandatory Medicare tax would be regressive.

There are a number of solid reasons for adhering to the COBRA compromise. Perhaps the most important single reason is the impact on the people who would be affected. The last several years have not been kind to teachers, fire fighters, police officers, social workers and other public servants. For example, a recent survey reported in the November 4, 1994, edition of USA Today, showed the average teacher's salary had increased by only two percent in the last year.

Family income for those in the middle income brackets has been virtually stagnant since 1977. A mandatory Medicare tax, imposed now on middle class citizens who benefit from solid retirement security plans, would be severely regressive. Nationwide, the average earnings of a full time state or local public employee are approximately $30,700; the Medicare tax on this amount (1.45 percent) would exceed $440. (See Table A for a state by state analysis.)

Most public employees fall in the second and third quintiles of income. These are families whose average income ranges from about $20,000 per year to about $32,000 per year. Studies based upon CBO data and prepared by the U.S. House of Representatives Ways and Means Committee staff indicate that many of these families actually lost ground during the period 1977 through 1989 or, at best, have progressed only minimally. For example, the second quintile, those between the 20th and 40th percentiles in terms of average family income, actually lost about 1.7 percent in after-tax income, measured in constant dollars, during this thirteen year period. Those in the third quintile, between the 40th and 60th percentiles in average family income, fared somewhat better, but still realized income growth of less than half a percent per year, uncompounded, throughout this period. Federal income tax rates, as a percentage of pre-tax income, actually increased slightly for the fourth quintile income group. (For the third quintile income group federal tax rates were essentially unchanged.)

Against this background, a proposal to impose a new Medicare tax on approximately 2.0 million middle class public employees is hard to justify. Some of these employees may have decided to remain in public service in part because of the deal that was made in 1986. It would not be fair to renege at this point.

For many public employees, mandatory Medicare would mean the difference between barely making it, and falling deeper into debt. For example, in Illinois, the average teacher's salary is $40,618, while average expenses equal about $700 more than this. The resulting deficit must be borrowed or offset by tightening an already lean allowance for entertainment and personal care. Mandatory Medicare would impose an addition burden of almost $600. Nationwide, this dilemma is fairly typical for public employees. The people who would be affected simply cannot withstand this kind of hit without serious effects on their middle class lifestyle.

II. Mandatory Medicare coverage of middle class public employees now outside of the Medicare system will do little to improve the fiscal soundness of the system.

The HI Trust Fund is currently in trouble. Most estimates indicate that the Trust Fund will run out of money in about the 2002. Thereafter, if no changes occur, the situation will continue

to deteriorate. The two principal reasons for these problems are: (1) the escalating cost of providing health care, well above the rate of inflation. In the last several years this situation has improved, but the basic problem remains; and (2) there is also the aging of the general population.

Suggested solutions to these problems have been wide ranging. Many have suggested incentives for managed care. Others have looked at limiting payments to providers. Increasing the eligibility age for Medicare has been suggested by some. Still others want to give the states, or individuals, much more flexibility in how they select health care providers (for example, through a voucher system), partly to provide incentives for Medicare beneficiaries to hold costs down, and partly to preserve the right of patient choice. Very few favor increased taxes.

Most people agree that it would be wise to take action in the near future to bring the HI Fund into long term balance. The reasoning is that the sooner we take action, the less painful the measures will have to be. Politically, however, this means a trade of short term pain for long term gain---always a difficult proposition.

Whatever solutions are adopted, mandatory Medicare should not be one of them. Balancing out Medicare will require hundreds of billions of dollars. Coverage of state and local government employees has been estimated by the Congressional Budget Office between now and the year 2000 to raise a little over $7 billion. Even this estimate may be optimistic. By the year 2000, only about 25 percent of the employees originally grandfathered out of Medicare will still be working for their government employers. After the year 2000, when the HI Trust Fund becomes actuarially insolvent, revenues from mandatory Medicare continue to fall off, eventually declining to virtually nil sometime within the first decade of the next century.

If states were forced, by mandatory Medicare, to raise current wages of employees in order to retain them, the increased state taxes required to pay these wages would, of course, be tax deductible for citizens of the state, thus reducing current federal revenues to some extent. For all of these reasons, mandatory Medicare will not alleviate the problem.

III. Mandatory Medicare would further handicap the ability of state and local governments to provide needed services. Those who are most dependent on government services as a safety net would be most affected.

The effects of mandatory Medicare coverage on state and local governments would be severe. Many states, including states which would be among the most adversely affected by mandatory Medicare coverage, are already suffering under federal mandates which they

cannot afford, or which must be financed by sacrificing other, much needed, programs.

In Illinois, the state legislature worked much of 1993 to prevent a total shut down of the Chicago school system which must, by law, have a balanced budget. In Michigan, it remained in doubt for many months whether, or how, the state school system would be funded beginning with the 1994 school year.

A July 30, 1993 article in The Washington Post described some of the problems which have been created for state and local governments by unfunded federal mandates. California, for example, was forced to reduce funding for primary and secondary public education by 15.6 percent.

According to reports recently issued by organizations of state and local governments, unfunded federal mandates or, more generally, actions of the federal government to push costs downward to the states, are the number one problem for state and local officials. [See The State of America's Cities, January 1994, published by The National League of Cities; The Fiscal Survey of the States, October 1993, published by the National Governor's Association and the National Association of State Budget Officers.]

Largely because of federal cost shifting, thirty-two states increased tuition for higher education. Twelve states imposed new Medicaid restrictions. Maryland, Montana, Nevada, Ohio, and South Carolina had budget cuts which exceeded three percent of their fiscal 1993 general fund expenditures.

Mandatory Medicare would only worsen the situation for state and local governments. (See attached Table B for a state-by-state cost analysis.) For example, California would have a first year cost of almost $250 million. Texas, Illinois, Ohio, Louisiana and Massachusetts would also face substantial burdens.

IV. Mandatory Medicare can not be justified on the theory that it would benefit the affected employees.

Some have argued that public employees would actually benefit by receiving Medicare coverage. The response to this concern is simple: if public employees wanted Medicare coverage, they would be asking for it. Since passage of COBRA, local jurisdictions have had the option of joining the Medicare system without also participating in the Social Security system. In short, if Medicare coverage were desirable, employees would certainly bring pressure to bear upon their employers (which are, after all, elected governments) to adopt it. In fact, the opposite is true; far from clamoring for Medicare coverage, public employee groups are vehemently opposed to efforts to impose these programs upon them.

They do not need the federal government to provide these programs "for their own good."

V. Mandatory Medicare coverage of the employees who were "grandfathered" outside the system by COBRA would create a variety of problems that were avoided by COBRA's compromise position.

Some state and local governments have health plans in place for their employees, including retirees. Adjustment of these plans to take care of Medicare coverage for existing employees would create an overwhelming task, or would result in the abandonment of these plans. While the phase-in provision adopted in COBRA affects the health benefits and take home pay of individuals at the time they commence employment, mandatory Medicare for all employees would displace benefit programs that individuals have enjoyed, in some cases, for many years, and would reduce the amount of take home pay they have come to expect. Abandonment of the careful compromise adopted in COBRA would unfairly disappoint the expectations of millions of public workers.

For all of these reasons, mandatory Medicare coverage of all state and local government employees should be squarely rejected.

Thank you for allowing me the opportunity to present the views of OPPOSE.

January 1995

Table A

ANNUAL COST TO STATE AND LOCAL GOVERNMENT EMPLOYEES
OF MANDATORY COVERAGE OF ALL EMPLOYEES

State	Annual Salary of Average Public Employee/1	Annual Tax Increase Resulting From the Proposal/2
Alabama	$ 23,616	$ 342
Alaska	40,956	594
Arizona	30,068	436
Arkansas	22,704	329
California	39,744	576
Colorado	31,104	451
Connecticut	38,460	558
Delaware	30,744	446
District of Columbia	38,100	552
Florida	27,264	395
Georgia	23,976	348
Hawaii	31,932	463
Idaho	24,600	357
Illinois	31,980	464
Indiana	27,480	399
Iowa	28,716	416
Kansas	25,812	374
Kentucky	25,356	368
Louisiana	23,364	339
Maine	26,592	386
Maryland	34,008	493
Massachusetts	32,832	476
Michigan	35,652	517
Minnesota	33,420	485
Mississippi	20,700	300
Missouri	25,380	368
Montana	25,080	364
Nebraska	26,340	382
Nevada	33,144	481
New Hampshire	29,328	425
New Jersey	36,876	535
New Mexico	24,132	350
New York	37,752	547
North Carolina	26,220	380
North Dakota	27,036	392
Ohio	29,820	432
Oklahoma	23,412	339
Oregon	31,212	453
Pennsylvania	31,704	460
Rhode Island	33,912	492
South Carolina	24,216	351
South Dakota	23,400	339
Tennessee	24,564	356
Texas	25,980	377
Utah	25,896	375
Vermont	28,284	410
Virginia	27,660	401
Washington	32,952	478
West Virginia	23,880	346
Wisconsin	33,048	479
Wyoming	25,872	375

1/ The most recent data available was obtained from the U.S. Bureau of the Census, Public Employment 1992 -Government Employment (Series GE-92-1) at 10.

2/ The amount of the new Medicare tax is derived by multiplying the average employee's salary by 1.45 percent.

January 1995 Table B

ANNUAL COST TO STATE AND LOCAL GOVERNMENTS OF COVERAGE OF THOSE EMPLOYEES NOT CURRENTLY COVERED BY MEDICARE

State	Employees Not Covered by Social Security/1	Employees Not Covered by Medicare Number/2	Employees Not Covered by Medicare Percentage/3	Cost of Coverage (Millions)/4
Alabama	27,000	11,556	4.4	4.0
Alaska	40,000	17,120	31.9	10.2
Arizona	21,000	8,998	4.0	3.9
Arkansas	39,000	16,692	11.2	5.5
California	991,000	424,148	24.8	244.4
Colorado	130,000	64,200	27.7	29.0
Connecticut	63,000	26,964	15.5	15.0
Delaware	14,000	5,992	13.8	2.7
District of Columbia	0	0	0.0	0.0
Florida	127,000	54,356	7.1	21.4
Georgia	64,000	27,392	6.3	9.5
Hawaii	24,000	10,272	13.4	4.8
Idaho	0	0	0.0	0.0
Illinois	299,000	127,972	18.6	99.1
Indiana	54,000	23,112	6.5	9.2
Iowa	5,000	2,140	1.1	0.9
Kansas	2,000	856	0.4	0.3
Kentucky	56,000	23,968	11.0	8.8
Louisiana	271,000	115,988	41.2	39.3
Maine	52,000	22,256	27.4	8.6
Maryland	29,000	12,412	4.5	8.1
Massachusetts	334,000	142,952	42.8	68.1
Michigan	19,000	8,132	1.4	3.9
Minnesota	96,000	41,088	13.2	19.9
Mississippi	2,000	856	0.5	0.3
Missouri	62,000	26,536	9.8	9.0
Montana	5,000	2,140	3.0	0.8
Nebraska	2,000	856	0.7	0.3
Nevada	49,000	20,972	28.8	10.1
New Hampshire	6,000	2,568	4.0	1.1
New Jersey	30,000	12,840	2.7	6.9
New Mexico	33,000	14,124	11.7	4.9
New York	153,000	65,484	5.1	35.8
North Carolina	43,000	18,404	4.3	7.0
North Dakota	6,000	2,568	4.6	1.0
Ohio	595,000	254,660	38.5	110.1
Oklahoma	33,000	14,124	6.4	4.8
Oregon	14,000	5,992	3.1	2.7
Pennsylvania	36,000	15,408	2.6	7.1
Rhode Island	25,000	10,700	19.4	3.3
South Carolina	6,000	2,568	1.1	0.9
South Dakota	2,000	856	1.5	0.3
Tennessee	29,000	12,412	4.3	4.4
Texas	486,000	208,008	18.9	78.4
Utah	1,000	428	0.3	0.2
Vermont	1,000	428	1.2	0.2
Virginia	72,000	30,816	7.7	12.4
Washington	36,000	15,408	4.8	7.4
West Virginia	7,000	2,996	2.9	1.0
Wisconsin	48,000	20,544	6.1	9.8
Wyoming	5,000	2,140	4.8	0.8
	4,564,000	1,953,402		897.8

1/ Social Security Administration, 1985 Current Population Survey and Continuous Work History Sample, reprinted in Congressional Research Service Paper "Medicare Coverage of Employees of State and Local Governments," by David Koitz (March 11, 1987).

2/ The Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-272, requires public employees hired after March 31, 1986, to participate in the Medicare system.

Because we assume employee turnover occurs at a rate of approximately 9% per year, in the eight and a half years since COBRA took effect, approximately 57.2% of previously non-covered employees are now covered by Medicare. The number of employees not covered by Social Security has therefore been reduced by 57.2% to reflect the number of employees who are currently not covered by Medicare.

3/ These figures reflect the percentage of the total number of state and local employees by state who would be affected by mandatory Medicare coverage.

4/ The figures reflect only the 1.45% that would be paid by governments as employers, and do not include the cost increase to their employees, who would also have to pay the 1.45% Medicare tax. (See Table A for increased tax burden on individual employees.) Given that the employer's part of the Medicare tax is 1.45%, this is multiplied by the average state or local government employee's salary for each state (U.S. Bureau of the Census, Public Employment in 1992 - Government Employment, Series GE-92-No. 1); each governmental employer's cost is equal to the number of employees, multiplied by the average salary, multiplied by 1.45%.

Testimony of Valeriano Alicea-Cruz, M.D.
President, Puerto Rico Medical Association

Before the Subcommittee on Health
of the
Committee on Ways and Means
July 20, 1995

Introduction:

Thank you, Mr. Chairman and members of this Sub-Committee, for the opportunity to testify before your committee on behalf of the physicians of the Commonwealth of Puerto Rico. We are proud to be the only state medical society that endorsed the Medicare law (Law 89-97) back in 1965. In 1967 we testified to this same Committee and the Finance Committee of the Senate with the intent that the amendments to the Social Security Act (HR-5710 and HR-12080) would establish the Medicare Program in Puerto Rico at the same time as in the mainland. The Puerto Medical Association was also crucial in the implementation of Medicaid Program by the local government. Since the creation of our Association in 1902 we have continued working according to the social justice ideal, which is inherent in this program, evidenced by the fact that 97% of all physicians in Puerto Rico accept the assignment from Medicare without any external coercion.

Present status of Medicare in Puerto Rico:

A December 1994 study, "Analysis of Medicare's Geographical Practice Cost Indexes and the Geographic Adjustment Factor for the Commonwealth of Puerto Rico", by Lewin-VHI Inc. demonstrates that the GAF applied by HCFA to Puerto Rico is wrong because:

- It does not estimate the value of physician's time directly,
- It does not estimate physician's office rent directly,
- It does not reflect the need to increase health care nonphysicians wages due to the application of the 1992 minimum wage law,
- It does not take into account the higher shipping costs for medical supplies and equipment incurred by physician's in Puerto Rico,
- It incorrectly found that Medicare premiums remained then same when in effect, insurance premiums in Puerto Rico rose at an average anual rate of 5.9 percent.

The low GPCI's applied to Puerto Rico arises from the fact that HCFA did not consider true economic reality in our region:

1. High cost of living in Puerto Rico as compared with the mainland,
2. Difference in the mix of professionals education between Puerto Rico and the main stream of the mainland,
3. Real cost of rent,
4. Changes in the salaries of non-physicians due to the dramatic reform and privatization of health services in Puerto Rico,
5. Transportation costs which affect Puerto Rico and not the mainland, and
6. Re-classification of physicians that has changed the cost of malpractice insurance.

For said reason the Puerto Rico Medical Association requests that the GPCI's for Puerto Rico be re-evaluated. This request is based on the following reasons:

- The people of Puerto Rico are United States citizens who pay full Social Security taxes since 1953, and are covered by Medicare.
- Low Medicare Part B payments affect the income, not only of physicians, but also of other health care professionals, which in turn has an effect on the quality of health care.
- Medicare providers in Puerto Rico receive paymetns equal to 79.4 percent of the average payment across the nation.
- A re-adjustment of the GPCI's will benefit health care services in Puerto Rico, not only for the elderly, but for the rest of the population.

Reduced Medicare payments adversely affect the incomes of physicians and health care workers in Puerto Rico. However, Medicare Part B reimbursements to physicians in Puerto Rico are, in the long run, not merely a matter of the incomes of physicians and the incomes of other health care workers. A policy which, in effect, consistently reimburses Puerto Rico's physicians at lower rates than physicians in other geographic regions for the same services, when those lower

reimbursement rates do not properly reflect underlying cost differences, will eventually result in fewer physicians and less access to health care for the people of Puerto Rico. This will adversely affect the welfare of both Medicare and non-Medicare patients in Puerto Rico.

Recommendations:

Puerto Rico GPCI's need to be re-evaluated in accordance to the real cost of our medical services and Puerto Rico must be compared with an area that is similar in costs, for example the neighboring Virgin Islands. No matter what formula or formulas are accepted for the survival of the Medicare Program, the treatment for Puerto Rico must be on equal basis as in the mainland.

We agree with the following recommendations made by the American Society of Internal Medicine (ASIM):

1. Increase the eligibility age for Medicare to align it with the elegibility for Social Security.

2. Increase the amount contributed by the upper income beneficiaries to financing the Medicare System.

3. Apply the Part B coinsurance to home health services.

4. Include in taxable income the value of health insurance benefits beyond a set value of insurance premium.

5. Limit the disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients.

6. Increase federal excise taxes on alcohol and tabacco if the revenues from the changes identified above prove inadequate to finance an appropiate leve of benefits.

7. Create a national all-payor funding pool for GME (Graduate Medical Education).

8. Increase the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the factor for others.

9. Create a private sector physician workforce planning initiative.

10. Apply risk adjustments, such as severity of illnes, in setting payments to risk contracting plans.

11. Broaden managed care choices for beneficiaries to include HMO's with POS (point of service) and PPO (preferred provider organizations), instead of limiting participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers.

12. Require that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them.

13. Mandate reasonable, non punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program.

We also agree with the following recommendations that we have evaluated from different sources:

1. Limit payments to Hospital physicians whose costs far exceed 115% of the National Median.

2. Transfer post-acute care decisions from the Government to the Private sector by bundling the Hospital payment.

[BY PERMISSION OF THE CHAIRMAN]

STATEMENT OF CHARLES R. MODICA, J.D., CHANCELLOR
ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE
GRENADA, WEST INDIES

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of St. George's University School of Medicine on budget reconciliation and Medicare issues.

Since its founding in 1976, over 2000 students have graduated from St. George's with degrees in medicine. Many of these students are U.S. citizens who come from tax-paying families. Because of the quality of education received by students at St. George's, fully one-third of our students complete their second year, and transfer to a U.S. medical school.

Graduates of St. George's University School of Medicine enter primary care specialties at a rate of 76% -- a percentage for any U.S. Medical School to admire. The default rate on student loans for U.S. graduates of St. George's is less than 1%, also an enviable number.

At St. George's, we are very proud of our achievements and academic record. The states of California, New York, and New Jersey have recognized this track record, and have approved St. George's students for clinical clerkships in their respective states. The approval process utilized by New York is based on LCME accreditation guidelines and is identical in many ways.

Mr. Chairman, I bring this information to your attention because it is important that this committee not paint every graduate of a non-U.S. medical school with the same broad brush and because it is important for this committee to recognize that not every non- U.S. medical school is the same.

Council on Graduate Medical Education Recommendations

The prepublication recommendations of the seventh report of the Council on Graduate Medical Education that were transmitted recently to Congress by COGME are arbitrary in nature as they relate to International Medical Graduates, and are also directly contradictory to recommendations made in its first report related to International Medical Graduates.

Seventh Annual Report

COGME's Seventh Annual Report identifies the following commendable goals:

1) Decrease the number of specialists trained.
2) Increase the number of generalist physicians and improve primary care teaching.
3) Increase minority representation in medicine.
4) Improve physician geographic distribution.
5) Train more physicians in ambulatory and managed care settings.

COGME's Seventh Annual Report also makes the following recommendations related to IMGs:

1) Continued medicare GME funding for U.S. Medical School graduate residents at current level but reduce payments for International Medical Graduate residents.
2) Transition programs to assist IMG resident-dependent institutions.

Mr. Chairman, neither of these two recommendations will help to achieve the 5 stated goals. In fact, one could make a persuasive argument that implementation of these recommendations would make it more difficult to achieve the 5 stated national goals. Graduates of St. George's University School of Medicine, and International Medical Graduates in general are:

1) More likely to enter primary care specialties.
2) Certainly much more likely to be an ethnic minority.
3) Much more likely to enter a residency program in a setting that treats disadvantaged populations and perform these services in an ambulatory setting.

Furthermore, Mr. Chairman, the Seventh Report of COGME directly contradicts COGME's landmark first report which had the mandate to carefully review issues related to International Medical Graduates, which states that:

1) Selection into GME programs should be based on the relative qualifications of the individual applicant, not on group or institutional associations; and

2) For the purpose of limiting access to GME, the federal government should not establish policies which would discriminate against medical school graduates on the basis of citizenship, immigration status, or medical school location.

Mr. Chairman, and members of the subcommittee, St. George's recognizes that this committee has been given reconciliation instructions to achieve savings in the medicare program. We propose that if savings must be achieved in Graduate Medical Education, that they be done across the board and not be arbitrarily targeted at U.S. students who receive their medical education abroad.

I would also question the value of the Council on Graduate Medical Education and the motives of its members when recommendations such as theirs are made that do nothing to achieve the stated goals, but go a long way to protect the status quo for the U.S. medical establishment.

July 25, 1995
Dearborn, Michigan

First, I would like to make a public apology to the President.

I'm sorry, Mr. President, I let you down.

I am one of thousands of Americans who truly understands the shortcomings of our present health care system...and I did not write my senator or my congressman about the Health Security Act.

As a physician who specializes in the care of the elderly, I was able to critically evaluate your plan for home and community-based care...and it was **outstanding.** It was consistent with the values of this group of Americans that built our bridges and our roads, worked and improved our factories, taught our children and paid life-long taxes.

Our nation's elderly deserve the right to remain at home, **if they so choose.** We should support their decision to remain active in the community...as long as is possible.

There needs to be some type of cost-sharing so that those who can afford to pay for that support, do pay...and those who truly cannot afford to pay, get our country's support.

And I'm sorry, Mr. President, because I know that this was all there in the Health Security Act...in black and white...for everyone to read...and I did...but I was a relatively quiet supporter.

I'm sorry, Mr. President, because I read with enthusiasm, over two years ago, how you were intent on bridging the gap between acute and long term care so that we could promote demonstrations which prevented costly hospitalizations and reduced the terrible fragmentation of care that presently typifies our health care system for the frail elderly.

Older adults want to be part of a health care system like "Cheers"..."Where everybody knows their name."

And, with a strong preponderance toward case management, your health care plan offered a chance for that type of health care system, and I, along with thousands of health care professionals and older adult advocates, let you down.

We knew that your plan called for greater emphasis on long term care insurance...insurance that would have supported our generation in planning for our later years (so that we could be secure, knowing that what is happening to our parents and grandparents all across America, in every town, in every city, doesn't have to happen to our generation when we get to be that age.)

Your Health Security Act clearly sent us a message that if we're ready to pitch in now, while we're younger, we'll not be forced to live out our final years in places others choose for us.

This is too great a country to continue to allow strangers to make the decision to place an older adult in a nursing home when that individual would rather be in their own home.

I am very worried about the Medicare and Medicaid cuts being proposed. As a Geriatrician, I have been witness to too many older Americans who have to decide between food and medications. One also has to wonder how many of those who died in Chicago from the heat could not afford air conditioning due to the high cost of their medical expenses.

I am very concerned with the idea that HMOs are the panacea for the reduction of the high costs of medical care for older Americans. The HMO industry, as a whole, is just not ready. One only has to look back to the late 1980s to examine the hazards of older Americans entering health care delivery systems developed for the young. Just as quickly as HMOs flocked into Medicare risk contracts, they soon closed up shop, leaving a population frustrated and angry. On the other hand, some of the best health care delivered to older Americans at present is delivered by HMOs. My point is move cautiously and slowly.

Quality measures specific to older Americans are in their infancy. We need to know more about how health care providers are doing in maximizing the physical, psychological and social functioning of the older individuals they serve. Activities of daily living (eating, toileting, dressing, bathing, transferring in and out of bed) and instrumental activities of daily living (housekeeping, cooking, shopping, using the telephone) are measurements of independence that older Americans value. How much information is presently out there on how HMOs do in supporting these values? Not much. How will your eighty-five year old grandmother really be able to choose? How will you choose for your 90 year old grandfather with Alzheimer's disease?

I am very nervous about the effects of Medicare cuts on hospital care. Social Workers and nurses are already scrambling to provide the type of service older Americans deserve and expect. Already, staff finds themselves without the time to walk and feed those unable to do so for themselves - let alone comfort and support them at a most traumatic time in their lives.

I am scared for the vulnerable older Americans who reside in our nation's nursing homes - if Medicaid cuts lead to a reduction in staffing and services. How can we do this to our parents and grandparents?

It makes me quite anxious to think that there may be a financial obstacle to older Americans receiving home care when they leave the hospital. I have witnessed many older Americans

underestimating their needs when they leave the hospital after an illness or surgery. The follow-up visit to the office confirms the extra time taken to convince the person of the benefits of home care is well worth it. Most are quite grateful that they finally agreed to receive home care. I am afraid that the pendulum will go the other way if there is a cost to the older person for these needed services.

Don't listen to any study you've read that doesn't support the fact that older Americans are leaving the hospital "quicker and sicker."

I am very supportive of giving older Americans choice in choosing a health plan - but let's give them real choice. It must be a strictly enforced federal law requiring all HMOs and other providers to accept all older Americans without discrimination against those with pre-existing conditions of any kind. We cannot allow older Americans who experience misfortune in illness and functioning to also be a victim of financial devastation as well.

I believe a real opportunity for savings is in the area of advance directives. If we, as a country, were more assertive in asking older Americans what they want, the reductions in costs would be enormous. Each one of us has been witness to a family member, friend, or parent who has received treatment that we know they would have never wanted. How many tests are done before asking the patient whether he or she would accept the treatment - if the test is positive? How many people are placed on respirators, transferred to the hospital or received feeding tubes that are inconsistent with their own personal values?

Another opportunity for savings is the coordination of Medicare, Medicaid and the Older Americans Act's many outstanding programs and services. An older American's health cannot be optimized unless their services are integrated. We cannot truly provide the greatest independence to older Americans unless we integrate case management, homemaker and chore assistance, respite services, adult day care, personal assistance services and assistive devices into our health care system. Anything else is an artificial separation.

So I hope that Congress will review the Health Security Act for its values (security, simplicity, savings, quality, choice and responsibility) and its insightful programs regarding older Americans. When one talks about all the waste in governmental programs let this not be another example! Hundreds of the country's most knowledgeable gerontologists and aging advocates worked on the proposals and policy papers which shaped the Health Security Act. Let's not waste all the time and human resources devoted to the task forces set up by the President and Mrs. Clinton.

Again, I am sorry, Mr. President. I, and hopefully all those who really care about our nation's elderly, will rise up this time and be heard.

And, to all congressmen and congresswomen, listen to your mothers and fathers, grandmothers and grandfathers - they deserve your greatest attention on this matter.

So, for now, for all of us who didn't support our President as strongly and as vocally as we could have, we can only say...

Things will be different in '95!

Steven M. Stein, M.D.

TRANSPLANT RECIPIENTS INTERNATIONAL ORGANIZATION, INC.

Transplant Recipients International Organization, Inc., (TRIO), a non-profit organization striving to have a positive impact on the state of organ donation and transplantation, respectfully submits the following remarks on the subject of Medicare reform. TRIO's four-fold mission is to promote donor awareness, provide to and receive support from transplant candidates, recipients, their families and donor family members, offer education and information on current developments in transplantation, and advocate for the needs and concerns of our members in local, statewide and national legislative efforts.

TRIO wishes to be included in the meaningful long-term effort toward controlling the growth of Medicare spending. The following recommendation focuses on the Medicare End Stage Renal Disease Program (ESRD), a cost effective program which has sustained and restored life to hundreds-of-thousands of transplant candidates and recipients.

Medicare

Prior to the advent of Medicare, health care for elderly and disabled persons depended upon individual wealth, or the generosity of one's friends and family. With the private market unwilling to address the health care needs of disadvantaged populations, Medicare was established. The subsequent effect has been the increase in the quality of cost-effective health care for millions of disadvantaged Americans.

TRIO recognizes the importance of fiscal responsibility, and we applaud the Committee's efforts to control the rising cost of health care. We are concerned about any abrupt dismantling of Medicare however, and are hopeful that reforms occur incrementally, without serious disruption to the lives of those entitled elderly and disabled beneficiaries.

End Stage Renal Disease Program (ESRD)

The ESRD Program was established in 1974 for the purpose of assisting those individuals suffering from life-threatening end stage renal failure, a disease that afflicts all segments of the American population and with little warning. Through subsidizing the costs associated with kidney dialysis, and immunosuppressive drugs for organ transplant recipients, the ESRD Program has sustained and enhanced the quality-of-life of hundreds of thousands of transplant candidates and recipients.

Privatization of the ESRD Program

Despite recent evidence regarding the cost-effectiveness of managed care, it is unclear whether or not the ESRD Program could be replicated by managed care facilities and still provide quality care with unlimited access.

Relative to other medical therapies reimbursable under Medicare dialysis is a costly therapy, but has remained stable over time. According to the Health Care Financing Administration (HCFA), their cost per dialysis in 1989 was around $125, representing a 61% reduction in inflation adjusted dollars from the payment level in 1974 ($138).

The ESRD Program as administered by the HCFA, has treated **all** eligible ESRD candidates without regard to age, sex, race or religion. Prior to 1974, ESRD care was characterized by inequities, with hospital boards deciding who would, and wouldn't, receive the life-saving benefits of dialysis. It is all to possible that an analogous situation would exist under an ESRD system controlled by managed care providers. In short, managed care providers would be the "gate-keepers," providing coverage to a limited number of ESRD patients while excluding older ESRD populations and those with limited financial resources. Faced with rising costs of treating ESRD patients, managed care providers will have greater incentive to reduce expenditures, perhaps by limiting ESRD for those populations at greater risk of hospitalization or unable to afford rising premiums.

Given the steady ESRD patient population growth (9% annually), the aging of the ESRD population, and the level of comprehensive specialized care required, the multi-billion dollar costs of ESRD is not representative of inefficiencies or inflated costs. Continued protections from rising inflation, HCFA's forthcoming analysis of ESRD capitation studies, and the exploration of alternatives to in-center dialysis (the most costly form of dialysis treatment), will serve to reduce the rising cost of Medicare.

<u>Transplantation as a Cost-Effective Alternative</u>

We believe that developing performance standards for organ donation in Medicare approved hospitals would be a cost-effective means of reducing Medicare expenditures while simultaneously maximizing the current supply of organs for transplant. In 1991, the most recent year for which complete data are available, Medicare costs for ESRD were $6.15 billion. Combining public and private sources, the total figure for direct medical expenditures is $8.59 billion (representing 8% of total Medicare expenditures).

According to one HCFA source, in terms of annualized costs the average cost to Medicare in the years following a successful kidney transplant is **$7,400 opposed to $44,000 per year to maintain dialysis treatment.**

Numerous studies have been conducted that compare the long-term costs of dialysis and organ transplantation. In many cases, when looked at over a period of between 7 to 10 years, transplantation has been the least costly treatment modality for ESRD patients. In his 1992 study, *Comparison of Treatment Costs Between Dialysis and Transplantation,*

Paul Eggars, of HCFA, concluded that:

> The results of this study confirm the widely held belief that kidney transplantation is, over time, a less costly alternative to maintenance dialysis. The high initial cost of transplantation is recovered in about 4.5 years (3 years for a living related donor) with a net discounted savings of about $42,000 over a 10 year time frame....the results would more forcefully favor transplantation as the preferred renal replacement therapy....[and] is the preferred alternative for ESRD patients both from a medical as well as an economic perspective (288).

With the advent of cyclosporine, and other life-saving immunosuppressive drugs, the survival rates of kidney recipients have shown marked improvements. According to data published in the United Network for Organ Sharing (UNOS), *Center Specific Report*, one year kidney graft survival for a cohort of patients (10/1/87 to 12/31/91) was 81.6 percent. One year patient survival rates for the same cohort was 93.8 percent. Given these increases in graft survival, it can be inferred that the initial costs of transplantation are recovered in less than 4 years.

TRIO is hopeful that the Committee will continue to support the ESRD Program as they look for ways to reduce Medicare expenditures. The ESRD Program is functioning with a high degree of success and cost effectiveness under current HCFA perview. We fear that without Federal involvement, the ESRD population will not be adequately served by private insurers. As has been the case in the past, private insurers have been unwilling to assist transplant candidates in need of life-sustaining dialysis therapy. We kindly request that the Committee strongly consider transplantation as a method of addressing the rising cost of health care. With the development of performance standards for organ donation in Medicare approved hospitals, and with proper incentive, kidney transplantation for a significant number of dialysis patients would be a realistic option. An option that would reap benefits that greatly exceed current ESRD costs.

Conclusion

Medicare provides valuable insurance protection to millions of entitled seniors and disabled individuals, insurance that would be difficult for many to obtain in the private market. We agree that the current health care system is characterized by problems, including escalating costs, but dismantling Medicare will not solve the problem. We must look for alternative methods of caring for our nations elderly and disabled, refining Medicare as we search for a resolution to our nation's overall health care dilemma. **TRIO points to organ donation and transplantation as a viable means for reducing Medicare expenditures.**

Again, we appreciate the opportunity to comment on Medicare reform and would be happy to evaluate legislative measures which would increase organ donation while decreasing costs associated with Medicare.

TESTIMONY OF W. BRUCE LUNSFORD
PRESIDENT AND CHIEF EXECUTIVE OFFICER
VENCOR, INC.

BEFORE THE SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS
JULY 19, 1995

Mr. Chairman, thank you for the opportunity to offer written comments to the Subcommittee as it prepares to draft Medicare program reforms. I hope you will give them consideration and feel free to ask for additional detail. I am a co-founder of Vencor, Inc. and have been its Chief Executive Officer since its beginning in 1985.

Vencor owns and operates 35 hospitals which are certified by Medicare as "long-term care hospitals" and thus are exempt from the Prospective Payment System (PPS). The company was founded in 1985 and will provide 500,000 days of care to catastrophically ill, medically complex patients during 1995. Vencor's 3,200 hospital beds, located in 17 states, represent a portion of the approximately 18,000 beds in the nation's 160 certified long-term hospitals.

Vencor's patients, however, represent a much more acutely ill patient than the typical patient treated in a majority of the long-term care hospitals. Most Vencor patients are referred from the intensive care units of acute care, PPS hospitals. The majority are dependent upon life-support systems and are being treated for multiple system failure. More than 75% of Vencor's patients are on ventilators during some portion of their hospitalization.

In every market where Vencor's mature hospitals operate, our acuity adjusted costs are the first, second or third lowest of all other hospitals. Vencor's long term hospitals cost Medicare less per discharge than the DRG and outlier payments combined at a short term hospital. Our patient outcomes are equivalent or better.

Vencor's successes have not attracted wide notice because long-term hospitals represent a very small niche within the Medicare payment system. PPS exempt hospitals account for less than 3% of Medicare Part A expenditures and fewer than 2% of Medicare discharges. Long-term hospitals account for approximately 15% of PPS-exempt program expenditures and less than 10% of the facilities.

Various proposals are under consideration by Congress that would penalize providers, such as Vencor, which successfully treat the most acutely ill patients and ultimately save the Medicare program money. We think that it is in the taxpayers' interest to maintain current incentives to reduce costs and not penalize the efficient provider by rebasing older long term hospitals that do not treat the same kind of patient admitted to a Vencor hospital. We also think that the unrestrained growth of the "hospital within a hospital" units is driving up Medicare costs and has created a loophole in the TEFRA payment system.

Vencor proposes that Congress take the following steps to achieve intermediate term budgetary savings in the long-term hospital segment of the Medicare program until a comprehensive new payment system is developed.

1) Establish 1997 as a target date for the Health Care Financing Administration (HCFA) to establish a new payment system for long-term hospitals.

2) Freeze target update factors for all long-term hospitals and avoid rebasing until a new payment system is developed by HCFA and approved by Congress.

3) Do not certify anymore "hospital within a hospital" units until a new payment system for long-term hospitals is adopted.

I appreciate the opportunity to bring these ideas to your committee and am available to discuss these proposals in detail at your convenience.

Beaumont
William Beaumont Hospital
Kenneth E. Myers
President

July 24, 1995

Mr. Phillip D. Moseley, Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

re: House Committee on Ways and Means
Subcommittee on Health
Hearing on Saving Medicare and Budget Reconciliation Issues
July 19, 1995

Dear Mr. Moseley:

On behalf of William Beaumont Hospital, I am submitting the following comments to the Subcommittee on Health of the House Ways and Means Committee on the Medicare program. While we support the direction that Congress has taken to reduce the federal deficit and maintain the financial viability of the Medicare program, we also support the American Hospital Association's position that Congress cannot continue to reduce payments to providers as the means to reach the $270 billion spending reduction target for Medicare. Rather, significant restructuring of the Medicare program is in order.

Attached is a fact sheet on our Royal Oak and Troy hospitals which shows our national ranking in terms of volume of patient care services. Beaumont is recognized by major employers in our area, including Ford Motor Company and Chrysler Corporation, as having two of the most cost efficient and high quality hospitals in southeast Michigan. Like all hospitals, Beaumont has been working to reduce costs and improve efficiency without impacting the quality of medical care we provide our patients. This has included the development of clinical pathways to reduce our lengths of stay. Our average length of stay for Medicare patients at Royal Oak has been reduced from 9.6 days in 1990 to 8.0 days in 1994. Even so, Medicare patients accounted for 46 percent of patient days in 1990 and 48 percent of patient days in 1994. Even as we have reduced the average length of stay, Medicare patients still represent a growing percentage of our days of care because of their growing number and severity of illness.

Because Medicare reimbursement under the prospective payment system has not yet kept up with acknowledged marketbasket inflation, Medicare paid our hospitals $29 million less than our costs last year for caring for Medicare beneficiaries, $14 million of which was for inpatient care. Therefore, we are understandably concerned about further arbitrary reductions in payment levels to hospitals without significant restructuring of the health care delivery system.

3601 West Thirteen Mile Road Royal Oak, Michigan 48073-6769 (810) 551-0681

VHA • Member of Voluntary Hospitals of America, Inc. •

As a major teaching hospital, we are most concerned about proposals to reduce indirect medical education from a factor of 7.7 to 3 percent. This would reduce Medicare payments to our hospitals by $17 million without any change in demand for service. As you know, the IME adjustment was instituted at the beginning of the prospective payment system to recognize that teaching hospitals have higher costs than non-teaching hospitals. The higher costs to support clinical education, biomedical research, and higher specialized patient care associated with teaching hospitals are real; reduction of IME will not make these costs disappear. Teaching hospitals cannot shift such burdens to other payers in the evolving concept of managed health care unless a way is devised for all payers to support IME.

You should also know that reductions in payments for graduate medical education would fall disproportionately hard on Michigan, which ranks in the top five states in the country for Medicare payments for both direct and indirect graduate medical education. A 60 percent reduction in Medicare IME payments would mean a loss of $100 million to our teaching hospitals, many of which are caring for a disproportionate share of indigent patients. Reductions in Medicare spending should not be directed at those states and hospitals that train the nation's supply of physicians. To illustrate, of the 110 Beaumont residents graduating last year, 44 left Michigan to begin their practice in other states.

Now that Congress is considering providing more managed care alternatives to Medicare patients, it is important that existing Medicare payments for GME, IME, and disproportionate share hospitals remain as separate components apart from the adjusted average per capita cost (AAPCC). It is essential that those payments go directly to the hospitals where those costs are incurred and not to a managed care plan that have no incentive to contract with higher cost teaching hospitals.

As the House Ways and Means Committee considers policies to reduce the rate of growth of Medicare spending, I urge members to make decisions that are equitable among both providers and beneficiaries, as well as among teaching and non-teaching hospitals. Thank you for your consideration.

Sincerely,

Kenneth E. Myers
President and C.E.O.

jc
Attachment

cc: Michigan Congressional Delegation

William Beaumont Hospital
1994 Data

	Royal Oak*	Troy**
Licensed Beds	929	189
Inpatient Admissions	40,940	11,599
Surgeries	31,837	11,087
Inpatient	13,908	3,741
Outpatient	17,929	7,346
Births	5,188	1,322
Emergency Visits	78,067	38,315
Occupancy Rate	76.1%	84%
Average Length of Stay	6.3 days	5.1 days
Medicare Avg. Length of Stay	8.0 days	6.6 days

* Based on 1993 AHA data for a single hospital campus, Royal Oak ranked 9th in the nation for inpatient admissions, 7th for total surgeries, 23rd for inpatient surgeries, and 4th for outpatient surgeries

** Based on 1993 AHA data for community hospitals under 200 beds, Troy ranked 12th in the nation for inpatient admissions, 8th for total surgeries, 33rd for inpatient surgeries, and 7th for outpatient surgeries



STANDARDS FOR HEALTH PLANS PROVIDING COVERAGE IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

AND THE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JULY 27, 1995

Committee on Ways and Means Serial 104–41
Committee on Commerce Serial 104–71

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(Ex Officio)

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STANDARDS FOR HEALTH PLANS PROVIDING COVERAGE IN THE MEDICARE PROGRAM

THURSDAY, JULY 27, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
JOINT WITH COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The Subcommittees met jointly at 10:17 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee on Health of the Committee on Ways and Means) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 20, 1995
No. HL-15

CONTACT: (202) 225-3943

Thomas and Bilirakis Announce a Joint Hearing On Standards for Health Plans Providing Coverage in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, and Congressman Michael Bilirakis (R-FL), Chairman of the Subcommittee on Health and Environment of the Committee on Commerce, today announced that their subcommittees will hold a joint hearing on standards for private health insurance plans seeking to participate in and provide coverage to beneficiaries under the Medicare program. **The hearing will take place on July 27, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include representatives of private organizations that develop standards for quality health care and accredit health care systems and plans as meeting those standards; representatives of state insurance regulators who assure the financial solvency and other critical aspects of insurance company operations; government oversight organizations that have reviewed the "state of the art" in setting appropriate standards for health plans; and representatives of private health plans. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committees and for inclusion in the printed record of the hearing.

BACKGROUND:

Currently, the Medicare program serves over 37 million beneficiaries, the majority of whom receive services under a Federally-administered system of paying hospitals and physicians directly for their services. However, under the auspices of the Medicare program, a growing number of beneficiaries are interested in and enrolling in organized health delivery systems, such as health maintenance organizations, that provide health services in local communities.

The Committees on Ways and Means and Commerce are committed to responding to this interest by improving the choice of plans available to beneficiaries. In so doing, the Committees are equally committed to assuring that private plans certified to provide services to beneficiaries meet the highest standards of quality in health care and accountability in their marketing and other business practices.

FOCUS OF THE HEARING:

The hearing will focus on two important matters. The first is to obtain testimony on the full range of standards currently applied in the health care system, both public and private, with emphasis on the needs and unique requirements of the Medicare program. The second is to take testimony on how best to discharge this responsibility and to explore what the appropriate roles are for private sector entities, the states, and the federal government. In particular, the Committees are interested in investigating the feasibility under the Medicare program of entering into agreements with states and with private accreditation organizations in order to balance the proper discharge of these responsibilities with minimal regulatory burden and intervention.

WAYS AND MEANS SUBCOMMITTEE ON HEALTH

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least twelve (12) copies of their statement, with their address and date of hearing noted, by the close of business, August 3, 1995. Six (6) copies should be sent to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Six (6) copies should be sent to Darlene G. McMullen, Chief Legislative Clerk Commttee on Commerce, U.S. House of Representatives, 2125 Rayburn House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Ways and Means' Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. Good morning.

It is a pleasure to welcome you to a joint hearing of the Health Subcommittee of the Ways and Means Committee and the Health Subcommittee of the Commerce Committee. I would like to welcome our colleagues from the Commerce Committee.

I consider the subject of today's hearings to be important to successfully providing more health plan choices to Medicare beneficiaries. I think the situation is clear: The Congress and the administration have an obligation to Medicare beneficiaries to assure that they get professional high-quality medical care. That applies to care provided through the fee-for-service system, as well as coordinated care plans such as health maintenance organizations and other health plan arrangements.

As we explore expanding the range of plan choices available to Medicare beneficiaries, we are committed to assuring that any private plans certified to provide services meet the highest standards of quality in health care and accountability in their financial and business practices.

This hearing I think has two major objectives. The first is to obtain testimony on the full range of standards possible, both public and private, that are currently applied to health services and plans. In this regard, we are particularly interested in evaluating the information in the context of the requirements of the Medicare Program.

The second goal I think is to receive testimony on how best to carry out the responsibility of developing and implementing standards for private health plans participating in the Medicare Program. We intend to explore what the appropriate roles are for private organizations and for both States and the Federal Government in this process.

In particular, I think we want to investigate the feasibility under the Medicare Program of entering into arrangements with States and private accrediting organizations to handle many of these kinds of tasks. We feel strongly about the importance of discharging these responsibilities with the absolute minimum of regulatory redtape and burden. I look forward to the testimony that we will receive today.

[The opening statement of Mr. Ganske follows:]

OPENING STATEMENT OF HON. GREG GANSKE

Mr. Chairmen, thank you for calling this hearing today. It is a pleasure to join my colleagues on the Ways and Means Committee as we continue our investigation of the Medicare Program and ways in which it can be improved.

Over the next few months, I expect the Members of these two panels to work quite closely on proposals to preserve, protect, and strengthen Medicare. With bankruptcy of the Hospital Insurance Trust Fund looming in 7 years, we will have to take bold steps to guarantee that Medicare will provide benefits to our grandparents today and to our grandchildren tomorrow.

The subject of this joint hearing, plan standards, is especially appropriate. Most Medicare reform plans which we will consider create incentives for elderly beneficiaries to enroll in managed care plans. As we move in the direction of more managed care for Medicare, we must pay special attention to the unique health needs of this population.

Before we endorse managed care as the silver bullet of reform, Congress must be satisfied that HMOs and other coordinated care networks will fully meet the health care needs of the elderly. While I believe that managed care must be an option for the elderly, I will support efforts to guarantee that these plans adhere to certain patient protection provisions. I look forward to working with my colleagues on both panels and both sides of the aisle to ensure that our efforts to protect the financial future of Medicare do not threaten the health of those who depend upon Medicare.

I thank the Chairmen and look forward to the testimony of the witnesses.

Chairman THOMAS. At this time, I would recognize the gentleman from Florida, the Chairman of the Health Subcommittee of the Commerce Committee, Mr. Bilirakis.

Chairman BILIRAKIS. Thank you, Mr. Chairman.

I, too, am pleased that we are holding a joint hearing this morning. As the two Committees in the House responsible for the Medicare Program, it is appropriate for us to meet together to discuss the important, but difficult issues of standards for health plans and the Medicare Program.

In addition to making the Medicare Trust Fund solvent to assure the continued existence of the program, one of our primary goals is to increase the choices available to senior citizens.

In today's health care market, new types of plans are constantly emerging. These new plans are available to those in the work force, but are typically not available to Medicare beneficiaries. As those currently in the work force become Medicare beneficiaries, we want to make that transition smoother by permitting them to remain in health plans with which they are familiar.

Currently, there are only two options available to them, traditional fee-for-service and HMOs, and HMOs are not available, as we know, in all areas of the country. Even where they are available, many seniors are unaware of this option.

As new types of plans enter the Medicare market, we must ensure that they are providing quality health care to seniors. In addition, these plans must be financially secure, so seniors will not be left without health coverage. Designing these standards will not be easy. We must decide on standards, whether or not the same standards should apply to all types of plans, including HMOs, PPOs and PHOs. Equally important is determining who should be responsible for enforcing these standards, the Federal Government, the States, private entities, or some combination.

Our witnesses today will describe for us the current requirements for the various types of health plans. Several of our witnesses will propose standards which they believe should apply to the different types of health plans that may be available. Along with the other Members, I look forward to the testimony of our witnesses and welcome your input.

Thank you very much, Mr. Chairman.

Chairman THOMAS. I thank the Chairman.

I will now recognize the Ranking Member of the Health Subcommittee of the Ways and Means Committee, the gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Before I comment upon the hearing today, I was asked by the gentleman from Washington, Mr. McDermott, and the gentleman from Maryland, Mr. Cardin, to apologize for their not being here.

They are in an Ethics Committee meeting to hear testimony from Speaker Gingrich as to what he did in his book contract.

It is interesting, I might note, the Speaker had suggested that he was not sure whether that was a murder or suicide for the President's staff, and that is an interesting comment. I am not really sure that the Speaker was harsh to his first wife on her sickbed, but maybe he was. Or I am not sure that he really did something unethical in taking that book contract and whether there was an exchange in title to that, but maybe he did. You are never sure whether somebody is really stealing money or they just appear to be. I am not sure. It is interesting.

Chairman THOMAS. Would the gentleman yield briefly?

Mr. STARK. I yield.

Chairman THOMAS. Obviously, the gentlewoman from Connecticut, Nancy Johnson, is not here, since she chairs the Committee on Standards of Official Conduct.

Mr. STARK. At any rate, I thank you for scheduling this hearing. It is a timely topic for us to explore. Those of us like Mr. Waxman and yourself, Mr. Chairman, remember the prepaid health plan scandals in California in the seventies, and others like ourselves who had to deal with the IMC scandal in Florida in the eighties know that vigilance is required to ensure quality in health plans.

I am troubled, though, Mr. Chairman, by the total lack of witnesses representing beneficiaries. Given the importance of health plan oversight to their health, I would think it appropriate that we hear testimony from those most affected. Beneficiaries surely have a point of view which is as important as hearing once again from the AMA representing doctors with average incomes of $189,000, and all the AMA wants to do is gouge seniors by allowing unlimited extra billing. Might not the seniors, who are going to have to pony up this $14.5 billion to enrich our Nation's physicians, have something to say?

Three recent surveys demonstrate why we need to listen carefully and act aggressively to protect the health of beneficiaries enrolled in private plans. I would like, Mr. Chairman, to ask unanimous consent that the three surveys be made a part of the record.

The Inspector General found significant problems with HMOs screening senior citizens about their health risk, with 43 percent of the Medicare HMO enrollees having been asked at application about specific health problems. That is not right.

The three surveys I mentioned were conducted by the Commonwealth Fund, the Robert Wood Johnson Foundation, and the Inspector General. All uncovered significant problems with managed care. We should not ignore their findings. Whether it is questions about access to services or questions about services for chronically ill patients, managed care plans are rated more poorly than fee-for-service plans. These findings do not suggest that we should stop enrolling beneficiaries in managed care, but they make clear that we must assure strong effective Federal standards, that they are in place to protect the health of beneficiaries who place their trust in us.

I note that many proposals would allow a major role for the States in overseeing health plans, with varying degrees of Federal oversight. In my view and in the view of the majority of experts

surveyed by the GAO, such oversight is absolutely essential by the Federal Government. The capacity of State health insurance regulators, as the GAO testified to in March 1993, is uneven, and the State regulators' records are spotty, at best. That testimony should not be ignored.

Last, Mr. Chairman, I would commend to your attention a bill that Mr. Waxman and I have introduced, the Medicare Beneficiary Protection Amendments of 1995, which all of the Members of the Ways and Means Health Subcommittee have cosponsored and many Members of the Commerce Committee Health Subcommittee have cosponsored. In my view it represents a balanced, fair approach to assuring that beneficiaries who enroll in a private health plan are as well served as if they had stayed in the regular Medicare Program.

Thank you, Mr. Chairman.

[The three surveys were not available at the time of printing.]

Chairman THOMAS. I thank the gentleman.

I just think the record should be clear. Other people can defend themselves, but this Subcommittee has held hearings more than 10 times in which seniors spoke representing various associations. Four of those times, the AARP was on panels. Once again, the AARP was asked to be here. They declined, for whatever reason. So the gentleman needs to know that his side of the aisle asked once again for the AARP to be here and they declined. So the reason seniors are not here is on the basis of their own decision.

The Chair now recognizes the Ranking Member of the Health Subcommittee on Commerce, the gentleman from California, Mr. Waxman.

Mr. WAXMAN. Mr. Chairman, I am pleased to participate in this joint hearing today to examine issues related to the standards for health plans providing coverage in the Medicare Program.

I regret, however, that we are again holding this hearing without having available the Republican plan to change the Medicare Program so that the budget requirements to reduce projected Medicare spending by $270 billion are accomplished.

It was exactly 1 month ago today that Ranking Members Dingell and Gibbons joined Mr. Stark and me and wrote to request that the specific proposal you intend to ask the Subcommittees and Committees to approve be made available. We made that request because we believe it is vital, and indeed the only responsible course for us to take, to provide time for the proposal to be analyzed and understood by the American public that relies on Medicare for health care services, and by the many health care plans and providers who are trying to deliver quality services to our aged and disabled citizens. We do not have such a proposal.

Today we are 1 week away from a recess of this House for the August period. When we return, we will be a mere 14 days from the deadline for reporting the legislation. It is difficult to escape the conclusion that a deliberate effort to keep the American people from knowing what you have in store for the Medicare Program is underway.

What we do have is one document that was obtained by the New York Times which lays out some very troubling proposals to reduce choice in Medicare—or at least leave choice in place only for those with enough income to pay the financial penalties they will face if they try to stay in Medicare as they have known it.

In light of the publicity that document received, we have heard many denials that this represents the Republican thinking. But it remains the only concrete proposal that we have seen, and it is clearly a set of proposals that takes away choice and puts quality at risk.

Without your specific proposal, Mr. Chairman, we can receive testimony on quality issues, but we cannot evaluate fairly the basic issue: Are we going to pay enough to maintain quality care, or have we set a budget target that will result in an increasingly inadequate voucher or defined payment which will ultimately lead to a restriction of services and an erosion of quality.

I would want to make one further point. Maintaining quality in the Medicare Program surely means maintaining protections for Medicare beneficiaries. It means strong Federal regulation and oversight to protect them from plans that discriminate against beneficiaries as they get older and sicker. It means policing plans to protect against risk selection and raising premiums to unaffordable levels. It means aggressive regulation to stop marketing abuses. It means assurance of effective complaint procedures and actions against plans which are not providing quality care to their enrollees.

Unfortunately, so far we have heard a lot about restricting choice and cutting expenditures and about asking Medicare beneficiaries to pay more. But we have heard nothing about the oversight and regulation needed to make this leap into the market anything more than a leap of faith. We have to remember the problem with letting the market work its will, is that sometimes too many people are left out of the will.

So I hope this hearing today will shed some light on these issues. They are not new issues. When I first got started in politics in the seventies, we had a massive push to prepaid plans in California for the MediCal population or Medicaid. What happened, these people were abused. They were taken advantage of. We have seen this over and over again and we are going to hear about it again today.

So I hope this hearing will shed some light on these issues, but I hope this hearing is only the first to address them. Most of all, I hope that the hearing we have the next time will be with a specific plan on the table.

I noted with interest that the Washington Post reported that this view is not only mine, as someone you might want to dismiss because I am a Democrat, but the view of Chairman John Kasich of the Budget Committee who thought that the Republicans ought to let people know what they planned for Medicare, not at the last minute, but with due deliberation and sufficient time for them to review it.

This is also the view expressed in a report from Senator Arlen Specter, a Republican from the State of Pennsylvania, even a Presidential candidate for the Republican nomination. So I hope this is

the first of hearings to address this issue and next time we will have a specific plan on the table.

I want to ask unanimous consent to put in the record a statement of Representative Elizabeth Furse, our colleague on the Commerce Committee. She has introduced, together with the American Diabetes Association, H.R. 1073 and H.R. 1074, to help empower people with diabetes. I think her statement is a very important one and should be part of this record.

Thank you.

Chairman THOMAS. Without objection, the statement will be made a part of the record.

[The prepared statement follows:]

Statement of Rep. Elizabeth Furse
July 27, 1995
before a Joint Meeting of the
Commerce Subcommittee on Health and the Environment
and
Ways and Means Subcommittee on Health

Thank you, Mr. Chairman. Members of the subcommittees, I appreciate your willingness to allow me to make a few remarks today. Diabetes continues to be a serious health problem in America. Diabetes is our fourth leading cause of death, affecting 14 million Americans and costing our nation over $100 billion annually. Contrary to popular belief, insulin is not a cure for diabetes; it only helps those with diabetes properly manage their disease.

If people with diabetes don't have the necessary tools and training to manage their disease, the results are costly, often fatal, complications such as blindness, heart disease, amputations, and stroke. The only way we can help reduce the burden of diabetes, and these costly complications, is to empower people with diabetes to manage their disease. According to the National Diabetes Research Coalition, an organization of leading endocrinologists and other scientists active in diabetes research, a 10% reduction in complications will save a staggering $5 billion.

Earlier this year, together with the American Diabetes Association, I introduced H.R. 1073 and H.R. 1074 to help empower people with diabetes. H.R. 1073 would provide people with diabetes self-management training and H.R. 1074 would ensure coverage of blood testing strips. I am pleased that H.R. 1073 has broad support in Congress, with currently 115 bipartisan cosponsors, including members of both the Commerce and Ways and Means Committees. Representatives Nancy Johnson, Jim McDermott, and John Lewis are currently cosponsors of H.R. 1073, as are Representatives Henry Waxman, Ron Wyden, Sherrod Brown, Gerry Studds, Bart Stupak, Ed Towns, and Bart Gordon. I am also pleased that the American Diabetes Association, the American Dietetic Association, and National Association of Diabetes Educators have testified before the Ways and Means Committee supporting H.R. 1073.

I believe that reforming Medicare is a prime opportunity to help make these important changes to help people with diabetes. Earlier this year, I had a very positive meeting with Speaker Gingrich on these bill, and I think it is fitting to quote from an appearance he made on Good Morning America last year. He said:

> "We don't today pay for training you, as a diabetic, how to take care of yourself. We will pay to put you in the hospital and to amputate your leg when you fail to take care of yourself. But literally, the government bias today is not to pay for the preventive and educational experience that will lower your costs." -- Speaker Gingrich, 7/27/94

Let's follow the Speaker's advice and change the government bias. As this Congress moves to reform Medicare, I urge my colleagues to ensure that people with diabetes have necessary tools -- in both training and equipment -- to manage their disease properly. It will save thousands of lives and potentially billions of health care dollars.

Chairman THOMAS. I will just respond briefly to my friend from California. Since we have not been together on these hearings, I am pleased that this is a joint hearing. We are trying something novel here. We are trying to hear the testimony before we write a plan. The hearing today is on standards for health plans providing coverage in the Medicare Program.

I know the gentleman wishes to refer back to the seventies. In fact, if he did so with the Medicare Trust Fund, he would find that it appeared to be in good shape then. This is the nineties, and we are 7 years away from a bankrupt part A program. I can assure you that when we finish putting a plan together, we will lay it on the table, and I fully anticipate at the time that we lay it on the table, you will lay one on the table, as well.

Mr. WAXMAN. Will the gentleman yield to me?

Chairman THOMAS. Certainly.

Mr. WAXMAN. You do things here differently in Ways and Means. We usually make our statements and then go on to the next Member. Here I guess the Chairman gets to comment on everyone's statement.

Chairman THOMAS. Reclaiming my time, the first witness is Dr. Carlotta Joyner, who is Associate Director for Federal Health Care Delivery Issues, Health, Education and Human Services Division, U.S. General Accounting Office.

Dr. Joyner, any written testimony that you may have will be made a part of the record, and you may proceed to inform us in any way you see fit in the time you have available to you.

Mr. WAXMAN. If the gentlelady would hold off for 1 minute, I would like to be recognized by the Chair.

Chairman THOMAS. The gentleman is recognized.

Mr. WAXMAN. I believe it is important for the American people to see in advance what major changes in Medicare will be and——

Chairman THOMAS. The gentleman said that.

Mr. WAXMAN [continuing]. They ought to have more than 2 weeks' notice, and there ought to be hearings on that plan.

Chairman THOMAS. The gentleman is repeating himself.

Mr. WAXMAN. I emphasize that point. Hopefully, through repetition, minds that are otherwise closed might listen to the message.

Thank you, Mr. Chairman.

Chairman THOMAS. I appreciate the gentleman for his advancement of this hearing.

Dr. Joyner.

STATEMENT OF CARLOTTA C. JOYNER, ASSOCIATE DIRECTOR FOR FEDERAL HEALTH CARE DELIVERY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY EDWARD STROPKO, ASSISTANT DIRECTOR, AND PETER SCHMIDT, SENIOR EVALUATOR

Ms. JOYNER. Thank you very much.

I would like first to introduce my two colleagues from GAO who will also be available to answer any questions that you might have, Edward Stropko and Peter Schmidt.

We are very pleased to be here with you today to discuss this important matter of quality health care for Medicare beneficiaries. As

health care cost containment efforts have increased over the past several years, so too has attention to ensuring the quality of that care.

Corporate purchasers of health care want to correct any problems that might result from actions they have taken, such as restricting patients' choice of providers or other actions in the realm of financial incentives that on the one hand might encourage limiting care or, on the other hand, encourage overtreating. These purchasers feel that by evaluating both cost and quality, they can select the plan that provides the best value.

You asked us to discuss today what HCFA, the Health Care Financing Administration, as a very major purchaser is doing and is planning to do to ensure quality of care and make sure that Medicare providers meet, as you said, the very highest standards of health care quality. You asked us also to describe what health care experts believe the important features of a quality assurance system should be.

To develop this information, we relied on our previous reports, our interviews with HCFA officials, and over 30 structured interviews with health care experts, some of whom have testified before your Committees in the past or will again in the future. We selected experts that represent a wide range of perspectives on the matter.

In summary, HCFA has three quality assurance programs. The first of these assesses whether fee-for-service institutional providers meet Medicare conditions of participation. The second assesses similar matters with respect to HMOs, and the third reviews care actually provided in inpatient care settings and in ambulatory surgery to both fee-for-service HMO arrangements.

These programs are carried out through a mixture of Federal and State government and private sector initiatives. For example, HCFA personnel conduct visits to HMOs. State agencies under contract with HCFA conduct these visits within the fee-for-service sector, unless the provider has been accredited by a private organization that HCFA will accept in lieu of its own visits. In addition, reviews of care actually provided are also now done by the private sector, by the peer review organizations comprised of local physicians under contract with HCFA.

Although these programs represent reasonable approaches, we have in the past reported serious problems with their implementation. I might note here also that, except in a recently initiated pilot program, HCFA has no program to assess the care furnished by physicians in their private offices.

The experts we interviewed agreed that the Federal Government, as a purchaser of health care, must continue to play a role in evaluating the quality of care provided to Medicare beneficiaries. They described some features of what they saw as an enhanced Federal quality assurance approach: First, that it would in fact build on existing Federal, State, and private efforts; second, that it would encourage continuous quality improvement; third, that it would obtain multiple kinds of information about providers, especially the adequacy of their basic structures, performance measures, stressing outcome measures and patient satisfaction; and, fourth, that it would make this information available to others.

They also talked about various roles Federal, State, and private entities might take, but really had no consensus on precisely what those would be.

I want to point out that HCFA is beginning to enhance its quality assurance programs in several ways. These include an emphasis on continuous quality improvement, on performance measures and patient satisfaction, and strengthening its collaboration with the private sector through such initiatives as the recently formed Foundation for Accountability. These changes are ones that will take advantage of successful private sector approaches and are consistent with the ideas that we heard from the experts.

The challenge facing HCFA is to make the specific decisions on implementation and to avoid the kind of implementation problems that we have observed in its past efforts.

This concludes my summary statement. I would be glad to answer any questions you might have.

[The prepared statement and attachments follow:]

STATEMENT OF CARLOTTA C. JOYNER
ASSOCIATE DIRECTOR FOR FEDERAL HEALTH CARE DELIVERY ISSUES
U.S. GENERAL ACCOUNTING OFFICE

Messrs. Chairmen and Members of the Subcommittees:

I am pleased to be here today to discuss quality health care for Medicare beneficiaries. As health care cost containment efforts have increased over the past several years, more attention has been paid to ensuring the quality of that care. Corporate purchasers of health care particularly want to identify and correct any problems that might result from restricting patients' choice of providers or from giving providers financial incentives that encourage them to withhold, delay, or limit needed care, or, on the other hand, that encourage them to overtreat. By evaluating both cost and quality, these purchasers believe they can select the plan that provides the best value.

Because of your interest in this subject, you asked us to discuss (1) what the Health Care Financing Administration (HCFA) is doing and plans to do to ensure that Medicare providers furnish quality care in both fee-for-service and managed care delivery systems and (2) experts' views on essential quality assurance components. Our discussion today reflects our past work and an ongoing study for the Subcommittee on Health.[1] To develop this information, we relied on our previous reports, interviews with HCFA program officials, and over 30 structured interviews with experts. We selected these experts to represent a wide range of perspectives: health plans, health care researchers, federal and state agencies, major purchasers of health care, and accrediting agencies. (See app. I for a list of related products and app. II for the experts we interviewed and their affiliations.)

In summary, HCFA has three quality assurance programs. These programs (1) assess whether fee-for-service institutional providers meet certain Medicare conditions of participation; (2) assess whether HMOs meet similar requirements; and (3) review inpatient care and ambulatory surgery furnished under fee-for-service arrangements or by HMO providers. Although these programs represent reasonable approaches, we have reported serious problems with their implementation. Except in a recently initiated pilot program, HCFA has no program that assesses care furnished to Medicare beneficiaries by physicians in their private offices.

Those we interviewed agreed that the federal government, as a purchaser of health care, must continue to play an important role in evaluating the quality of care provided to Medicare beneficiaries. They described an enhanced federal quality assurance strategy as one that (1) builds on existing federal, state, and private efforts; (2) encourages continuous quality improvement; (3) obtains multiple kinds of information about providers--adequacy of basic organizational structures, performance measures, and patient satisfaction--and (4) makes information about providers available to beneficiaries and others in a manner that is useful and understandable. The experts identified enhanced roles that could be played by the federal or state governments and private entities in collecting and evaluating this information, but no consensus emerged on the most appropriate roles.

HCFA is beginning to enhance its quality assurance programs in several ways. These changes include a greater emphasis on continuous quality improvement, performance measurement, and patient satisfaction. Furthermore, HCFA is strengthening its collaboration with the private sector. The changes HCFA is making are ones that will take advantage of successful private sector approaches and are consistent with the ideas expressed by the experts we interviewed. But HCFA faces a challenge in implementing these changes in ways that avoid the kind of implementation problems that have occurred with its past efforts.

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[1]We plan to issue a report to the Subcommittee on Health later this summer that will discuss quality assurance approaches in more detail.

BACKGROUND

Widespread professional interest in monitoring the quality of health care services arose after World War II. Attention increased with passage of federal Medicare legislation in 1965 and, in the early 1970s, the Joint Commission on Accreditation of Healthcare Organizations' mandate that hospitals implement an internal quality assurance program to be accredited.

In 1985, the Department of Health and Human Services (HHS) initiated a nationwide program to expand Medicare beneficiaries' use of HMOs paid on a capitated basis.[2] At that time, federal quality assurance programs were designed to identify HMOs where providers may have withheld or denied treatment because of the financial incentives that result from capitation. In addition, as managed care options became more prevalent, states began to regulate them, and health care purchasers, such as employers, began to develop a greater interest in quality assurance as well.

Quality health care has been difficult for experts to define and measure, but most agree that clinical quality would include

-- appropriateness--providers giving the right care at the right time,
-- technical excellence--furnishing the care in the correct way,
-- accessibility--patients being able to obtain care when needed, and
-- acceptability--patients being satisfied with the care.

These attributes would be measured using indicators that represent (1) structure of care--resources and organizational arrangements in place to deliver care; (2) process of care--physician and other provider activities carried out to deliver the care; and (3) outcomes of care--the results of physician and provider activities. Survey, certification, and accreditation activities generally look at structure measures; performance measurement systems focus on process and outcome measures.

Ensuring quality of care involves reaching consensus about standards and developing reliable and valid structure, process, and outcome measures. Then approaches must be developed to make it more likely that health care will be furnished in ways that will meet the standards. Approaches to ensuring quality have changed in recent years. Under the more traditional quality assurance approach, reviewers focus on a search for individual practitioners or "bad apples" who do not meet minimal acceptable standards of care. But this approach has shortcomings: it creates an adversarial relationship between the reviewers and those being reviewed, and it targets only those providing substandard care. Little attention is paid to those who may be providing care that is better than substandard but less than excellent. The alternative approach, continuous quality improvement, strives to make everyone's performance better, regardless of prior performance. At the same time, this approach acknowledges the importance of taking action, if necessary, against providers with consistently unacceptable performance. Although most health care providers and experts support this new approach, implementing such a dramatic change will take time.

In the private sector, large corporate purchasers of health care use a variety of tools to determine the health care providers with which they will contract. As a baseline, they look for individual providers who are licensed by the state or who are certified by their respective organizations, if state licensure is

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[2]Capitation requires an individual provider or managed care plan to furnish all necessary medical care in return for a predetermined monthly payment for each beneficiary enrolled.

organization. But these structural measures--licensure, certification, and accreditation--have not proven to be fail-safe mechanisms for ensuring quality. As a result, the private sector has taken the lead in developing ways to compare providers using measures of performance, including the results of care provided and employees' satisfaction with their care.

HCFA'S CURRENT QUALITY ASSURANCE STRATEGIES

HCFA has three activities directed specifically toward ensuring that clinical quality standards are met.[3] The oldest of these, the Medicare Provider Certification Program, has existed since Medicare's inception in 1965. It targets fee-for-service institutional providers of health care. A second certification program, the Federal Qualification Program for HMOs, determines whether HMOs meet similar preestablished standards. The third, the Medicare Peer Review Organization (PRO) Program has existed in some form since 1972. PROs review care furnished in hospitals and HMOs, although they are not precluded from reviewing care provided in other settings.

The Medicare Provider Certification Program

HCFA's fee-for-service provider certification program is oriented toward institutional providers, such as hospitals, skilled nursing facilities, and home health agencies. With respect to individual providers, such as physicians, HCFA accepts a valid state license as a sufficient basis for direct Medicare reimbursement.

Medicare law requires that if institutional providers of care are to receive direct fee-for-service Medicare reimbursement, they must meet certain physical and organizational conditions of participation. A full-service community hospital, for example, must meet 20 such conditions. These conditions relate to such matters as the hospital's governing body, physical plant, clinical and emergency services, nursing service, and food service. Each of these conditions of participation has multiple standards, most of which must be met if the institution is to comply with the condition.

Conditions of participation identify minimal conditions thought necessary for quality to occur. They relate almost exclusively to structural measures of quality. Furthermore, surveyors checking for compliance only determine whether the institution has established organizational policies and procedures to meet the conditions of participation. Little attention is paid to how well those policies and procedures are adhered to or what the results are.[4]

HCFA contracts with state agencies to perform certification surveys for most types of institutional providers. These agencies periodically (usually annually) send survey teams to the institutions to check compliance. If the team finds that the institution is not in compliance with one or more standards, it will ask for a corrective action plan. For hospitals, home health

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[3]In testimony before the Ways and Means Subcommittee on Health (Mar. 21, 1995), HCFA's Administrator also listed other quality assurance and improvement activities: provisions for beneficiary education; studies in state-of-the-art quality assessment; elimination of fraud and abuse, which are detrimental to quality; and use of clinical practice guidelines.

[4]The Joint Commission is developing a measurement system designed to measure outcomes. This system is intended to be used in conjunction with its current accreditation program.

agencies, and clinical laboratories,[5] HCFA deems the accreditation of designated private accrediting organizations to be adequate assurance that a provider meets its conditions of participation.[6] In deciding whether to accept accreditation by a private third party as a substitute for certification by a state agency under contract with HCFA, HCFA looks at the accrediting agency's survey procedures and compares its standards with HCFA's conditions of participation. Those standards must be at least as stringent as HCFA's conditions.[7] (App. III shows the organizations whose accreditation is deemed equivalent to certification by HCFA; it also lists other organizations that accredit institutional health care providers or units within providers.) State agencies do validation surveys on a small proportion of those institutions whose accreditation is accepted for Medicare certification purposes.

For institutions surveyed directly by state agencies, HCFA personnel perform validation surveys on a small proportion of the institutions. HCFA personnel also survey state-owned institutional providers and clinical labs that are not approved by a Medicare-designated accrediting body.[8]

If problems noted as a result of any of these reviews remain uncorrected, or are of such severity as to seriously endanger beneficiaries, the institution's certification to receive Medicare reimbursements may be revoked. However, in our previous review of this program, we found that HCFA's application of termination procedures casts some doubt on its willingness to terminate any but the worst hospitals from the Medicare program.[9]

The Medicare HMO Qualification Process

HMOs that wish to serve Medicare beneficiaries must have risk or cost contracts with the Medicare program.[10] To qualify for such contracts, HMOs must meet both the requirements of title 13 of the Public Health Service Act relating to federal qualification of HMOs and the requirements of the Medicare statute. As with fee-for-service providers approved under the Medicare Provider Certification Program, these requirements are primarily structural. They require, for example, that the HMO have an adequate governing body, that it have utilization review and quality assurance systems, and that it have an adequate grievance system.

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[5]HCFA certifies clinical laboratories under the Clinical Laboratories Improvement Act (CLIA), rather than under the Medicare program.

[6]HCFA is considering extending deeming authority to private organizations that accredit ambulatory surgical centers.

[7]Procedures HCFA examines include survey procedures, qualification requirements for surveyors, surveyor training programs, procedures for notifying the surveyed entities of survey results, and time frames for conducting follow-up visits if deficiencies are found.

[8]HCFA exempts clinical laboratories in Washington State from inspection because of state licensure requirements that are at least as strict as those under CLIA. A HCFA official told us that a regulation that will exempt labs in two other states--New York and Oregon--is awaiting publication in the Federal Register.

[9]Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 1991).

[10]An HMO that has a risk contract with HCFA is paid a fixed amount for each enrolled beneficiary based on the average Medicare costs for all beneficiaries in the HMO's service area. An HMO that has a cost contract is paid by HCFA a predetermined monthly amount per beneficiary on the basis of a total estimated budget.

HCFA personnel visit contracting HMOs at least once every 2 years to ensure that they are complying with title 13 and Medicare requirements. If an HMO is not in compliance, HCFA may terminate its contract or, in specific circumstances, require it to suspend enrollment. At this time, HCFA does not accept accreditation from any agency as evidence that an HMO meets federal standards.

We have been critical of HCFA for failing to aggressively enforce its quality assurance standards in this process. We have reported on these matters in the past and testified before the Subcommittee on Health, Committee on Ways and Means, earlier this year.[11] In the last 10 years, for example, HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed or withheld, and test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

The Medicare Peer Review Organization Program

The PRO program has focused mainly on ensuring that Medicare beneficiaries received good quality of care in fee-for-service inpatient hospital and ambulatory surgical settings.[12] The program's primary methodology has been to review individual medical records, with a focus on process, to make a determination about the quality of care furnished a beneficiary. In addition, there has been a secondary focus on outcomes through focused case review of adverse events such as deaths and hospital readmissions within 15 days of a discharge.

Beginning in 1987, the Congress mandated that the PRO review be expanded to include the quality of care provided by Medicare risk HMOs. In conducting HMO reviews, PROs evaluate the medical records of both ambulatory and inpatient care for a sample of beneficiaries. In a previous report, we made several recommendations to HCFA regarding ways to strengthen the PRO review of risk HMOs.[13] For example, we urged HCFA to incorporate the results of PRO efforts into HCFA's compliance monitoring process.

Although PROs have the authority to review fee-for-service ambulatory care, HCFA has been reluctant to venture into this area. At present, except for ambulatory surgical procedures, the only fee-for-service ambulatory review performed is a pilot project recently begun in three states. In this project PROs and 100 volunteer physicians in each state are cooperating to improve the quality of care provided to diabetics.

Concurrently, PROs in five other states are working cooperatively with 23 HMOs on a similar project. Both the fee-for-service and HMO initiatives will be based on collecting information from medical records about 22 specific performance measures such as the results of important laboratory tests.

HCFA PLANS FOR THE FUTURE

HCFA officials discussed with us several initiatives intended to improve HCFA's quality assurance approach. The initiatives are similar to the kinds of changes occurring in the private sector and in some cases include a closer collaboration with the private

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[11]Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

[12]Before the 1984 implementation of Medicare Prospective Payment for Hospitals, federal oversight concentrated on utilization of hospital services rather than the quality of those services.

[13]Medicare: PRO Review Does Not Ensure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

sector. HCFA's initiatives include increasing the emphasis on continuous quality improvement, developing performance measures, and implementing a more in-depth survey of beneficiaries' satisfaction with HMOs.

HCFA is presently reengineering the entire PRO program to incorporate continuous quality improvement concepts. It found that the old model of review, which focused on individual aberrant cases, was confrontational, unpopular with the physician community, and of uncertain effectiveness. It is restructuring the PRO program to emphasize cooperative projects with providers designed to improve the overall quality of care beneficiaries receive. These projects, which have existed to a limited extent, will increasingly become the main focus of the program over the next 2 years.

HCFA recently announced it was joining a group of large corporate purchasers of health care to form a new organization called the Foundation for Accountability, or FAcct. Among the many goals of this organization are compiling and reviewing the most promising performance measures available on health outcomes and health plan performance. Because this group represents over 80 million insured persons, HCFA and the other FAcct members believe that health plans will adopt their measures and supply the results to them, other purchasers, and individual consumers. According to a HCFA program official, joining in these efforts will help to eliminate duplication of quality assurance efforts and increase the likelihood that managed care organizations will meet purchasers' needs.

Currently, HCFA's Office of the Actuary annually surveys some 12,000 beneficiaries, treated predominantly under fee-for-service arrangements, about their health status, access to care, and satisfaction with the care they receive. To get detailed patient satisfaction data on beneficiaries enrolled in managed care plans, HCFA's Office of Managed Care is considering an additional separate survey.

COMPONENTS OF AN ENHANCED QUALITY ASSURANCE APPROACH

Many of the experts we interviewed believed that the federal government should continue to play a role in ensuring that Medicare beneficiaries receive quality care regardless of whether that care is provided in an HMO, preferred provider organization (PPO), or fee-for-service setting.[14] They cited the need for information such as (1) performance measures, (2) patient satisfaction surveys, and (3) assurance that basic structural standards have been met. Because each type of information has strengths and weaknesses, the experts recognize that no one technique can be relied upon as the sole determinant of whether an organization provides quality care. But they believed that all programs should foster continuous quality improvement efforts of providers. Furthermore, the experts believed that the strategies should build on existing federal, state, and private efforts.

Information to Measure Quality

Many experts said that performance measures, particularly those that reflect the outcomes of care, should be used to evaluate quality of care. Furthermore, attention must be given to collecting information about chronic conditions and other unique needs of the Medicare population. When information is gathered, it should be shared with beneficiaries to assist them in their health care purchasing decisions. Experts believed that performance

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[14]Our interviews were structured so that we covered the same questions with each person, but because we used primarily open-ended questions some issues were not discussed by each expert.

measurement information could be collected by health plans or providers from their administrative databases or by sampling medical records. However, those we interviewed stressed that PROs or another independent third party would need to verify the accuracy of the data.

The importance of having standardized measures was also frequently cited. Some experts suggested that a national board, composed of public and private health care professionals representing regulators, providers, and purchasers, could be convened to establish a set of uniform measures. However, all agreed that, regardless of who performs the task, any effort to develop performance measures must be a collaborative one with "buy-in" from the provider community.

Most experts also recommended that patient satisfaction surveys be used to evaluate health care quality. Measuring patients' perceptions may include asking them about their satisfaction with the care furnished, their health status, and efforts they make to enhance their health. One expert said that patient survey results can be used to provide information to the consumer or purchaser, to guide a provider in its quality improvement efforts, and to make external comparisons between providers.

As with performance measures, experts stated that consumers like patient satisfaction information. Furthermore, patient satisfaction surveys are already commonly used by health plans and providers. But these surveys also have limitations. They may not produce reliable and valid data, and survey questions and sampling techniques have not been standardized. Other limitations include (1) the difficulty of reaching minorities and others with special needs, (2) the high cost of telephone surveys, and (3) the relative ease of introducing bias into the questionnaire.

Many of the experts said that health care organizations should continue to meet basic structural requirements for participation in the Medicare program. These requirements could be confirmed through a certification or accreditation process. When asked who should make the certification or accreditation visits, experts' opinions were evenly divided among HCFA, states, or another third party. Currently, HMOs and PPOs can seek voluntary accreditation from a third-party accrediting organization, such as the National Committee on Quality Assurance (NCQA) or the Joint Commission. One expert suggested that managed care organizations be given incentives to seek accreditation. For example, an accredited organization might be exempt from a HCFA site visit or perhaps be required to report a lesser amount of performance measurement data.

Some of the experts we interviewed raised questions about the basic concept of voluntary accreditation by a private third party. For example, one expert noted the inherent conflict of interest when an accrediting organization's revenues come from those they are accrediting, as is usually the case. Another noted that it is rare for a plan seeking accreditation not to receive it. However, this individual acknowledged that because accreditation is voluntary, only those who believe they will pass an accreditation survey will seek it. Another expert pointed out that it takes time to develop the systems necessary to be accredited by some organizations. New plans might not have those systems developed initially.

Continuous Quality Improvement

Experts consistently stated that a commitment to continuous quality improvement must be made by regulators, providers, and plans regardless of the quality assurance system implemented. Many managed care organizations implement their own internal quality assurance programs to help evaluate the care they are providing and to identify and correct any problems. Experts also recognized the

value and importance of external oversight programs that are designed to ensure that providers are continually assessing and improving their delivery of care. Such oversight programs are an important tool to identify previously undetected problems, to provide management with constructive feedback, and to assist the providers and plans in improving their overall delivery of health services.

Build on Existing Strategies

Federal and state governments and the private sector have already undertaken a number of initiatives to obtain data about the quality of care. Building upon these efforts was viewed as desirable and beneficial. As discussed earlier, HCFA presently requires HMOs that participate in the Medicare program to have processes in place to identify and resolve quality assurance problems, and some state legislatures have imposed quality standards on HMOs operating in their states. Additionally, the National Association of Insurance Commissioners is discussing the feasibility of developing a model uniform licensing act for all types of health insurers which will include requirements for quality assurance. In the private sector, NCQA and others have developed performance measures. Furthermore, NCQA, the Joint Commission, and others have established quality standards that must be met by any HMOs or PPOs that seek accreditation. And now many employers are requiring managed care plans to gain accreditation before contracting with them for health care services.

CONCLUDING OBSERVATIONS

The federal government, as a prudent purchaser, continues to play an important role in ensuring that Medicare providers meet the highest standards of quality in health care. HCFA has quality assurance programs with that goal, although we have identified problems in their implementation. The enhancements HCFA is making to its quality assurance approach are consistent with the direction in which the private sector is moving and with the consensus of the health care experts we interviewed. The challenge facing HCFA is to make the specific decisions about how these changes will be implemented, confirm that they are effectively implemented, and resolve the relative roles of federal and state governments and the private sector.

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Messrs. Chairmen, this concludes my formal remarks. I will be happy to answer any questions from you and other members of the Subcommittees.

For more information on this testimony, please call Sandra K. Isaacson, Assistant Director, at (202) 512-7174. Other major contributors included James A. Carlan, Jean Chase, Debra J. Carr, Nancy Donovan, Peter E. Schmidt, and Darrell Rasmussen.

RELATED GAO PRODUCTS

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (GAO/HEHS-95-138, May 4, 1995). Testimony on the same topic (GAO/T-HEHS-95-143, May 4, 1995).

Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Home Health Care: HCFA Properly Evaluated JCAHO's Ability to Survey Home Health Agencies (GAO/HRD-93-33, Oct. 26, 1992).

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate (GAO/HRD-92-93, Apr. 20, 1992).

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 5, 1991).

Medicare: PRO Review Does Not Ensure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

EXPERTS INTERVIEWED

American Association of Preferred Provider Organizations
Lisa Sprague, Director of Legislative Affairs

Gordon Wheeler, President and Chief Operating Officer

American Association of Retired Persons (AARP)
Mary Ellen Bliss, Regulatory Associate, Federal Affairs Department

Joyce Dubow, Senior Analyst, Public Policy Institute

Mary Jo Gibson, Senior Analyst, Public Policy Institute

Alan Kaplan, Consultant to AARP

American Group Practice Association
Julie A. Sanderson-Austin, Director, Quality Management and Research

American Hospital Association
Karen A. Milgate, Associate Director, Policy Development

Ellen A. Pryga, Director, Health Policy

California Consolidated Edison
Pam Kroll, Plan Manager, Health Care Plans

Suzanne Mercure, Benefits Administration Manager, Health Care Plans

Colorado Hospital Association
Larry H. Wall, President

Consumers First
Clark Kerr, President

Department of Veterans Affairs
Dr. Galen L. Barbour, Associate Chief Medical Director for Quality Management, Office of Quality Management

M. Scott Beck, Director, Office of Planning and Evaluation, Office of Quality Management

Debby Walder, Director, Office of Risk Management, Office of Quality Management

Federation of American Health Care Systems
Tom Scully, President and Chief Executive Officer

Good Samaritan Health System
Molly J. Coye, Senior Vice President, Clinical Operation

Group Health Association of America
Kelli Back, Senior Policy Associate, Government Affairs

Carmella Bocchino, Director of Medical Affairs

Candy Schaller, Director of Policy, Government Affairs

Julie Goon, Director of Legislative Affairs

Group Health of Puget Sound
Kathleen Cromp, Director of Quality of Care Assessment

Harvard School of Public Health
Heather Palmer, Director, Center for Quality of Care Research and Education

Health Care Financing Administration
Gary Bailey, Team Leader, Beneficiary Access and Education, Office of Managed Care

Paul Elstein, Health Insurance Specialist, Office of Managed Care

Dr. Steven Jencks, Clinical Advisor to the Bureau Director, Health Standards and Quality Bureau

Tracy Jensen, Policy and Program Improvement, Office of Managed Care, Health Care Financing Administration

Jean D. LeMasurier, Director, Policy and Program Improvement, Office of Managed Care

Health Pages Magazine
Carol Cronin, Senior Vice President

Henry Ford Health Institute
Dr. David Nerenz, Director for Center of Health System Studies

Jackson Hole Group
Dr. Sarah Purdy, Health Policy Analyst

Jefferson Medical College
Dr. Leona Markson, Associate Director, Clinical Outcomes Research

Dr. David Nash, Director, Director of Health Policy and Clinical Outcomes

John Deere Health Care, Inc.
Dick Van Bell, President

Geri Zimmerman, Director of Quality Management Programs

Joint Commission on Accreditation of Healthcare Organizations
Dr. Paul M. Schyve, Senior Vice President

Margaret VanAmringe, Associate Director, Government Relations

Midwest Business Group on Health
James D. Mortimer, President

National Capitol Preferred Provider Organization
Dr. Robert Berenson, Medical Advisor

National Council on Quality Assurance
Steve Lamb, Director of Government Relations

Margaret O'Kane, President

Park Nicollet Medical Foundation
Dr. Jinnet Fowles, Vice President, Research and Development

Physician Payment Review Commission
David Colby, Principal Policy Analyst

Prudential Center for Health Research
Dr. William Roper

The RAND Corporation
Dr. Elizabeth A. McGlynn, Department of Social Policy

State of Florida
Randy Mutter, Administrator, Research and Analysis Section, Agency for Health Care Administration

State of Michigan
Janet Olszewski, Chief Division of Managed Care, Michigan Department of Public Health

UNIVA Health Network
Dr. William Jesse, President and Chief Executive Officer

Utilization Review and Accreditation Commission
Randall H. Madry, Executive Director

Washington Business Group on Health
Sally Coberly, Director

Wisconsin Peer Review Organization
Dr. Jay A. Gold, Principal Clinical Coordinator

ACCREDITING ORGANIZATIONS

Table I.1: Organizations Whose Accreditation HCFA Deems to Be Adequate Assurance That Providers Meet HCFA Conditions of Participation

Type of provider	Accrediting organization
Hospitals	Joint Commission on Accreditation of Healthcare Organizations American Osteopathic Association
Home health agencies	Joint Commission on Accreditation of Healthcare Organizations Community Health Accreditation Program
Laboratories under the Clinical Laboratories Improvement Act	Joint Commission on Accreditation of Healthcare Organizations College of American Pathologists American Society for Histocompatability and Immunogenetics American Association of Blood Banks (pending) American Osteopathic Association (pending)
Ambulatory surgical centers	Status awaiting final publication and approval of Federal Register notice

Table I.2: Organizations That Accredit Institutional Health Care Providers or Units Within Providers

Accrediting organization	Type of provider accredited
Joint Commission on Accreditation of Healthcare Organizations	Hospitals, skilled nursing facilities, home health agencies, health networks, and others
American Osteopathic Association	Hospitals, laboratories
National Committee on Quality Assurance	Managed care plans
Commission on Accreditation of Rehabilitation Facilities	Rehabilitation facilities
Commission on Office Laboratory Accreditation	Physician office laboratories
College of American Pathologists	Laboratories
American Association of Ambulatory Health Care	Ambulatory health centers, ambulatory surgical centers
American Society of Histocompatibility and Immunology	Laboratories performing tissue-typing and related tests
American College of Surgeons	Trauma systems
American Speech and Hearing Association	Speech and hearing programs
Commission on Accreditation of Free Standing Birthing Centers	Free standing birthing centers
National Commission on Correctional Health Care	Health units in correctional facilities
American Association of Blood Banks	Laboratories
Utilization Review Accreditation Commission	Free standing utilization review programs and utilization review programs in HMOs and PPOs
American College of Radiology	Diagnostic and therapeutic radiology units in all settings
Community Health Accreditation Program	Home health agencies
American Accreditation Program, Inc.	PPOs

Chairman THOMAS. Thank you very much, Dr. Joyner.

Does the gentleman from Florida wish to inquire?

Chairman BILIRAKIS. I would, Mr. Chairman.

Dr. Joyner, this is one of those times when we wish that the witness had more than 5 minutes. Should HCFA in your opinion accept accreditation by private organizations such as NCQA, the National Committee on Quality Assurance, as sufficient?

Ms. JOYNER. You are saying to do with the HMOs what it now does, for example, with hospitals and home health care and other entities in that respect?

Chairman BILIRAKIS. Yes, and considering it is a private organization. In your opinion, do you think that they should accept their accreditation or is their opinion sufficient?

Ms. JOYNER. What we have done in the past, as you may know, is we have looked at HCFA's process in deciding whether in the case of individual institutions it would accept Joint Commission accreditation or other accrediting organizations' decisions. I think our view would be that such a decision would be more of a policy matter rather than one for GAO to decide. If they choose to do that, we would be glad to do whatever kind of oversight on your behalf that might be useful to see that HCFA follows the procedures they set out for making that determination.

Chairman BILIRAKIS. But you would not hazard an opinion in that regard?

Ms. JOYNER. I think our view would be that that decision—these are difficult and complex decisions as to what actions should be done directly by the Federal Government, by the private sector, by the States—that those decisions are more policy matters to be decided by the administration and by Congress.

Chairman BILIRAKIS. In your opinion, do you think that their quality standards, meaning the NCQA's quality standards, are higher than those utilized by HCFA? Would you have an opinion in that regard?

Ms. JOYNER. We have not done a direct comparison of that. I know that some groups have. I think some of the people that we interviewed felt that the NCQA standards were higher than the standards being used by HCFA. That is something that I could not speak to directly.

I know that HCFA commissioned a study that was just released this last spring that provided a crosswalk amongst various sets of standards, both in NCQA, I believe, and some Joint Commission standards and its own standards and several States, and I think that kind of analysis is the one that certainly would help provide an informed basis for making a judgment like that.

Chairman BILIRAKIS. We depend upon GAO so very much. Do you have any view of the quality of care that Medicare beneficiaries in the traditional fee-for-service have received, are receiving, versus those enrolled in managed care HMOs and other managed care type plans?

Ms. JOYNER. I do not believe GAO itself has done that kind of direct analysis. What we have looked at is how well HCFA has carried out its responsibilities in setting standards and in enforcing them, and we have identified problems primarily with their taking action where they have found problems.

We have identified problems both in fee-for-service and HMOs. HCFA did not take action against a hospital, regardless of the extent to which it was not meeting HCFA standards. We have certainly identified problems with HMOs also where problems exist for a long time after HCFA finds that the HMO is not up to the standards. We certainly would not be in a position to say in general whether people get better or worse care in fee-for-service or managed care.

Chairman BILIRAKIS. How well has HCFA been doing their job, in your opinion, if you have one, regarding services provided by physicians in their offices?

Ms. JOYNER. As I said, HCFA has relied primarily on other ways to ensure that physicians are monitored. First, HCFA relies on State licensing activities. Also, when a physician sends a patient to a hospital, then that care gets monitored through the oversight of the hospital. HCFA's activity has been of that nature, rather than direct oversight of physicians in their own offices.

Chairman BILIRAKIS. To sort of finish up, in general, am I to assume from your remarks that you have not really analyzed the overall HCFA review mechanisms and analyzed the NCQA's quality standards on a routine type basis? What have you done when problems have taken place?

Ms. JOYNER. Are you asking what has GAO done?

Chairman BILIRAKIS. Yes.

Ms. JOYNER. We have not done this kind of analysis of the standards. What we have done, as you know primarily as requested by the Congress, rather than at our own initiative, we have looked at how well HCFA is carrying out its responsibilities. That is where we came up with our observations that I made about the problems that we have identified and made recommendations about in the past on implementation and taking action against providers.

Chairman BILIRAKIS. My time is expired. Thank you, Dr. Joyner. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The Chair wishes to acknowledge the arrival of the Ranking Member of the full Committee on Commerce, the gentleman from Michigan, Mr. Dingell.

Does the gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Dr. Joyner, thank you. I am concerned about a proper balance between State and Federal issues and I guess a proper balance between the regulators and the legislators. I just want to suggest a problem in our own State of California.

In California, for example, HMOs are regulated by the Department of Corporations. Traditional insurance is regulated by the Department of Insurance, which I might point out in California these people can be of two different or conflicting political parties because of the structure of our elective process. The Department of Health has the responsibility for general quality of care. So you have three independent and differently directed agencies, each of which has some regulatory authority over a variety of health plans. I am sure the same exists in other States, but I am not that familiar with them.

Would it not be far preferable to have a standard—I do not suppose it makes a lot of difference which department regulates—so

that we know and patients and beneficiaries know that there will be a regulatory authority to whom they can complain or inquire? Would this seem to you from the results of your study to be a desirable feature that we ought to have for any managed care under Medicare?

Ms. JOYNER. I certainly would not want to presume to tell the State of California how to organize its governmental entities. But we did hear from the people that we interviewed a concern about multiple standards. What I pointed out is that, at least with respect to Medicare, there are the Medicare conditions of participation established by HCFA which are uniform throughout the country.

So if we wanted to stay within the realm of the Federal sector, some of the experts we interview saw one Federal role as setting uniform standards, even though it could, should, and would by necessity through the public rulemaking process involve participation of a variety of people. That was sometimes described to us as a Federal role, rather than leaving standard setting up to each State. You were speaking to within the State, but what we heard more was across States.

Mr. STARK. I am just saying that with a variety of managed care plans which are not really defined now, you could have a variety of regulators in each State administering them, and it would seem to me that is somewhat confusing, if not downright inefficient. I am just suggesting that States certainly could choose whom they want to be the regulator. But it would seem to me that if we have Medicare plans and we have a set of standards, that it would be simpler to have them regulated similarly in each State.

I want to raise another issue. I will refer some of the witnesses to some correspondence from Secure Horizons by Pacific Care, a for-profit IPA/HMO in California, some of their marketing material, and a letter that they addressed to the Health Insurance Counseling Advocacy Program.

For the purpose of the question here, one of their statements is that, in accordance with California health and safety code section 1370, the results of their quality assurance reviews are kept confidential.

Now, I have heard a lot about suggesting that beneficiaries ought to be able to choose based on quality. If you are going to keep the reviews confidential, it is a little puzzling to me how the beneficiaries are going to find out who has quality care and who does not. What is the Federal position? Do our rules conflict with that, or are there any standards now for making available quality reviews to potential beneficiaries, and should there be?

Ms. JOYNER. One of the things that I referred to when testifying about the direction that HCFA is going with the enhancing of their quality assurance procedures gets to the issue of providing information to beneficiaries so that they can choose among the plans. This is something that HCFA has expressed a commitment to, getting information out to beneficiaries and identifying valid, reliable performance measures that would be then comparable across various plans and to make that information available.

Mr. STARK. You cannot do that if the State law requires they be kept confidential, can you?

Ms. JOYNER. I believe that the information they collect through these performance measures could and would be public, and they are working with the private sector in doing that.

Chairman THOMAS. The gentleman's time has expired.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Illinois.

Mr. HASTERT. I thank the Chairman.

I certainly welcome this opportunity to have you before us today.

One of the things that I want to pursue a little bit, you have looked at your review of HCFA at how they set up the standards and how it relates. One of the focuses here in the questioning is that we need to have uniform standards across the country. Is it not apparent that in different areas in different States and different types of populations that sometimes standards need to be a little bit flexible? Have you found that in your inquiry?

Ms. JOYNER. At this point, one of the ways that HCFA does take into consideration to some extent the local difference is in their peer review program. PROs are comprised of local physicians who are doing the review of the records. Furthermore, PROs are setting up cooperative projects where the data suggests that there is a problem with the kinds of practice that is occurring in a certain area.

We know that there is wide variation nationwide in the frequency of certain medical procedures, such as hysterectomies or the kind of treatment that occurs after heart attack. Some people see this as a quality problem rather than a likely response to actual differing in what treatment works best. So I think that is one way that they are both reflecting the local situation and wanting to find the best practice and trying to make that more commonly used, rather than continuing the same questionable practice.

Mr. HASTERT. The focus should not be uniformity, but what works best.

Ms. JOYNER. What works best, exactly.

Mr. HASTERT. So that is really kind of a pragmatic view, is it not?

Ms. JOYNER. In terms of individual medical practices, one would assume that what works best would be fairly standard. Individuals are the same around the country.

Mr. HASTERT. Let us look to the future here a little bit. I know that it is hard to do that if you are working in dealing with testimony from the past. In your view of what you have discussed with HCFA, there will be new plans in the future. One of the questions that we have to look at, especially if we want standards, is should those plans have different quality standards of any kind from those that we have had in the past? I mean if we are going to do business in a different way, possibly should those quality standards be flexible enough so that we can do business in a different way?

Ms. JOYNER. One thing that we heard clearly from the experts that we interviewed, when we asked about the central features of a quality assurance approach and strategy, specifically whether they thought the way the government would go about assuring quality would differ depending on whether it is fee-for-service or different kinds of managed care plans, they uniformly said they did not see why that would differ.

What would differ would be, for example, the kinds of data that might be readily available. A more highly structured managed care plan might be more readily able to provide certain information than, say, a PPO or another type of plan. Fee-for-service has certain kinds of information, the actual encounter data available that others do not, but not in the overall goal or approach. That would be different.

Mr. HASTERT. I do not want to frame your answer, but basically there needs to be enough flexibility in there that you can measure, and the future may have to depend a little bit on market and what people drive to and what they want and what is out there for people to go to. Those standards probably need to be in place, but yet with some flexibility, is that not correct?

Ms. JOYNER. The overall standards they felt could be the same. You would have to have some flexibility in applying them, in that you could not expect an entity that had never had a need to collect certain kinds of data to suddenly have it overnight.

Mr. HASTERT. And that information should be available so people can make intelligent choices?

Ms. JOYNER. That information about measures of quality should definitely be available, because people need that in order to make an informed choice.

Mr. HASTERT. Thank you very much. I yield back the time.

Chairman THOMAS. I thank the gentleman.

The gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

I want to put this issue in perspective. I authored with others the provision in the Medicare Program that would give Medicare beneficiaries an option, if they chose to, to sign up in an HMO. I think Medicare beneficiaries ought to have more choices, but it ought to be their choice.

I know from my own experience, as well, what can happen if we simply say to people that they go out and sign up in a capitated plan, because some of those plans can be scams. People can be taken advantage of. So we have at the Federal and State levels standards that are required of these plans, to be sure that people are not abused. Some of the standards are to be sure people are not abused, and some of the standards are to give people information so they can shop effectively as best they can. After all, it is not that easy a decision.

We are looking at the biggest change in Medicare in 30 years, a dramatic change in health care policy, when we talk about taking $270 billion out of the program. From what I hear from the Republicans, they want to have a lot more plans available. In fact, they would like people to only belong, if they had their choice, in capitated plans, because then you could seal off the amount of money you spend.

Right now, only 1 percent of the Medicare population has signed up voluntarily in HMOs. That has been their choice. Do you think there is any way possible to maintain the level of quality assurance that we see today for that small number of beneficiaries who are enrolled in managed care plans, if we take this kind of money out of Medicare, even that part of the population that is in HMOs?

I know that is a tough question, but it really is the kind of question we are going to have to ask and have answered, in my view, before we start changing the Medicare process. I know it is a difficult question and that is why the Chairman is so prickly about the fact they do not have their plan to accomplish this result. But can we take $270 billion out and still have quality assurance and standards met?

Ms. JOYNER. I really would not have a basis to answer that question. I do not know what would be changed. I do not know what would be different about the program. Even if I did, I am not sure I could really predict what impact that would have on the quality.

Mr. WAXMAN. Well, you can predict on past experience with 9 percent of the Medicare population signing up in these plans. If we end up with 80 percent suddenly signed up in plans that may or may not exist at the moment and move that rapidly, it is going to be a dramatic change.

You emphasize that one essential component of quality assurance strategy is continuous quality improvement. How can health plans be continuously improved if they are limited to increasing spending on enrollees by no more than 5 percent annually?

Ms. JOYNER. Well, the concept of continuous quality improvement would say that the real focus is on finding out what you are doing, how well it is working, and using that information to feed back into your system and try to improve it.

So, instead of just focusing on finding the pieces of your plan that are not working well or the individual providers who are part of your plan who are not following good practices, you would want to look at the patterns of care over the entire plan and try to move everyone to a better level of performance.

It takes some money to do that, to gather information that people may not have had in the past, the data to look at the patterns of care and to set up the process——

Mr. WAXMAN. But the fact is the plans are going to get less money. The plans are going to get less money to do all the things they are supposed to do, including not just making the assessments, but actually providing the care. Are they going to be able to continually improve under those circumstances?

Ms. JOYNER. They would have to make their own decisions about how to live within a reduced budget. I really could not speak to what impact that would have on continuous quality improvement vis-a-vis continuing to have the same amount of money.

Mr. WAXMAN. They will make their decisions, but we have to monitor it, and right now we have a Federal monitoring. But you think HCFA is doing a better job and we need to have State monitoring, but that is all spotty from State to State. Do you think we ought to have defined roles for the Federal and State governments in this regard?

Ms. JOYNER. I am sorry, I did not hear your last question.

Mr WAXMAN. You think we ought to have defined roles as to what will be monitored by the States and what will be monitored by the Federal Government?

Ms. JOYNER. As it is now, there are differing roles and different activities being carried out. HCFA has made certain decisions, and the Congress in its oversight effort has looked at those and given

them advice when they felt they were making the wrong decision. But we would not have a basis for saying exactly what activities should be carried out by the Federal Government, the State, or the private sector. That is a policy matter for them and Congress to determine.

Chairman THOMAS. The gentleman's time has expired.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes, Mr. Chairman. Thank you.

Dr. Joyner, I want to congratulate you on your responses to the questions from the most recent questioner from California. You will notice he started out asking whether quality can be assured with only a 5-percent increase, and then he slyly changed to asking whether quality can be assured if they get a decreased budget—trying to imply that there are going to be cuts in the Medicare Program. Of course, that is not the case under any scenario. We fully intend to increase spending on Medicare every year. There will be an increase for these plans that enroll Medicare beneficiaries. So I congratulate you for not slipping into that dialog.

In your testimony, you mention that the NAIC, the insurance commissioners, is studying the feasibility of developing a model uniform licensing act. Can you elaborate on their efforts? For example, what areas are they reviewing, where are they in the process, and are they looking at all types of delivery vehicles?

Ms. JOYNER. Well, they have had several groups over some time working on these issues. When we last spoke with them, they told us that they are drafting 8 model standards. These are in the areas of provider credentialling, utilization management, quality assurance, and grievance procedures. These four they think they will have ready by the end of this calendar year.

The remaining four are on provider contracting, data reporting, accessibility, and confidentiality, although they may combine some of these. They have had various drafts of these standards and are getting comments on them. They are expecting that by the end of the year they will have approved model standards in four of those areas, and then it will be up to the State to decide the extent to which, as it is with the other NAIC guidelines, they would then take legislative action to adopt them within their States.

Mr. MCCRERY. Is the NAIC looking at developing a model standard for all forms of insurance and delivery vehicles in the health care system?

Ms. JOYNER. They are seeing these standards as being ones that would apply across the board, in fee-for-service and in all types of managed care. That apparently has been a difficult discussion that they have had, as to whether certain managed care arrangements could adequately be addressed in the same guideline, the same standard, and at this point they feel that it can be.

Mr. MCCRERY. Thank you, Dr. Joyner.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Michigan, the Ranking Member of the full Commerce Committee, an ex-officio Member of the Subcommittee, does he wish to inquire?

Mr. DINGELL. Thank you, Mr. Chairman. I appreciate your courtesy.

I have a particular concern and that is if we cut Medicare by $270 billion as has been suggested by my colleagues on the Republican side, does that mean that there will be any room for the traditional freedom of choice plan, or will it all move toward an HMO-type plan for the care of senior citizens receiving benefits under the Medicare Program?

Ms. JOYNER. I would not have any basis to know how that would be done.

Mr. DINGELL. You would not know the answer to that question?

Ms. JOYNER. Excuse me?

Mr. DINGELL. You would not know the answer to that question?

Ms. JOYNER. That is correct. I would not be able to predict how HCFA would decide to allocate the resources, whatever resources it has available for beneficiaries.

Mr. DINGELL. That is a significant cut, is it not, in Medicare benefits?

Ms. JOYNER. I really would not know what adjective to put on it. I think that is more a matter of personal judgment.

Mr. DINGELL. Maybe I ought to put it a different way. Would you call it an insignificant cut in Medicare benefits?

Ms. JOYNER. I would rather not put any adjective on it at all, sir.

Mr. DINGELL. $270 billion is a lot of money.

Ms. JOYNER. That is a lot of money, yes, sir.

Mr. DINGELL. It would pay for a lot of health care benefits?

Ms. JOYNER. Excuse me, I did not hear the question.

Mr. DINGELL. It would pay for a lot of health care benefits?

Ms. JOYNER. Yes, sir, it would.

Mr. DINGELL. If we took $270 billion out of Medicare, what would that leave us in the way of health care benefits?

Ms. JOYNER. I am not sure exactly what the dollar figure would be.

Mr. DINGELL. A lot less health care benefits?

Ms. JOYNER. It would be less, yes, sir.

Mr. DINGELL. Now, would we assume that this would lead us toward a system of HMOs for Medicare recipients?

Ms. JOYNER. You are saying would that be sufficient to meet the needs?

Mr. DINGELL. Yes. In other words, if you take $270 billion out, is that going to put pressure on Medicare to go to HMOs?

Ms. JOYNER. I really would not have a basis for answering that.

Mr. DINGELL. I would be able to assume that it would put pressure on, and certainly that it would not remove pressure to go to HMOs. Is that not right? Because it is going to require cuts in expenditures, is that not right?

Ms. JOYNER. I really would not have a basis for knowing what that would do with respect to more or less managed care.

Mr. DINGELL. Who aside from my Republican colleagues would be able to give me an answer to these questions?

Ms. JOYNER. Excuse me?

Mr. DINGELL. Who aside from my good friends and Republican colleagues would be able to give me answers to these questions?

Ms. JOYNER. You might talk with the people at HCFA on how they would respond to varying levels of resources.

Mr. DINGELL. I think I will have to be doing that. One of the things that sort of tweaked my concerns with being a member of the bar, I got, as did a number of Members around here, letters from the D.C. Bar Association, the Membership Benefits Committee of the District of Columbia Bar, and it involved two things. One was a letter which you see over there, and the other was a pamphlet of which we have reproduced the first copies. Basically, what it says is that managed care—well, first of all, it says that members of the D.C. Bar should contact the bar, and they said this:

> In the rush to cut costs, some health care plans have been steadily restricted to the amount of care your family can receive. In fact, it has gotten to the point where some plans refuse to cover certain procedures, even if your doctor deems them necessary. Unfortunately, that could never happen under a major medical plan like ours.

They go on and they talk about being essentially forced into HMOs. In the brochure that they have put around, they said, "Settle for a managed care plan and you would find yourself on some pretty thin ice." They go on and say, "Watered down medical protection could put your family at risk." These are a pretty smart bunch of people in the D.C. Bar Association, are they not, good lawyers, a lot of lobbyists interested in things like government and government programs, including Medicare.

I wonder if we ought not listen to them on their point with regard to watering down plans. I wonder if maybe the plans that are coming forward from my Republican colleagues are not going to water down Medicare so that it is going to put, as the D.C. Bar Association says, families at risk, or it could put people on thin ice. I guess maybe I will have to ask HCFA, should I not?

Ms. JOYNER. Yes.

Mr. DINGELL. Thank you, Mr. Chairman. You have been very curious.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Texas wish to inquire?

Mr. BARTON. I thank the distinguished Subcommittee Chairman. It is a pleasure to be in this hearing room of the Ways and Means Committee as a Member of the Energy and Commerce Committee. I have never been in a hearing room that had gilded chandeliers and Greek or Roman columns and gilded water pitchers with their names on it. We do not have that over in our Committee, and I am impressed. We do, however, have Members that are just as interested in finding some solutions to the Medicare problem which, if we do not do anything, everyone acknowledges that Medicare is going to go bankrupt.

Today's hearing is focused on quality assurance. In reading the testimony of our first witness, I am a little concerned about what HCFA is and is not doing in that area. In your written testimony, you say:

> Surveyors are checking for compliance only to determine whether the institution has established organizational policies and procedures to meet the conditions of participation. Little attention is paid to how well those policies and procedures are adhered to or to what the results are.

Then it says: "HCFA's application of termination procedures"—and this is with respect to hospitals—"casts some doubt on its willing-

ness to terminate any but the worst hospitals from the Medicare Program."

My first question is do you think that HCFA needs to do more in the enforcement area or in the investigative area about insisting that the quality plans that are in place are actually carried out, and if they are not, that those hospitals and other organizations that HCFA surveys for quality are decertified?

Ms. JOYNER. Absolutely. GAO has spoken to that issue for several years now and our message is still the same. We feel that where a provider is not providing quality care and it is not meeting Medicare requirements, then action should be taken against such a provider.

Mr. BARTON. Do you think that the senior leadership in HCFA has gotten that message? Do you think they realize that as we look at the problem of waste, fraud, and abuse in Medicare, that part of that solution has got to be stricter scrutiny and also enforcement when there is a problem?

Ms. JOYNER. I believe I will let Mr. Stropko speak to that.

Mr. STROPKO. We have been looking at this issue since probably 1984. I personally have been looking at it, and every single year I thought it would get better the next year and it has not.

Mr. BARTON. Mr. Bilirakis and I have been holding some joint hearings in the Energy and Commerce Committee on waste, fraud, and abuse in the Medicare Program, and we are developing as we speak at the staff level a list of proposed remedies to deal with that. But part of it has got to start at the top with the leadership realizing that there is a problem and committing themselves and their senior associates to dealing with it, because we have seen again in our Committee, Chairman Dingell and Chairman Waxman have held hearings in the past and they say the same things every year and they do not do anything. This year we think it is going to be different.

I have one more question, Mr. Chairman, and then I will yield back.

Another witness after you for the private quality assurance organization talks about, as they look at their standards, the NCQA standards. They have a section on members' rights and responsibilities when they are looking at HMOs. It says, "How clearly does the plan inform members about access to services, how to choose a physician or change physicians, and how to make a complaint." I notice that HCFA right now, when they are looking at the HMOs, apparently does not list that as a standard. Do you think that patient information and members' rights and responsibilities should be included in these standards, as we look at the HMOs and PPOs?

Mr. STROPKO. Most certainly.

Mr. BARTON. Mr. Chairman, I am going to yield back. I love your orange light. We do not have that. We just have a red light and a green light. As an industrial engineer, I think that orange light is very useful to moving the hearing along, so I am going to try to get our Committee to adopt that as an improvement.

Thank you.

Chairman THOMAS. I will tell the gentlemen we used to have a stop sign which he might be more familiar with, but we thought the lights were a little more modern.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I am amused that my friend from Michigan is relying upon a letter from the trial lawyers and the D.C. Bar Association for help on Medicare. In my opinion, he is really scraping the bottom of the barrel to buttress his argument. These are the same people that are fighting the American people on tort reform and frivolous lawsuits, and it is amazing that you would have to go to the D.C. Bar Association to try to get help.

I want to thank Dr. Joyner for not giving a political answer to my friend from Michigan, because truly, to remind the people again, $4,800 this year, $6,700 in 2002 is what the spending will be on Medicare; a $1,900 increase.

With that increase and the rapid growth rate that we see with the baby boomers coming also in the year 2012, do you think that HCFA, since it is having a hard time now in keeping up with its enforcement of quality assurance in the risk contracts, will be able to keep up with the significantly expanded program that we have, or are we going to have to look elsewhere to continue to make sure that quality assurance is there?

Ms. JOYNER. I would assume that you could call on HCFA to allocate its resources appropriately if more beneficiaries are in one kind of program than in another. Again, in part that goes back to some questions that were raised earlier. Right now, HCFA does its own reviews for the risk HMOs, unlike relying on private sector accreditation as something that takes some of the burden of direct checking, if you will, on people themselves, and unlike what they do in the fee-for-service with the State involvement. So they are using other models in the fee-for-service and they may or may not wish to consider some of those on the HMO side, on the managed care side.

I think that you are raising a good question about how they respond to a changing world that they are responsible for overseeing in terms of quality.

Did you want to add anything to that?

Mr. STROPKO. The only other thing is there is a sort of funding barrier, administrative funding for that program has gone down over the last 5 years on a per capita basis largely because of the Budget Enforcement Act, of course. There are some amendments that you could make to the act to make it a little easier to provide additional funding to the extent that you think it is warranted by a change in program direction. It is just that within the existing budget constraints it is very hard to do.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Ms. Joyner, I can see how it is difficult to answer some of the questions, when what we are doing is just surmising. We are talking about a phantom plan which will not be before us until probably sometime in late September or mid-September. Our problem is that you will not be invited back and your experts will not be invited back to respond at that time. So based on what we know

today, we are trying to get some feedback from people like yourself to make sure that we have some direction on where we are going.

If in fact we would take about one-third of the Medicare population, let us say 10 million people and put them into HMO's managed care immediately, would your guesstimate be that there would be savings or large savings to the Federal Government and to the program?

Ms. JOYNER. I do not think we would have a basis for estimating what those savings would be.

Mr. STROPKO. Right now, there probably would not be savings largely because the existing formula for developing payment rates in HMOs is widely recognized as flawed. They do not adequately account for the differences in health status between those people who choose to enroll and those who remain in the fee-for-service sector, so something would have to be done with the reimbursement structure.

Mr. KLECZKA. What would that be? Do you have any guesstimates? Using the scenario of 10 million people, what would have to change in the reimbursement to make sure that we can extract at some point in time $270 billion over the next 7 years?

Mr. STROPKO. That is kind of a technical question, but basically you would need some better ways of measuring the health status of those who choose to enroll. They are called risk adjusters, and it is something that has befuddled HCFA and the researchers for the last decade.

Mr. KLECZKA. Do you think the possibility exists that HMOs would cherrypick to make sure that they are not exposing themselves to large risk and that the sickest of the folks would be left back in the old fee-for-service?

Mr. STROPKO. That is the name of the game.

Mr. KLECZKA. So that game could be played unless we prohibit it?

Mr. STROPKO. That is part of marketing in insurance. That is part of the game.

Mr. KLECZKA. So then the savings would not really be realized because the sick people, the big risk, would still be in the program, very possibly still in the fee-for-service?

Mr. STROPKO. Until you have fixed the payment rate problem, you are not likely to realize savings, unless somehow you have a way of dealing administratively and assigning people to HMOs.

Mr. KLECZKA. No, we want to give them choice. We do not want to assign people. What would happen to the people in the program who would stick around in the fee-for-service, if in fact the insurance companies, like they do now, cherrypick off the healthier individuals? If the sickest ones are in the fee-for-service program, what would have to happen in the fee-for-service? Would we have to cut back benefits, raise out-of-pocket costs? What would occur there?

Mr. STROPKO. Costs would increase at a more rapid rate.

Mr. KLECZKA. Again, under the guise of trying to pull out $270 billion, knowing full well the Federal contribution is not going to be increasing, in fact it is going to be decreasing, what would the effect be on the beneficiaries who stayed in the fee-for-service mainly because they do not have a choice?

Mr. STROPKO. That is hard to predict. I think the program would be facing an increasing growth in cost and pressure on the benefits side.

Mr. KLECZKA. We have had Medicare Select on a pilot basis in various States. Has the GAO looked at that at all? I know we are getting a study at the end of the year.

Mr. STROPKO. I do not believe so.

Mr. KLECZKA. Because in my query to HCFA, they indicate that even though there is some increased benefits for the beneficiaries, we find that the Federal Government has not saved much, if any, through the Medicare Select Program, which I would guess is being used as the model for the phantom changes in Medicare which we have not seen yet.

I thank you for your responses.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Texas wish to inquire?

Mr. JOHNSON of Texas. Thank you, Mr. Chairman.

I would just like to remark that the phantom plan out there has as lot of choices and they are all phantom choices, and all of them are less costly than the fee-for-service. Maybe we can resolve it among ourselves when we actually see the results of what people can select when they are given a choice.

I have no more phantom questions, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Pennsylvania wish to inquire? Any phantom speculations?

Mr. GREENWOOD. Thank you, Mr. Chairman.

I am sorry that the Ranking Member of the Commerce Committee Mr. Dingell has left, because I wanted to respond to a question he posed to the panel. His question was: If we have to significantly reduce the rate of growth in the Medicare Program, do we have to move people from fee-for-service into managed care? The panel clearly was not prepared to answer that question.

He asked the panel to whom he could address that question other than the Republicans. My suggestion to Mr. Dingell would be that he go to his staff and say: The President wants to reduce the rate of growth in the Medicare Program by $121 billion over the next 7 years. That is based on the OMB baseline.

If you correct that for the CBO baseline, you add $74 billion and you see that the President wants to reduce the rate of growth in the program by $195 million over 7 years. Then he could turn to his staff and he could do what the Republicans have done. That is, he could bring in experts from all over the country and sit down hour after hour, day after day after day in a very scholarly, conscientious, and diligent fashion and try to determine what the appropriate response would be. I would recommend that to my colleagues on the other side of the aisle. They might try to have some of the creativity that we have.

Mr. WAXMAN. Would the gentleman yield to me?

Mr. GREENWOOD. Briefly.

Mr. WAXMAN. It is interesting to hear that the Republicans are meeting with all these experts. Are these closed-room meetings and are the rest of us invited?

Mr. GREENWOOD. You are invited to participate in the same exercise, as you choose.

Reclaiming my time, I was interested to read in your testimony, Dr. Joyner, that HCFA has joined a new organization called the Foundation for Accountability. I was also interested to read that a number of experts have recommended the formation of a national board composed of public and private health care professionals representing regulators, providers and purchasers, which could be convened to establish a set of uniform measures. Do you see redundancy there? Do you think that this new Foundation for Accountability and the national board would have different functions to perform?

Ms. JOYNER. I might say that our interviews with the experts preceded the announcement of the Foundation for Accountability, so some of them may have known that those ideas were being considered, but it was prior to the time that the Jackson Hole group convened. I think they are both in the same direction.

At this point, we have talked with some people who are part of the foundation group about how they plan to proceed with this, but I do not think they have the specifics worked out yet of exactly how they will move ahead. If we were to go back to the experts again, they might no longer feel the need for something like a national board.

When the experts we interviewed spoke of a national board, it was seen as something like the PPRC or the ProPAC. For example, there could be an advisory board and then people would talk to researchers who worked on this to seek input and really try to pull together all the information about measures such as the pros and cons of different ones. So if we were to go back to them after the foundation has proceeded with its work, they might feel that that was sufficient. I think it is a little early to know for sure.

Mr. GREENWOOD. You noted in your testimony that HCFA's Office of the Actuary annually surveys some 12,000 beneficiaries treated predominantly under fee-for-service arrangements about their health status, and so forth. Has the Office of the Actuary done a similar study exclusively on the Medicare population within managed care?

Ms. JOYNER. No, they have not. The current survey would potentially include people who are in managed care if they happened to be in the sample, but it is not focused on managed care. That is why the Office of Managed Care is considering doing a separate survey to get specific information about satisfaction of beneficiaries in managed care.

Mr. GREENWOOD. I assume that you would encourage them to do that.

Ms. JOYNER. I would certainly encourage that, one way or another, HCFA get that kind of information and ideally that they get it in some form that is comparable for fee-for-service and managed care. That is a question that gets raised, and I think that HCFA has some responsibility to provide some answers.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Iowa wish to inquire?

Mr. GANSKE. Thank you, Mr. Chairman.

Dr. Joyner, I remember when I first decided to run for office, I decided to do a survey. And when I talked to the pollster, he said, What do you want the poll for? I looked at him quizzically and I said, Well, I want to know what my chances are, why did you ask? He said, Well, because we can find out the truth or we can use a poll for other purposes.

Now, part of what we have going on is we have a lot of surveys and polls that are being done and it is hard to get at exactly what the statistical validity is because of the way questions can be asked and the facts are moved around.

We have a lot of data where proponents of managed care say that patients are very happy, and opponents say they are not so happy. How does HCFA get at the validity of patient satisfaction surveys, and should this be done by a totally separate entity, an office of statistics, or something that can review this?

Ms. JOYNER. We have talked with people about this issue, and you have certainly hit on a point that many of them raised: the objectivity and the importance of the wording of the question and a lack of confidence at this point in the results. For example, individual plans will often put out information about how satisfied their patients are, and then you have this competition. Everybody says our people love ours. It is exactly that concern, with each plan developing its own, that the potential for bias is there.

So what we heard was that surveys should be done by a more independent source. So if you were to consider HCFA to be unbiased in what it is trying to get at, and if it were collecting information on beneficiaries in both kinds of plans, then I think the people we talked with would certainly consider that to be more credible than surveys done by an individual plan or by an organization that represents managed care plans. There is always going to be the recognition of the inherent bias, intended or otherwise.

Mr. GANSKE. I think it would be important for us to look, if we are going to be providing choices, at having patients be able to compare apples to apples, and so forth.

Ms. JOYNER. Exactly.

Mr. GANSKE. I imagine that you have thought a great deal about how to make sure that there are some patient protections in wherever we are going, and I am sure managed care will be part of that, and some other options will be, also.

Let me ask you a few specific questions. Do you think that it would be reasonable to ensure a prompt authorization within some time-limited period of time for a patient who is in an emergency room waiting for treatment? Should that be something that is included?

Ms. JOYNER. That that should be an expectation of a quality program, that this authorization come quickly, I would assume so. I do not know how that is dealt with in standards right now.

Mr. GANSKE. I could tell you right now it is a weakness in the Medicare Program. They have a pretty good appeals process, but from the perspective of a beneficiary that feels that they need urgent services and need an emergency room and they are obviously not necessarily in a position to know whether they really do need emergency service, they are not likely to get an answer to the question of whether or not that is covered for 6 or 8 weeks, sometimes

6 or 8 months. They end up being liable for some fairly substantial payments that they do not feel they justifiably should pay. Would you think that it is important to have a prompt and fair appeals process for resolving coverage denial complaints?

Mr. STROPKO. Yes. We have a good process right now, but it is not timely.

Mr. GANSKE. How about a ban on financial incentives on providers which may limit referrals or treatment options?

Mr. STROPKO. Right now, HCFA is responsible for coming up with some guidelines. The statute was 1990, and they still have not come up with guidelines for risk-sharing arrangements. I think that is critically important.

Mr. GANSKE. It looks like my time is finished.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Oklahoma wish to inquire?

Mr. COBURN. Thank you, Mr. Chairman.

Dr. Joyner, thank you so much for being here. One of the things I observed as I have heard the questions asked, do you have studies to show that the only way we improve the quality of care is by spending more dollars?

Ms. JOYNER. We have not done such studies.

Mr. COBURN. So the assumption that we hear made routinely by many is that we in fact cannot improve quality of care unless we spend more money, and that is pretty disturbing to me because that frames the whole debate. That says that the way we are treating and caring for our patients today under the provisions of Medicare is a very efficient, cost-oriented, quality-oriented program, and that the only way we could improve that would be by spending more dollars to offer more services.

In the Medicare system today as you all look at it, are there hurdles that prevent improved quality of care without spending more dollars?

Ms. JOYNER. Mr. Stropko, you touched on one of those a moment ago. I will let him elaborate on that, on the kinds of obstacles to improving within the same amount of money.

Mr. STROPKO. HCFA is almost legislatively prohibited from using a lot of the basic managed care techniques in the fee-for-service sector.

Mr. COBURN. Remember, I am talking about quality of care. I am not talking about reducing dollars. I am talking about improving the quality of care with the same dollars.

Mr. STROPKO. In a sense, that implies to me the ability to manage care a bit, to apply a case management approach that could help you look at both what is necessary and what is cost effective. Right now, there is no mechanism in HCFA to do that. HMOs presumably do that when they are under contract with HCFA, but HCFA cannot apply that strategy to the fee-for-service sector, say, as Blue Cross & Blue Shield could apply through development of preferred provider networks and certain case management programs that they have for diabetics, and so forth.

Mr. COBURN. At the same time, there is not the assumption that we cannot—what I am trying to get to is the baseline is that we have to spend more money to improve quality of care. That is just

not true. We can improve quality of care by spending no additional dollars, if in fact we spend the dollars more wisely, if we allow a large portion of choice with those who are Medicare beneficiaries, but also in the system as it works to supply that need. Is that not true?

Mr. STROPKO. I think there is so much waste in the system right now that it is a pretty good strategy to say that is true. It is very true. It seems to me that with better management of care, you could save a lot of money and also maintain or even enhance quality.

Mr. COBURN. So you would agree with the principle that with a flat number of dollars and given the same number of providers, if we looked at doing it a better way, that we could in fact enhance quality of care with the same dollars?

Mr. STROPKO. Doing it is another matter, but I think theoretically——

Mr. COBURN. So it would follow that if we had a marked increase in the number of dollars over the next few years, that we ought to both be able to take care of an additional number of people and at the same time improve the quality of care, if we say that is what our goal is.

Mr. STROPKO. It is not impossible.

Mr. COBURN. Let me go to one other area. We have seen lots of data and you have heard mention several times fraud and abuse. Give me your feeling. The range is anywhere from 10 percent of the total dollars down to 4 percent, and some people even say 20 percent. If you had to pick a number, a percentage number on Medicare, where would you say pure fraud and then fraud and abuse?

Mr. STROPKO. We have never looked at it that way. We have picked a number for fraud and abuse and the number we have picked is 10 percent, and largely that is a number that we got from talking to a lot of people that are in the claims processing business, both in the private and the public side. That number has been on the street for the last 4 or 5 years, and the numbers have been, just as you said, all around that. I do not think anyone could ever by its very nature define what a precise number is, because it is invisible.

Mr. COBURN. So if we did look at that and we assumed that an average of all the experts that we have heard was around 10 percent, and that if we eliminated 5 percent of that, one-half of that, 50 percent of that, we eliminated that, we would see significant dollars to be able to be put back in for care, would we not?

Mr STROPKO. I think both GAO and the OIG can point to those dollars in our studies. There is a lot of waste out there and a lot of abuse.

Mr. COBURN. So there is significant savings from the elimination of fraud and abuse?

Mr. STROPKO. They are documentable, yes.

Mr. COBURN. Thank you very much.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Georgia wish to inquire?

Mr. NORWOOD. Thank you, Mr. Chairman.

Dr. Joyner, I am a freshman and would ask that you be very gentle with me. I am trying to figure out how this system works

up here. I have so much admiration for Mr. Dingell, who has done such a fine job for 40 years. I sit here on this panel and I know that we are talking about a Medicare Program that is going to increase its spending by 40 percent, and he keeps telling me, you fool, that is a cut, do you not understand? I really am trying to understand how we can increase our spending in such a considerable manner, and we seem to get a lot of people shaking their heads even out there that, boy, you are really cutting that program.

Help me with some numbers. It is my understanding that over the next 7 years the Medicare Program will spend $1.87 trillion. Tell me, what that would be?

Mr. STROPKO. I cannot do math that quickly in my head. We are talking about $160 billion right now growing at 10 percent a year, and so somebody better than I is going to have to do the calculating.

Mr. NORWOOD. That is not too far wrong, is it?

Mr. STROPKO. I do not know.

Mr. NORWOOD. Who in Washington determines that that is what we are going to spend?

Mr. STROPKO. I think we just sort of look at what we have spent in the past and that is sort of the best——

Mr. NORWOOD. Who is we?

Mr. STROPKO. HCFA.

Mr. NORWOOD. Is it HCFA or is it the 104th Congress who decides it? Who made the estimate that we will spend *x* amount of dollars, that amount Mr. Dingell wants to spend over the next 7 years, HCFA?

Mr. STROPKO. They, ProPAC, those are the numbers that are——

Mr. NORWOOD. So we find that HCFA and Mr. Dingell want to spend *x* amount, the President wants to spend a little less than that, and the 104th Congress is saying we are just going to slow this growth down enough and it will not be the same amount of dollars. Is that how we get to that? Who do we trust? Who do we know who knows how much it will cost?

Mr. STROPKO. I think to a large degree how much it will cost in the future depends on the policies you make this year and in the coming years. I think if you say things are going to continue to go as they are going right now, then you have a fairly good baseline to measure and the 10-percent growth rate is not an unreasonable expectation. Wanting to live with that growth rate and being able to live with that growth rate is quite another matter.

Mr. NORWOOD. I gather that is what my distinguished friend wants to do, just lest it go on like it is going. If we do that, what do you think will happen to the trust fund in 2002?

Mr. STROPKO. That is a for sure. I mean the trustees indicate that we are going to be in big trouble.

Mr. NORWOOD. Do you mean it will be out of money?

Mr. STROPKO. Yes, sir.

Mr. NORWOOD. What about all these people who need health care, senior citizens who want their Medicare Program?

Tell me, Do you have any idea what we spent in Medicare in 1990, $150 billion?

Mr. STROPKO. Less than that.

Mr. NORWOOD. $140 billion? $130 billion?

Mr. STROPKO. Probably.

Mr. NORWOOD. $130 billion, let us just say that is it. Back in 1965, somebody up here decided that they would look out into the future and determine what the Federal Government would be spending in Medicare in 1990. I do not know who it was. I do not guess HCFA was up and going then. Maybe it was Congress. Somebody looked out and said that Medicare was going to cost us $9 billion in 1990. What in hell happened? We must not be very good with our numbers in this town and we are seriously talking about big dollars here, and we do not have a clue what it might cost in 2002. Yet, we have our friends over here saying do it anyway.

That is all, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from North Carolina wish to inquire?

Mr. BURR. Thank you, Mr. Chairman.

Welcome, Dr. Joyner. I would like to go straight to the concluding observations that you made in your testimony, and I will read a couple of sentences.

> HCFA has quality assurance programs with that goal. Although we have identified problems in their implementation, the enhancement HCFA is making to its quality assurance approach is consistent with the direction in which the private sector is moving and with the consensus of health care experts we interviewed.

Now, I interpreted that to say that HCFA is trying to replicate the successes that have been experienced in the private sector. Would that be a correct interpretation of your conclusion there?

Ms. JOYNER. They are attempting to use some of the techniques. To take as an example, continuous quality improvement has been shown to be helpful not just in the health care industry, but in many other industries, as well, as a way to improve the product or the services that you are delivering. That is the point that we are making.

Mr. BURR. Could I also interpret that "although we have identified problems in their implementation" means that they are not doing as good a job as one would hope?

Ms. JOYNER. In the past, they have not done as good a job as we—and I am sure you—would have hoped in carrying out their program.

Mr. BURR. Since in health care Mr. Norwood very eloquently displayed that we use the past to predict the future, can we expect a different outcome than what we have seen, which is failure?

Ms. JOYNER. Well, that is why we pose it as a challenge facing HCFA and facing the Congress in its oversight of HCFA, to make sure that as it moves in these directions, that it does so effectively.

Mr. BURR. In the private sector plans that you referenced, who determines the quality of care?

Ms. JOYNER. The corporate purchasers that we talked about collect data on the kind of care that is being provided. They often require accreditation.

Mr. BURR. Who do they ultimately answer to about the plans that they choose?

Ms. JOYNER. Well, they ultimately answer to their stockholders and they answer certainly to their employees who are in these plans who expect to receive good care and who, if they do not receive good care, in fact end up costing the company more money.

Mr. BURR. Is it realistic for the Members of the Subcommittees to believe that seniors in this country can make the same quality of care decisions that we see exemplified in the private sector plans?

Ms. JOYNER. That Medicare beneficiaries can make the same choices, make the same decisions, is that what you are saying?

Mr. BURR. The discussion on this Subcommittee now is can we inject some of the private sector successes, the choices of different types of plans, into what has traditionally been a government dominated, government run HCFA administered health care delivery system, not to do away with it. You have identified that in fact they are struggling to meet the private sector accomplishments. My question would be, Can we expect seniors to also respond in a similar fashion that we do people in private sector plans to the quality of care? If the quality of care is not there, seniors will scream, if it is, they will praise the plan.

Ms. JOYNER. They will need information just as people not on Medicare need information about the quality of care. To some extent, individuals—I or you or a Medicare beneficiary—are able to judge the quality of what we are getting. But sometimes we do not know and we need somebody else to help identify the quality of care and give us some report card, give us some consumer reports that we can use so that we know whether we are getting the right care. If so, I would assume that they can make choices.

Mr. BURR. From the standpoint of the GAO, let us consider that down the road we inject into Medicare private sector options, different plans for seniors with the high quality of care that you have made reference to here. Will the current HCFA, the HCFA that your report was about, need to change significantly to compete on both a cost and quality of care standpoint for those people accessing care?

Ms. JOYNER. Yes, it will need to more effectively carry out its quality assurance activities.

Mr. BURR. Thank you, Dr. Joyner.

Mr. Chairman, I yield back the remainder of my time.

Chairman THOMAS. I thank the gentleman.

I want to thank you. Just a couple of questions on a followup, so that people can understand some of the points that were made. I will not go into the dollar amount discussion. Although "cut" is continually used, that is not what we are talking about. We are talking about increasing the funds to the program, but simply not at the rate that they have been increased in the past.

The gentleman from Oklahoma's point about the fact that you can get quality care out of the same dollars I think is a valid one. That in essence is what is occurring in the private sector. If you increase the money as you go along, you ought to be able to get both.

I am interested in the comment Mr. Stropko made about HCFA's ability to create a program that adequately reimburses and would hopefully reinforce quality in the coordinated care programs. I believe you used the term that most people know that that reimbursement structure is flawed.

Mr. STROPKO. Yes, sir.

Chairman THOMAS. Is HCFA currently working on unflawing the reimbursement system, do you know?

Mr. STROPKO. Yes, it has been working on it for the past decade.

Chairman THOMAS. I think that is the point I want to underscore. They have been working on it. In fact, they have been working on it for the past decade and they still have not come up with a better program. We are constantly reminded by my colleague from California, Mr. Stark, how much a model of the bureaucratic form HCFA is, that the administrative costs are low, it is a lean fighting machine that does a great job, and we certainly ought not think about replacing it with anything in the private sector, God forbid, something from a State structure to help it do the job.

Dr. Joyner, I understand that the GAO is going to be releasing a study shortly about HCFA and its performance in the area of administration. Are you going to tell everybody that HCFA is this lean quality machine that ought to be emulated everywhere in the system?

Ms. JOYNER. We are going to be releasing a report looking at its enforcement in risk HMOs. I am not at liberty at this point to say anything about what we will be saying, but we expect to release that on August 3 in hearings before the Senate Select Committee on Aging. We will be glad to come over and brief your staff fully as soon as we have issued that report.

Chairman THOMAS. So we are going to have it released August 3 on the administrative quality of HCFA over HMOs?

Mr. STROPKO. Yes, we are looking at the broad issue of how effective they are in overseeing the HMO Program. We have done this almost every 2 years.

Chairman THOMAS. On how effective they are?

Mr. STROPKO. Right.

Chairman THOMAS. We know that the reimbursement scheme that HCFA has created for the HMOs, in essence, is flawed. Are we going to say that the oversight structure for HCFA is good, or flawed, as well?

Mr. STROPKO. I do not think I am letting anything out of the bag to suggest that there is a lot they could learn from the private sector approaches that we have talked about today.

Chairman THOMAS. So the direction that we are going in terms of taking a look at private sector models and things that are going on in the private sector, in your opinion, is a positive thing, and maybe HCFA does not know everything and perhaps there is a thing or two that HCFA can learn from what has been going on in the outside world?

Mr. STROPKO. Something as simple as letting beneficiaries know what is going on with the HMOs that they are enrolled in is a very positive step that they need to take.

Chairman THOMAS. A little bit of education and assistance in terms of making choices would go a long way toward assisting the beneficiaries in making the right kind of choices.

Mr. STROPKO. And I think making HCFA a lot more effective.

Chairman THOMAS. And HCFA does not do that now?

Mr. STROPKO. No.

Chairman THOMAS. I appreciate your testimony.

The Subcommittees will stand in recess for just a few brief moments, because the gentleman from Florida, Mr. Bilirakis, Chairman of the Health Subcommittee, will be coming back and chairing the second panel. So as soon as he gets here, we will begin the second panel.

The Subcommittees stand in recess.

[Recess.]

Chairman BILIRAKIS [presiding]. We are going to continue on here.

If they have not left, I would like to call the next panel: Margaret E. O'Kane, president of the National Committee for Quality Assurance, and Dennis O'Leary—two Irish names—president of the Joint Commission on Accreditation for Healthcare Organizations, Oakbrook, Illinois.

With your indulgence, I know I am only here at the outset to listen to you, but you are also probably experienced with how we do things up here, unfortunately. Many of the others will be right back.

In the interest of time, we will maybe kick it off. Ms. O'Kane.

STATEMENT OF MARGARET E. O'KANE, PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. O'KANE. Good morning, Chairman Bilirakis.

My name is Margaret O'Kane. I am president of NCQA, the National Committee for Quality Assurance.

As Congress and the administration look to increase the use of managed care in the Medicare Program, I commend both Subcommittees for convening this hearing on the standards for health plans providing coverage to Medicare beneficiaries.

NCQA is an independent nonprofit organization which oversees two complementary approaches to health plan evaluation, accreditation, and performance measurement. NCQA accreditation examines the heath plans' infrastructure, while clinical and service performance are measured through our health plan employer data and information set.

NCQA is governed by a broad-based board of directors which includes large purchasers, health plan representatives, a consumer representative, a State legislator, a union representative, an AMA representative, and independent quality experts.

By the end of this year, we will have accredited nearly one-half of the Nation's health maintenance organizations against a set of rigorous and evolving standards. I should mention that this is a new accreditation program which was launched in 1991.

This figure includes 80 health plans which currently enroll two-thirds of the Medicare beneficiaries and TEFRA risk contracts. The NCQA standards are divided into six sections: (1) Quality improvement, how well does the plan manage and improve quality throughout the health plan, does it coordinate all parts of the delivery system, which is a very important issue for the Medicare population; what steps does it take to make sure members have access to care in a reasonable amount of time; (2) credentialling, how does the plan meet specific requirements for investigating the training and experience of the physicians in its network, how does it choose hospitals and other provider organizations; (3) member rights and

responsibilities, how clearly does the plan inform members about how to get services, how to choose a physician or change physicians, and how to make a complaint; how responsive is the plan to member satisfaction ratings, how effectively does it handle member complaints and grievances; (4) utilization management—does the plan use a reasonable and consistent process when deciding what health care services are appropriate for individual needs; when the plan denies payment for services, does it respond to member and physician appeals; are physician consultants from the appropriate specialty areas used when these decisions are made; (5) preventive services, does the plan encourage members to have preventive tests and immunization, does the plan ensure that its physicians are encouraging and delivering preventive services; and (6) medical records, how consistently do records kept by the physicians meet NCQA standards for quality care.

Approximately one-third of health plans reviewed against standards have received full accreditation, and 13 percent of the plans that have applied have been denied. The results of our accreditation process are available free of charge to any individual who phones or writes our officers, and summary reports for every plan reviewed after July 1 will be made available in 1996. We are committed to providing information in the marketplace.

The primary reason that so many health plans have undergone such a rigorous process is the purchasers' interest in ensuring that their employees are enrolled in quality organizations. Large employers such as Xerox, GTE, IBM, Allied Signal, and certain States have required that the health plans with whom they contract seek NCQA accreditation.

In addition to accreditation, we have developed a standardized system for measuring health plan performance, the health plan employer data and information set, which contains information on quality, access, patient satisfaction, and health plan management.

While HEDIS, the Health Plan Employer Data and Information Set, was initially designed for commercial purchasers, we are committed to broadening this set of measures to address the needs of all payers, including Medicare and Medicaid. We are working with the Packard Foundation and are just releasing for comment a set of measures particularly geared to the Medicaid population, and we are about to launch an initiative to address the special issues of the Medicare population with some funding from the Kaiser Family Foundation.

The framework for the development of HEDIS will come from our Committee on Performance Measures, which is again a broad-based group of experts, which includes corporate purchasers, health plans, AARP, consumers, other consumer organizations, CalPers, and a State Medicaid director. Our approach really is to develop a broad consensus between the health plans and the purchasers.

I think I am out of time, so I will be submitting this testimony and am happy to respond to questions.

Chairman BILIRAKIS. You are certainly welcome to summarize, if you have something else you would like to say.

Ms. O'KANE. The two methods we use to evaluate health plans are both based on the premise that a health plan is responsible and

accountable for the quality of care and service that its members receive.

Many of the options now under consideration by Congress and the administration would encourage a wider variety of managed care organizations such as PPOs to enter the Medicare market. One of our concerns is that HMOs, which really have come forward for this measurement and have been willing to be held accountable, might be subjected to an additional measurement burden when compared to the other managed care alternatives that you are planning to allow in the Medicare marketplace.

There is sort of a perverse problem when you have people that are able to be measured having more reporting burden than those that are not able to be measured, and I think this is not an easy problem to solve. You cannot just say overnight that organizations that have not been able to measure should be held accountable, especially if they do not have the infrastructure. But I do think this is a serious issue that ought to be addressed as you try to move forward.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARGARET E. O'KANE, PRESIDENT NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Good morning Chairman Thomas, Chairman Bilirakis, and members of the Subcommittees. I am Margaret E. O'Kane, President of the National Committee for Quality Assurance (NCQA). As Congress and the Administration look to increase the use of managed care in the Medicare program, I commend both Subcommittees for convening this hearing on the standards for health plans providing coverage to Medicare beneficiaries.

NCQA is an independent, non-profit organization which oversees two complementary approaches to health plan evaluation: accreditation and performance measurement. NCQA accreditation examines a health plan's infrastructure, while clinical and service performance is measured through NCQA's Health Plan Employer Data and Information Set (HEDIS 2.0 and 2.5). NCQA is governed by a broad based Board of Directors which includes large purchasers, health plan representatives, a consumer representative, a state legislator, a union representative, an AMA representative, and independent quality experts.

By the end of this year, we will have accredited nearly half of the nation's health maintenance organizations (HMOs) against a set of rigorous and evolving standards. This figure includes eighty health plans enrolling two thirds of the Medicare beneficiaries in TEFRA risk contracts. The NCQA Standards are divided into six sections:

- *Quality Improvement:* What improvements in care and service can the Plan demonstrate? Does the plan full examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time?

- *Provider Credentials:* Does the Plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the Plan keep track of all physicians' performance and use that information for their periodic evaluations? Does the Plan look for any history of malpractice or fraud? Has the Plan performed a quality assessment for health delivery organizations such as hospitals, home health agencies, nursing homes, and free-standing surgical centers?

- *Members' Rights and Responsibilities:* How clearly does the Plan inform members about how to access services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members' satisfaction ratings and complaints? Does the appeals process for grievances include a second review with different individuals?

- *Utilization Management:* Does the Plan use a reasonable and consistent process when deciding what health care services are appropriate for individuals needs? Are appropriateness criteria clearly documented and available to participating physicians? When the Plan denies payment for services, does it respond to member and physician appeals? Are physician consultants from the appropriate specialty areas of medicine and surgery utilized as needed?

- *Preventive Health Services:* Does the Plan encourage members to have preventive tests and immunizations? Does the Plan ensure that its physicians are encouraging and delivering preventive services?

- *Medical Records:* How consistently do medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

Approximately one third of health plans reviewed against our standards have received Full Accreditation and thirteen percent have been denied. The results of our accreditation process are available free of charge to any individual who phones or writes our offices, and summary reports for every plan reviewed after July 1st will be made available so that purchasers and consumers will have even more information with which to evaluate health plans.

The primary reason that so many health plans have undergone such a rigorous process is the purchasers' interest in ensuring that their employees are only enrolled in a quality organization. Large employers such as Xerox, GTE, IBM, Allied Signal, the States of New York, Tennessee, and many others have all required that the health plans with whom they contract seek NCQA accreditation.

In addition to accreditation, NCQA has developed a standardized system for measuring health plan performance, the Health Plan Employer Data and Information Set (HEDIS). HEDIS 2.5 is a set of sixty standardized measures of health plan performance in five areas. More than two thirds of the nation's HMOs are now using HEDIS to generate performance information. HEDIS covers five areas of a health plan's performance: **Quality, Access and Patient Satisfaction, Membership and Utilization, Finance, and Health Plan Management and Activities.**

While HEDIS 2.5 was initially designed for commercial purchasers, we are committed to a performance measurement tool which addresses the needs of all populations served by a health plan, regardless of the payor relationship. With funding from the Packard Foundation and in conjunction with HCFA and the State Medicaid Directors Association, NCQA just released a draft set of Medicaid HEDIS measures for review and comment. In addition, we are in the final stages of discussions with HCFA and the Kaiser Family Foundation for the development of Medicare HEDIS measures to be incorporated into HEDIS 3.0.

The framework for the development of HEDIS 3.0 will come from NCQA's Committee on Performance Measurement. The Committee on Performance Measurement is a broad based group of experts charged with overseeing the development of the next generation of health plan performance measures (HEDIS 3.0). In addition to corporate purchasers, health plans, providers, labor, AARP, CalPers, and a state Medicaid Director, we are pleased to have the director of HCFA's Health Standards and Quality Bureau as a member of the Committee.

The two methods NCQA uses to evaluate health plans, accreditation and performance measurement, are both based on the premise that a health plan is responsible and accountable for the quality of care and service that its members receive. Many of the options now under consideration by Congress and the Administration would encourage a wider variety of managed care organizations, such as PPOs, to enter the Medicare market.

We are concerned that HMOs which have made accreditation and performance information publicly available, could be held to a higher set of standards than less "accountable" health plan model types. All health plans, regardless of their financing and delivery structure, should be held accountable for the quality of care and service, and required to provide data on their performance. A central goal of Medicare reform should be to reward health plans for making themselves more accountable to the federal government and beneficiaries. Easing the standards for less accountable health plans would have the opposite effect.

As I mentioned earlier, NCQA will have accredited over half the nation's HMOs by the end of this year; a figure which includes health plans responsible for 66 percent of the seniors enrolled in TEFRA Medicare Risk Contracts. While NCQA Accreditation should not be a condition of participation in the Medicare program, health plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

Such a consolidation would minimize the administrative burden on health plans, while at the same time providing HCFA with a body of expert knowledge and experience. Federal oversight resources could then be re-allocated to higher priority areas such as new health plan model types, new entrants into the Medicare market, or existing plans experiencing large gains in Medicare enrollment. A model for this public/private partnership already exists in six states (PA, FL, OK, KS, RI, VT) where NCQA works closely with health plan regulators. Just as these states have coordinated their regulation of health plans with NCQA accreditation to eliminate duplication and increase efficiency, so too should the federal government.

NCQA recognizes that reducing the rate of growth in the Medicare program is a critical component of deficit reduction efforts, and we believe there is real potential to reduce costs and improve quality through the use of managed care. However, I urge both Subcommittees to build on the work of this hearing and ensure that efforts to reduce costs do not compromise quality in the process.

Thank you again for the opportunity to testify.

Chairman BILIRAKIS. Thank you very much, Ms. O'Kane.
Mr. O'Leary.

STATEMENT OF DENNIS O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, OAKBROOK, ILLINOIS

Dr. O'LEARY. Thank you, Mr. Chairman.

I am Dennis O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate the opportunity to appear before this joint Subcommittee hearing on standards for health plans providing services through the Medicare Program.

I would like to leave you with two messages today. The first is that progressive advances in quality evaluation techniques have to date provided accreditors with sophisticated and meaningful mechanisms for overseeing the quality related performance of health plans, mechanisms that are fully capable of addressing the priority concerns of the Medicare population.

Second, there is a need to standardize the quality evaluation framework for Medicare managed care plans to assure consistent and relevant oversight of these plans. Health plans and other emerging delivery systems are poised to plan an increasingly important role in the future of American health care. The Nation, therefore, has a vested interest in ensuring that health plans provide the high quality of services that Americans have come to expect.

This is especially true for the Medicare Program, if there is an intent to encourage and sustain greater enrollment in managed care arrangements. Quality measurement and public disclosure of how well the health plans accomplish quality goals provide the opportunity for educated decisionmaking by consumers, and offer a means to track their own performance against the established goals.

However, the trend toward vertical integration of services creates new challenges for quality evaluation. Health plans have new responsibilities for integrating services across multiple sites of care and for assuring that the needs of their enrollees are met. How well a plan performs these and other key functions has a large bearing on enrollee outcomes, the cost of providing services, and the eventual health status of the population served.

We also need to remember that health plans share a common incentive in seeking to determine the appropriate intersection between cost containment and quality. This incentive creates risk; that is, what makes a plan successful in controlling its costs also causes exposure to quality concerns. There is a growing belief among major private sector purchasers that the progress already made in paring down system costs has led us to a mandate for vigilant quality oversight initiatives.

Groundbreaking efforts in recent years, both in creating performance-based standards and in developing performance indicators, now provide the tools for effective quality measurement and permit the evaluation of quality across a spectrum of health plan configurations. This capability will be essential, as innovative ap-

proaches to delivering and financing cost-effective health care emerge.

The thorough evaluation approach for health plans and more complex delivery entities should address two broad areas, performance of key organization functions and patient/enrolling outcomes. The former requires the application of contemporary standards, and the latter involves the use of carefully selected performance indicators.

Evaluation of each of these areas provides essential and often complementary information. Together, the two measurement approaches form the fundamental basis for effective quality review in both the fee-for-service and managed care sectors.

To ascertain the likelihood that a health plan will achieve their future results, one must evaluate organization functions that are basic to both the clinical services provided to enrollees and to the management of the organization. In developing standards around key functions that all health plans must perform and by articulating them as performance objectives, we have established a basis for evaluating quality without prejudice to how the provider is structured or even how the provider undertakes to meet the expectations.

The government has the potentially important role in standardizing the quality measurement framework for health plans participating in the Medicare Program. To this end, the Secretary of Health and Human Services, acting through existing agencies and in conjunction with States, consumers, and private sector experts, could, and we believe should articulate quality expectations for health plans.

These expectations should include both minimal standards and a menu of consensus outcomes measures applicable to the full range of health plans. The government should not feel the need to establish any new oversight bureaucracy. Rather, its determination as to minimum standards and consensus outcomes measures should permit a judgment as to the desirability of reliance on private sector entities to perform evaluations of health plans, using at a minimum the explicit expectations of the Medicare Program. The remaining responsibility of government would then be to oversee its delegated evaluation agents to ensure its satisfaction with their performance in providing quality oversight of health plans.

The private sector is well prepared, we believe, to evaluate the array of emerging variations of managed care plans. Our cutting-edge standards permit us to evaluate the centralized "brain" of the plan, the functions pertinent to its successful operations, and the performance of providers in all of the component delivery sites in a plan or system, such as hospitals, nursing homes, and home health agencies.

Chairman BILIRAKIS. Please summarize.

Dr. O'LEARY. Throughout the Nation, restructuring of health care delivery is taking place. New options are being considered for the Medicare Program. Meaningful quality evaluation is essential to the success of and public confidence in the new delivery models.

The Joint Commission has previously worked in successful collaboration ventures with the public sector and is prepared to do so in this area. We believe there is a rich opportunity to design an effective quality evaluation and improvement system that will build public confidence in Medicare managed care plans, while continually upgrading the level of care provided to our Nation's elderly and disabled citizens.

Thank you.

[The prepared statement follows:]

STATEMENT OF DENNIS O'LEARY, M.D.
PRESIDENT, JOINT COMMISSION ON ACCREDIATION OF HEALTHCARE ORGANIZATIONS

I am Dr. Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate the opportunity to appear before this joint committee hearing on standards for health plans providing services through the Medicare program.

I would like to leave you with two messages today. The first is that progressive advances in quality evaluation techniques have today provided accreditors with sophisticated and meaningful evaluation approaches for overseeing the quality-related performance of health plans -- approaches that are fully capable of addressing the priority concerns of the Medicare population. Second, there is a compelling need to standardize the quality evaluation framework for Medicare managed care plans to assure consistent and relevant oversight of these plans.

Health plans and other emerging delivery systems are poised to play an important role in the future of American health care. The nation, therefore, has a vested interest in ensuring that health plans and their hands-on care sites provide the high quality of services that Americans have come to expect. This is especially true for the Medicare program if, as a matter of public policy, we wish to encourage and sustain greater enrollment in managed care arrangements.

The potential impact of health plans is significant. The capitated payment systems that characterize most integrated delivery models provide strong incentives to keep patients healthy by focusing on wellness, prevention and early intervention. Health plans are also in a unique position to coordinate care along the entire continuum of service delivery. Quality measurement and public disclosure of how well the health plans accomplish these and other quality goals will provide the opportunity for educated decision making by consumers in selecting among their options, and will offer a means for plans to track their own performance against established goals.

However, the trend toward vertical integration, coupled with growing purchaser and consumer demands for information about value, creates new challenges for quality measurement. Health plans are complex entities that are more than the sum of their parts; they have new responsibilities for integrating and coordinating services across multiple and differing sites of care, and for assuring that the needs of their enrollees are met along the full continuum of care. How well a plan performs these and other key functions has a large bearing on enrollee outcomes, the cost of providing effective and appropriate services, and the eventual health status of the population served.

Health plans can take a variety of forms, and some of these are not fully tested. They share a common incentive, however, seeking to determine the appropriate intersection between cost containment and quality. This incentive creates risk; that is, what makes a plan successful in controlling its costs, also causes exposure to quality concerns. There is in fact a growing belief among major private sector purchasers that the progress already made in paring down system costs has led us to a mandate for vigilant and substantive quality oversight initiatives.

Performance measurement is usually undertaken for two primary reasons: as a basis for making decisions and to serve as a basis for quality improvement. In the ideal world, consumers, purchasers, and other stakeholders would make a range of decisions about health care plans based on measurement information about various aspects of organization performance. In addition, these measurements of quality would provide plans with useful, comparable information upon which to base internal quality improvement activities. Ground breaking efforts in recent years -- both in creating performance-based standards and in developing performance indicators -- now provide the tools for reaching those goals of quality measurement, and permit the evaluation of quality across a spectrum of health plan configurations. This capability will be essential as innovative approaches to delivering and financing cost-effective health care emerge.

A thorough evaluation approach for health plans and more complex delivery entities should address two broad areas: *performance of key organizational*

functions and *patient/enrollee outcomes*. The former requires the application of contemporary standards, and the second involves the use of carefully selected performance indicators. Evaluation of each of these areas provides essential, and often complementary information. Together, the two measurement approaches form the fundamental basis for effective quality review and assessment in both the fee-for-service and managed care sectors.

Performance of Key Organizational Functions

To ascertain the likelihood that a health plan will achieve good future results, one must evaluate organizational functions that are basic to both the clinical services provided to enrollees and to the management of the organization. The performance of these systems and processes, such as credentialing of practitioners, management of information, and patient assessment, is usually measured by assessing compliance with relevant standards. For health care organizations, a standard is a statement of expectation that defines the processes that must be functioning well in order to optimize the likelihood of good outcomes. In developing standards around key functions that all health plans must perform, and by articulating them performance objectives, we have established a basis for evaluating quality without prejudice as to how the provider is structured or even how the provider undertakes to meet the expectations. This is designed both to encourage the organization to have an accountable locus of responsibility for its performance in providing services, and to stimulate innovation in the creation of cost-effective delivery models.

Patient/Enrollee Outcomes

Information on patient/enrollee outcomes is necessary to complement the information gathered from an assessment against performance standards. Outcomes are the product of the performance of clinical services and management functions, and are understood to include certain measures of process (e.g., staging of cancer for appropriate treatment selection) that are proxies for likely outcomes (e.g., survival). An advantage to outcomes data is that it can be monitored routinely between the onsite visits made to assess compliance with standards. Such data thus is available to support internal quality improvement activities in the health plans, and to provide external assurances that plan performance is being sustained or improved.

The Measurement Framework

A potential role of the government is to help standardize the quality measurement framework for health plans participating in the Medicare program. Toward this end, the Secretary of Health and Human Services, acting through existing agencies and in conjunction with states, consumers, and private sector experts could, and we believe should, articulate quality expectations for health plans and their component providers. These expectations should include both minimal standards and a menu of consensus outcomes measures applicable to the full range of health plans. This need not be a costly effort. To accomplish this task, the government could borrow from the substantial work already done in the private sector. For example, accrediting organizations have already created a comprehensive array of quality standards for health plans.

Neither should the government feel a need to establish any new oversight bureaucracy. Rather, its determination as to minimum standards and consensus outcomes measures (performance indicators) should permit a judgment as to the desirability of reliance on private sector entities to perform evaluations of health plans, using, at a minimum, the explicit expectations of the Medicare program. The remaining responsibility of government would then be to oversee its delegated

agents to ensure its satisfaction with their performance in providing quality evaluation and oversight of health plans.

The private sector is well prepared, we believe, to evaluate the array of emerging variations of managed care plans. The Joint Commission has developed a top-to-bottom adaptable capability for measuring quality in new delivery system models, regardless of their financing arrangements. Our cutting-edge standards permit us to evaluate the centralized "brain" of the plan, the functions pertinent to its successful operation, and the performance of providers in all of the component delivery sites in a plan or system, such as hospitals, nursing homes, and home health agencies. With the current changes taking place in the health care system, we believe that a solid oversight program must include direct evaluation of actual delivery sites as part of plan evaluation. Our accreditation process involves this type of review.

The Joint Commission has been the leader in developing performance-based standards, and we recently completed the redesign of our standards manuals for the more than 11,000 health care organizations we accredit. The standards are patient focused and are stated as performance objectives rather than as inflexible requirements. The Health Care Financing Administration has also begun to recast its standards for certain health care facilities, such as hospitals, along similar lines. Further, the Joint Commission has taken a leadership role in the area of public disclosure of standards compliance information through the development of performance reports on accredited organizations. These activities and others provide ample evidence that accrediting bodies continue to be at the leading edge of advances in quality evaluation.

The Near Future in Quality Measurement

Both regulators and accreditors are now aggressively moving toward the development, testing and broad application of outcomes measures and other performance indicators as integrals of the modern quality oversight approach. The Joint Commission has been a pioneer in the development of performance indicators, especially for inpatient care. However, the population-based nature of managed care plans requires a more elaborate range of indicators capable of addressing a continuum of services. On the positive side, prolific efforts in recent years have yielded an inventory of hundreds of indicators that are now available for potential use in managed care settings. On the cautionary side, considerable work remains to be done to evaluate these performance indicators against the dimensions of reliability, validity, discrimination capability, and the benefit-to-burden balance. With the right partners at the table, we believe that the Medicare program could rapidly assimilate the work currently being done by accrediting organizations, to the benefit of the Medicare population.

Specifically, there is a need for outcome measures that will lead to improved patient care for the Medicare population, while at the same time optimizing the resources available to support data gathering and quality improvement activities. We see an important potential role for the federal government in establishing a simple forum for arriving at an acceptable menu of performance indicators applicable to the Medicare population. This type of public/private sector collaboration could be achieved quickly, potentially placing Medicare at the forefront of quality measurement in all of its health care programs.

Along similar lines, the Joint Commission undertook a pilot project in 1993 with a number of stakeholders interested in developing consensus performance indicators for use in evaluating health plans and other emerging entities. The work group agreed upon eleven principles (see addendum) that should shape the measurement framework for the Joint Commission's new accreditation activities in this area. These principles then provided the structural underpinning for identifying those measurement categories for indicators to complement the already-established performance-based standards. These categories included:

+ clinical performance, including prevention, early detection,

appropriateness of care, and effectiveness of treatment.

+ functional status
+ satisfaction of enrollees, practitioners, and purchasers

Indicators within these categories could be general or can relate to specific disease states. The work group also identified a set of priority medical conditions that should be targeted for measurement.

Confidence in performance indicators will only be achieved when there are adequate numbers of relevant and well-tested indicators that can offer a full profile of health plan performance. With respect to health plans, this will require the gathering and, as appropriate, adaptation of existing measures and the design of new ones to fill in any gaps in the measurement framework. The Joint Commission has begun this task by gathering information from existing databases of outcomes measures, and by establishing a process to determine the specific criteria against which indicators will be judged.

The Joint Commission's long-term objectives are to use outcomes and other performance data to focus the on-site evaluation of the health plan standards compliance, and eventually to create a continuous accreditation process. Standards compliance is generally a good predictor of future good outcomes. Where outcomes are less than satisfactory, this information can rapidly point to areas where processes are not functioning properly (i.e., failed standards compliance) and set the stage for performance improvement. Such improvement initiatives need not occur periodically (that is, awaiting the next survey) but can, and should occur on a real live basis as outcomes data are monitored continuously. The Joint Commission is beginning to field test a continuous accreditation model in central Pennsylvania where over 40 organizations have already agreed to participate.

Throughout the nation, restructuring of health care delivery is taking place. Spurred by market forces, as well as by state reform initiatives, provider organizations, practitioners and insurers are coming together in a variety of innovative organizational structures to form new and increasingly complex delivery systems. New options are also being considered for the Medicare program. Meaningful quality evaluation is essential to the success of, and public confidence in, the new delivery models. The private sector's accrediting bodies have developed and are using, relevant quality evaluation tools in the form of performance-based standards and outcomes measures. We have previously worked in successful collaborative ventures with the public sector and are prepared to do so in this area as well. Working as a public/private partnership, we believe there is a rich opportunity to design an effective quality evaluation and improvement system that will build public confidence in Medicare managed care plans while continually upgrading the level of care provided to our nation's elderly and disabled citizens.

ADDENDUM

Principles for Performance Measurement of Health Care Networks

1. Measurement of health status and health care quality are essential to the improvement of health care.
2. The design of any meaningful measurement system must involve all key stakeholders, including purchasers, providers, evaluators, consumers, and government.
3. A basic requisite to the creation of a measurement system is the establishment of a national framework within which measurement priorities can be determined and measures developed.
4. The measurement framework must be applicable to networks and components of networks; useful to purchasers and consumers in evaluating the quality of networks and their components; useful to government in formulating and assessing public health policy; and useful to providers in improving care.
5. The measurement framework must promote efficient and concise measurement that minimizes the associated administrative burden.
6. The measurement framework must promote the accountability of both the network and the stakeholders of the network.
7. The measurement process should include definition of the individual or unit accountable for each specific measure.
8. The measurement system should be able to describe the health benefits achieved both by individuals and the population served by the network.
9. Data system used for quality measurement and comparison must be built on relevant measures that meet established criteria for reliability, validity, and ease of data collection.
10. Data collection must focus on those data necessary for the measures, rather than those data most readily available.
11. The measurement system must constantly anticipate its own improvement.

Source: Joint Commission on Accreditation of HealthCare Organizations 1993 workgroup on identifying indicators for use in the network accreditation program.

SELECTED CRITERIA FOR EVALUATING INDICATORS

Relevance	-	Applicability and pertinence of the indicator
Reliability	-	Ability of the indicator to accurately and consistently identify the events it was designed to identify across multiple settings
Validity	-	Extent to which the indicator raises legitimate questions about the quality of care provided and the extent to which opportunities for improvement are identified.
Discrimination Capability	-	Extent to which indicator shows significant variation in performance across multiple networks
Benefit/Burden Balance	-	Importance of the measure balanced against the accessability of needed data elements, the relative effort required to abstract or collect the data, and the associated costs.

Chairman BILIRAKIS. Thank you very much, sir.

Ms. O'Kane, what level of acceptance would you say that the NCQA has in the industry?

Ms. O'KANE. Well, I think we have been controversial in the industry to some degree in terms of we are willing to draw lines. As you might imagine, some plans have not come out as well as others in this process. So while there is a lot of support in the industry, we are not universally loved.

I think a quality oversight organization that was universally loved probably would not be doing its job.

Chairman BILIRAKIS. I was in the aerospace industry for many years as an engineer, as well as a lawyer, and the quality assurance people were never really the most loved in the organization.

Dr. O'Leary, what does your group think about the NCQA?

Dr. O'LEARY. We have high regard for our colleagues in this arena. We have collaborated on a variety of arenas, not in actually performing evaluations, but I think we see eye-to-eye pretty much on the standards base and the measurement base. In fact, I believe you will see a lot of similarities between our standards for managed care networks and between our respective measures.

Chairman BILIRAKIS. Ms. O'Kane, I have sort of glanced over your written testimony here, and I understand that you are currently in the process of accrediting 80 health plans.

Ms. O'KANE. Eighty health plans that have Medicare risk contracts. There are about 200 health plans.

Chairman BILIRAKIS. Which enroll about two-thirds of the beneficiaries in risk contract HMOs.

Ms. O'KANE. Yes.

Chairman BILIRAKIS. By the way, I think Mr. Waxman used the figure like 2 percent of Medicare beneficiaries are in managed care. I believe that figure is about 9 percent.

Ms. O'KANE. I thought so, too.

Chairman BILIRAKIS. In any case, do your standards differ in any way from those set by HCFA for these HMOs?

Ms. O'KANE. Yes, they are considerably different. When we wrote out standards, which was in 1990, we basically went through a process of reviewing HCF"s oversight standards, some of the Joint Commission standards, and other organizations that do quality review. We particularly paid attention to what many Fortune 500 companies were doing in terms of evaluating the quality of the health plans that they offered, because many of them were really at the cutting edge, in our view.

So we like to think our standards advance the state of the art. They really are very quality improvement oriented, as well. I think there is some degree of overlap with the quality oversight process within the Federal qualification and Medicare certification process, but also considerable divergence.

Chairman BILIRAKIS. But where there is, shall we say, a clear distinction—I hate to use the term disagreement, but clear distinction between certain standards, who basically controls it? Does HCFA basically control, because they are the government?

Ms. O'KANE. Yes, they wrote their own. I believe that came out of their regulatory processes.

Chairman BILIRAKIS. I see. Is that good?

Ms. O'KANE. Obviously, we believe ours are better, of course we do. We just went through a big process of rewriting them and we think they are really quite good. This is a complicated business and there is always room for improvement.

Chairman BILIRAKIS. When I asked my first question regarding the industry and your acceptability—and that is not intending to just refer the providers, I also was thinking in terms of beneficiaries, the consumer, and that sort of thing—what is your status with those?

Ms. O'KANE. Well, we get increasing numbers of consumer calls because we have had more press coverage lately.

While we are on the topic of consumers, we have been doing a lot of focus groups with consumers asking them about what kind of quality information they would like to have when they choose a health plan. I think particularly for the Medicare population, there really needs to be a lot of attention to educating consumers about what to look for when they are choosing a health plan, especially if a lot of consumers are going to be moving into Medicare managed care. I think some thought ought to be given to some kind of information broker organization that could actually help people sort through the information that is increasingly going to be made available. Because I think the information is complicated and there could be a reaction that it is too confusing, and I do not want to deal with it. So I would urge you to consider that.

Chairman BILIRAKIS. Certainly. If it is complicated now, it may tend to be a little more complicated as we are talking about these additional choices, and certainly it is not our intent to do that. I just hope we do a good enough job of it.

The gentleman from Wisconsin.

Mr. KLECZKA. Thank you, Mr. Chairman.

The previous panel, in response to a question from one of the Members of the Subcommittee, indicated that in the Medicare Program there is about 10 percent fraud, waste, and abuse. Would either of you in your professional judgment be able to speak to that? I am trying to ascertain whether or not it is realistic to say that it is 10 percent or something close to that.

Ms. O'KANE. I do not really have any basis for shedding any additional light on it. I would agree with the statements that they made that that is the number on the street, but it is obviously really hard to know for sure whether all fraud has been uncovered, so it is a speculative number.

Mr. KLECZKA. Dr. O'Leary.

Dr. O'LEARY. Neither one of us has standards that specifically address or have the ability to ferret out financial fraud and abuse kinds of issues.

Mr. KLECZKA. Let us leave aside for the moment the Medicare Program. How about in the private insurance market, HMOs, and managed care type operations, would a 10-percent figure be comparable there also?

Ms. O'KANE. That seems to be the consensus number, the conventional wisdom again. There may be some variation between the private and public sector, I would imagine there might be.

Mr. KLECZKA. Like how much variation?

Ms. O'KANE. I cannot say.

Mr. KLECZKA. So you do not really know if there is any?

Ms. O'KANE. I really do not know much about this at all.

Mr. KLECZKA. Let us say it is somewhere in the vicinity of 10 percent. Where in your estimation would the bulk of the fraud be coming from? Is it from providers, is it from a particular group of providers? If I wanted to divvy up 10 percent, who would I attribute the problem to?

Ms. O'KANE. I guess I think that there is fraud and abuse in the system, I think that the major opportunities for improving the value we get in health care comes from getting rid of some of the costs of poor quality. I think that there are many costs in the system of poor quality, unnecessary bad things that happen to patients like wound infections in the hospital that could have been prevented. I think there are just enormous opportunities.

Mr. KLECZKA. But that would not be waste or fraud. That is just poor medical care.

Ms. O'KANE. That is what I am saying.

Mr. KLECZKA. Let us go back. I am trying to ascertain who is responsible for it. Is it the providers? Can we say that the doctors are at 5 percent, medical suppliers are 3 percent?

Ms. O'KANE. I do not know that there is any particular number that would be true nationwide. It probably varies in local situations. I do not have anything really to shed on the subject.

Dr. O'LEARY. I do not have any information, either. I think that those who are inclined to commit a crime are not readily categorized and are more on an individual basis. You may be an individual practitioner, you may be running a group, you may be running an organization, you might be an insurer. People are inclined to commit crimes. The system does not have tight controls on it to prevent those crimes and they will occur.

Mr. KLECZKA. In your estimation, is there any opportunity for the beneficiaries themselves to engage in fraud and abuse?

Dr. O'LEARY. I think there are opportunities.

Mr. KLECZKA. Like where?

Dr. O'LEARY. Well, it is not an area that I have studied particularly, but I think that mechanisms for payment and reimbursement are complex. I have been a user of the delivery system and my family has, and you can see that the system is not tightly run to prevent duplicative payments, for instance.

Mr. KLECZKA. But the payments would go to providers and the only way the beneficiary would share in the fraud and abuse would be if in fact they are in concert with the provider.

Dr. O'LEARY. No, that is not true. There are times when the beneficiary pays or alleges to have paid a provider and seeks reimbursement directly from an insurer or from an HMO. That really does happen. I can see opportunities for at last petty larceny in the system. I do not know whether we are talking about a lot of money, but these systems are complex and complex systems have a tendency to die under their own weight.

Mr. KLECZKA. I am aware that this panel did not make the statement and the other panel was gone by the time I got to my second round, so I thank you for shedding a little light on it.

Chairman BILIRAKIS. I thank the gentleman.

The gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Ms. O'Kane, can you give us your opinion of how effective a mechanism the 50–50 rule is as a means of assuring quality?

Mr. O'KANE. Well, I think it has played some mitigating role perhaps, although it is a crude way of ensuring quality. As we evolve the ways that we can look at quality, I think that the 50–50 rule will become less pressing, although there was a certain logic to the 50–50 rule when it was put in place.

Mr. MCCRERY. And what was that logic?

Ms. O'KANE. I believe that the logic was that an organization that could hold commercial enrollees would have to be providing a certain level of quality and would have to have a certain infrastructure, so that presumably some of that could impact, would spill over onto the Medicare population.

Mr. MCCRERY. In other words, the rationale was that when you say commercial enrollees, you are really talking about private sector enrollees——

Mr. O'KANE. Right.

Mr. MCCRERY [continuing]. People that are not in government programs, but are in private sector programs.

Ms. O'KANE. Right.

Mr. MCCRERY. The rationale was that those private sector enrollees would demand quality and therefore assure a certain level of quality that would then trickle down, shall we say, to the government enrollees?

Ms. O'KANE. I suppose, yes.

Mr. MCCRERY. As we hear more from the private sector about ways to measure quality, and we are talking today a little bit about how the government can catch up to the private sector, it really concerns me that we are studying another government mechanism or structure to put in place. We have found through the years that as the government puts in place a structure or a mechanism, it is sometimes quickly outdated. Can you give us any insight as to how we create a mechanism or how we keep from locking in a mechanism that might work well today, but soon becomes outdated?

Dr. O'LEARY. I think that what you need is an adaptable mechanism that does not create a hierarchy nor add people. Our experience in working with HCFA, for instance, in hospital oversight, is that HCFA has required relatively little staff in order to run a pretty effective oversight program in the private sector.

I see the role of government in this arena as being the standardization of the measurement tools that are going to be applied; to work with the private sector in determining what those should be, and then putting them in place and using that as the reference point; then determining who in the private sector is capable of carrying out evaluation against those standards, and even spot checking our performance. That is not an elaborate system, but it has the checks, balances, and oversight that permits the government to meet its oversight responsibilities.

Ms. O'KANE. May I answer that?

Mr. MCCRERY. Sure.

Ms. O'KANE. I think we agree with the implication in your question that there is a real opportunity here for the public and the private sectors to work together and for the public sector to benefit

from the ability of organizations like ours to move quickly to advance the state of the art and to respond to changing conditions in a way that we seem to be able to do more effectively maybe, because we do not have to go through the political process.

Mr. MCCRERY. Thank you. I certainly would not mean to imply anything with my questions, but I appreciate your responses.

Chairman BILIRAKIS. I thank the gentleman.

Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. O'Leary, in your testimony, you argue that there is no need to create new standards because organizations such as yours have already developed them and that there is no need to add any new oversight bureaucracy. If this is the case, how quickly do you believe we could implement a standard system for measuring quality?

Dr. O'LEARY. I think that putting in place a standards based system could occur within months to, at the outside, 1 year. Now, the development of applicable standards, just like the development of applicable performance measures, is an evolving process, so whatever you put in place, you need to have an ability to update over time. But I feel sufficiently confident in the standards that we have for managed care networks and in the ones that NCQA has, to say that those are state-of-the-art standards. Those could be melded together very readily with very little cost to put in place the kind of oversight mechanism that I think people are interested in.

Mr. ENSIGN. Do you think—and this gets back to a little bit earlier questioning—that the Medicare population is a fairly, let us not say cynical, but skeptical group on whether what somebody is telling them is the truth and they can count on the information? Do you think that these are standards of quality that this population would be willing to accept?

Dr. O'LEARY. Yes, I think as long as they understand what they are. My experience in dealing with the Medicare population is that their knowledge base as to available mechanisms and their ability to interpret performance information is limited. I put that burden on us. That is our job, to make sure that they learn about that.

But the kinds of standards that we are looking at are of the most basic, and we are talking about patient rights and responsibilities, organization ethics, patient assessment, patient care, management of information, and performance improvement. This is not esoteric stuff. These are basic fundamental expectations of the performance of any health care organization.

Mr. ENSIGN. Ms. O'Kane, I would like to explore this. You mentioned the cost of poor quality and that whole concept. I would just like to take a couple of minutes and address that with you. In business outside of the health care industry, whether it is manufacturing or the service industry, people understand the cost of quality and actually how much money they can save in the long term with proper management techniques, and with proper systems put in place that people can operate under. That is usually within one organization that you are doing that with, and it is usually top-down driven.

Addressing perhaps those kinds of concepts within the whole Medicare field, we are dealing with all these different companies, all these different doctors, their own bosses, their own type of situation where it is not a top-down driven system.

Ms. O'KANE. I think that while it may not be necessarily top-down and sort of uniform the way a manufacturing firm is, there is a system quality in a good managed care organization that has to be there in order for it to effectively do its job. I think about examples like asthmatics that wind up in the emergency room or admitted to the hospital because their asthma has not been managed effectively. That drives up the costs of the system, and it makes the patients unhappy and very anxious. There is really little good to be derived from a system that is not working in that area.

To use the Medicare example, people with chronic obstructive lung disease also carefully managed on the outpatient side, you can avoid those kinds of crises and that kind of exacerbation which drives up the costs of the system tremendously. There are just multiple examples of chronic illnesses in the Medicare population that, if effectively managed in the outpatient setting, will prevent hospitalizations that are costs for quality.

Mr. ENSIGN. Do you see this then mainly being applicable to a managed care situation and not to the general population, as well?

Ms. O'KANE. Only a managed care population has the system quality so that it is able to find out who are the relevant populations, how do they intervene, which parts of the system are not working, where do they need to put in a case manager, where do they need to put in a patient education program. So you cannot do that in a cottage industry, which is what I believe fee-for-service Medicare is at this point.

Mr. ENSIGN. Thank you.

Thank you, Mr. Chairman.

Chairman BILIRAKIS. I thank the gentleman.

The gentleman from North Carolina, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Welcome, Ms. O'Kane and Dr. O'Leary. I am fortunate that in Winston-Salem, North Carolina, we just had an insurance company who introduced an HMO plan for seniors, so I have first-hand knowledge of the fact that we can introduce options into the marketplace. I am just curious, has that plan been rated, or is that too new?

Ms. O'KANE. I do not know, but I can get you that information.

Mr. BURR. I would appreciate that.

Ms. O'KANE. I know that we have done some partners plans, but I do not remember if the North Carolina plan has been evaluated or not.

Mr. BURR. I would appreciate it if you could supply that.

[The following was subsequently received:]

CIGNA HealthCare of North Carolina is scheduled to be surveyed on October 7, 1996. Kaiser Foundation Health Plan of North Carolina received provisional acceditation. PARTNERS National Health Plan of North Carolina received provisional accreditation. Personal Care Plan has been surveyed and is awaiting a decision. Prudential Health Care System of Charlotte received full accreditation.

Mr. BURR. Let me go back to a question I asked of the GAO, and it specifically dealt with HCFA trying to replicate the successes of the private sector. I guess what I want to ask you is, as one who is an expert on the quality of plans in the private sector, would you agree with the GAO that HCFA has quite a ways to go to replicate the successes?

Ms. O'KANE. We are very proud of the work that we have done. We think we have advanced the state of the art.

Mr. BURR. I will try one more time, and I certainly understand that you are on a fine line. Seldom do we have somebody whose expertise is in front of us that deals with the quality of care, and I think that the challenge for this Subcommittee is to meet or exceed the current quality of care that is created in the system.

To do that, we must first establish what that quality of care is, and a very important aspect of that is to determine whether HCFA and the fee-for-service plan as currently designed and really underwritten by the Federal Government can be improved, and if in fact the private sector has made advances ahead of the Health Care Financing Administration.

Dr. O'LEARY. I think we always will be ahead, because we have ready access to the kinds of expertise and input that are necessary to build state-of-the-art standards, and we can tap into a wide range of professional expertise, to consumer groups, to purchasers, and we do not have a regulatory bureaucracy to go through in order to put those in place. So we will always I think be on the cutting edge.

My experience and I think my colleague's experience is there has been a lot of interest on the part of HCFA in tapping into what we have been able to develop. The process through which new regulations or conditions of participation are put in place is cumbersome. It takes time and there are a variety of obstacles, and sometimes HCFA seems to fall short I think of both the timeliness and the degree of toughness of its standards.

There is also some philosophy that has been afoot in government that government standards should be minimum standards, and I understand the need for that where you are an enforcing and certifying agency. We are not bound by that and we can engage more in reach-for-the-sky standards, and indeed both of us have standards that are strongly intertwined with quality improvement principles that say that the oversight mechanisms should not create a ceiling. It should be a base upon which organizations build, and private organizations will always have that advantage over the government.

Mr. BURR. So, in fact, the private sector displays much more creativity in its approach to specific problems than in this particular case?

Dr. O'LEARY. We are unshackled in that regard.

Ms. O'KANE. Let me just add, though, that we have been talking to HCFA about working with them jointly on some HEDIS measures that would really address particular concerns of the Medicare population, so I want to make that for the record.

Mr. BURR. I think we would all admit that HCFA has reached out to try to take advantage of some of the lessons that are out there. I think the disagreement we might have with some of the administration is how quickly they understand and if they ever do implement them, and I think that is certainly something we have to find out.

Mr. O'Leary, just one thing, in your testimony you wanted to leave us with two messages. The second one is there is a compelling need to standardize the quality evaluation framework for Medicare managed care plans to assure consistent relevant oversight of these plans. I would just ask you, is there a difference in evaluating the quality of a Medicare managed care plan and an HMO outside of the senior population?

Dr. O'LEARY. For all intents and purposes, no.

Mr. BURR. Let me ask either one of you or both of you: Based upon the work that you do, if you were to rate the current health care plan that we have for seniors in this country, how would it rank from a standpoint of quality assurance?

Ms. O'KANE. Do you mean where we are right now in terms of the way the Medicare Program is working?

Mr. BURR. Yes.

Ms. O'KANE. I could not give it a very high mark.

Dr. O'LEARY. I think if you at least focus on the areas in which we have relationships with the Federal Government, HCFA, I think you are seeing some fairly major changes in——

Mr. BURR. I am asking you to make a decision, if you were to rate it, base it off of where we are today—the point here is can we make progress, can we improve the quality of care for seniors over what they have today?

Dr. O'LEARY. I think the answer has to be yes. My only caveat was I know that there are plans in process to move forward, irrespective of where we are today, that the answer to your question is yes.

Chairman BILIRAKIS. The gentleman's time is expired.

Mr. BURR. I thank both of you. I yield back the remainder of my time.

Chairman BILIRAKIS. They are both shaking their heads yes.

Mr. Thomas, the Chairman of the Ways and Means Subcommittee.

Chairman THOMAS. I thank the gentleman.

I want to continue in that direction in just a slightly different way. It is interesting that most of the examples are of critics who do not want us to really focus on making what I think are positive and healthy changes by turning HCFA inside out, as I say, or relying on the private sector and those who are out there.

What bothers me a lot is that the implication is that, well, folks on Medicare are getting the best quality assurance program, we have got the best administration, and the folks out there in the private sector really—I mean there are a bunch of sleazies out there and the structures that are out there overseeing what is going on, I mean you would not want them, if you really knew what was going on.

I get this constantly from our critics, and it just amazes me that they have to rely on examples of 20 or so years ago to talk about

the state of the industry. Ms. O'Kane, where was your organization 20 years ago?

Ms. O'KANE. Well, this organization existed, but it was not active 20 years ago. It existed on paper, really.

Chairman THOMAS. So clearly with the growth of coordinated care programs in the private sector through the eighties and especially——

Ms. O'KANE. Actually, 20 years ago it did not exist. Excuse me, I did bad math there.

Chairman THOMAS. Around 1975.

Ms. O'KANE. Right. No, it did not exist in the seventies.

Chairman THOMAS. I know how you feel. To me, 10 years ago was 1975, and then someone says no, that was 20 years ago. You did not exist. In fact, you have grown and developed as the approach to the delivery of medicine that you now oversee on quality assurance has grown.

Ms. O'KANE. Right.

Chairman THOMAS. Dr. O'Leary, your organization 20 years ago?

Dr. O'LEARY. We did exist, but we had an accreditation process that you will find very few threads of remaining today. Basically, it has totally revamped itself to focus on performance and on outcomes measures, and we in fact——

Chairman THOMAS. In fact, did you not go through a name change during this period?

Dr. O'LEARY. We went through a radical change during this period of time.

Chairman THOMAS. And name in terms of focus. Were you not originally just looking at hospitals?

Dr. O'LEARY. Looking at hospitals, and today we accredit across seven fields and over 15,000 organizations. Hospitals are a significant segment, but not the majority of what we do.

Chairman THOMAS. So when folks use the examples of horror stories and they have to go back 20 years, I mean the value of that in reflecting on today's marketplace, today's private sector certification and the rest really is not of much value. Do you not think that is true?

Dr. O'LEARY. Yes.

Chairman THOMAS. Then let us take a look at today's performance standards. I understand, Ms. O'Kane, that you mentioned that you accredit 80 health plans which enroll about two-thirds of the Medicare beneficiaries in the TEFRA risk contracts?

Ms. O'KANE. Let me clarify that again, because you were not here. We have accredited about 200 health plans, 80 of which have TEFRA risk contracts.

Chairman THOMAS. Of course, HCFA has to approve those. And where were you in matching up with approval of what HCFA had approved?

Ms. O'KANE. We have not done that analysis, but I just told one of my staff we ought to do that analysis, because I know that there have been discrepancies.

Chairman THOMAS. And discrepancies meaning what, that maybe some HMOs met the Federal standards and actually flunked your standards, that in fact the private sector standards

may be more rigorous and closer to what we are currently looking for on quality standards than what HCFA is doing?

Ms. O'KANE. Yes. I do not know how many cases that happened in, but I know of at least two cases where that happened.

Chairman THOMAS. I hope you move into that study fairly quickly——

Ms. O'KANE. We will have it done by next week.

Chairman THOMAS [continuing]. Because my understanding from the previous panel is we are going to get a GAO study, and it always worries me a little bit when government gives us an opinion. I would love to have a second opinion from the private sector on whether or not their accreditation process seems to give HCFA high marks in terms of the Federal standards, and I look forward to your cursory examination. But my understanding is that—I apologize for speaking over you—is that you know of two instances in which somebody got flying colors from HCFA and in fact failed your standards.

Ms. O'KANE. That they were federally qualified. I do not know if they got flying colors.

Chairman THOMAS. The way we operate, if they meet the standards, that is it?

Ms. O'KANE. Yes, I think so. I do not think there are gradations, but I am not that familiar with the Federal qualification process.

I do want to make the point that we set our standards high. We did try to make them stretch standards, so there is a different philosophy about setting not a floor, but this is considered a good health plan if it is accredited by NCQA.

Chairman THOMAS. The bottom line is that if we turn to the private sector, we are probably going to find a better quality product because the standards are higher in the private sector.

Thank you very much.

Chairman BILIRAKIS. I thank the gentleman.

Dr. Ganske, would you like to inquire?

Mr. GANSKE. Thank you, Mr. Chairman.

Ms. O'Kane, can you delineate a few of the patient protections that you think would be important, as we look at Medicare managed care plans?

Ms. O'KANE. I think it is important that the complaint and grievance system work very effectively. I think it is important that there be an effective process for credentialling the physicians in the health plan. I think it is important that the utilization management practices of the health plan are based on current medical knowledge, that there are appeals mechanisms for physicians, that patients also have the right to appeal in the case where there is a denial.

Mr. GANSKE. Do you have any specific ideas in terms of how you would set up an appeals mechanism that would help meet insurer due process for both patients and providers?

Ms. O'KANE. We have a grievance system, a set of grievance system standards in our member rights and responsibilities statement which I will be happy to submit for the record. Basically, we want to see that there has been effective resolution of the problem in a timely manner, that the plan studies what is causing a lot of the complaints and grievances and goes back and corrects root causes,

and so forth. So we are looking for an effective process that solves individual problems, but also that goes back and is addressed at the system level.

I was really talking about the utilization management. If a plan were to say a certain medical service was inappropriate and the physician disagreed that it was inappropriate, our plans have to have an appeals mechanism for the physician where that decision can be reviewed.

[The following was subsequently received:]

MEMBERS' RIGHTS AND RESPONSIBILITIES

Note: A managed care organization may delegate complaint and grievance handling, and monitoring and evaluation of member satisfaction to another entity. NCQA may perform an on-site review of the delegated entity and will consider the delegated activities in evaluating the MCO's performance on Members' Rights and Responsibilities Standards 4.0 and 8.0. In addition, NCQA will perform a review of the MCO's oversight of delegation on Members' Rights and Responsibilities Standard 9.0. The MCO is accountable for ensuring that the delegated activities are in compliance with NCQA Standards.

RR 1.0 The organization demonstrates a commitment to treating members in a manner that respects their rights.

RR 1.1 At a minimum, the organization has a written policy that recognizes the following rights of members to:

RR 1.1.1 voice grievances about the managed care organization or care provided;

RR 1.1.2 be provided with information about the managed care organization, its services, the practitioners providing care, and members' rights and responsibilities;

RR 1.1.3 participate in decision making regarding their health care; and

1996 Clarification: RR 1.1.3 prohibits restrictions on the clinical dialogue between practitioner and patient.

RR 1.1.4 be treated with respect and recognition of their dignity and need for privacy.

The MCO should have a written, officially adopted members' rights policy that covers the points above.

DOCUMENT REVIEW

Document	*What To Look For*
Member Rights Policy for MCO and Delegated Entities	Review the policy statements and determine if the policy covers all of the points listed above.

Interview the...	*Discussion Points...*
Chief Medical Officer	How does the MCO ensure that its agreements with practitioners, and delegates' agreements with practitioners, do not limit clinical dialogue between practitioners and patients?

NARRATIVE Complete the table in the *Data Collection Tools* for RR 1.0, and comment on any items not covered or limitations on rights statements.

RR 2.0 The managed care organization has a written policy that addresses the members' responsibility for cooperating with those providing health care services.

RR 2.1 The written policy addresses the members' responsibility for:

RR 2.1.1 providing, to the extent possible, information professional staff need in order to care for the member; and

RR 2.1.2 following instructions and guidelines given by those providing health care services.

The MCO should have a written, officially adopted members' responsibility policy that covers the points above.

DOCUMENT REVIEW

Document	*What To Look For*
Member Responsibilities Policy	Review the policy statements and determine if the policy covers all of the points listed above.

NARRATIVE Complete the table in the *Data Collection Tools* on RR 2.0 and comment on any deficiencies in the statement of responsibilities.

RR 3.0 The managed care organization provides a copy of the organization's policies on members' rights and responsibilities to all participating providers and directly to members.

The MCO should provide its policies on members' rights and responsibilities to all participating providers and all members. The provider distribution can be done as part of an initial mailing when the provider contracts with the MCO, or it can be incorporated into a provider handbook, as long as all providers receive it. The MCO should also give a copy of the statement of members' rights and responsibilities to all members. This can be done by incorporating the statement into a member services handbook that is sent to each subscriber or by sending a separate statement to all subscribers at the time of enrollment. Additionally, the MCO should have a mechanism for notifying members of updates to the policy as they occur.

DOCUMENT REVIEW

Document	*What To Look For*
Statement Sent to Providers	Does the document state members' rights and responsibilities as shown in the adopted policies? Is the document clearly written, unambiguous, and understandable?
Provider Manual	Same as for the Statement Sent to Providers, above.
Statement Sent to Members	Same as for Statement Sent to Providers, above.
Member Services Handbook	Same as Statement Sent to Providers, above.

INTERVIEWS

Interview the...	*Discussion Points*
Key Member Services Staff	Review with the staff how and when the MCO sends the members' rights and responsibilities statement to existing and new members.
Key Provider Relations Staff	Review with the staff how and when the MCO sends the members' rights and responsibilities statement to existing and new providers.

NARRATIVE Describe how and when the MCO sends the statement of member rights and responsibilities to existing and new providers and to existing and new members, and any differences between the member statement and the provider statement.

RR 4.0 The managed care organization has a timely and organized system(s) for resolving members' complaints and formal grievances. (Surveyors will consider delegated as well as nondelegated activity.)

RR 4.1 The system(s) includes:

RR 4.1.1 Procedures for registering and responding to complaints and grievances in a timely fashion;

RR 4.1.1.1 The managed care organization establishes and monitors standards for timeliness.

RR 4.1.2 Documentation of the substance of complaints, grievances and actions taken;

RR 4.1.3 Procedures to ensure a resolution of the complaint or grievance;

RR 4.1.4 Aggregation and analysis of complaint and grievance data and use of the data for QI; and

RR 4.1.5 An appeal process for grievances that includes at least the following:

RR 4.1.5.1 The member has a right to a review by a grievance panel;

RR 4.1.5.2 The member has a right to a second review with different individuals;

RR 4.1.5.3 At least one of the levels of review permits the member to appear before the panel; and

RR 4.1.5.4 There is an expedited procedure for emergency cases.

The formal complaint and grievance system should be designed to handle individual complaints and grievances in a timely fashion. The process should include all of the steps listed above to ensure an appropriate resolution. Having appropriate procedures to ensure resolution means that: 1) the member's issue stated in the complaint or grievance is addressed directly, 2) the MCO's response is appropriate to the seriousness of the complaint in the surveyor's judgment, and 3) any complaints that potentially relate to quality of care are referred to a clinical person for review. The process should also provide summarized information so that trends and problems can be identified and resolved through the QI process.

DOCUMENT REVIEW

Document	*What To Look For*
Complaint and Grievance Policy and Procedures *(May include member services instructions or standard operating procedures)*	Are all of the process requirements listed in RR 4.1.5 addressed? Are the maximum time frames appropriate for the submission and resolution of complaints and grievances? Is there a system for monitoring the complaint and grievance process to assure that time frames are met? Is there a procedure to resolve each problem for the member and for the system, if appropriate, e.g., are complaints about providers investigated? Is the procedure for resolutions, including clinical review, appropriate? Are complaints and grievances controlled through a central file? Is there a process of recording and categorizing complaints and grievances by type and provider so that the MCO can identify trends? Are complaint and grievance reports produced periodically and reviewed, as appropriate, by the QI Committee? Do the procedures include informing the member of his or her right to appeal during each step of the complaint and grievance process?
Evaluation of 10 Complaint and Grievance Files *(May be computerized)*	**Randomly select complaint and grievance files from the resolved complaint and grievance log. Assess the files on the "Evaluation of Complaint and Grievance Handling" worksheet.** Does the MCO adequately document each complaint? Were the grievance policies and procedures followed? Were the time frames met? Did the MCO respond to the substance of the complaint? Were all complaints and grievances that had a possible medical component reviewed by a clinician? Was the extent of the MCO's response commensurate with the seriousness of the complaint? Was the member informed of the resolution of the complaint and of his/her rights of appeal?

INTERVIEWS

Interview the...	*Discussion Points*
Staff Responsible for Complaints and Grievances	Review the complaint and grievance policies and procedures, complaint and grievance files, and complaint and grievance reports with the staff. • Identify any problems with the grievance policies and procedures; • Identify any case files which show inadequacy in any area, including problems with meeting the time frames or resolving the complaints; • Discuss how the complaint and grievance reports are used by staff to identify and monitor trends.

NARRATIVE Complete the Complaint and Grievance Review Worksheet. Under each appropriate substandard, state (1) whether the procedures meet the substandard, and (2) the percent of cases reviewed that met the substandard.

Note: Surveyors will consider delegated as well as nondelegated activities. Note any findings that are different for delegated entities.

RR 5.0 The managed care organization informs members about services provided, access to services, charges, and scheduling.

RR 5.1 Members are provided a written statement that includes information on the following:

RR 5.1.1 The managed care organization's policy on referrals for specialty care;

RR 5.1.2 Provisions for after-hours and emergency coverage;

† RR 5.1.2.1 the managed care organization's policy on when members should seek direct access to emergency care and/or utilize 911 services.

RR 5.1.3 Benefits and services included and excluded from membership and how to obtain them. This includes a description of:

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† Note: Standard 5.1.2.1 is a new Standard and is being monitored. The substandard was added to address the issue of providing members with information and instructions on how, and under what circumstances, members should seek direct (i.e., without pre-authorization) access to emergency care and/or 911 services.

RR 5.1.3.1 **any special benefit provisions (e.g., payment, higher deductibles, rejection of claims) that may apply to services obtained outside the system; and**

RR 5.1.3.2 **the procedures for obtaining out-of-area coverage.**

RR 5.1.4 **Charges to members, if applicable, including:**

RR 5.1.4.1 **policy on payment of charges; and**

RR 5.1.4.2 **copayments and fees for which the member is responsible;**

RR 5.1.5 **Procedures for notifying those members affected by:**

RR 5.1.5.1 **termination or change in any benefits;**

RR 5.1.5.2 **termination of any services; or**

RR 5.1.5.3 **the termination of any service delivery office/site.**

RR 5.1.6 **Procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;**

RR 5.1.7 **Procedures for changing practitioners;**

RR 5.1.8 **Procedures for disenrollment of nongroup subscribers; and**

RR 5.1.9 **Procedures for voicing complaints and/or grievances, and for recommending changes in policies and services.**

If the NCQA review covers more than one product and the MCO uses different member materials for its different products, check the materials for each product. These different products may include HMOs, point-of-service plans (POS), preferred provider organizations (PPOs), Medicaid plans, and Medicare plans.

For most MCOs, the information listed above is included in one or more of the following documents:

- member handbook;
- identification card;
- benefits summaries;
- participating provider handbooks;
- member newsletters.

If the information is presented in the member newsletter, the MCO should also include the information in other documents available to new members. Legal documents such as the Certificate of Coverage are generally not adequate vehicles for communicating important information to members.

DOCUMENT REVIEW

Document	*What To Look For*
Member Literature	Are all of the points listed above covered in logical places in clear, understandable language in the documents?

INTERVIEWS

Interview the...	*Discussion Points*
Key Member Services Staff	Review any deficiencies in the documents with staff. If information is presented in member newsletters or through mailings to members, request and review copies of applicable newsletters and mailings. Ask staff how this information is provided to new members.

RR 5.2 The managed care organization takes steps to ensure that services offered are accessible to members:

RR 5.2.1 The points of access to primary care, specialty care, and hospital services are identified for members.

RR 5.2.2 Members are informed about how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

The member services handbook usually provides a general description of the MCO's health care delivery system. The provider directory usually includes lists of providers (primary care, specialty, and inpatient).

DOCUMENT REVIEW

Document	What To Look For
Member Services Handbook, Member ID Card	Is there a clear, understandable description of how to obtain services during regular hours of operation, how to obtain urgent and after-hours care, and how to obtain emergency care? Is there a clear description of how the member can obtain the names and professional qualifications of primary and specialty providers?
Provider Directory	Does the provider directory list the names, addresses, and telephone numbers of providers, including primary care providers, specialty care providers, and inpatient providers? Is there a clear description of how the member can obtain the names and professional qualifications of primary and specialty providers? If the MCO uses a primary care gatekeeper system, does the provider directory clearly explain that specialists should be accessed through the primary care physician? Does it explain exceptions such as self-referrals for behavioral healthcare and well-woman visits if the MCO provides for exceptions? If a behavioral health gatekeeper system is used, does the provider directory clearly explain how to access behavioral health services?

INTERVIEWS

Interview the...	Discussion Points
Key Member Services Staff	Review any problems with the MCO's materials for members.

NARRATIVE Complete the table in the *Data Collection Tools* for RR 5.0, showing a source for each item. Note any missing items in materials for any product.

RR 6.0 Member information is comprehensible and well-designed.

RR 6.1 Member information is written in language that is readable, easily understood, and consumer tested, if possible.

RR 6.2 Member information is available, as needed, in the language(s) of the major population groups served.

Member information should be designed for use by a broad audience. Materials should be visually attractive and the type should be easily readable. If the MCO serves major population groups whose principal spoken and written languages are other than English, or for which literacy is at a lower level, the MCO should be able to provide member services materials in alternative forms.

DOCUMENT REVIEW

Document	*What To Look For*
All the Materials Reviewed under RR 5.0	Do the materials show elements of readable design, including easily readable typeface, frequent headings, and short, simple explanations? Are materials available in the languages that the principal populations read?

INTERVIEWS

Interview the...	*Discussion Points*
Key Member Services Staff	How were the documents designed? Was any pre-testing done with representative members? What was the result? What is the readability level of each document? How has the MCO determined what percentage of its members speak other languages? What percentage of the MCO's population primarily speak languages other than English?

NARRATIVE Describe the readability of the materials and the languages in which materials are available. Attach copies of any documents which contain problems.

RR 7.0 The managed care organization acts to ensure that the confidentiality of specified patient information and records is protected.

RR 7.1 The organization has written confidentiality policies and procedures.

RR 7.2 **The managed care organization ensures that patient care offices/sites have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons inside and outside the managed care organization who should not have access to such information.**

RR 7.3 **Patients are afforded the opportunity to approve or refuse the release of identifiable personal information by the managed care organization, except when such release is required by law.**

The extent of patient policies and procedures on confidentiality will vary according to the delivery model type. Staff and group-model MCOs require more extensive confidentiality policies and procedures because they maintain original medical records and have more employees who are directly involved in the establishment and maintenance of the records than some other models. In all models, there should be policies and procedures about confidentiality that apply to claims processing staff, UM and case management staff, and QI staff. (Note: "Staff" includes participating practitioners who serve on committees.) Policies should address:

- maintenance of confidentiality of information within the organization;
- protection of medical record information (both original information and documentation used for UM and case management);
- protection of claim information;
- release of information; and
  - at the request of the member
  - in response to legal requests for information
- orientation of employees to confidentiality policies and procedures.

The MCO should also require that all contracted providers, including primary care physicians' offices, have appropriate policies and procedures to preserve patient confidentiality. The MCO should assess the adequacy of the PCP offices' policies and procedures during its primary care physician site visit. (See Credentialing Standard 8.0.)

DOCUMENT REVIEW

Document	What To Look For
Patient Confidentiality Policies and Procedures	Do the policies and procedures address all of the above issues?
Primary Care Physician Site Visit Protocol	Does the protocol address PCP office confidentiality policies and procedures?
Credentialing Files	Do the completed site visit forms indicate that provider confidentiality policies were reviewed? Do the completed forms indicate that the physicians' offices have appropriate confidentiality policies and procedures?

NARRATIVE Complete the table in the *Data Collection Tools* for RR 7.0 and comment on any procedures that are deficient.

RR 8.0 The organization assesses and enhances member satisfaction with its services. (Surveyors will consider delegated as well as nondelegated activity.) The managed care organization:

RR 8.1 Periodically assesses at least a sample of:

RR 8.1.1 patient complaints;

RR 8.1.2 requests to change practitioners and/or facilities; and

RR 8.1.3 disenrollments by members.

RR 8.2 Conducts periodic surveys of member satisfaction with the managed care organization's services;

RR 8.3 Identifies sources of dissatisfaction;

RR 8.4 Addresses sources of dissatisfaction; and

The MCO should have a systematic method of accomplishing the following;

- assessing member satisfaction by routinely categorizing and analyzing:

  - patient complaints and grievances,

  - requests to change primary care providers, and

  - disenrollments.

  Depending on the MCO's organizational structure, different organizational units may carry out these activities. For example, Member Services may summarize and analyze complaints and grievances; the enrollment staff may summarize and analyze requests to change primary care sites; and the Marketing Department may summarize and analyze disenrollments. Alternatively, the MCO's provider relations or QI staff may have responsibilities for some or all of these activities.

- conducting periodic surveys of member satisfaction with the MCO's services, including the provision of health care services. The survey results should be presented to the QI Committee;
- using the tools listed above to identify sources of dissatisfaction; and
- implementing actions to improve member satisfaction and measuring the effectiveness of corrective actions.

DOCUMENT REVIEW

Document	*What To Look For*
QI Studies and Reports: survey analysis, complaint and grievance reports, PCP change reports.	Is there evidence that the activities listed above have been carried out? What areas of dissatisfaction have been identified? What actions for improvement have been taken?

INTERVIEWS

Interview the...	*Discussion Points*
Key Member Services Staff	Review any complaint and grievance reports, provider transfer reports, disenrollment surveys, and member satisfaction surveys. • How do staff analyze the data? • Who in management receives the information? • What QI Committee or subcommittee receives the information? • What sources of dissatisfaction have you identified? How has the MCO addressed them?
CEO	What information on complaint and grievance reports, provider transfer reports, disenrollment surveys, and member satisfaction surveys do you receive? How do you use this information? What sources of dissatisfaction have you identified? How has the MCO addressed them?
Key Provider Relations Staff	Same as for CEO, above. Does the MCO aggregate and analyze complaints and grievances and satisfaction data on a practitioner-specific basis? How is this information used?
QI Program Staff	Same as for CEO, above.

NARRATIVE Describe the mechanisms by which the MCO assesses member complaints and grievances, primary care transfers, and disenrollments. Briefly describe and critique any member satisfaction surveys. Describe the sources of dissatisfaction that have been identified, and evaluate how the MCO has addressed those problems. If the MCO has taken action to improve an area, and then re-measured and demonstrated improvement, include that information in QI 10.1 and QI 11.2.

RR 8.5 Informs practitioners and providers of assessment results.

The MCO should provide reports of member satisfaction to practitioners and providers. If applicable, practitioner/provider-specific results should be reported directly to the affected individuals or institutions. The MCO should communicate its overall findings to the practitioner/provider population in general.

DOCUMENT REVIEW

Document	*What To Look For*
Individual Surveys and Studies	Are results presented clearly? Is there evidence that results were shared with the appropriate practitioners/providers? Were providers given an opportunity for feedback?
Provider Communications	Are results of the MCO's patient satisfaction studies and surveys presented clearly?

INTERVIEWS

Interview the...	*Discussion Points*
Key QI Program Staff and Medical Director	Review how the MCO shares the results of member satisfaction studies and surveys with practitioners/providers.
Primary Care and Specialty Physicians	Are they aware of the MCO's activities to measure member satisfaction? Have they ever been involved in a study or survey. If yes, did the MCO send the physician the results of the survey? Has the MCO ever communicated the overall results of member satisfaction activities? Are the primary care and specialty physicians aware of any activities that the MCO has undertaken to improve member satisfaction?

NARRATIVE Describe how the MCO keeps practitioners and providers informed of member satisfaction issues.

Note: Surveyors will consider delegated as well as nondelegated activities. Note any findings that are different for delegated entities.

RR 9.0 If the managed care organization delegates any member services activities (e.g., complaints and grievances, processes, and member surveys), to contractors, there is evidence of oversight of the contracted activity.

Delegation is a formal process by which an MCO gives a contractor the authority to perform member services functions on its behalf. Although an MCO can delegate the authority to perform member services activities, it should retain oversight to ensure that the function is performed appropriately. Oversight is defined as the monitoring of a set of activities in order to assess performance. The MCO is accountable for ensuring that the delegated activities are in compliance with NCQA Standards.

RR 9.1 There is a written description of:

RR 9.1.1 the delegated activities;

RR 9.1.2 the delegate's accountability for these activities;

RR 9.1.3 the frequency of reporting complaints and grievances, and member survey data, to the managed care organization; and

RR 9.1.4 the process by which the delegation will be evaluated.

There should be a mutually agreed upon description of the delegation of any member services activities to contractors. This could be included in the provider contract, a memorandum of understanding, and/or the MCO's provider policy and procedure manuals. The description should encompass the points listed above.

RR 9.2 There is evidence of:

RR 9.2.1 approval of the delegate's member services program; and

RR 9.2.2 evaluation of regular specified reports.

The managed care organization should:

- approve the delegated entity's method of handling the full scope of the delegated activities;
- obtain regular reports from the delegated entity that describe performance on the delegated activities, including complaints and grievances and member survey data, as applicable, and planned improvement actions; and
- evaluate the delegated entity's performance against the applicable NCQA Standards.

DOCUMENT REVIEW

Document	*What To Look For*
Agreement or letter with delegated entity	Are all of the points in 9.1 covered in the written agreement between the managed care organization and the delegated entity? If complaint handling is delegated, is there a clear description of the member's appeal rights for complaints and grievances? Is the document signed by both the MCO and the delegated entity?
Delegated Entity Reports	If complaint handling is delegated, does the delegated entity routinely report aggregated complaint and grievance information? Does the entity report its planned follow-up of problems identified through the complaint and grievance process, and the results of follow-up activities? If satisfaction surveying is delegated, does the delegated entity routinely report member satisfaction information? Does the entity report planned follow-up of problems identified through member surveys, and the results of follow-up activities?

INTERVIEWS

Interview the...	*Discussion Points*
Key Member Services Staff	Review the scope of the contract with the delegated entity. Review how the MCO monitors the delegated entity's activities. Confirm the frequency with which such monitoring takes place. Review how the MCO determines whether the delegated entity's activities meet NCQA Standards. Review the provider's and member's rights to appeal decisions to the delegated entity and to the MCO. Review how the MCO monitors member satisfaction with the delegated entity's services. Review how the MCO monitors the effectiveness of and satisfaction with the delegated entity's staff.

NARRATIVE Describe the scope of the delegation of member services. Describe how the MCO monitors the delegated entity's performance, any problems identified, and any actions taken to improve.

Mr. GANSKE. Frequently, I suspect disputes arise because enrollees will claim that they did not fully understand the full provisions of a plan or the restrictions of a plan. Do you think it will be important for us to address that issue as we talk about expanded managed care?

Ms. O'KANE. Yes, I do. In our standards, we have standards about the clarity of the information. We actually look through their materials to make sure they are clearly explaining how the system works. We have done a lot of focus group work, and this is an area where patients consistently tell us that they did not understand how the plan worked, and where I have suggested, particularly with the Medicare population, that additional care should be taken to have information brokers, perhaps some senior organizations, that could help people really understand how the system works before they choose to enroll in the system.

Mr. GANSKE. Thank you very much. I yield back my time.

Chairman BILIRAKIS. I thank the gentleman.

I am going to excuse this panel at this point. Thank you so very much. You cannot imagine how helpful you have been.

Ms. O'KANE. Thank you very much.

Chairman THOMAS [presiding]. The next panel, I would ask you to come forward, consists of Dr. Bristow, president, American Medical Association; Mr. Sprenger, chair-elect, Board of Trustees, American Hospital Association; Mr. Walworth, president, Health Alliance Plan of Michigan; and Ms. Lehnhard, senior vice president, Policy and Representation, Blue Cross & Blue Shield Association.

I will indicate to all of you that if you have any written testimony, it will be made a part of the record and you may proceed to inform the joint Subcommittees in any manner you see fit.

Dr. Bristow, by your attendance today—and I have not been keeping count—you may now be only two behind the American Association of Retired Persons. They declined to come today, so you have a chance down the stretch to at least break even with certain senior organizations. It is a pleasure to have you with us and to underscore the fact that you are one of the groups that have taken us seriously in saying, look, folks, this is not easy, take a look at it and give us your ideas. So we are pleased to have all of you with us, and we might as well start with Dr. Bristow.

STATEMENT OF LONNIE R. BRISTOW, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. BRISTOW. Thank you very much, Chairman Thomas and Members of the Subcommittees. My name is Lonnie R. Bristow, M.D. I am a practicing internist from San Pablo, California, and president of AMA, the American Medical Association.

Today I am pleased to offer our views and suggestions on the most important questions this Congress will face in reforming Medicare, that is what should be the appropriate standards required to protect our Medicare patients and who should be responsible for developing these standards. While choice is the heart of our proposal, the AMA believes that health plan standards and patient protections are its backbone.

As we see it, there are two challenges that the transformation will present: First, patients must be assured that the quality of

care they have come to expect will continue. To meet this objective, standards must be put in place in both the public and private sectors. Second, the innovations in quality and efficiency occurring throughout the country must be identified, evaluated, and then integrated into Medicare plans. Now, this will allow a transformed Medicare system to provide the cost savings needed while improving the quality of care provided.

As Medicare beneficiaries are offered more choices, they must be given the appropriate tools and information to make the choices meaningful. To this end, the AMA urges Congress to include the following five principles in Medicare reform which have enjoyed bipartisan support:

Disclose to patients plan information on their rights and responsibilities; appropriate professional involvement in medical policy matters; disclose utilization review plan policies and procedures; patients must have reasonable opportunity for choice of physicians, delivery systems and plans; and patients must have reasonable access to physicians and specialists.

In addition, there are legitimate concerns regarding market segmentation and practices designed to attract healthy enrollees. Plans should benefit from competition and their ability to constructively improve the health care delivery process, but they should not be allowed to seek out and cover only relatively healthy individuals, while avoiding the sicker, more costly elderly. An insurance company should be prohibited from offering physicians and physician groups inducements to reduce or limit medically necessary services provided to patients.

In order to allow the market to operate, however, there should be flexibility in how these principles are achieved. For example, accreditation by voluntary private sector bodies should be recognized as an alternative to direct government regulation. Also, the patient-physician relationship must be safeguarded by allowing physicians to seek reasonable participation in plans. They should also have the ability to review the reasons why participation would not be continued.

To guarantee fairness, enrollees and providers should have access to a disputes resolution system where differences occur with administration policy. Physicians have a duty to ensure that patients receive necessary and appropriate care. It is therefore reasonable that physicians should be allowed to be involved in the development of medical policies of a plan. We also believe that quality management systems and utilization review programs should be based on sound scientific and medical information. Costs cannot be allowed to drive quality.

To put muscle on the backbone of Medicare standards, we are proposing the creation of a "partnership for health care value," to give practitioners and plans the best clinical judgments possible. This congressionally chartered corporation would be governed and funded by a broad range of private and public health care entities. The work of the partnership is detailed in the AMA's transformation proposal previously submitted to you.

Members of the Subcommittee, choice demands options, and many physicians want the opportunity to order their own integrated delivery systems. They believe they could compete against

the large corporate health care plans and powerful insurance companies, if given the chance. Many multispecialty group practices already do so; for example, the Cleveland Clinic, Oschner Clinic, and the Mayo Clinic.

The second obstacle in their way, however, relates to antitrust concerns. The Department of Justice and the FTC have promulgated a very narrow set of guidelines. Unlike insurers and other nonproviders, it is still considered illegal for physicians to form certain kinds of networks and plans such as PPOs. Additional legislative action is needed to clarify the antitrust laws in this area.

In closing, the AMA's proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare Program. It offers more choice and the greatest value to senior citizens and the disabled. Patients will have the opportunity to make wise prospective choices of physicians and financing mechanisms, but Congress must ensure that adequate standards are in place to protect them.

Thank you for the opportunity to present our views, and I welcome your questions.

[The prepared statement and attachments follow:]

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means

and the

Subcommittee on Health and Environment
Committee on Commerce

U.S. House of Representatives

RE: STANDARDS FOR HEALTH PLANS PROVIDING COVERAGE IN THE MEDICARE PROGRAM

Presented by Lonnie R. Bristow, MD

July 27, 1995

Mr. Chairman Thomas, Mr. Chairman Bilirakis and Members of the Subcommittees, My name is Lonnie R. Bristow, MD. I am a practicing internist from San Pablo, California, and President of the American Medical Association (AMA). As you know, I have recently had the opportunity to testify before both of your Subcommittees regarding the AMA's views on the factors precipitating Medicare's current crisis as well as the AMA's proposal to transform Medicare. Today, I am pleased to offer our views and suggestions concerning what we believe is one of the most important questions Congress will face during this debate -- that is -- what are the appropriate standards required to protect our Medicare patients in an environment that is conducive to choice and who should be responsible for developing standards and protections.

As I mentioned in previous testimony, the heart of the AMA's proposal is based on a competitive market-driven system which offers more choice to senior citizens and the disabled without placing them at risk. Without again going into detail, these choices would range from remaining in the restructured Medicare program, to selecting from various competing health plans, including managed care plans, to investing in a Medical Savings Account (MSA) coupled with a catastrophic coverage. The government would pay the same amount regardless of the patient's choice.

The AMA believes that while choice is at the heart of our proposal, health plan standards and patient protections are its backbone. As we see it, there are two challenges that the transformation will present. The first is to adequately assure patients that the quality of the care they have come to expect can be maintained at a high-level, even in a market-driven system focused on costs. We believe that to successfully achieve this objective, standards must be put in place in both the public and private sectors.

The second challenge is ensuring that innovations in efficiency and quality occurring throughout the country can be identified, evaluated and then integrated into Medicare plans. In other words, Medicare beneficiaries, if given a choice must also be given the appropriate information to make these choices in an informed manner, and plans must be given the appropriate clinical information to improve quality and reduce costs.

The AMA maintains that as Medicare beneficiaries are offered more choices they must be provided with the appropriate tools to make these choices meaningful. The AMA urges that plans be guided by the following principles which enjoyed bipartisan support in the past Congress. In general, plans should:

- disclose to patients plan information, rights and responsibilities;
- provide for appropriate professional involvement in plan medical policy matters;
- disclose utilization review plan policies and procedures;
- provide reasonable opportunity for patient choice of plans and physicians; and
- provide reasonable access to physicians and specialists.

DISCLOSURE

More specifically, plans should disclose to patients information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. In selecting plans, individuals need information to understand how the plan operates, what they get in benefits, what they must do to ensure that services are covered, where and from whom they get services, and how plans compare on items such as quality indicators, patient satisfaction, cost control programs, and grievance procedures.

Furthermore, there are legitimate concerns regarding market segmentation and marketing practices designed to attract healthy enrollees. While plans should be allowed to benefit from competition and their ability to constructively improve the health care delivery process, they should not be allowed to seek out and cover only relatively healthy individuals while avoiding the sicker, more costly elderly. Marketing practices need to be evaluated as well and insurance companies should not be allowed to offer physicians and physician groups inducements to reduce or limit medically necessary services provided to patients. The AMA believes that there should be a minimum set of provisions that plans must meet and enrollment procedures that plans must comply with that are fair and avoid inappropriate market segmentation.

As a federally funded program it is important to assure that there be some minimum set of services that each plan provides with appropriate incentives for preventive services. Plans should have flexibility as to how they provide the services and should be able to enhance the benefit package in any way that meets customer and market needs. At the same time, plans also need to have arrangements so that enrollees can expect reasonable access to all medically necessary and appropriate care. In order to allow the market to operate, however, there should be several allowable alternatives in achieving these requirements. For example, to the greatest extent possible, accreditation by voluntary private sector bodies should be recognized instead of direct government regulation. Therefore, procedures should be put in place for recognition of private sector accreditation programs.

DISCLOSURE OF PLAN POLICIES AND PROCEDURES

In order to guarantee fairness and that necessary medical services are provided, procedures must be established that provide enrollees and providers with a system to resolve disputes within the plan. In cases where the grievance or dispute cannot be resolved within the plan, participants should be able to seek independent means to address the problems.

Due to the nature of the patient-physician relationship, physicians should be allowed to seek

participation in plans. Physicians should also have the ability to examine with the plan the reasons why participation would not be continued, for example, where involuntary termination occurs.

APPROPRIATE PROFESSIONAL INVOLVEMENT

We believe that it is the duty of physicians to ensure that their patients receive necessary and appropriate care regardless of the setting or method of payment in which that care is delivered. To make certain that physicians are able to meet this obligation, plans need to provide a process, such as a medical staff, for meaningful physician involvement in the development of medical policies of the plan, including drug formularies. It is also necessary for plans to have procedures and methods that assure that high quality care is provided, yet plans should also be given some degree of flexibility in order to achieve these standards and to encourage innovations in quality improvement and cost-effective care. In addition, the AMA believes it is well suited to develop a program for physician performance assessments.

DISCLOSURE OF UTILIZATION REVIEW

In plan quality management systems and utilization review programs, it is necessary that these programs operate to enhance patient care and be based on sound scientific and medical information. Cost alone cannot be allowed to drive quality. Those who are involved in final decisions should be knowledgeable and qualified in the area they are reviewing. Procedures need to be fair and prompt.

ADMINISTRATIVE SIMPLIFICATION

Accrediting bodies that now exist for managed care and other health benefit plans, such as the National Committee on Quality Assurance (NCQA), properly require that each plan have procedures regarding credential verification, inspections and other mechanisms to assure that the practitioners and the facilities within their programs are capable of delivering care and meeting plan quality and other standards. Unfortunately, when a physician or a medical group participates in more than one plan, there can be multiple inspections and other administrative requirements that serve the same purpose but provide no new information and increase costs and divert attention away from patient care. Therefore, to the greatest extent possible, uniform information requirements and inspection or certification procedures should be established to avoid duplication of efforts and increased costs. The federal government should foster this uniformity by providing grants to private sector organizations for the development of acceptable uniform standards, procedures and inspections. Provider credential verification should be made as easy as possible. To avoid duplication of efforts, a private verification service should be recognized in lieu of repeated validation of primary source data. Likewise, when a plan contracts with an Individual Practice Association (IPA) for the provision of physician services, it should delegate verification to the IPA.

With respect to federal regulations and administrative simplification, federal law currently requires an opportunity for public comment on proposed rules. This involvement takes place after the drafting has already occurred and in a context that is not conducive to give and take. Therefore, in areas where there will be continued federal regulation, the AMA recommends that a major emphasis be placed on using negotiated rulemaking procedures to improve the quality of needed regulations in the health care sector.

PARTNERSHIP FOR HEALTH CARE VALUE

Just as Medicare beneficiaries should be afforded the tools to make wise and informed choices, plans and practitioners should also be given the appropriate tools to make the best clinical judgments. Therefore, to put muscle on the backbone of the Medicare standards we are proposing, an unprecedented **"Partnership for Health Care Value,"** should be created. The Partnership could be a Congressionally chartered corporation similar to the National Academy of Sciences and the Institute of Medicine and would focus on private and public sector efforts devoted to practice guidelines development and organizing a structure to guide

development and dissemination of improvements in medical practice and health care delivery. The Partnership should be governed and funded by representatives from medical societies, hospital associations, insurers and national managed care companies, accrediting agencies, employers, consumer groups, and the federal agencies. It would act as a clearinghouse and marshall private sector resources devoted to the development and application of medical standards. These standards or practice guidelines would be used by both clinicians and health benefit plans as a basic protection for patients to assure that they receive state-of-the-art medical care. The work of the Partnership would include:

- Developing standards for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data;
- Coordinating technology assessment and establishing standards for technology, dissemination and use;
- Establishing priorities for guideline development through analysis of variations in practice or important procedures;
- Creating guidelines for coordinating the development of, and disseminating practice parameters;
- Creating guidelines for the development of methodology for profiling and evaluating health care providers;
- Developing interventional tools and education programs to change practice patterns;
- Making recommendations about the content of basic benefits packages; and
- Evaluating health care spending and pinpointing areas needing study and corrections.

While it may come as a surprise to the uninitiated, it is a fact that current standards for treatment practices and outcomes vary considerably. The AMA believes that by creating the Partnership, both practitioners and plans may begin the arduous and comprehensive process of developing a common standard of medical care that can be measured, analyzed and evaluated.

PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS

The AMA recognizes the need to transform the Medicare system. The AMA also understands that many physicians want the opportunity to offer their own integrated delivery systems and believe they could compete against large corporate health care plans and powerful insurance companies, if given the chance. The benefits to the Medicare program would be lower costs and higher quality of care than in non-physician/provider health plans. For example, costs would be lower because contracting with a Physician Sponsored Coordinated Care Organization (PCCO) instead of an insurer could eliminate a layer of profit and overhead. Quality would be higher because physicians would have direct control over medical decision-making, and physicians are best qualified to strike the balance between conserving costs and meeting the needs of the patient.

There is already a substantial infrastructure of PCCOs. The ideal PCCO is physician directed, with vehicles for input from the physicians that deliver health care through the PCCO. They include large, multispecialty group practices such as the Permanente Medical Group, and, in more recent years, the Cleveland Clinic, Oschner Clinic, and the Mayo Clinic, academic medical centers, large "clinics without walls," and hospital systems that have partnered with physician networks. Many of these PCCOs include a full range of

providers and are capable of contracting to provide care for Medicare beneficiaries.

In addition, many physicians and other providers are interested in forming PCCOs. Physicians and hospitals are exploring ways to organize themselves so they can operate on a prepaid basis. There are almost no communities in the United States where physicians and other providers are not considering or actively forming a PCCO. If these explorations resulted in the formation of numerous new PCCOs, the public benefits would be substantial.

There are, however, obstacles to realizing the benefits of competitive PCCOs. One is a trend towards treating PCCOs that operate on a prepaid basis as insurance companies that are required under state law to register as insurers and comply with all applicable state regulations. Treating PCCOs as insurers does not make sense because, unlike the conventional insurer or HMO, a PCCO consists of the physicians and providers capable of delivering the product that it has contracted to provide on a prepaid basis. The PCCO does not have to contract with providers to deliver the care. Requiring the PCCO to comply with insurance regulations adds unnecessary costs to their operations. Instead, a PCCO should be likened to a self-insured plan in so far as a self-insured plan pays out its own benefits using its own resources and assets in conjunction with reinsurance as a guarantee against excess claims.

The second problem is legal obstacles to the formation of PCCOs. Physicians and other providers face substantial practical problems that must be solved in the formation of a PCCO. While they do have on hand the ability to provide the services, they lack the capital resources that insurance companies and national managed care organizations have, and they lack the management infrastructure. To make matters even more difficult, legal regulations simply bar the formation of certain kinds of PCCOs. Compliance with legal regulations adds substantial costs and time to the organizational effort. For example, although the Department of Justice and the Federal Trade Commission have promulgated a set of Guidelines, it is still considered illegal for physicians to form certain kinds of networks and plans. Insurers and other non-providers may organize networks and plans without the same legal barriers. Additional legislative action is necessary on issues such as single and multi-provider networks.

Current trends in health care delivery and finance require that physicians and other providers cooperate to form health care delivery networks that are (1) capable of providing comprehensive health care services in a coordinated fashion, and (2) capable of managing financial risk, such as capitation and fee withhold arrangements. However, our legal structure has not yet adjusted to the new economic conditions. Several sets of laws actually interfere with the ability of providers to develop health care delivery systems, including antitrust laws, bars on legitimate self-referral, fraud and abuse laws, the tax regulation of pension plans, laws regulating tax exempt entities, and others.

To prevent physician values from being submerged and lost as a contribution to the competitive system, the minimum accommodation needed today is clarification of the antitrust laws supporting the rights and abilities of physicians and other providers to jointly present their views on any matter to insurance plans on behalf of themselves and patients. These changes should be made with the clear recognition that they are appropriate as long as no boycott and price-fixing is involved.

CONCLUSION

The reforms we propose are a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. The AMA's proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice with the greatest value to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and financing mechanism, with the reasonable opportunity to change either if they prove unsatisfactory. An effective health care marketplace is only achievable if we rid ourselves of the current program's distortions that have had the perverse effect of aggravating, rather than easing, the government's burden in keeping Medicare's promise. We do, however, recognize the need for appropriate patient protections and rules to assure that a competitive market place meets the programs goals and responsible. As long as Medicare insulates patients from the true cost of the services they are consuming, a competitive Medicare marketplace will never flourish and costs will continue to escalate. We have taken the liberty of including legislative specifications regarding reforms to facilitate the formation of PPCOs and the antitrust laws as well as a description of our Partnership for Health Care Value. We stand ready to work with you and your staffs on this important issue.

LEGISLATIVE SPECIFICATIONS: REFORMS TO FACILITATE THE FORMATION OF PCCOs

ANTITRUST REFORMS

Risk Sharing

- The physician participants in a PCCO should engage in risk sharing, which includes, without limitation, the following:

  - when the PCCO agrees to provide services at a capitated rate;

  - when the PCCO creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a substantial amount of the compensation due to them, with distribution of that amount to the members only if the cost-containment goals are met;

  - when the PCCO agrees to provide services for global fee packages; or

  - when most of the member physicians hold significant ownership or equity interests in the PCCO, where the capital contributed by the members is used to fund the operational costs of the PCCO such as administration, marketing, and computer-operated medical information, if the PCCO develops and operates comprehensive programs for utilization management and quality assurance that includes controls over the use of institutional, specialized, and ancillary medical services.

Size

- PCCOs may have exclusive physician panels that include up to 30% of the physicians in the market, in aggregate and by specialty.

- PCCOs may have nonexclusive physician panels that include at least 50% of the physicians in the market.

- PCCOs may have exclusive or nonexclusive panels larger

than those set forth above if the PCCO is not in violation of any federal law.

- ▸ Alternatively, no size limits are set on PCCOs, and they are evaluated on whether they intend to or in fact engage in anticompetitive conduct.

Payment Arrangements

- Physician members of a PCCO may jointly determine the terms of financial arrangements between the PCCO and the physicians, including the method and amounts by which the physicians will be paid. The physician members may also jointly determine the terms of financial arrangements between the PCCO and any purchaser of the products offered by the PCCO.

- The physicians participating in a nonexclusive PCCO may not agree to boycott any purchaser, and they may not agree to fix prices for physician services when contracting with purchasers other than through the PCCO.

New Product

- A PCCO will be considered to be offering an additional or "new" product in a market for the finance and delivery of health care if it offers one of the following:

  - ▸ A preferred provider organization which has the following characteristics:

    - □ Physicians and other providers on the PPO's "panel" of providers agree to discount their fees or charges for treatment of PPO beneficiaries.

    - □ The PPO gives its beneficiaries financial incentives to use the providers on its panel. Beneficiaries may use providers who are not on the panel, but if they do so they are personally liable for larger copayments than are required when they use panel providers.

- ☐ The PPO engages in utilization review and quality assurance to control costs and maintain quality.

- ☐ The PPO administers and pays claims.

Studies

- Adopt the recommendation of the Physician Payment Review Commission that the DOJ and FTC conduct studies of the market for health care delivery and finance and the structure and role of PCCOs in the market. One part of the study should be directed at market definition to provide better guidance about how to define the size of the market in which a PCCO is being formed or is operating.

SELF REFERRAL

- Physician members of a PCCO may make arrangements among themselves to coordinate the care of patients who are beneficiaries of contracts between the PCCO and a purchaser. This includes referring to facilities or providers in which the other providers have a financial interest. Safe harbors should be created in the existing self referral laws for this kind of coordination of care.

FRAUD AND ABUSE

- Provider members of a PCCO may purchase physician practices and other providers or engage in other kinds of financial arrangements with providers that remain independent but commit to becoming part of the network. Safe harbors should be created for this activity.

PENSION PLANS

- Tax regulations should be developed which permit the formation of PCCOs without requiring aggregation of pension plans that have been independently developed and funded. Aggregation may be permitted on a prospective basis when a PCCO becomes fully integrated.

CERTIFICATE OF NEED LAWS

- Medicare providers should be exempt from Certificate of Need laws.

REGULATION OF TAX EXEMPT ENTITIES

- Tax regulations should be developed that allow tax exempt hospitals and tax exempt clinics to purchase physician practices at fair market value without endangering their exempt status. Tax regulations should be developed that allow tax exempt hospitals to affiliate with PCCOs without losing their exempt status. Tax regulations should allow up to 50% of the governing board members of a tax exempt health care delivery system to be physicians.

STATE INSURANCE REGULATION

- The National Association of Insurance Commissioners is asked to develop model regulations for risk bearing PCCOs that are appropriate for the function performed by those entities as opposed to treating them as insurance companies. These model regulations would not contain onerous capitalization, reserve, and surplus or registration requirements.

LEGISLATIVE SPECIFICATIONS: REFORMS TO CLARIFY THE ANTITRUST LAWS WITH REGARD TO JOINT DISCUSSION WITH PLANS

- Where physicians are unable to create effective competing plans their only avenue for making effective input into the increasingly concentrated delivery system/payer control is through joint presentation of their views and patient views about plan matters. The Court of Appeals for the Ninth Circuit recently held, " ...individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input....." (Alston v. United States).

  Alston demonstrates the need to correct the FTC's interpretation of the antitrust laws regarding physician involvement in the development of fees by a physician network or health plan. Antitrust officials must issue a clear statement that physicians are free to approach health purchasers and plans jointly in order to provide input on fees and other payment-related issues, as long as the physicians do not engage in a boycott or threat of boycott. An agency or trier of fact should not infer a boycott threat from the mere fact of discussions -- some express or implied threat of coercive conduct by the physicians must be made. Otherwise, health care providers will be deterred from engaging in useful and potentially procompetitive activities.

PARTNERSHIP FOR HEALTH CARE VALUE

Structure The Partnership would be established as a Congressionally chartered corporation. Therefore, it would operate under the auspices of Congressional purpose and would have some direct involvement of the federal government, but would not be an agency or an instrumentality of the Executive or Legislative Branches. Both the National Academy of Sciences and the Institute of Medicine are such corporations. The NAS was chartered in statute in 1863 (36 USC 251 et.seq.). It is recommended that we seek such a Charter to establish the purpose of the Partnership in law while allowing for the operation of the activity in the private sector.

Purpose The purpose of the Partnership is to advance the science of medical practice and health care delivery through improvement in the development, recognition and dissemination, coordination and focusing the effort to develop medical standards to be used by clinician and health benefit plans as a basic protection for patients to assure that they receive state-of-the-art medical care. Dissemination of medical practice guidelines and health services research would be the major focus initially.

The work of the Partnership would be to develop a plan that would include priorities for:

- Developing standards for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data.
- Developing standards for and coordinating effectiveness research and technology assessment.
- Coordinating technology assessment and establishing standards for technology, dissemination, dispersion and use.
- Establishing priorities for guideline development through analysis of variations in practice or important procedures.

- Creating guidelines for coordinating the development of, and disseminating practice parameters.
- Creating guidelines for the development of methodology for profiling and evaluating health care providers.
- Developing interventional tools and education programs to change practice patterns.
- Making recommendations about the content of basic benefits packages.
- Evaluating health care spending and pinpointing areas needing study and corrections.

Powers

The Partnership would be allowed to make it own organization , including the make-up and composition of the Board of Trustees, by-laws , rules and regulations, to hold property, to enter into contracts, to receive money, pursuant to grant, contract or contribution from public or private sources to carry out its purposes. The Partnership would the authorized and empowered to receive, by devise, request, donation,or otherwise, either real or personal property,and to hold the same absolutely or in trust and to invest, reinvest and manage the same in accordance with the provision of its constitution and to apply said property and the income arising therefrom to the objections of its creation and according to instruction of donors, contractors and grantors. The Partnership would exist until such time as it dissolved and/or its charter is revoked.

Incorporators

Original incorporators would include entities that are significant in the development and dissemination of new medical information represented by the Chief Executive Officers of:

The AMA;

An organization that represents those in the field of accrediting health care delivery systems, such as the National Committee for Quality Assurance (NCQA)

An organization representing health services research including outcomes assessment research and the development of practice guidelines;

An organization that represents those in the field of biomedical research;

The Secretary of Health and Human Services (covering AHCPR and HCFA); and

The Director of the National Institutes of Health.

The original incorporators or their successors can increase the number of and identify further additional incorporators.

The original incorporators shall establish an advisory committee that seeks representation from all involved in the health care delivery system including, but not limited to, providers, insurers, consumers, other payers, standard setting bodies and employers. This advisory committee shall meet on a regular basis to provide views to the Partnership on the practical implications and aspects of the Partnership's work. Organizations that should be involved include:

Organizations representing hospitals such as the American Hospital Association or the Federation of Health Systems;

Organizations representing health insurers and health care delivery systems such as the Health Insurance Association of American and the Blue Cross/Blue Shield Association;

Organizations that represent employers, both large and small, that provide health benefits to their employees;

Organizations that represents consumers of health care services;

Operation — The Partnership would be able to hire staff to assist in carrying out its functions. In addition, it would be able to contract with other organizations to provide staff for its functions and it would be able to contract with other organizations for the performance of various functions.

It is expected that the Partnership would have a relatively small staff, and would, instead, rely upon resources that the private sector or government agencies bring to it within the context of grants and contracts to conduct research or develop initiatives consistent with its purposes. The Partnership would focus on setting the methodologies for these activities, setting priorities for them, and in reviewing and approving of the work done by private sector organizations. For example, in the development of practice parameters, the Partnership would proceed by reviewing the efforts of various organizations to develop methodologies for the creation of parameters. These would include the attributes of practice parameters developed by the AMA\Medical Specialty Society Practice Parameters Partnership, the principles developed by the AHCPR, the principles developed by the Institute of Medicine, and by others. The Partnership would then reach a consensus on a single set of attributes or principles. Subsequently, the Partnership would review existing practice parameters against the principles that it develops. Sources of existing parameters include those listed in the compendium of practice parameters developed by the American Medical Association, those developed by the AHCPR, and others. Practice parameters which met the approval of the Partnership would then be adopted by it. Approved practice parameters would be forwarded to HCFA for use in the Medicare and Medicaid programs. HCFA would review and approve of them, and then put them through a public notice and comment process. Any problems discovered would then be referred back to the Partnership for resolution.

After completing this process, the Partnership would then set priorities for the development of practice guidelines. The priorities would be disseminated to the public. Organizations that had an interest in a topic would then inform the Partnership of their intent to form a practice parameter, and would provide the Partnership with a time table for development.

Similar procedures could be used for the other topical areas, such as the development of standards for the measurement and reporting of outcomes, for the performance of outcome studies, and others.

Funding Each of the original incorporators would contribute to the initial operation of the Partnership. Thereafter, the operations of the Partnership would be financed through grants, contracts and donations for services provided. The HHS Secretary and the Director of the National Institutes of Health would provide funding for the initial work plan and priority setting by the Partnership under Contract with the Partnership.

Rational A revolution is occurring in medicine which promises to substantially reduce costs while maintaining and enhancing quality. However, this revolution will not succeed unless a coordinated effort is made to develop the tools necessary for the revolution to take place. Medical societies, many other private sector organizations, and government agencies such as the Agency for Health Care Policy and Research are working at creating the tools necessary for the revolution. However, these efforts are fragmented and duplicative, and the tools needed are being developed at far too slow a pace.

The basis of the revolution is the information explosion in medicine and systems designed to manage information made possible by computer technology. The revolution involves:

- The reassessment of virtually all medical practice to determine the extent to which generally accepted clinical practices help patients. Much of medicine is

based on the experience of physicians and does not have a basis in scientific research. The object is to weed out generally accepted practices that cost money but do not result in a significant benefit to the patient. This reassessment is conducted by gathering together all information about a medical topic and synthesizing the best of it into practice parameters that can be used by physicians in clinical practice.

- This reassessment is supported by outcomes measurement and reporting, which involves the gathering of massive amounts of data about how well patients responded to medical treatment and analyzing that data. This kind of information gathering and analysis is now possible with computer technology.

- The continuous assessment and improvement of the quality of care actually delivered to patients by providers. This involves gathering outcomes data for the patients of a health care delivery system and individual physicians, and using that information to determine ways in which the cost and quality performance of the provider can be improved.

- Making information about the cost and quality performance of health care delivery systems available to the public. This information can then be used in the selection of health plans and providers.

There is a need for generally accepted and authoritative medical standards for use developing the tools necessary for the medical revolution, and there is a need to develop the tools themselves. At present, numerous entities are developing standards of some kind for one or more purposes. These include efforts to develop practice parameters, computer software designed to screen claims, protocols designed for physicians to follow as they treat patients, and other tools. However, the methods used to develop these tools and the meaning of vocabulary used within them is often not disclosed. Vendors of utilization control systems often refuse to disclose the medical standards used in their systems on the grounds that the information is proprietary. The result is a confusing array of materials that are difficult for potential users to understand, evaluate and use. Further, there is no way that the tools being developed can be used together in a coordinated fashion to maximize the benefits that can be achieved with modern information systems technology.

Chairman THOMAS. Thank you, Dr. Bristow.
Mr. Sprenger.

STATEMENT OF GORDON SPRENGER, EXECUTIVE OFFICER, ALLINA HEALTH SYSTEM, MINNETONKA, MINNESOTA; ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. SPRENGER. Thank you, Congressmen Thomas and Bilirakis.

I am Gordon Sprenger, executive officer of the Allina Health System in Minnesota, and chairman-elect of the American Hospital Association. We include in our membership 5,000 hospitals, health systems and networks, and other providers of care, and we are pleased to present our thoughts to you today.

Chairman THOMAS. Mr. Sprenger, let me tell you that these microphones are very unidirectional and you need to be right in front of it, or we are going to miss some of your remarks.

Mr. SPRENGER. Mr. Chairman, the private sector has been opening all kinds of doors, as we have heard this morning, in search of innovative ways to make the health care system more effective and user-friendly. Medicare meanwhile has mostly remained on the outside looking in. We believe that it is time for Medicare to offer more choices to its beneficiaries.

Our main theme to you today is that options will be necessary, as you consider Medicare reform, and it is a process of change. It is not a light switch you can just turn on. It is transition we will be going through. Not one solution is going to fit all. Moving more toward risk-reward sharing will bring the kind of behavioral change in providers which we think we will need to foster in order to get some of the cost savings that we want out of the system.

Medicare beneficiaries who want to choose coordinated care, rather than fee-for-service coverage, today just have two choices, an HMO, health maintenance organization, or a CMP, competitive medical plan. These plans accept full risk for the coverage they provide and are very important elements in a restructured health care delivery system. But Medicare should look beyond full risk contracts, as we look at multiple options. It should also consider limited risk-sharing arrangements with locally based networks of care, what we will call provider-sponsored networks, and I will comment on why.

First, the definition, what is a PSN. PSNs are formal affiliations of health care providers organized and operated to provide health care services under contract with insurance companies, HMOs, or other health plan companies. These networks commonly take the form of hospital-physician organizations or independent practice associations and are often called integrated delivery systems. They exist today in many parts of the country.

Many PSNs have formed HMOs or have become partners with insurers to do so, but some have not become HMOs. Some serve populations that are too small or too sick to support the full risk of an HMO. Some are in States where it reportedly takes up to 2 years to get an HMO license, and others are in areas where Medicare's HMO payment is simply too low to provide adequate care. Frankly, we are taking care of these patients as providers already,

and what we are asking for is the opportunity to move them into coordinated care.

We agree that any entity delivering care to Medicare beneficiaries must meet high standards. The current regulatory thinking limits the ability of these PSNs to serve Medicare beneficiaries in a coordinated care context. We believe the Medicare Program should take full advantage of the health care innovations and efficiencies offered by these PSNs by Medicare joining them in risk-sharing arrangements. We need Congress to change laws to allow the PSNs to contract directly with Medicare.

The standards these plans should follow should include the same important consumer protection standards and safeguards found in the HMO requirements. But because we are talking about PSNs not taking all the risks of a full risk HMO, they should be regulated differently. This means eliminating the requirement for a State HMO license, if the PSN's contract contains appropriate risk limiting provisions.

The purpose of a Medicare HMO or CMP is to protect against unexpected illness or injury and similar insurance risks, but this role is played by Medicare in a partial risk arrangement. The required inclusion of risk sharing or limit is clear evidence of an intent to avoid asking the PSN to take on an insurance role. This is particularly true when coupled with the fact that the arrangement predominantly covers services provided directly by providers.

Also, solvency requirements for PSNs should acknowledge that they need to invest their capital in providing services, and not in creating cash reserves to pay claims.

By making these changes, Mr. Chairman, PSNs can be recognized for what they are, organizations of providers that do not take on the full risk of unexpected illness or injury that ensures care. They would still, however, be regulated.

In conclusion, allowing these networks to contract with Medicare on a limited risk basis we think opens doors for everyone involved. We need many options to go through this transition. Medicare and the network providers and beneficiaries themselves would be able to choose their local hospitals, physicians, and other practitioners who organize to provide benefits in a coordinated and efficient way. It is a choice we think the seniors deserve to have.

Thank you.

[The prepared statement follows:]

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Statement
of the
American Hospital Association
before the
House Committee on Ways and Means, Subcommittee on Health
and the
House Committee on Commerce, Subcommittee on Health and Environment
Joint Hearing
on
Standards for Health Plans Providing Medicare Coverage

July 27, 1995

I am Gordon Sprenger, executive officer of the Allina Health System in Minnetonka, Minnesota, and chairman-elect of the American Hospital Association's (AHA) Board of Trustees. AHA includes in its membership 5,000 hospitals, health systems, networks and other providers of care. I am pleased to testify today on their behalf.

In recent hearings before both of these subcommittees, AHA has made the case that the Medicare program needs to change. While the private sector has been opening all kinds of doors in search of innovative ways to make the health care system more efficient and user-friendly, Medicare has effectively remained on the outside looking in, stuck in the traditional, fee-for-service mindset. Last week we laid out a road map on Medicare restructuring that included increasing beneficiary incentives to choose coordinated care, eliminating barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation, fixing the problems with how Medicare calculates capitated rates for risk contractors, and expanding the choices available for Medicare beneficiaries.

My testimony today will explain how Congress can open the door for Medicare and its beneficiaries to benefit from provider-sponsored, locally-based networks of care. AHA believes that any entity that takes on the task of delivering care to Medicare beneficiaries must meet high standards, and be held accountable for the quality of care it delivers. But we also believe that ill-suited regulation must not close the door on groups of providers that can offer efficient, high-quality care for Medicare and its beneficiaries.

<u>Making the most of provider-sponsored networks</u>
Moving Medicare to the future will require the thoughtful restructuring of the program itself. Restructuring must include offering Medicare beneficiaries the same coverage options enjoyed by people with private sector coverage.

It is therefore critical that, in an effort to broaden beneficiaries' options, Congress not limit its thinking to the current options -- health maintenance organizations (HMO) or competitive medical plans (CMP). While those options are important in a restructured market and need some modification to make them work better, we believe Medicare must look beyond full-risk contracts with HMOs and CMPs. It must stimulate the availability of more plan choices to create a dynamic local market by also considering risk-sharing arrangements with what we generically call provider-sponsored networks (PSNs).

Provider-sponsored networks are formal affiliations of health care providers -- such as physicians and hospitals -- organized and operated to provide health care services under contract with insurance companies, HMOs or other health plan companies. Some PSNs are known as physician-hospital organizations, under which physicians create a joint venture with

a hospital. That joint venture in turn contracts on behalf of its members with health plan companies to offer a variety of health care services.

Other PSNs may be more integrated -- that is, there may be greater economic or corporate ties among the participants. These PSNs are often called integrated delivery systems. In my state of Minnesota, for example, hospitals may directly acquire physician practices and employ the practitioners. Still other PSNs may be less integrated -- independent practice associations, for example, allow providers to jointly contract with health plan companies and offer reduced rates to patients that are members of a plan without formally merging their practices.

These arrangements have evolved into a variety of corporate and organizational structures that reflect local market conditions and regulatory constraints. But, PSNs have several things in common. Among them: They are initiated, financed and governed by health care providers; and they are formed to deliver health care services through contracts with health plan companies.

Provider-sponsored networks play an important and positive role in health care delivery, particularly in the delivery of coordinated health care. Health plan companies find that the expansion of coordinated care programs is facilitated by PSNs, because they:

- Offer an established network of providers.
- Promote provider accountability for quality by acting as a mechanism to simplify administration and implement clinical quality management programs.
- Reduce a health plan's administrative expenses by providing a single party through which to negotiate contract terms.

Many PSNs have formed HMOs, or have become partners with insurers to do so and, as a result, have been able to provide coordinated care choices for Medicare beneficiaries. But others have not become HMOs for several reasons. Some serve populations that are either too small or too sick to support the full risk of an HMO. Some are in states where it reportedly takes up to two years to get an HMO license. And others are in geographic areas where Medicare's HMO payment would be too low to provide adequate care. Current regulatory thinking could limit the ability of these organizations to serve Medicare beneficiaries.

We believe the Medicare program should not limit beneficiary choices of coordinated care programs by contracting only with plans in which an insurer or HMO acts as the intermediary. Medicare should take full advantage of the health care delivery innovations and efficiencies offered by PSNs by joining them in risk-sharing arrangements as well.

Under such arrangements, PSNs would be paid on a partial capitation basis, but the risk assumed by the PSN would be limited. Financial risk-sharing arrangements would not expose PSNs to full insurance risk for unexpected illness or injury, yet would still create incentives for providers to manage utilization and keep people healthy.

Medicare should limit financial risk-sharing arrangements to PSNs that contract for the full benefit package and directly provide substantially all of the services through their own affiliated providers. This type of risk-sharing arrangement has worked well in the private sector to help contain health care costs. Because PSNs would not be taking on all the insurance risk of a full-risk HMO, they should be regulated somewhat differently than insurers or HMOs. If a PSN wishes to assume full capitation, then it should comply with HMO regulations.

AHA's recommendations

We believe that true restructuring of the program means that Medicare should contract directly with provider-sponsored networks, just as we have supported that freedom for ERISA self-insured employer group health plans. The standards that these plans should follow should include the same important consumer protection safeguards found in HMO requirements, but a few key modifications are needed. These include:

The 50/50 government/private enrollees rule, which requires that no more than half of a plan's enrollees be Medicare or Medicaid beneficiaries, is no longer necessary, particularly in this context. This rule was adopted to safeguard the quality and accessibility of care for government beneficiaries, but there are now other, more direct mechanisms to ensure quality. This would allow PSNs, particularly those that serve rural and chronically ill patients (primarily people covered by Medicare and Medicaid), to participate in the program.

The minimum-5,000-enrollee threshold has impeded the development of coordinated care in smaller rural communities. As long as the PSN can demonstrate its ability to provide a full range of services in a coordinated fashion, this requirement is also unnecessary.

The requirement for a state HMO license should be eliminated if the PSN's contract contains appropriate risk-limiting provisions. The purpose of a Medicare HMO or CMP is to ensure protection against unexpected morbidity (illness or injury) and similar insurance-type risks. This "back-stop" role can just as easily be performed by the Medicare program as by an HMO or CMP without having to pay the HMO additional fees for those insurance services. The required inclusion of risk-sharing or limits is clear evidence of an intent to limit the PSN's risk, particularly when coupled with the fact that the arrangement covers predominantly services produced directly by the providers. This would open more options for beneficiaries by overcoming the problem of long delays (reportedly up to two years) in obtaining HMO licenses.

This is not to say the PSNs should not demonstrate their own financial ability to deliver services. PSNs should be subject to appropriate solvency requirements. These solvency requirements, however, should acknowledge that PSNs must invest most of their capital in delivering high-quality services, not creating cash reserves to pay claims. PSNs should be held to a solvency standard that takes into account the amount and type of risk the network takes on and its delivery assets, but ensures its ability to meet its obligation to Medicare beneficiaries. Compliance with the standards could be streamlined by requiring that PSNs obtain and submit independent actuarial certification about their compliance with the standards.

Quality issues

This is also an opportune time to completely re-examine Medicare requirements that address quality and access, and the provision of information to beneficiaries to help them choose plans and treatment options that ensure ready access to high-quality care. Standards should ensure access to providers on a timely basis and at the appropriate level of care. Standards should ensure an adequate number, geographic distribution and specialty mix of network practitioners and providers. They should also ensure that utilization review procedures encourage quality delivery of services, and are not used to restrict medically necessary services -- especially after-hours and emergency room services.

Quality assessment and improvement standards should require that providers in the network are chosen for how well they deliver care and with the expectation that they actively participate in an ongoing effort to monitor and improve care. Quality assessment measures should include the traditional clinical outcomes, but also begin to utilize patient-reported information on their functional ability after treatment, and on emotional and educational support from practitioners. As a safety valve and ongoing monitoring tool, provider-sponsored networks and other coordinated care systems should maintain easily accessible, responsive complaint and grievance processes. Consumers should feel their complaints are heard and that every attempt is made to settle disputes.

The responsibility for giving beneficiaries information to choose between networks must be shared by the Medicare program. While networks should not be precluded from advertising in local markets, the advertising should meet some common national standards. In addition, networks should be required to provide information in a simple standard format that HCFA would develop.

We also believe Congress should consider federal certification of PSNs to establish their ability to enter into direct risk-sharing arrangements with the Medicare program. We have been discussing a similar approach with Rep. Harris Fawell (R-IL), chairman of the House Committee on Economic and Educational Opportunities Subcommittee on Employer-Employee Relations, in the context of ERISA self-insured employer group health plans. Such a certification process would ensure that standards are applied without requiring the overly broad state regulatory framework for health carriers and HMOs.

To streamline standards enforcement, the Medicare program should consider using private accrediting bodies through deemed status where appropriate. However, this is a new area of standards development that requires a careful assessment of network and health plan standards, both public and private, before such an arrangement is implemented.

HCFA's Medicare Choices Demonstration Project

We had hoped that the Health Care Financing Administration's (HCFA) Medicare Choices demonstration project would open more doors for beneficiaries by exploring how Medicare can take advantage of delivery systems such as provider-sponsored networks. However, it would appear that the criteria for applicants could effectively require that applicants be licensed HMOs in all but possibly one of the nine metropolitan areas targeted by HCFA. Consequently, the project may be limited to demonstrating alternative payment methods for HMOs. While such efforts are needed, Congress may want to stimulate much broader efforts to bring Medicare into the future of health care delivery. Medicare beneficiaries should be able to continue relationships with local health care providers that they have built up over the years. Provider-sponsored networks can offer this option to them.

Conclusion

Mr. Chairman, America's hospitals and health systems are proud of the service they've provided for Medicare beneficiaries over the past 30 years. We're proud that we've been able to maintain high levels of quality, make new technology available to Medicare beneficiaries, and increase efficiency.

But we cannot continue to cut costs and become more efficient without a significant realignment of financial incentives. If PSNs cannot take some risk without being required to have an HMO license, most of our members will be driven away from incentive-based payment arrangements because they are either too small to accept full risk or because it takes too long to get an HMO license from their state.

Appropriate public policy is key to making sure the door is not shut on the provider-sponsored network option. Allowing provider-sponsored networks to contract with Medicare on a limited-risk basis opens doors for everyone involved: Medicare and the network's providers, and the beneficiaries themselves, who would be able to choose local hospitals, physicians and others organized to provide benefits in a coordinated and efficient manner. It's a choice they deserve to have.

Chairman THOMAS. Thank you very much.
Mr. Walworth.

STATEMENT OF JAMES WALWORTH, PRESIDENT, HEALTH ALLIANCE PLAN OF MICHIGAN, DETROIT, MICHIGAN, ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA

Mr. WALWORTH. Thank you, Mr. Chairman and Members of the Subcommittees. I am James Walworth, president, Health Alliance Plan of Michigan, and I am here today testifying on behalf of GHAA, the Group Health Association of America, the Nation's leading association for health maintenance organizations. Our 385-member HMOs account for more than 80 percent of the 50 million Americans who are today served through HMOs.

We are pleased to have been asked once again to testify before Congress and these Subcommittees with respect to the future of the Medicare Program. We look forward to continuing to work with Congress and the administration as you review the Medicare Program.

Medicare can best be strengthened, in our view, by offering beneficiaries the same kinds of choices that are already available to millions of working Americans in the private sector and those working for the Federal Government. In prior testimony before other Committees, we have put forth our view of the basic elements of that kind of an approach.

Today, at the request of these two Subcommittees, we will focus on the standards that should apply to the alternatives that may be created as part of the Medicare Program. In order to participate in Medicare today, HMOs and competitive medical plans must meet detailed standards on many aspects of their operations, from marketing, enrollment, disenrollment, infrastructure and access to care, to grievance procedures and appeal processes reporting disclosure, solvency standards, and other forms of enrollee protection.

While recognizing that their administration should be simplified and streamlined, we believe that these standards provide a very strong foundation for criteria that should apply to the full spectrum of options that may seek to participate in a reformed Medicare Program. Based on years of experience of Medicare contracting with the HMOs and CMPs, these standards are known to address certain fundamental issues that will remain as valid in the future as they are today.

These include, in particular, assurances that beneficiaries have the information necessary to make an informed choice among the options available and the information necessary to understand how to obtain the covered services through organized delivery systems, as well as under the traditional Medicare Program.

Second, to assure that enrollees have access to needed services; third, that those who will provide services demonstrate an accountability for the quality of care; fourth, that there are adequate mechanisms for resolving enrollee grievances; and, finally, that all the options that accept risk have financial capacity sufficient to provide those promised benefits.

GHAA believes that as the array of offerings available to Medicare beneficiaries expands, it is vitally important to maintain strong and comparable standards for all options. We believe that

States and the Federal Government can work in partnership and play equally important roles in achieving that goal, but with the Federal Government continuing to bear the responsibility for determining that the options available meet standards for entry into the Medicare Program, and for ensuring that they meet these and other rules for program participation on an ongoing basis.

However, where State licensure standards are at least as stringent as the Federal standards, plans should not be subject to unnecessary duplicative reviews. Under this framework, Medicare beneficiaries can be assured that all options available to them in all regions of the country are held to a consistent set of standards.

We believe and recommend that all organized systems of care, as well as providers under the fee-for-service Medicare Program, should meet comparable standards. This means that where options include similar elements or activities, those are the areas where comparable standards apply, particularly in issues of State licensure, quality, access, grievance procedure, solvency, marketing, and administration.

There are a couple of other areas I would like to quickly mention. We recommend that a statutory criteria be established for the waiving of the 50–50 rule with respect to enrollment in HMOs. Also, it is important and essential to avoid the inhibition of developing HMOs and other organized systems of care through such antimanaged care proposals and changes to antitrust laws as has been suggested.

We think that deemed status is also an appropriate role for the private sector with respect to issues of quality and standards and their application. While GHAA favors building on the existing standards, we do believe that there is room for improvement in the HCFA's administration of the program, particularly with regard to the processing of applications and the expansion of service areas.

We appreciate this opportunity, Mr. Chairman, to present our views. We know, too, that there will be efforts to relax some of the current standards. We think that, as you view those, it is essential that you keep in mind how they would affect the operation of the program.

We look forward to working with the Subcommittees on these issues and with Congress, as you go through this debate.

[The prepared statement and attachment follow. The Consumer Protection and Quality Assurance: Current Regulations and Standards for Medicare HMOs and CMPs are being held in the Committee's files.]

STATEMENT OF JAMES WALWORTH, PRESIDENT
HEALTH ALLIANCE PLAN OF MICHIGAN
ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA

Mr. Chairmen and members of the Committees, I am James Walworth, President of Health Alliance Plan of Michigan, and I am testifying today on behalf of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs). Our 385 member HMOs serve 80 percent of the 50 million Americans receiving health care through HMOs today.

We are pleased to be asked to testify as your Committees explore the future of the Medicare program, and look forward to working with the Congress and the President in a bipartisan fashion on Medicare. GHAA believes that Medicare must be modernized to reflect the dramatic developments that have occurred in the private sector since Medicare was enacted 30 years ago. Medicare can best be strengthened by offering beneficiaries the same kinds of choices that are already available to millions of working Americans both in the private sector and in the federal government. Today, I would like to:

- o review GHAA's guiding principles for discussion of Medicare reform;
- o summarize briefly the recommendations GHAA has already made to Congress on the beginning steps needed to modernize Medicare; and
- o present GHAA's views on the standards that should apply to options available to Medicare beneficiaries in an era of expanded choice.

Guiding principles for discussion

As you know, the health care environment of 1995 is vastly different than the one that prevailed in 1965, when Medicare was enacted. Fee-for-service coverage is no longer the predominant approach to coverage in the private sector. More than 60 percent of all working Americans with private health coverage now receive their care through HMOs and other organized systems of care. Medicare too is changing, but slowly -- only about 10 percent of today's Medicare beneficiaries are in HMOs. The result is that Medicare beneficiaries no longer have coverage that is typical of that available to the working population and do not derive the benefits of the choices available to other Americans.

Medicare must be updated to reflect the dramatic changes that have occurred in the private sector during the three decades since the program began. GHAA believes that Medicare can best be strengthened by giving beneficiaries the same kinds of choices that are already available to millions of working Americans, including federal employees and members of Congress. Medicare -- and the Health Care Financing Administration (HCFA) -- should be reoriented toward a model in which Medicare beneficiaries have the opportunity to choose from among a broad array of options that compete on the basis of quality, service, and cost, and are held to comparable standards. When beneficiaries can choose the option that best meets their needs, Medicare will benefit from the progress that has been made in the private sector.

GHAA believes that the following principles should guide discussions of Medicare reform:

- o **Beneficiary choices**: Medicare reform should be consistent with the promise of providing access to Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population. Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.
- o **Medicare standards**: Our experience also tells us that standards are vitally

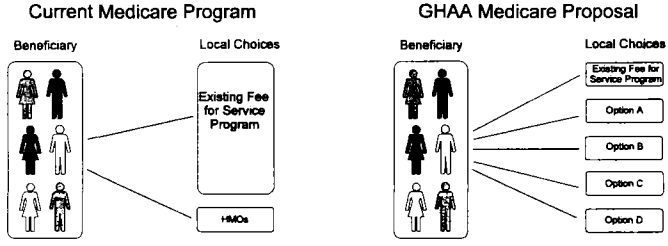
important. All organized systems of care, as well as providers under the fee-for-service Medicare program, should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency.

- **Medicare payments**: Medicare payments should permit widespread availability of organized systems of care, as well as the traditional fee-for-service option, for Medicare beneficiaries nationwide. The Medicare program should act in a fashion similar to private sector purchasers. This can be done by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis, with an equitable allocation of resources between organized delivery system options and the fee-for-service program. Total expenditures should be trended forward on an appropriate basis to meet program goals.

Beginning steps

Looking at the current Medicare program and using the GHAA principles as a guide, the question, of course, is how to begin to take the steps necessary to modernize Medicare. Based on the practical and proven experience of our member plans in serving tens of millions of Americans, including three million Medicare beneficiaries, we have recommended a series of changes to transition from the current approach to a model based on beneficiary choices.

Figure 1



The changes are designed to foster expansion in existing Medicare markets, encourage new Medicare markets to emerge, permit the development of increased capacity for Medicare beneficiaries to enroll in organized options offered by HMOs and other entities, and provide the experience necessary to permit informed decision-making by the Congress on the future design of the Medicare program. We have recommended changes in the following five areas:

- improving beneficiary information, awareness, and enrollment process;
- expanding the infrastructure of choices available to beneficiaries;
- maintaining strong standards for options participating in Medicare;
- beginning to transition HCFA from a model that relies on fee-for-service regulation to one that relies on beneficiary choice model; and
- transitioning to improved Medicare payment methodologies.

Maintain strong standards for options participating in Medicare

In previous testimony, GHAA has focused on increasing the choices available to beneficiaries, and issues related to payment. Today, at the request of your two committees, we will focus on the standards that should apply to the alternatives to the traditional Medicare program that will be available in an era of increased beneficiary choice.

Strong and comparable standards: In order to participate in Medicare today, health maintenance organizations (HMOs) and competitive medical plans (CMPs) [1] must meet detailed standards on many aspects of their operations, including marketing, enrollment and disenrollment procedures, benefits, delivery system (access to care), quality assurance programs, grievances and appeals, reporting and disclosure, solvency, and other enrollee protections. Because a description of these standards would consume more time and space than this hearing permits, a chart summarizing them has been submitted for the record.

While recognizing that their administration should be simplified and streamlined, GHAA believes that these standards provide the best foundation for standards for assessing the full spectrum of options seeking to participate in a reformed Medicare program. Based on years of experience of Medicare contracting with HMOs and CMPs, these standards address certain fundamental issues that will remain as valid in the future as they are today, including:

- assuring that beneficiaries have the information necessary to make an informed choice among the options available to them, and the information necessary to understand how to obtain covered services through organized delivery systems, as well as under the traditional Medicare program.
- assuring that enrollees have access to needed care;
- assuring that all who provide services demonstrate their accountability for quality of care;
- assuring that there are adequate mechanisms for resolving enrollee grievances; and;
- assuring that all options that accept risk have the financial capacity to provide promised benefits.

GHAA believes that as the infrastructure of offerings available to Medicare beneficiaries expands, it is vitally important to maintain strong and comparable standards for all options. Both the states and the federal government have important roles to play in achieving this goal. The federal government should continue to bear the responsibility for determining that options meet standards for entry into in the Medicare program and for ensuring that they meet these and other rules for program participation on an ongoing basis. However, where state licensure standards are at least as stringent as the federal standards, plans should not be subject to duplicative reviews. Under this framework, Medicare beneficiaries can be assured that all options available to them in all regions of the country are held to a consistent set of standards.

- **Comparable standards**: All organized systems of care, as well as providers under the fee-for-service Medicare program should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency. This means that where options include similar elements or activities, they should meet comparable standards with respect to those elements or activities. For example, the same standards should

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[1] Competitive medical plans (CMPs) are HMOs that have not chosen to become federally qualified but meet similar federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMOs and CMPs.

apply whenever options have delivery systems, engage in marketing activities or accept risk for providing services or benefits. Standards should include:

- -- State licensure: All options should be offered by state licensed entities, and all providers should be licensed, certified or accredited, as appropriate.

- -- Quality: All offerings and providers should have the capacity to develop reports on performance that permit comparisons among options and providers.

- -- Access: All options and providers should accept all beneficiaries who wish to enroll or who select those providers up to the limits of the capacity of such offerings/providers and without regard to health status.

- -- Grievance procedures: All offerings and providers should make available to beneficiaries procedures for hearing and resolving grievances under the Medicare program.

- -- Solvency: All offerings should be fiscally sound and meet standards for an initial deposit, initial net worth and ongoing solvency.

- -- Marketing and Administration: All offerings should provide to beneficiaries easily understood information that describes the coverage offered, the structure of the delivery system and rules and procedures for obtaining covered services. HCFA should work with entities offering these options to develop comparative information for beneficiaries that includes all of the choices available to those including the traditional Medicare program.

- -- Confidentiality: All offerings and providers should establish procedures for maintaining the confidentiality of patient records that are consistent with applicable laws.

- o **50/50 rule**: Statutory criteria in connection with waiving the 50/50 enrollment requirement for HMOs and other organizations offering organized options should be developed.

- o **Anti-managed care**: Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.

- o **Deemed status**: To enhance and streamline Medicare's quality assurance program, organized offerings that are accredited under standards at least as stringent as those established by the Medicare program by private sector organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC), should be deemed to comply with applicable Medicare quality standards.

As a broader range of options become available to Medicare beneficiaries the standards established in all of these areas must be comparable. We have carefully considered the way in which the current framework of federal regulation for HMOs and CMPs can form the foundation for this expanded participation. Our recommendation, one that is consistent with an approach that has been adopted by the NAIC, is to require that all options that involve comparable elements or activities should meet the comparable standards for those activities.

How would this work?

Many organized systems of care provide services to their enrollees primarily through affiliated providers, and ordinarily will not cover services furnished by others. Because the universe of providers available to their enrollees is defined, the current framework requires these plans to meet standards designed to assure access to care through those providers. Indemnity coverages pay for services but do not take responsibility for providing care through arrangements with providers. Such plans would be subject different standards for access, because they do not perform coordination of care functions that are carried out by HMOs.

By contrast, every health plan seeking to participate in the Medicare program will engage in marketing activities in order to enroll Medicare beneficiaries; thus, they should be held to comparable marketing standards in areas such as the accuracy of their marketing materials and avoiding prohibited marketing activities, such as door-to-door solicitation and offering gifts to induce enrollment. Likewise, every option to which Medicare makes a capitated payment for an enrolled beneficiary -- regardless of who owns the entity offering the option or how its delivery system is organized -- has accepted risk and must be held to comparable solvency standards designed to ensure it is able to deliver promised benefits without interruption.

Requiring all options to meet comparable standards is critical to ensuring that all beneficiaries can have the same confidence in the soundness of the option they select. It is also critical to ensure that all options compete under comparable rules on the basis of quality and cost effectiveness. Therefore, the standards established for the range of choices under a modernized Medicare program are one of the paramount elements that make the choices meaningful for beneficiaries.

GHAA strongly believes that the way you resolve the issue you are considering here today will be critically important in determining the success or failure of any Medicare reform initiative emerging from the 104th Congress. The standards that Medicare options must meet will have a major impact on whether or not the new choices available to beneficiaries in a restructured Medicare program are capable of delivering the benefits and quality of care they have promised to provide -- and of doing so over the long run, not just for a year or two. And this, in turn, will help determine whether Medicare beneficiaries see them as reasonable alternatives to the current fee-for-service Medicare program.

Congress will undoubtedly be asked to relax some of the current standards as it expands the number and type of available health choices for Medicare beneficiaries. Those making such requests may argue that a particular option is distinguishable from existing HMOs -- or that temporary relief is needed during an initial start-up phase. While GHAA does not necessarily believe that all such requests should be rejected out-of-hand, it believes that the greatest risks to Medicare reform lie in its initial stages, and we urge Congress to evaluate requests for differential standards in light of whether, if granted, they will increase or decrease the likelihood that the option in question will meet the needs and expectations of Medicare beneficiaries and remain financially viable. It will not take many health plan failures to discredit Medicare reform in the eyes of the public -- setting back reform and imposing a substantial financial burden on the program and the taxpayer who ultimately stands behind the failed plan.

Streamlined administration: While GHAA favors strong and comparable standards for all options -- and believes that existing HMO/CMP standards provide the best framework upon which to build -- there is room for improvement in the way the current standards are being administered. Changes in HCFA's focus on individual claims payment and basic improvements in administrative mechanisms can help enhance the modernization of the choices available to beneficiaries.

- **Transition to new model**: HCFA needs to begin the process of reorienting its

approach from management of the transactions in a fee-for-service system to implementation of a beneficiary choice model oriented toward oversight of organized delivery systems.

- **Administrative procedures and processing of applications**: In the short-term, HCFA should take immediate steps to improve administrative procedures and processing time:

  - -- reduce the time it takes to process and approve two types of applications from HMOs: initial applications to serve Medicare beneficiaries, and applications from approved plans to expand their service area and be able to serve additional Medicare beneficiaries;

  - -- simplify administrative procedures for submission and processing of applications (i.e., permit information associated with the application to be submitted on computer disk); and

  - -- streamline oversight of multi-state organizations, for example by eliminating duplicative filing requirements and facilitating communications among regions.

- **Policy guidance/ regional variations**: HCFA should take steps to identify and narrow the variation in interpretation of policy by regional offices and promote consistency in decision making in such areas as review and approval of contracts, products, and marketing materials; this should include the development and issuance of guidelines for regional offices.

Anti-managed care proposals: Finally, we would be remiss in testifying on standards for a broadened range of Medicare options if we failed to address proposals that would require HMOs and other organized offerings to contract with certain providers and to follow complex and burdensome procedures for credentialing and selecting providers. GHAA opposed such proposals last year in the context of comprehensive health care reform, and we oppose them now in the context of Medicare reform. Current HMO/CMP standards address the issue of beneficiary access to care in considerable detail and are designed to protect consumers in key areas. Like other anti-managed care proposals, these proposed restrictions run counter to the central requirements of a system that is based on an array of choices competing on their ability to provide high quality, cost-effective care. Such provisions, if enacted, could undermine the ability of HMOs and other organized systems of care participating in the Medicare program to select the physicians best suited to the needs of their members.

Conclusion

GHAA appreciates this opportunity to present our views about modernizing the Medicare program and establishing standards for the choices that will be available to beneficiaries. We look forward to working with the Committee on this issue, and I would be pleased to answer any questions that you may have. Thank you.

GHAA

Quality Assurance in HMOs
Medicare Requirements and NCQA Accreditation Standards[1]

[1] In this document. "CFR" refers to the Code of Federal Regulations, "Review Guide" refers to the Medicare Contractor and Performanace Monitoring System: Review Guide (External) (1993 revision). All NCQA references are to NCQA Standards for Accreditation, 1994 edition.

Subject	Regulations	Agency Guidance	NCQA
Quality Assurance Program §1876 (c)(6) Social Security Act	Ongoing quality assurance program: must have ongoing quality assurance program meeting four conditions: Stresses health outcomes Provides review by physicians/other health professionals of the process of providing health services; Data collection, interpretation, intervention: uses systematic data collection of performance, patient results; interprets data to practitioners; institutes needed change Includes written procedures for taking remedial action when • inappropriate or substandard services are provided • services that ought to be provided have not been provided. 42 CFR 417.106(a); 417.418	**Ongoing QA program** **See also: Review Guide section VI, pp VI 1,2** **Stress on health outcomes See also: Review Guide, section VI, ppVI 2,3.** **Peer review** **See also: Review Guide, Section VI, p. VI 3.** **Systematic data collection** **See also: Review Guide, section VI, pp. VI 3,4.** **Remedial action** **See also: Review Guide, section VI, p. VI 4.**	Ongoing quality improvement (QI) program is designed to monitor and evaluate quality and appropriateness of care and service provided members and pursue opportunities for improvement. QI 5.0 - 5.4.3 Clearly defines and assigns to appropriate individuals organizational arrangements and responsibilities for QI processes. QI 1.0 - 2.5 QI committee is accountable to the HMO's governing body. Demonstrates evidence of a formally designated structure, accountability at the highest levels of the organization and ongoing and/or continuous oversight of the QI. QI 2.0 - 2.5 Documents and reports to appropriate individuals findings, recommendations, actions taken as a result of QI activity. QI 3.0 - 3.3 Takes an active role in improving the health status of members. QI 8.0 - 8.3

Subject	Regulations	Agency Guidance	NCQA
Quality Assurance Program			Incorporates into all provider contracts and employment agreements requirements to participate in QI activities. Specifies that hospitals and other contractors will allow access to medical records of HMO. Uses measurements, QI data collection, and analysis to track quality improvement. QI 9.0 - 9.2.1 Establishes standards for the availability of primary care providers and access. Assesses performance against these standards. QI 7.0 Uses a variety of mechanisms to identify important areas for improvement and to set meaningful priorities. QI 6.0 - 6.4 Takes actions to improve quality and assesses the effectiveness of these actions through systematic follow-up. QI 10.1 - 10.3

Subject	Regulations	Agency Guidance	NCQA
Quality Assurance Program			Evaluates the overall effectiveness of its QI program. QI 11.0 - 11.2 If any QI activities are delegated to contractor, demonstrates evidence of oversight of the contracted activity. QI 12.1 - QI 12.2.2
Utilization management	HMO must have effective procedures to monitor utilization and to control the costs of services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers. 42 CFR 417.103(b)	See also: Review Guide, section III, code UM01, p. III 1.	HMO must have a documented utilization management program description that describes both delegated and nondelegated activities. UM 1.0 Uses qualified medical professionals to supervise review decisions where procedures are used for preauthorization and concurrent review. UM 2.0 - 2.2 Has a set of written UR decision protocols based on reasonable medical evidence. UM 3.0 -3.3.1 Efforts are made to obtain all necessary information, including pertinent clinical information, and consultation with treating physicians as appropriate. UM 4.0

Subject	Regulations	Agency Guidance	NCQA
Utilization management			Makes decisions in a timely manner depending on the urgency of the situation. UM 5.0 Clearly documents reasons for denial and makes them available to member. Denial notification includes appeal process information. UM 6.0 Has policies and procedures in place to evaluate appropriate use of new medical technologies. UM 7.0 - 7.2 Has mechanisms to evaluate the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means. UM 8.0 If the HMO delegates any UM activities to contractors demonstrates evidence of oversight of the contracted activity. UM 9.0

Chairman THOMAS. Thank you very much, Mr. Walworth.
Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, POLICY AND REPRESENTATION, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman and Members of the Subcommittees, my name is Mary Nell Lehnhard. I am senior vice president for Policy and Representation for the Blue Cross & Blue Shield Association, and I am here representing the 68 Blue Cross & Blue Shield plans.

We appreciate this opportunity to testify on the appropriate standards that you are considering in introducing more choice of programs into the Medicare Program. Blue Cross & Blue Shield plans are eager to participate in broadening the choice of options to Medicare beneficiaries. These plans currently enroll more than 30 million Americans in a range of managed care network products that include HMOs, PPOs, and point-of-service products. Thirteen Blue Cross & Blue Shield plans currently have risk contracts, and 30 plans are in the process of qualifying for these contracts.

As you consider specific standards for these new types of health plans, we urge you to keep in mind three general recommendations. First, the existing standards in 1876 which set the standards for the risk contracts already provide a comprehensive framework for consumer protection. We do not think you need to look any further. These standards cover such protections as open enrollment, solvency standards, consumer grievance procedures, health plan marketing, coverage of emergency and out-of-network services, explanation of benefits, and continuation of coverage upon contract termination. We have appended to our testimony a list of those standards. We think these standards have served beneficiaries very well and we urge you to resist more regulation.

Second, in applying these standards to the new options, we recommend three things: First, apply these standards uniformly to all types of health plans that offer coverage to Medicare beneficiaries. This includes health plans offered by physicians and hospital organizations, the so-called PHOs. Second and very importantly, require all participating health plans to be licensed by the State in which they operate. Again, this would include the PHOs.

Health plans that participate in Medicare are going to be accepting. All of them, whether a PHO, HMO, or point of service are going to be accepting an insurance risk of providing services in exchange for a capitation payment from Medicare. This is the business of insurance, and beneficiaries will not be protected unless the health plans meet very carefully designed insurance or HMO laws on solvency and other consumer protections.

The National Association of Insurance Commissioners is currently working aggressively on a strategy to assure that PHOs that accept capitation payments are licensed either as insurance companies or HMOs in the States.

The third recommendation with respect to the application of those existing standards is to use private accreditation, where possible. You have heard today that Medicare has already laid a foundation for this. Hospitals that are accredited by JCAHO are

deemed to be in compliance with the Medicare standards. In other words, it is very simple: Congress sets the standards and if a private accreditation organization wants to participate in deeming those standards, then their private rules have to encompass Medicare or be equal to or better than, and HCFA would make that determination.

Beyond the obvious cost implications of reducing costs for health plans, private accreditation should be encouraged, because it would first say to beneficiaries that their health plan meets the same high standards that major employers are demanding, and, second, provides beneficiaries the advantages of private market demand for not just the infrastructure rules, but the performance measurements and the information on performance that would be given to purchasers.

Our third and final overall recommendation as you develop these rules is to recognize the two facets growing in most popular managed care products. PPOs encourage the use of a health plan's network by offering lower cost sharing when the network providers are used. And point of service, actually the most popular product, point-of-service products rely on lower cost sharing to encourage use of the network providers, but they include certain important features of HMOs, primarily primary care referral requirement and authorization for specialty services.

Mr. Chairman and Members of the Subcommittees, this is a summary of our recommendation and we look forward to working with you.

[The prepared statement and attachment follow:]

STATEMENT OF MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. Chairmen, and members of the committees, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 68 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for 68 million people — including more than 7 million Medicare subscribers with supplemental (Medigap) insurance coverage and 200,000 beneficiaries enrolled in Blue Cross Blue Shield HMOs. I appreciate the opportunity to testify before you on ways to strengthen and improve the Medicare program.

Our statement today primarily addresses the issue of setting appropriate standards for private health plans offered to Medicare beneficiaries and the role of federal, state and private agencies in the oversight of these standards. In our view, the structure of standards established under Section 1876 by the Social Security Act offers a comprehensive framework for health plans to be made available to seniors. We recommend, in addition, that:

- health plan standards be applied uniformly to all health plans, including those sponsored by physicians and hospitals (PHOs);
- all health plans offered to Medicare beneficiaries be licensed to offer health care coverage by the state and
- that Medicare expand its reliance on private accreditation to certify compliance with applicable federal health plan standards.

In addition, we recommend that Medicare move quickly to expand the availability of health plans such as PPOs and Point-of-Service plans.

In 1965, the Medicare program was designed to give seniors and the disabled access to mainstream medical care and coverage modeled after the most common kind of health insurance available to those under age 65 — health insurance that was pioneered by Blue Cross and Blue Shield Plans. Since 1965, mainstream coverage in the under 65 population has changed and Blue Cross and Blue Shield Plans have led the way with innovative managed care options.

In an effort to make more comprehensive benefits available at lower cost, Blue Cross and Blue Shield Plans have successfully developed and marketed to the working population a wide range of health plan options. Blue Cross and Blue Shield Plans Plans, collectively, have enrolled nearly 30 million subscribers in managed care products. Blue Cross and Blue Shield, collectively, have the largest number of subscribers enrolled in HMOs.

Medicare, however, has not changed. Only 10 percent of Medicare beneficiaries have enrolled in HMOs. More tellingly, the options that dominate the under-65 market — Preferred Provider Organizations (PPOs) and Point-of-Service (POS) products — are not available to beneficiaries. Medicare can best be strengthened by making available to Medicare beneficiaries the same broad range of options that have been widely adopted by the under-65 population.

Blue Cross and Blue Shield Plans are working to make the current limited Medicare options available to seniors. Thirteen Blue Cross and Blue Shield Plans offer HMOs or similar coverage to Medicare beneficiaries. As of the end of last year, Blue Cross and Blue Shield HMOs enrolled more than 200,000 Medicare beneficiaries, and the number is growing rapidly. In addition, nearly 30 Blue Cross and Blue Shield Plans are in the process of developing and launching risk-based HMO products to offer to Medicare beneficiaries.

In the more traditional area of Medigap coverage, Blue Cross and Blue Shield Plans have also been innovators. Medicare Select products offer beneficiaries more affordable Medigap coverage that relies on a selected network of providers. The Select products are, in fact, virtually the only way Medicare beneficiaries can obtain

PPO-like or POS-like coverage. We believe that these products have a vital role to play in offering superior coverage to Medicare beneficiaries and have demonstrated the need for expanding the range of health plan options in a revitalized Medicare program.

Guiding Principles for Reform

We believe that Medicare should move beyond the current limited options offered to seniors. Medicare should apply the lesson learned by the private sector that private competitive markets offer a better solution to the problem of controlling costs, assuring quality, and providing better coverage than central bureaucratic controls. In applying this lesson, we believe that three principles should guide the effort to revitalize the Medicare program.

- Medicare beneficiaries should be able to obtain coverage from the same range of mainstream health care coverage options that millions of working men and women rely on, including HMOs, PPOs, and Point-of-Service plans, in addition to the traditional indemnity coverage offered by the Medicare program.
- Medicare beneficiaries should be able to choose coverage within a competitive market in which private organizations design, develop, manage and offer innovative products to provide beneficiaries better coverage at a better total cost. The federal government should continue to offer the traditional program as an option for beneficiaries — but should rely on private health plans to offer alternatives to traditional coverage.
- Medicare should rely on a combination of federal, state and private accreditation organizations to make available to beneficiaries licensed health plans that offer high quality care and good value, and to supply beneficiaries with the comparative information that will enable them to select the health plan that best meets their needs.

The federal government should strive to establish a competitive private market that meets the needs of seniors for high quality medical care and coverage. The federal government should protect beneficiary interests by adopting regulations that promote vigorous, responsible competition by emphasizing outcomes and performance over process and paper work compliance. A program restructured along these lines would work as follows:

- Medicare beneficiaries would have the option of obtaining coverage from among certified private health plans or the traditional Medicare program.
- Only health plans that are offered by licensed insurers and HMOs (or other licensed entities), and meet federal standards would be able to participate. To the extent possible, the federal government should rely on private certification and state licensure to determine compliance with standards.
- Health plans would have maximum flexibility to design products that meet the diverse needs of the Medicare population within basic standards for adequacy of benefits.
- Medicare would determine the contribution that it would make toward the cost of coverage provided by a health plan related to the actual costs of Medicare beneficiaries.
- Beneficiaries would select a health plan and pay the health plan the difference between the Medicare contribution and the premium established by the health plan. Beneficiaries would be able to switch health plans at least annually.

A restructured, competitive Medicare market can provide beneficiaries access to innovative health plan coverage options that millions of working Americans currently enjoy.

Specific Principles for Health Plan Standards
Standards to safeguard vital beneficiary interests are a necessary part of any Medicare reforms designed to expand access to private health plans. Standards should be designed to encourage, not stifle, innovation in the design of products and the management of costs. They should emphasize the results that the health plan delivers to its subscribers, not detailed procedural requirements.

The existing requirements for Medicare capitated programs, Section 1876 of the Social Security Act, establish a comprehensive framework for consumer protections. (An outline of these requirements is attached.) These standards address:

- open enrollment;
- solvency;
- health plan capacity;
- grievance procedures;
- health plan marketing;
- coverage of emergency services;
- continuation of coverage upon termination of contracts;
- explanation of benefit limitations such as requirements to use network providers; etc.

We believe that this extensive list of standards speaks for itself. Even a cursory review of the attachment suggests that health plans do not suffer from a lack of standards. Congress should resist calls for still more regulation of the details of provider selection and contracting or utilization management. We believe that the current standards sufficiently protect consumer interests.

In applying these standards to health plans, however, we believe that Congress should:

- uniformly apply the same health plan standards to all types of health plans offering coverage to Medicare beneficiaries, including health plans sponsored by physicians and hospitals (PHOs);
- require all participating health plans to be licensed to offer health benefit plans by the states in which they operate;
- rely more extensively on private accreditation or state certification to identify the plans that comply with its requirements.

A few comments on the second and third of these three points is in order. State licensure is important to make sure that the health plans available to seniors meet solvency and other financial standards. Federal law should, however, preempt state laws that restrict the ability of managed care plans to actually manage costs on behalf of their subscribers.

Private accreditation would reduce the Medicare program's administrative costs and avoid imposing duplicative costs of regulatory compliance on health plans and consumers. Medicare has successfully relied on private accreditation to determine compliance with the Medicare conditions of participation for hospitals. Hospitals that are accredited by the Joint Commission for the Accreditation of Healthcare Organizations are 'deemed' to be in compliance with the Medicare standards for hospitals. Those hospitals that are not accredited (for the most part small, rural hospitals) may be certified by the states under cooperative agreements with the federal government. We believe this model has potential application to health plans.

The private accreditation organizations that employers are beginning to use to certify their health plans offer a foundation for Medicare to use to certify compliance with its standards. We believe, however, that accreditation should be one means of

demonstrating compliance with Medicare health plan standards, not a requirement. The purpose of accreditation is to reduce administrative costs by accepting a private certification as evidence that the health plan satisfies Medicare standards. Medicare would determine whether an accrediting organization's standards are, in fact, at least as rigorous as Medicare's own standards.

We believe that using accreditation to certify compliance with federal health plan standards has significant merit for two additional reasons. It would say to beneficiaries that the health plan meets the same high standards that health plans offered to millions of employed Americans meet.

In addition, private accreditation is demonstrating innovative approaches to setting standards and reviewing health plan performance that will keep pace with the demands of a competitive — and demanding — marketplace. For example, NCQA has pioneered the development of methods of measuring performance and is using these measures both in the accreditation process and as a means of providing comparative performance information to purchasers. We believe that Medicare should learn and benefit from this private sector innovation.

Standards for Health Plan Options

Medicare's rules and regulations governing benefit design are showing their age. For all practical purposes, Medicare limits the private health plan choices that are available to beneficiaries to those that were available in the early 1970s: traditional indemnity coverage and the close-panel HMO.

The Medicare program is making some attempt to expand the range of choices available to beneficiaries. We support these efforts, but believe that Medicare should go further, faster. There is today — after more than fifteen years of development and real-world testing in the market — nothing experimental about products that combine a provider network with more limited coverage of out-of-network services. Medicare should take steps to rapidly expand the availability of two well-tested health plans:

- Preferred Provider Organization products which would create incentives for consumers to use the health plan's provider network in the form of lower cost sharing when a consumer receives care from a provider that is part of the health plan's provider network.
- Point-of-Service products also rely on lower cost sharing to encourage use of the health plan's provider network, but they include other features of HMOs, including primary care referral and authorization for specialist services.

In both types of products, when a subscriber is referred to a non-network physician or other provider for services that are not available within the provider network, the services will be covered as an 'in network' service (i.e., at the lower cost sharing amount).

Beyond this relatively simple rule, the design of out-of-network benefits should be left substantially to the dictates of the market place. Federal law should not prescribe, in detail, cost sharing for out-of-network services. Such regulations, while well intentioned, will increase the cost of coverage by limiting the incentives for subscribers to use the providers that have agreed to participate in the health plan's provider network.

Conclusion

We appreciate this opportunity to present our perspectives on Medicare reform, generally, and the more specific changes that are needed in health plan standards. We believe that Medicare already has in place a comprehensive set of health plan standards. Improvements can be made in three areas.

- the uniform application and enforcement of health plan standards to all types of health plans offered to seniors;
- allowing only entities that are licensed by states to offer health plans to make coverage available to Medicare beneficiaries; and,
- the introduction of private accreditation by organizations recognized by Medicare as adopting standards at least as rigorous as those established in federal law as an alternative means of demonstrating compliance with health plan standards.

We look forward to future opportunities to share with the Committee the results of our analyses as they are completed over the upcoming weeks and to work with you as you take up the complex challenge of bringing Medicare into the 1990s and putting it on a sound footing to face the 21st century.

Attachment: Section 1876 standards

Section 1876 of the Social Security Act already establishes a comprehensive framework of consumer protection regulations. Section 1876(c) establishes a broad range of standards designed to protect consumers:

- Subsection 1876(c)(2)(A) requires health plans to cover the services covered under Part A and B of the traditional program and allows health plans to offer supplemental benefits as an option available to beneficiaries.
- Subsection 1876(c)(2)(B) requires risk-contractors to comply with Medicare's national coverage determinations or policies.
- Subsection 1876(c)(3)(A) requires risk-contractors to have an annual 30 day open enrollment period, and to maintain continuous open enrollment for any beneficiary who loses coverage because another risk-contractor's contract is terminated.
- Subsection 1876(c)(3)(B) requires health plans to terminate a subscribers enrollment within one month of the subscriber's notice of termination.
- Subsection 1876(c)(3)(C) requires marketing materials and practices of risk-contractors to be approved by the Secretary and prohibits the use of materials that are inaccurate or misleading.
- Subsection 1876(c)(3)(D) prohibits risk contractors from refusing to enroll or renew coverage on the basis of a beneficiary's health status.
- Subsection 1876(c)(3)(E) requires risk contractors to provide subscribers with an explanation of:

  - benefits,
  - out-of-network coverage,
  - out-of-area coverage,
  - emergency coverage, and
  - appeal rights/procedures.

- Subsection 1876(c)(3)(F) requires risk contractors to provide 'continuation coverage' in the form of supplemental benefits for up to six months in the event that it terminates its contract with Medicare.
- Subsection 1876(c)(4) requires risk contractors to make services "available and accessible" to all subscribers with reasonable promptness and whenever medically necessary 24 hours a day and seven days a week.
- Subsection 1876(c)(5) requires risk contractors to establish grievance procedures. It also allows members who are dissatisfied with the outcome of the grievance procedures to submit unresolved disputes to an appeal to the Secretary and to seek judicial review.
- Subsection 1876(c)(6) requires risk contractors to establish a quality assurance program for the health services that it provides to its subscribers.
- Section 1876(c)(7) limits the liability of the risk-based contractor for primary coverage of medical care that is in progress at the time the beneficiary elects coverage from the risk contractor.
- Section 1876(c)(8) requires risk contractors to comply with Medicare regulations concerning advance directives.

In addition to these standards,

- Section 1876(h) establishes solvency standards; and,
- Section 1876(i) establishes various administrative standards that risk contractors must meet, including:
  - prohibitions on actions designed to deny or discourage enrollment by beneficiaries in need of substantial future medical services;
  - requirements for review by Peer Review Organizations; and,
  - restrictions on the type of contractual relationships that the health plan can enter into with providers.

Chairman THOMAS. Thank you very much for your testimony.

Does the gentleman from North Carolina wish to inquire?

Mr. BURR. Thank you, Mr. Chairman.

Dr. Bristow, the rest of the panelists thank you. We just saw each other last week, so I will be very brief with you, because I have had an opportunity recently.

Dr. Bristow, does the AMA believe that a market-driven system can meet or exceed the quality of care standards currently under the HCFA driven plan?

Dr. BRISTOW. Thank you, Congressman. We certainly do believe that that is feasible to do by utilizing a good deal of the private sector efforts that are already underway, some of which you have heard testimony from earlier today. We believe that by bringing those private sector coordinates together with representation from government, the insurers, the purchasers in the form of business and consumers, that certainly one could be able to develop the sort of guidelines that are needed for assessing outcome studies, assessing effectiveness studies, putting together practice guidelines that would, we believe, be even more effective in terms of assuring quality care to Medicare recipients than they have today.

Mr. BURR. Let me ask you a question as it relates specifically to your proposal. You mentioned that physician networks are able to assume risk, effect self-insure by securing the risk with their assets and their services. Yet, you also acknowledged that these groups lack capital, the management infrastructure, and I think to some degree the resources that managed care companies currently have in the marketplace.

I guess my question would be, help me sell the fact that a decision to go to something like what you are proposing is responsible on the part of the Congress of the United States.

Dr. BRISTOW. The rationale behind our suggestion is that the physician and provider network would already have that which an insurer would have to go out and purchase and therefore has the capability, if there is a shortfall in terms of funding, to still provide the services by virtue of the contractual arrangement that they have made. So capital is not important. Capital is still important, but the degree of capital reserves that an insurer has to have we believe would be excessive for those who have the capability of assuring that the services are going to be provided.

Mr. BURR. Let me move quickly, if I can, because the clock in Ways and Means is much quicker than the clock in Commerce. Mr. Sprenger, risk reward savings, could you define that for me?

Mr. SPRENGER. Sure, this is where you accept a certain amount of risk within a quarter in that if you can help save costs, you get to keep some of that reward.

Mr. BURR. Insurer or beneficiary?

Mr. SPRENGER. The insurer and the provider.

Mr. BURR. The reason I ask is that the administration has referred to that as financial coercion and would be vehemently opposed to any sharing of those savings with seniors in this country, and I think that testimony has already been made.

You indicated that a partial capitation arrangement might be an option with Medicare Programs. I think the exception would be that you would propose not to assume the risk for the high-cost

cases or the worst case scenarios. Was that an accurate description?

Mr. SPRENGER. No, not at all. What it was was a shared risk. We agree with my colleagues at the table here who talk about the fact that if we as a group of providers are going to become an insurance company and assume all of the same risk that they assume, we need to be regulated and we need to be licensed in the same way.

What we are talking about is there are parts of this country that——

Mr. BURR. I can see people turning to me saying if we allow you to assume a level of risk up to a point, you have written a plan that lets them really skim the cream.

Mr. SPRENGER. You would have all the same requirements in terms of who you enroll into that risk. This would not be creaming off. By risk, I am talking about the risk of taking care of an individual, not risk by their health condition.

Ms. LEHNHARD. Congressman, could I interject here?

Mr. BURR. Yes, ma'am.

Ms. LEHNHARD. I think it is very important to realize that State licensure for HMOs and particularly insurance companies already recognize that different organizations have different levels of risk. We are subject to a range of different reserve requirements based on different types of business we have. The business that we have with HMOs that we provide only a stop loss, we do not have to have the same level of reserves for.

What I think is very important to realize is that the contract that a PHO would have with Medicare to accept the capitation payment, that transfers risk and the PHO would further transfer risk to the physicians participating. That is another contract. A number of States have already said that is illegal, unless they are licensed as an insurance company or an HMO. They do not have to reserve at the level that our fully insured business does. There is adequate adjustment for that.

Mr. BURR. Mr. Chairman, one last question, if I may. I believe this is very important and I would like to direct this to Ms. Lehnhard. If we in fact try to inject choice into the senior self-care system, how many options do you see that Blue Cross & Blue Shield itself creates for that possible scenario?

Ms. LEHNHARD. In addition to the current HMO option, we think there are two that we would like to put on the table, and that is one of service, which is by far and large the most rapidly growing option, and that lets people go outside the network when they need to, and also the preferred provider option. What is ironic is that the options that people are voting with their feet on are most popular and not available to Medicare beneficiaries.

Mr. BURR. In fact, the debate is not over HCFA as it exists and an HMO. We are not limited to two choices?

Ms. LEHNHARD. We think the basic program should continue to be available, but we think you can put at least HMO point of service and PPO very distinct products on the market.

Mr. BURR. I thank all of you. We have run out of time. Mr. Chairman, I yield back.

Chairman THOMAS. The gentleman's time has expired. I will tell the gentleman that he perhaps inadvertently reinforced Einstein's

theory of relativity, because I understand that the Commerce clock is 5 minutes and our clock is 5 minutes. The difference is you may be having more fun here than in Commerce. [Laughter.]

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

I have basically two questions. I wish we had more time, but the Chair wants to cover a lot of ground here today. I referred earlier to a letter written by Secure Horizons—Pacificare, a for-profit operator of health plans, in responding to an advocacy group representing a patient who was unhappy. What Secure Horizons says is please be advised that Secure Horizons is not a provider of medical care; rather, it pays independent health care providers and the physicians and other providers of treatment that are independent, basically saying to the patient, I am sorry, we are not going to tell you. The last paragraph says, "In accordance with the California Health and Safety Code, the results of our quality assurance reviews are kept confidential."

In their marketing brochures, while I suppose a lawyer would say they skimmed by here, they say that by administering and coordinating your benefits, we are able to deliver comprehensive health care coverage efficiently and cost effectively. They go on to say that they want virtually no paperwork and they want to be the premier health care organization, and so forth.

My sense is that they are selling one thing and providing another. So I would ask each of you—and I have looked at your testimony and I think all of you advocate choice and having the beneficiaries be able to select—two questions. Do you not all think that the results of quality surveys or accreditation surveys or whatever other empirical data and/or subjective data that is available should be made available to beneficiaries? That is one question.

The other question that I would ask is whether all of you feel that the entities that you represent will be able to provide or continue to provide quality care, if there is over the next 7 years a $452 billion reduction in payments for both Medicare and Medicaid? I know the American Hospital Association has suggested $160 billion. That leaves you $100 billion light just for Medicare. But I want to know whether you think that $452 billion in the aggregate is about the right amount, too much of a cut, or too little.

Dr. Bristow, should rankings or studies be made available to beneficiaries to help them judge?

Dr. BRISTOW. Congressman, we feel very strongly that patients should have as much information about the quality of care that they are trying to select among as possible.

Mr. STARK. How about getting the numbers. Is $452 billion about right, too big a cut, too little a cut?

Dr. BRISTOW. We have not examined numbers per se. What we have done is said that we believe that we can have quality——

Mr. STARK. The light is going to go on.

Dr. BRISTOW. I am sorry.

Mr. STARK. Mr. Sprenger, should the studies and the reviews be available to——

Mr. SPRENGER. Absolutely, and in the system I represent, we have 99 percent approval from our Medicare enrollees.

Mr. STARK. What about the $452 billion in cuts?

Mr. SPRENGER. I can say that cannot happen without some change. Some change needs to occur, and what is the amount——

Mr. STARK. Do you think your members could continue to provide good quality care with those big cuts?

Mr. SPRENGER. I do not know what the right number is. We did support $160 billion, as you referred to, but we know that we can only approach the numbers that we are trying to approach if we do move into more coordinated care programs with our seniors.

Mr. STARK. Mr. Walworth.

Mr. WALWORTH. Again, I would respond in much the same way as the prior two panelists. I think that there is no question that studies and comparable factors ought to be part of a program, and I think that is one of the critical standards that needs to be developed.

Mr. STARK. And made public?

Mr. WALWORTH. And made public. Just to clarify—and I do not know the specifics of the Secure Horizons Program that you referenced—I think that there is an issue of confidentiality related to each specific case review that takes place.

Mr. STARK. This is the plan's ranking, not the——

Mr. WALWORTH. I think that there is no question but what——

Mr. STARK. How about the number?

Mr. WALWORTH. I think the number again is part of the whole debate we are engaged in and you——

Mr. STARK. You do not have an opinion of whether it is just right, too high or too low?

Mr. WALWORTH. I do not know the answer, because part of that is related to the question of exactly how are we going to respond and change the Medicare Program.

Mr. STARK. I will see if Mary Nell wants to weigh in on this.

Ms. LEHNHARD. We have supported the private accreditation. It is my understanding that NCQA on the infrastructure rules makes that public to purchasers, and on the performance standards they are moving into, HEDIS, the primary objective is to make that available to purchasers, so it would be available.

Mr. STARK. It is a California law that they are hiding behind, and I do not really know what the Federal law is. I just think if we are going to ask the people to make choices, they have got to have something to compare besides advertising brochures.

Ms. LEHNHARD. We agree.

Mr. STARK. What about the numbers? Is Blue Cross making a statement on the numbers?

Ms. LEHNHARD. I agree that the best hope of slowing the rate of increase is to move to the——

Mr. STARK. Do you think we can hit $452 billion in cuts over the next 7 years?

Ms. LEHNHARD. We are not qualified to answer that.

Mr. STARK. Thank you.

Chairman THOMAS. Does the gentleman from Iowa wish to inquire?

Mr. GANSKE. Thank you, Mr. Chairman.

Dr. Bristow, earlier in the hearing there were some rather unkind class warfare type of comments, and I am going to be very kind to you because I am not going to ask you to comment on the

fact that congressional salaries place Congressmen in the upper 5 percent, and I am certainly not going to ask you to comment about congressional pensions.

Dr. BRISTOW. Thank you.

Mr. GANSKE. I would like to ask you and Mr. Sprenger a question about provider antitrust, because I see a relationship developing in the PHO area. Have your organizations worked together to address some of the areas where we could correct some of the antitrust provisions that are limiting this area? Have you found any common ground?

Dr. BRISTOW. We have had discussions between the two organizations and we are attempting to find common ground. I do not think we are prepared at this time to try to report on that, but the discussions are ongoing.

Mr. GANSKE. I would very much appreciate it if both of you could provide me with specific language on areas in the code related to antitrust that are preventing increased competition in this area.

I want to move really to the subject of the hearing, which is standards of care, and I would like to ask Mr. Walworth and Ms. Lehnhard if they would care to enter into this.

You both cautioned the Subcommittees against enacting laws which would frustrate the ability of managed care plans to control costs, and I certainly agree with that, but you did not specify exactly what fell into this category. So let me ask you about a few specific proposals and you tell me if these proposals are "antimanaged care."

Would it be antimanaged care to establish and maintain a sufficient number and geographic spread of providers to ensure that all covered services are accessible to each enrollee in a reasonably prompt manner?

Mr. WALWORTH. From my perspective, not at all. I think it is the issue of what goes into those numbers. You will find in most HMOs, particularly under State law, that there are requirements and guidelines under the Federal HMO requirements, as well, that guide access to care, and these become measurements of that access to care.

Mr. GANSKE. Ms. Lehnhard, would it be antimanaged care to ensure a prompt or timely authorization of payment for emergency medical care?

Ms. LEHNHARD. No, and I would make the comment on all three of these that Medicare standards currently for risk contract address all of these and NCQA gets into a great deal of detail of looking at these. For example, Medicare has a 30-minute drive time rule on certain types of providers, so there are extensive standards in all these areas already.

Mr. GANSKE. Let me specifically ask you, because I have stayed in emergency rooms and waited for extended periods of time to get authorizations for managed care to go ahead with treatment. Would you think it was reasonable, if you placed a call through a managed care organization and you have not received a reply within say 30 or 40 minutes that you could proceed with treatment, and then expect payment? Ms. Lehnhard.

Ms. LEHNHARD. I hesitate to comment on that specifically. I do not know what the rules are in the accreditation process. There are

rules for these things and it is a question in some cases of enforcing those rules, just like under the basic program.

Mr. GANSKE. That it would not be unreasonable to have something related to that issue?

Ms. LEHNHARD. I do not know about specific times, but treatment in emergency rooms is definitely part of both the current Medicare and accreditation process standards.

Mr. GANSKE. Thank you so much.

Chairman THOMAS. Thank you.

Does the gentleman from Florida, the Chairman of the Subcommittee on Health, wish to inquire?

Chairman BILIRAKIS. Yes, Mr. Chairman. Thank you.

Mr. Sprenger, just one specific question to you and then maybe a general one to particularly Dr. Bristow, plus a couple of the others of you.

Mr. Sprenger, in your written testimony—of course, you mentioned this in your oral testimony, too—you talked about the provider sponsored networks which, generally speaking, frankly I think are a good idea. But you said that Medicare should take advantage of the innovations and efficiencies offered by PSNs by joining them in risk-sharing arrangements. Under such risk-sharing arrangements, PSNs would be paid on a partial capitation basis, but the risk assumed by the PSN would be limited, and that is when you referred to the fact they should be regulated somewhat differently. But that is another question and I am not going to go into that.

But who would assume the risks? That is the key thing. Basically, my question is, Who would assume the risks that the PSN is not subject to? Are we expecting that the beneficiaries would be liable in any way whatsoever?

Mr. SPRENGER. No, Medicare now goes under the fee-for-service system. You basically are an insurance company and you bear the risk for that. What we are suggesting is, for instance—and I am sorry Congressman Burr is not here, but his question about that quarter of the risk reward—right now, provider groups have such arrangements with HMOs, with Blue Cross and other organizations, where we take a certain portion of the risk, as well as the reward in managing care efficiently and effectively.

What we are suggesting is that if we are going to make major strides of moving managed care into the Medicare population to depend upon just where there are licensed HMOs in order to have that kind of risk-reward kind of sharing arrangement, that is why we are suggesting that there be an opportunity for provider groups to work directly with Medicare. We have communities where the 50–50 rules do not work, and the 5,000 minimum does not work. We have some rural communities where we can start moving into managed care and that is that direct relationship we think should be done.

Chairman BILIRAKIS. That is fine, but why should there be a partial compensation basis?

Mr. SPRENGER. Otherwise we need to get licensed as a full HMO, if we are going to take on the full risk.

Chairman BILIRAKIS. But this is all part of the overall picture, is it not, that AMA has made certain recommendations?

Mr. SPRENGER. That is correct.

Chairman BILIRAKIS. But if you did not have to go through the onerous regulations of trying to get the proper approvals and licenses, and so forth, is there any reason why you should be partially capitated?

Mr. SPRENGER. No. I think that with provider groups, you are going to limit it, though, with a number of provider groups that are prepared today to go at full risk. When you deal with populations all over the country, they are just not all ready to take on that full risk, and I think this is a transition period we are talking about and that we ought to start moving some of those managed care principles as quickly as we can as choices in the population——

Chairman BILIRAKIS. Dr. Bristow, in the AMA red booklet, you suggested this sort of thing, but were you thinking partial capitation?

Dr. BRISTOW. We were thinking that physicians should not be required to put up the same amount of reserves an insurance company has at risk because of the fact that physicians do have some capability of providing the services should the bank run dry, so to speak. But they also obviously have the opportunity to purchase reinsurance to back up the risk taking that they do assume through other entities. We believe that those are all viable ways in which provider groups could accept the risk and move on.

Our problem is that the way the current antitrust laws are written, they were written for a different time, and we do not want physicians to be exempted from the antitrust laws. We simply want the sort of accommodation that will allow them to compete in today's market in a realistic way.

Chairman BILIRAKIS. Well, all right. My time is about to expire, and I for one want to make the Korean memorial dedication because I am a Korean veteran. And I know we have another panel to go, so I am just going to yield back the balance of my time, Mr. Chairman. But I am very curious about how we should measure, how we are measuring physician performance and any recommendations on how that should maybe better be done, so possibly I give unanimous consent for Dr. Bristow and the others to submit that information to the Subcommittees.

Thank you very much.

Chairman THOMAS. Does the gentleman from Ohio wish to inquire?

Mr. BROWN. Thank you, Mr. Chairman. Thank you for holding this joint hearing to both Subcommittee Chairs.

I am concerned about the standards for managed care, and I do not want to be characterized as antimanaged care, but I am concerned about the standards. I look at something as scary, if you will, as the drive-through deliveries, that term that has been bandied about, where some insurance companies have basically pushed women that have just had children out of the hospital after one night's stay in order to save money, and demonstrating the extent to which your health insurance plans are intruding into medical practice. I know that physicians are concerned about that. Dr. Ganske mentioned that a moment ago, just that physicians' practices tend more and more to be dictated to by insurance companies.

Dr. Bristow, in your testimony you state that choice is at the heart of your proposal. I also note that the AMA supports allowing physicians to charge Medicare beneficiaries the amount that they want above what Medicare will pay. If the majority of Medicare beneficiaries are making less than $25,000 a year, how can they afford these extra charges? Increasing the fee-for-service cost, how does that increase choice for those people that cannot afford to go beyond what they are paying now?

Dr. BRISTOW. Well, the AMA proposal calls for full payment of the premiums for those who are below 100 percent of poverty and for partial payment of premiums on a sliding scale for those up to 150 percent of the poverty level.

We also have a longstanding existing policy within the AMA calling upon physicians to accept whatever Medicare sets as the payment for service for anyone who is below 200 percent of poverty. So that we do not believe that the low-income individual is going to be hurt by our proposal for those reasons.

We also feel, however, that there are opportunities, even with a low-income individual, to provide positive incentives for them to be cost conscious. If there is a way in which particularly the low-income individual can make a judgment as to whether or not to go to the emergency room with a cold or wait until tomorrow and go and see the doctor in his office with this same cold, and there is a possibility that at the end of the year he may get a few hundred dollars from his refundable deductible, that is all that we are trying to encourage: the use of judgment in obtaining health care services.

We think that is going to have a very salutary effect, and as you have seen from our physician paper, the red book, Price Waterhouse thinks that that would amount to a substantial savings over the course of 7 years.

Mr. BROWN. Well, certainly understanding in the case of someone that is home and is sick but probably not sick enough to go to the emergency room and makes that decision based on costs that might accrue to them, that they may have to pay out of pocket to wait until tomorrow to do that, that is not the case every time, obviously. The patient is not really making those cost decisions much because the patient is relying on the physician.

How do we cut $270 billion from Medicare as proposed in the House with Medicare paying less to doctors—presumably paying less to doctors—and find a way that senior citizens are not going to have higher copayments, higher deductibles, higher premiums? How is that going to happen?

Dr. BRISTOW. Well, the proposal that we have put forward suggests that using the incentive of cost consciousness and individual responsibility on the part of the beneficiary, plus making physicians more price sensitive by making their cost of services available to patients is a combination that we think will work effectively in terms of ameliorating the rate of increase of cost at the present time.

Mr. BROWN. The average senior citizen making $25,000 a year pays about 20 percent out of pocket right now for health care costs. That number can go up. That is not price sensitive enough?

Dr. BRISTOW. Well, what Price Waterhouse says, Congressman, is that of the entire spectrum of Medicare patients, 40 percent of them will actually pay less out of pocket with the proposal we have made, 50 percent will pay the same out of pocket with the proposal we have made, and 10 percent will actually pay more, most of those being the high-income elderly.

Mr. BROWN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Ms. Lehnhard, I want to ask you a few questions regarding the existing requirements for Medicare capitated programs listed in your statement. I want to ask you if these requirements that are outlined in section 1876 of the Social Security Act, if Blue Cross & Blue Shield has any feeling or opinion whether these standards are sufficient to protect consumer interests.

Ms. LEHNHARD. Yes, we think they are sufficient, and they have done a very good job of protecting the Medicare enrollees in the current HMO risk contracts.

Mr. LAUGHLIN. Then I want to ask, it is my understanding these standards were written some 10 years ago, and would you agree that the medical marketplace has changed significantly in the last 10 years? And if you agree with that, do you have an opinion as to whether the Subcommittees should reevaluate these standards to determine if they sufficiently reflect the current managed care practices? I refer you to your statement where in section 1876(c)(5), you state that it "allows members who are dissatisfied with the outcome of the grievance procedures to submit unresolved disputes to an appeal to the Secretary and to seek judicial review." As I read that, that would require me to go back and tell my senior citizens that if they have a grievance, they have got to find a Federal bureaucrat to take their complaint to.

Ms. LEHNHARD. First of all, I would definitely urge that the Subcommittees review these standards to be sure you are comfortable with them. Second, I think these standards are backed up by pages and pages, hundreds of pages of regulation that change frequently. And that is the beauty of these standards, is that they are broad and they do allow regulatory interpretation to keep up with the market.

In terms of the people having to go to the Secretary, I think it is very appropriate to have the Secretary available as a last resort on some types of—and I can very quickly get out of my depth here—on some types of appeals. But, again, Medicare and TQA require the health plan itself to have a series of appeals available to consumers. Whether or not the Secretary is the last step in the appeal process would be up to the Committees.

Mr. LAUGHLIN. Well, I want to continue with those standards and ask you: Who enforces these standards at the current time?

Ms. LEHNHARD. Right now I believe—and I look to other people here—HCFA does.

Mr. LAUGHLIN. That is my understanding also.

Ms. LEHNHARD. I do not think that there is any deeming in any of the——

Mr. LAUGHLIN. I next want to ask you, once an HMO is certified as meeting the section 1876 requirement, who reviews and evaluates them to be sure the requirements are being met?

Ms. LEHNHARD. That would be HCFA's responsibility.

Mr. LAUGHLIN. That is all I have, Mr. Chairman.

Thank you very much.

Chairman THOMAS. Thank you.

I will kind of divide the four of you into two groups, and I want to ask a series of questions so I can understand either the similarities or the differences.

Dr. Bristow and Mr. Sprenger, what you seem to be saying, a little bit in terms of your desire to do the partial risk with HCFA, is that it might be easier for people to understand an analogy between a farmer and a city folk, and that when you are dealing with food, the city folk have to buy it so they need more money, and the farmers do not need as much money because they grow the food and they can eat it. You folks are saying you are the providers, and so you do not have to pay for part of it; you can provide it yourself, and so you ought to be able to create a structure where you do not have the same profile. The farmer should not have to have the same cash reserves as the city folk because insurance companies would have to buy the services that you folks have contained in the structures.

Is that basically the point you folks are making about your structures?

Dr. BRISTOW. I think that is a very good homey way of expressing it, and I think it does a good job.

Chairman THOMAS. Well, I thought it was rather sophisticated, but that is OK. [Laughter.]

Mr. SPRENGER. Congressman, I would go one step further. We are not advocating that if we were going to take on the full risk that we should not meet all the requirements that apply to HMO. If we are going to change the rules, it ought to be a level playingfield, and the rules ought to change for an HMO as well as for those who take full risk.

I think the important thing for us is: Why aren't more enrolled in HMO plans today? If we are going to——

Chairman THOMAS. I understand your point, but you understand our concerns that it looks like we are creating a privileged group who get to pick and choose a little bit. So that is why I want to pursue some questions to understand it.

In the red book from the AMA, they do describe a profile, which is a Physicians Coordinated Care Organization, or something like that. Is that basically in your understanding, Doctor or Mr. Sprenger, the same thing you are talking about in terms of the integrated networks? Are we talking basically about the same thing?

Mr. SPRENGER. In terms of an integrated network, we are including all components.

Chairman THOMAS. So that would be similar to what? So you folks are both focusing on the same concept, with the understanding that Medicare would be the fall-back risk responsibility of last resort. And it occurred to me in trying to think through that model, would HCFA as an entity meet the standards that we currently apply to folk to carry out that full risk, any of you?

Mr. WALWORTH. If I may, Mr. Chairman, I think that the proposals that you have heard for partial capitation significantly alter the role of the Federal Government as the administrator, because it suggests that they are going to do something remarkably different than they have been historically doing—that is, really overseeing, operationally, the payment of claims on a fee-for-service basis.

Now you are getting into them being part of a process in which they have delegated to someone else the responsibility for managing care toward a target, but they are going to be holding the dollars.

Chairman THOMAS. What is part of my concern, we are taking a culture that is locked into a particular arrangement and assuming that in a relatively short period of time, or almost instantaneously, they turn into a different kind of a structure. It is an interesting idea. I think we ought to take a look at it because, clearly, it does get us in the field faster. But I think, Mr. Walworth and Mr. Sprenger, one of the problems I have is that I fall back on HCFA and I look at them and I just do not see somebody there who is ready to assume those kinds of responsibilities.

Now, the other side, I want to ask you folks, obviously Blue Cross & Blue Shield is in a lot of places. Do you have some real problems in terms of trying to meet State standards that are different? Do you see a broad range of standards out there that make you folks different in different States significantly?

Ms. LEHNHARD. Well, we are regulated differently in different States. We have supported a level playingfield, but in some States we are regulated much like the rest of the industry, in some States we are regulated as the carrier of last resort.

Chairman THOMAS. Well, have you found that in some States the standards that you have to meet are pretty much the same or higher than the Federal standards?

Ms. LEHNHARD. I think those types of standards you are talking about are unique to the private sector. They have to do with rates in a small group market, enrollment practices in the individual markets. They do not overlap with the Medicare standards.

Chairman THOMAS. But what I have heard here from a number of folks is that when, in fact, they do overlap, the private sector standards are oftentimes higher than the Federal standards, and that as a matter of fact, some organizations that have met the Federal standards flunk the private sector standard.

Ms. LEHNHARD. I know in California there are some unique issues that I am really not qualified to address.

Chairman THOMAS. Well, my concern is—and I was going to use California as another homey example—that in air quality standards, California is higher than the Federal standards, and that one of the difficulties we have now is that we cannot get the Feds and the State together because on the way to meeting the State standards, they meet the Federal standards, but the Feds will not allow certification for the Federal standards in trying to meet the State standards. So instead of pursuing one level which is higher than the other, you wind up having to meet two different standards, which, in fact, you met in a portion of the other one. I am just scared to death that if we try to build up a very heavy, top-heavy bureaucratic standard structure, make HCFA better in that regard,

we are not only going to not do as good a job as the private sector is doing, but create in a State-Federal structure here duplication that is not only needless but probably does not do the job we thought it was going to do.

My time has expired, and I want to thank this panel very much.

Chairman BILIRAKIS [presiding]. I would ask the next panel to come forward now, if they would, please.

Dr. Richard V. Aghababian, chairman of the Department of Emergency Medicine, University of Massachusetts Medical Center, Worcester, Massachusetts, on behalf of the American College of Emergency Physicians, and he is accompanied by Dr. David S. Davis, who is the attending physician in North Arundel Hospital, Glen Burnie, Maryland.

And we have Dr. Peggy M. Connerton, director of Public Policy, Service Employees International Union.

As per usual, your written statement is made a part of the record, and we would ask you to do the best you could to try to stay as close to the 5-minute rule as you might be able to.

We will start off with Dr. Aghababian. Did I mess that name up too badly?

Dr. AGHABABIAN. No. You have done quite well, sir. Thank you. I appreciate that.

Chairman BILIRAKIS. With a name like mine, I should do well.

STATEMENT OF RICHARD V. AGHABABIAN, M.D., CHAIRMAN, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER, WORCESTER, MASSACHUSETTS; ON BEHALF OF AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; ACCOMPANIED BY DAVID S. DAVIS, M.D. ATTENDING PHYSICIAN, NORTH ARUNDEL HOSPITAL, GLEN BURNIE, MARYLAND

Dr. AGHABABIAN. Chairman Thomas, Chairman Bilirakis, I am Dr. Richard Aghababian, president of the American College of Emergency Physicians, a practicing emergency physician, and chairman of the Department of Emergency Medicine at the University of Massachusetts.

In 1992, 12.5 million of all emergency department visits in the United States were made by patients over the age of 65. Yet, today, emergency medical services are the single set of medical services most subject to payment disputes involving Medicare HMO enrollees. Nowhere is there a greater need for standards to protect seniors than in the area of emergency medical services.

The magnitude of this problem first surfaced in 1992 when a study commissioned by HCFA revealed that 40 percent of the coverage disputes involved "in-area" emergency services and an additional 20 percent of coverage disputes involved "out-of-area" urgent care services. The study's author described emergency services as "dispute prone."

Senior citizens in the emergency department setting are particularly challenging because their symptoms are often complicated and, therefore, diagnosis may be difficult.

Let me quickly review a case for you which exemplifies this problem. A 71-year-old male was admitted to the emergency department with vague chest discomfort and general malaise. He had suf-

fered a heart attack 2 years before. However, his blood pressure and pulse were normal, and the initial cardiogram did not indicate a heart attack.

The primary care physician denied authorization and advised that the patient be discharged home. It was the decision of the emergency physician to hold the patient in the emergency department for further observation. The old record indicated the patient had had similar vague symptoms before his prior attack and that he had not visited the emergency department since that previous episode. One hour later, while being observed in the emergency department, the patient went into cardiopulmonary arrest. Fortunately, he was successfully resuscitated in the emergency department.

This case demonstrates clearly that a telephone consultation is not a substitute for a physical examination. We have to remember that some patients are more stoic than others and react differently than other patients when they experience pain or frightening symptoms. This is why it is so critical to consider the patient's own experience when evaluating the urgency of the patient's condition.

As noted, the crux of the problem with regard to Medicare involves the definition of emergency medical condition.

HCFA's current definition places emphasis on the ability to judge the risk of permanent damage to the patient's health if treatment is denied. This is an issue that even qualified physicians might disagree on. Perhaps of greater importance for patients is a lack of any mention of the patient's subjective experience or symptoms as a legitimate reason to seek emergency medical services.

The college has advocated that a prudent layperson definition of emergency medical care be adopted for all health care plans, including the Medicare Program. This definition was first adopted by the State of Maryland in 1993 and has since been adopted in Virginia and Arkansas. The Maryland statute is also the core component of H.R. 2011, the Access to Emergency Medical Services Act of 1995, which has been introduced by Representative Ben Cardin of Maryland. Representative Stark has also included this definition in his bill, H.R. 1707.

The adoption of the prudent layperson definition will not take away the managed care plan's ability to review these cases. It simply directs that the focus of the review should be appropriately on the patient's presenting symptoms and whether, from a lay perspective, the patient acted prudently.

It is important to point out that emergency medicine is the only specialty that is required by Federal statute to treat all comers regardless of their ability to pay. Under section 1867 of the Social Security Act, emergency physicians and hospital emergency departments must provide a medical examination and treatment to stabilize the patient.

Increasingly, emergency physicians are being pressured by managed care plans to transfer patients to other plan hospitals or to discharge patients for economic reasons against the advice of the treating physician. Under H.R. 2011, plans would be required to provide coverage of emergency medical services regardless of whether they had a contractual arrangement with the hospital or emergency physician providing the care. In addition, plans would

be required to cover all services necessary to fulfill the requirements of section 1867 of the Social Security Act, including paying for the federally mandated screening examination.

Plans today routinely deny payment for emergency medical services if the patient did not obtain prior authorization. Coverage is frequently denied for emergency services simply because the patient was unable to reach the primary care physician. In many instances, these denials are issued regardless of the patient's condition and regardless of whether the primary care physician was available. Most plans do not have 24-hour-a-day, 7-day-a-week access to persons who are capable of making prior authorization determinations, as are required. In other cases, payment for services is denied even though the plan enrollee was referred to the hospital emergency department by the patient's primary care physician. Today plans are also trying to discourage the use of 911 emergency telephone numbers. Under H.R. 2011, these practices would be prohibited. The college urges the Subcommittees to adopt the provisions set out in H.R. 2011 as standards for the Medicare Program.

In closing, I want to emphasize that our overriding concern is the safety and well-being of the patients we encounter every day.

Thank you, sir.

[The prepared statement and attachments follow:]

STATEMENT OF RICHARD V. AGHABABIAN, M.D.
UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER
ON BEHALF OF AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Chairman Thomas and Chairman Bilirakis, I am Dr. Richard V. Aghababian, President of the American College of Emergency Physicians (ACEP), a practicing emergency physician and Chairman of the Department of Emergency Medicine at the University of Massachusetts Medical Center in Worcester, Massachusetts. I appreciate the opportunity to be here today to testify on behalf of the nearly 18,000 emergency physicians who are members of ACEP.

The purpose of this hearing is to explore and discuss the need for standards for private health insurance plans which seek to provide health care coverage to beneficiaries under the Medicare program. No where is there a greater need for standards to protect seniors than in the area of emergency medical services.

In 1992, the last year for which we have reliable statistics, 14 percent (approximately 12.5 million) of all emergency department visits in the United States were made by patients over the age of 65. The emergency department evaluation of senior citizens is especially challenging because atypical symptoms of specific ailments are masked or altered. Yet, today, under the existing Medicare program for participating Health Maintenance Organizations (HMOs), retrospective denial of payment for legitimate emergency medical services provided to seniors is common. In fact, emergency medical services are the single set of medical services most subject to payment disputes involving Medicare HMO plan enrollees.

The magnitude of this problem first surfaced in 1992 when a study commissioned by the Health Care Financing Administration (HCFA) revealed that 40 percent of the coverage disputes involved "in-area" emergency services and an additional 20 percent of coverage disputes involved "out-of-area" urgent care services. The study's authors described emergency services as "dispute prone." According to the study's authors, HCFA's statutory definition of emergency places beneficiaries in the "unreasonable position of making quasi-clinical evaluations of their symptoms and conditions and do not, expressly, make allowances for subjective experience (e.g., pain or suffering)." The authors of the study went on to say that "As a consequence, enrollees who appear to act prudently from a lay perspective may face substantial or even catastrophic out-of-pocket liabilities."

The HCFA data tracks and verifies the College's own findings, based upon the hundreds of case examples provided by emergency physicians of denials of emergency medical services by managed care plans over the last several months. The problem, we are afraid, is even more significant in the private sector where there is not a public reporting mechanism.

Just this past week, ACEP was presented with several case examples of the kind of denials being experienced by patients today. This case was presented to us by Marcus Martin, M.D., FACEP, an emergency physician in Pittsburgh, Pennsylvania. Dr. Martin provides this case example –

A 20 year old female presented to the emergency department complaining of lower abdominal pain and heavy vaginal bleeding. She was sexually active and not using birth control. Her primary care physician denied authorization for emergency department care and sent her to a medical clinic where she was diagnosed with Pelvic Inflammatory Disease and treated with Doxycycline without a pelvic exam or pregnancy test being performed. One week later, she returned to the emergency department complaining of severe suprapubic pain. The onset was one hour prior to arrival. She was again denied authorization for emergency department services but was seen in the emergency department anyway and had a positive pregnancy test. An ultrasound showed no intrauterine pregnancy. Gynecology was consulted and the patient was taken to the operating room for laparoscopy and resection of ruptured ectopic pregnancy.

These are the kind of cases that emergency physicians are witnessing everyday with private pay patients enrolled in managed care plans. Our concerns for senior citizens are even more profound because we know that seniors are more difficult to diagnose because their symptoms are often atypical and are masked or altered. The following example is an actual case from my own hospital emergency department within the last two weeks.

The senior resident on duty sees a 71 year old male who had presented to the hospital emergency department with vague chest discomfort and general malaise. This patient had suffered a heart attack two years previously. However, his blood pressure and pulse were normal and the initial electrocardiogram did not indicate a heart attack. After consulting with the attending emergency physician, the senior resident called the patient's primary care physician to request authorization to admit the patient for observation. The primary care physician denied authorization and advised that the patient should be discharged home with appropriate follow-up home care. Despite the primary care physicians directive, the senior resident held the patient in the emergency department for continued observation. In the meantime, the medical record of the patient was obtained from the previous admission for the patient's earlier heart attack. It was determined that the patient had presented to the emergency department at that time with the same vague or atypical symptoms. One hour later, while still being observed, the patient went into cardio-pulmonary arrest due to a fatal heart rhythm. Fortunately, the patient was successfully resuscitated in the emergency department with no damage to his vital functions.

This case demonstrates clearly that a telephone consultation is not a substitute for a physical examination. The art of medicine is listening to the patient, observing the patient, and synthesizing all of the information that you have before you and based upon your education and previous experience, making an assessment of what should be done for the patient. A critical part of this process is observing the patient closely and listening carefully. We have to remember that some patients are more stoic than others and react differently

than other patients to their pain and general symptoms. This is why it is so critical to consider the patient's own experience.

As noted, the crux of the problem with regard to Medicare involves the definition of an emergency medical condition. HCFA's current statutory definition (Attachment 1) defines emergency services as services that:

(1) are furnished by an appropriate source other than the HMO or CMP;

(2) are needed immediately because of an injury or sudden illness; and

(3) cannot be delayed for the time required to reach the HMO or CMP providers or suppliers without risk of permanent damage to the patient's health.

HCFA's current definition places emphasis on the ability to judge the risk of permanent damage to the patient's health if treatment is delayed. This is an issue that even qualified physicians might disagree upon. Perhaps of greater importance for patients is the lack of any mention of the patient's subjective experience or symptoms as a legitimate reason to seek emergency medical care services. A central premise of emergency medicine is that emergency medical conditions occur unpredictably and usually involve a sudden onset of symptoms. The patient's subjective assessment of the severity of his symptoms is central to the patient's decision to seek emergency medical services. The definition of an emergency and the payment determinations that result from that definition should clearly take into account a prudent layperson's assessment of the severity of his symptoms. This is, after all, the information that a treating physician would use to focus his medical evaluation.

The problem with "after-the-fact" denials is that they ignore the patient's presenting symptoms, which is the reason patients go to the emergency department in the first place, and base the payment decision on the patient's final diagnosis. For example, a middle-aged male presents to the hospital emergency department with a chief complaint of chest pain. Only an appropriate medical evaluation by a qualified physician can determine whether the patient is having a heart attack or whether it is a less serious condition. Clearly a medical evaluation is appropriate if the symptoms are of sufficient severity to the patient to prompt the patient to seek emergency medical services. The important fact is that the patient's subjective experience is the principle patient determinate of whether to seek emergency medical services. You cannot eliminate the patient's subjective experience. It is a critical source of information upon which to base your medical examination.

According to the Centers for Disease Control, the number one complaint of people presenting to the emergency department is abdominal pain. Again, the abdominal pain can indicate many different conditions with varying degrees of severity. It could be very serious conditions such as cholecystitis, appendicitis, pancreatitis, ectopic pregnancy, dissection of the aorta or it could be less serious conditions such as gastroenteritis, a urinary tract infection or constipation. The

problem is that on the front end you simply don't know whether it's serious or non-urgent.

The College has advocated that a prudent layperson definition of emergency be adopted for all health care plans, including the Medicare program. The College's proposed definition says –

> "Emergency health care services are those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

This definition was first adopted by the State of Maryland in 1993. Since 1993, the prudent layperson definition has been adopted in Virginia and Arkansas. The Maryland statute is also the core component of H.R. 2011, The Access to Emergency Medical Services Act of 1995 which has been introduced by Rep. Ben Cardin of Maryland, who, as you know, is a member of the Ways and Means Health Subcommittee. The College wishes to thank Rep. Cardin for the introduction of this important legislation and his leadership on this issue. The College would also like to thank Rep. Stark for the inclusion of this definition in his bill, H.R. 1707.

The following Emergency Medical Service and consumer advocacy organizations have endorsed H.R. 2011: the Emergency Nurses Association, the Coalition for American Trauma Care, the National Association of EMS Physicians, the EMS Section of the International Association of Fire Chiefs, the International Association of Firefighters, the American Ambulance Association, Public Citizen, Citizen Action and Consumer's Union.

The Cardin legislation would codify HCFA's current payment guidelines (Attachment 2) to HMOs on the coverage of emergency medical services. HCFA's guidelines say to HMOs that emergency services "must be, or appear to be, needed immediately." HCFA's guidelines go on to say "There does not need to be threat to a patient's life." "Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature." With these guidelines in effect, why, you may ask, do we need legislation? There are two reasons.

> (1) Despite the laudable efforts of HCFA to persuade the HMOs to provide appropriate coverage of emergency medical services, as recently as March of this year, Dr. Rodney Armsted, Director of the Office of Managed Care, issued an official reminder (Attachment 3) to the Medicare participating HMOs reminding them of their responsibility to cover emergency medical services. In short, the guidelines have had some impact, but HCFA continues to review a disproportionate number of emergency care cases. These reviews are time consuming and costly.

HCFA only reviews those cases that were not decided in favor of the beneficiary after an initial plan appeal.

(2) The statute and HCFA's guidelines are clearly inconsistent. It is not clear whether HCFA can enforce its guidelines if contested. In the 1992 study of HMO claim denials for emergency services conducted for HCFA, the authors' recommended that "Definitions of 'emergency' in regulation should be modified so that a reasonable and prudent layperson can anticipate claims that would be covered versus denied."

The enactment of the prudent layperson standard for the Medicare program would be an important first step in protecting Medicare beneficiaries from being inappropriately denied access to emergency medical services. The effect of adopting the definition would be to shift the focus of any disputed service from a review of the patient's discharge diagnosis to a review of the patient's presenting symptoms. The adoption of this definition does not take away the managed care plan's ability to review these cases. It simply directs that the focus of the review should be appropriately on the patient's presenting symptoms and whether, from a lay perspective, the patient acted prudently.

It is important to point out that emergency physicians and hospital emergency departments do not enjoy the luxury of being able to second-guess patients about the severity of their symptoms or provide "eye-ball" diagnosis when patients walk in the door of the hospital emergency department. Emergency physicians are the only medical specialty that is required by federal law to treat all comers regardless of their ability to pay. Under Section 1867 of the Social Security Act, emergency physicians and hospital emergency departments must provide an appropriate medical screening evaluation to determine whether the patient is having a medical emergency and provide appropriate treatment to stabilize the patient. Violations of the COBRA statute can result in civil monetary penalties of up to $50,000.

Increasingly, emergency physicians are being pressured by managed care plans to transfer patients to plan hospitals or to discharge patients for economic reasons and against the advice of the treating physicians. Under H.R. 2011, plans should be required to provide coverage of emergency medical services regardless of whether they have a contractual arrangement with the hospital or emergency physician providing the emergency care to the plan enrollee. In addition, plans would be required to cover all services necessary to fulfill the requirements of Section 1867 of the Social Security Act, including payment for the federally mandated medical screening evaluation.

Plans today routinely deny payment for emergency medical services if the patient did not obtain prior authorization to go to seek care in the emergency department. Coverage is frequently denied for emergency services simply because the patient was unable to reach the patient's primary care physician. In many instances, these denials are issued regardless of the patient's condition and regardless of whether the primary care physician was available. In many cases today, plans still do not have 24 hour, seven day a week access to the persons who are capable of making prior authorization determinations required by the

plan. In other cases, payment for services are denied even though the plan enrollee was referred to the hospital emergency department by the patient's primary care physician. Today plans are also trying to discourage the use of the 911 emergency telephone number. Under H.R. 2011, these practices would be prohibited. The College urges the Committee to adopt the provisions set out in H.R. 2011 as standards for the Medicare program.

In conclusion, Chairman Thomas and Chairman Bilirakis, the College would like to thank both of you and the Members of the Ways and Means and Commerce Health Subcommittees for this opportunity to testify today on an issue of great importance to the emergency physicians of this country. In closing, I want to emphasize that our overriding concern is the health and safety of the patients we encounter everyday. Patients who believe they are experiencing a medical emergency should not delay seeking treatment because they are uncertain whether those services will be covered. Thank you for allowing me to testify today.

Subparts G through I—[Reserved]

Subpart J—Qualifying Conditions for Medicare Contracts

[¶ 20,896J.400]

§ 417.400 Basis and scope.

(a) *Statutory basis.* The regulations in this subpart implement section 1876 of the Act which is added by section 114 of Pub. L. 97-248. Section 1876 of the Act authorizes Medicare payments to HMOs and competitive medical plans (CMPs) through contracts under which the HMOs and CMPs are reimbursed for furnishing covered services to Medicare beneficiaries.

(b) *Scope.* This subpart sets forth the requirements an entity must meet in order to enter into a contract with HCFA as an HMO or CMP to be reimbursed, through capitation payments, for services furnished to Medicare beneficiaries who are enrolled with the HMO or CMP. Subparts N, O, and P set forth the principles that apply for each of the two methods for reimbursing HMOs and CMPs: reimbursement on a risk basis and reimbursement on a reasonable cost basis.

.01 Source:

As adopted, 50 FR 1314 (Jan. 10, 1985, effective Feb. 1, 1985), and amended at 58 FR 38062 (July 15, 1993), and at 59 FR 49834 (Sept. 30, 1994).

[¶ 20,896J.401]

§ 417.401 Definitions.

As used in this subpart, and Subparts K through R of this part, unless the context indicates otherwise—

Adjusted average per capita cost (AAPCC) means an actuarial estimate made by HCFA in advance of an HMO's or CMP's contract period that represents what the average per capita cost to the Medicare program would be for each class of the HMO's or CMP's Medicare enrollees if they had received covered services other than through the HMO or CMP in the same geographic area or in a similar area.

Adjusted community rate (ACR) is the equivalent of the premium that a risk HMO or CMP would have charged to Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees if the benefit package was limited to covered Medicare services.

Arrangement or arrangements means a written agreement executed between an HMO or CMP and another entity in which the other entity agrees to furnish specified services to Medicare enrollees of the HMO or CMP, but the HMO or CMP retains responsibility for those services. Under an arrangement, Medicare payment to the HMO or CMP discharges the beneficiary's obligation to pay for the service.

Benefit stabilization fund means a fund established by HCFA at the request of an HMO or CMP with a new risk contract to withhold a portion of the per capita payments available to the HMO or CMP for payment in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits provided by the HMO or CMP to its Medicare enrollees.

Demonstration project means a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b-1 (note)), relating to the provision of services for which payment is made under Medicare on a prospectively determined basis.

Emergency services means covered inpatient or outpatient services that—

(1) Are furnished by an appropriate source other than the HMO or CMP;

(2) Are needed immediately because of an injury or sudden illness; and

(3) Cannot be delayed for the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) without risk of permanent damage to the patient's health.

These services are considered to be emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or designated alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition.

Geographic area means the area found by HCFA to be the area within which the HMO or CMP furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means an individual who is entitled to Medicare benefits (Part A and Part B or Part B only) and who has been identified on HCFA records as an enrollee of an HMO or CMP that has a contract under section 1876 of the Act.

New Medicare enrollee means a Medicare enrollee who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part;

- Physician assistants (see MCM § 5259);
- Nurse practitioners (see MCM § 2156) *;
- Clinical nurse specialists *;
- Nurse midwives (see MCM § 2138); and
- Certified registered nurse anesthetists (see MCM § 5261).

See § 2153.4 for a discussion of the coverage of auxiliary personnel when furnished without physician supervision.

* Section 4155 of the Omnibus Budget Reconciliation Act of 1990 amended coverage of nurse practitioners in rural areas and added coverage of clinical nurse specialists effective January 1, 1991.

B. *Transplants.*—You are required to cover organ and tissue transplants that the Secretary determines are not experimental. Required transplants include:

- Kidney (see CIM § § 35-35, 35-58, 45-22, and 50-26 [¶ 27,201]);
- Heart (see CIM § 35-87);
- Liver (see CIM § 35-53);
- Bone marrow (see CIM § 35-30); and
- Cornea.

You are required to provide or arrange for certain transplants in out-of-area hospitals. Heart and liver transplants may only be performed in Medicare approved transplant centers. Not all hospitals performing transplants are Medicare approved transplant centers, even if they are participating hospitals for other services.

If one of your Medicare enrollees is a candidate for heart or liver transplant surgery, give him/her written notification that the procedure is a covered Medicare service and that it is performed in facilities approved by Medicare. The transplant facility makes the determination as to whether the enrollee meets the patient selection criteria. Refer your enrollees who are appropriate candidates only to Medicare approved heart or liver transplant facilities for evaluation. HCFA notifies you of each new Medicare approved transplant facility. The Regional Office (RO) has a complete list of these facilities. The facility determines whether to perform the transplant. Failure to refer appropriate candidates to, or to provide or arrange for the service in, a Medicare approved heart or liver transplant center is subject to a civil money penalty of up to $25,000 for each violation.

C. *Midyear Coverage Changes.*—As benefits become covered, they must be made available to Medicare enrollees on the effective date of Medicare coverage. The cost of providing new or expanded benefits which are mandated by Congress midyear must be borne in its entirety by contracting risk HMOs and CMPs. However, when the Secretary expands benefits which the Secretary identifies as involving significant costs, and these benefits were not included in the adjusted average per capita cost (AAPCC) calculation, risk-based HMOs and CMPs are not responsible for providing or paying for these benefits. When HMO/CMP enrollees receive such services, Medicare pays the benefits under fee-for-service until the next contract year, when the benefits are included in the AAPCC.

HMO/CMP Manual § 2102 (as revised by Trans. 9, Jan. 1992).

The Secretary is required to study the availability of covered chiropractic services in HMOs and present its findings to the congressional committees no later than January 1, 1993 (¶ 17,805).

Sec. 4204 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). [A summary of the law was originally reported at NEW DEVELOPMENTS ¶ 38,951.]

.22 **Emergency and urgently needed services.**—HCFA guidelines state as follows:

Emergency Services

Assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See § 2107 [¶ 13,960.35] for the permissible limits on the amount you must pay.)

Definition.—Use the definition provided in 42 CFR 417.401. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

Example: While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the HMO/CMP is required to pay for the physician's services because the enrollee's

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medical condition appeared to require immediate medical services.

There does not need to be threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treates a skin lesion. You are not responsible for any costs, such as biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, pay the cost of medically necessary follow-up care. (See § 2105.)

Transfers.—If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under § 1867 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See § 1867(c)(2) of the Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:

—Provides medical treatment to minimize the risks to the individual,

—Forwards all relevant medical records, and

—Uses qualified personnel and transportation equipment for the transfer;

- The receiving facility:

—Has available space and qualified personnel, and

—Except for specialized facilities that under § 1867(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and

- The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO/CMP.

HMO/CMP Manual § 2104 (as revised by Trans. 9, Jan. 1992).

Urgently Needed Services

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or an injury. Cover these services if:

- The enrollee is temporarily absent from your geographic area, and

- The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Attachment 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Washington, D.C. 20201

MAR 2 7 [illegible]

TO: CURRENT MEDICARE-CONTRACTING HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SUBJECT: FINANCIAL RESPONSIBILITY FOR EMERGENCY SERVICES

Dear Sir/Madam:

As a result of complaints received regarding access to emergency services in managed care, we are sending this letter to remind all Medicare-contracting HMOs and CMPs of policies relating to the provision of emergency services for Medicare beneficiaries.

The enclosed document (Operational Policy Letter 95-5) references regulatory and HMO/CMP manual citations relating to emergency services.

Sincerely,

Rodney C. Armstead, M.D.
Director

[illegible] System

Enclosure

Office of Managed Care
Operational Policy Letter 95-5

Issue:

Policies relating to the provision of emergency services for Medicare beneficiaries.

Policy:

Federal regulations at Title 42 Part 417.414(c)(1) state:

> An HMO or CMP must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in § 417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the HMO or CMP even in the absence of the HMO's or CMP's prior approval. [Emphasis added].

Therefore, Medicare-contracting managed care plans cannot require prior authorization for emergency services. This policy is also stated in section 2104 of the HMO/CMP manual: "Do not require prior authorization."

In addition, section 2104 of the HMO/CMP manual states "Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature." Therefore, if emergency services appeared to be needed, plans may not decide upon retrospective review to refuse to cover emergency services provided.

Refer to section 2104 of the HMO/CMP manual for further detail on Medicare policies relating to emergency services.

Contact Person:

Anne Manley, Office of Managed Care, (202) 619-3166

Mr. BURR [presiding]. I thank you, Doctor.

At this time, the Chair would recognize Dr. Davis.

Dr. DAVIS. Thank you, Mr. Chairman. I am here at the invitation of Congressman Cardin to answer any questions you might have about the experience in Maryland where we have had similar legislation in place for the last 2 years.

Mr. BURR. I apologize to you, Doctor. The Chair was not paying attention. If you could repeat your question?

Dr. DAVIS. Certainly. I am here to answer any questions about the experience we have had in Maryland where this legislation has been in effect since 1993.

Mr. BURR. Doctor, do you have any formal testimony that you would like to make or any comments other than just taking questions?

Dr. DAVIS. I would say that it has not increased at all any inappropriate use of emergency services, and it has not raised the cost to the HMOs. It may have decreased costs by allowing fewer costly hospital admissions.

The Maryland Association of HMOs has now deemed this law to be prudent public policy even though they opposed it 2 years ago.

Mr. BURR. Dr. Davis, I appreciate that.

At this time, the Chair would recognize Dr. Connerton.

STATEMENT OF PEGGY M. CONNERTON, PH.D., DIRECTOR OF PUBLIC POLICY, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL–CIO, CLC

Ms. CONNERTON. Thank you, Mr. Chairman. I am here on behalf of the 1.1 million members of SEIU, the Service Employees International Union, and I would like to provide this afternoon the perspective of the private sector on the current state of the art on monitoring quality and where we need to go in the future.

Let me say at the outset that SEIU strongly supports reforms that will improve the program's efficiency and effectiveness and ensure its ability to provide benefits over the long term. Indeed, many of the private sector innovations that policymakers are currently considering incorporating in the Medicare Program, such as managed care, selective contracting, broader use of centers of excellence, and case management, were, in fact, pioneered by labor unions and their employers over the last two decades.

Our written testimony addresses the labor movement's deep concern with the unprecedented magnitude of the cuts and outlines the principles against which we will judge overall Medicare reform.

There are two principles that are really relevant for today's topic. The first is the issue of choice. SEIU believes that Medicare beneficiaries should have access to the same range of mainstream health care coverage options available to working Americans. And in bargaining with our employers, SEIU has tried to ensure that a wide range of choices are, in fact, available to our members.

The second principle that is relevant to today's hearing is that health plans and providers who would provide services to Medicare beneficiaries must be able to meet rigorous quality standards.

Now, while labor and management have had success in getting costs under control, particularly in recent years, we often know very little about the quality of the product that we are buying.

I recently attended a meeting of the Jackson Hole group that brought together purchasers of health care from both sides of the bargaining table, as well as the public sector, including HCFA.

The purchasers at this meeting expressed the concern that they were having tremendous success in pushing down prices, but were unsure of what the impact was on the quality of care. This is exactly the same kind of discussion that took place earlier this morning about whether or not cost cuts of this magnitude will or will not affect quality of care for Medicare beneficiaries.

From SEIU's perspective, we have been finding more complaints about managed care from our members as these integrated delivery systems become tighter and hence more restrictive. And, indeed, our health care membership has reported dangerous reductions in staffing levels, increased patient falls, high medication errors in hospitals, and other signs that this price-driven competition may be threatening the quality of patient care.

Purchasers at the Jackson Hole meeting seemed to have concluded that report cards based on process measures like NCQA were, while helpful, not particularly useful in comparing different health plans. Purchasers also expressed the frustration about the strong resistance of health plans and providers to providing standardized information on quality that could be used to compare health plans.

It is clear that the incentives in the private sector market are today very much weighted toward competition based on price and not on quality.

With this in mind, I would like to say that there are several principles that we have been using in the private sector that we think are important to helping make health plans more accountable for their performance. The first is in the area of access to high-quality care.

NCQA and other kinds of private accrediting groups simply track the word "access" by looking at the percentage of members who visited a plan provider within the past 3 years. Now, this obviously is not an adequate measure of access of services, which includes things like convenience and location, hours of operation, and accommodation of participants with special needs.

There is also a very important interest in getting patient satisfaction surveys, and it would be important that Medicare regularly survey beneficiaries on their use and satisfaction about their health plans.

The third area is consumer rights, which, in fact, most of the private purchasers do not address at all. It really is a State-by-State function, and that is the whole question of consumer rights. In a managed care environment, public disclosure and other protections for consumers are vitally important, yet on the State level there are very few requirements by most of the State health departments other than that a plan has to have a grievance procedure in effect.

In short, there are not particularly good protections at the State level today in the HMOs to assure that grievance procedures and everything else are addressed. This would be particularly important in the case of our most vulnerable populations, the Medicare beneficiaries.

The fourth principle, of course, comes down to monitoring quality. This is something I think that is extremely important that both the private and the public sectors need to collaborate on. It is not a problem which is unique to the Medicare population. It is a problem that the private sector is confronting across the board. As I said earlier, we still have no good measures by which consumers can judge the quality and the performance of health plans. It is important that health plans provide the data on some health outcomes measures, and that is the direction that the private sector is heading.

However, I just simply need to point out that this is an issue that is at its infancy, and so the idea of putting 37 million Medicare beneficiaries into private health plans in the next several years is simply unrealistic. In fact, given that the private sector has not yet figured out how to monitor quality at this time, I think that would be a very dangerous move.

Mr. BURR. Doctor, I am going to ask you to summarize as quickly as you can, please.

Ms. CONNERTON. I am finished.

[The prepared statement follows:]

TESTIMONY OF

DR. PEGGY M. CONNERTON
DIRECTOR OF PUBLIC POLICY

SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

BEFORE THE

SUBCOMMITTEES ON HEALTH
COMMITTEES ON WAYS AND MEANS AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

JULY 27, 1995

Mr. Chairman, members of the Committee, I am Peggy Connerton, Director of Public Policy for the Service Employees International Union, AFL-CIO, CLC. With over 1.1 million members, SEIU is the third largest union in the AFL-CIO and the fastest growing. SEIU members work in both the public and private sectors and include 450,000 health care workers who work in acute care hospitals, nursing homes, mental hospitals and other health care facilities. On their behalf, I would like to thank the chairman and the other members of the subcommittee for this opportunity to testify today about the future of the Medicare program.

In three days we will mark the 30th anniversary of the creation of Medicare, signed into law by President Lyndon Johnson on July 30, 1965. It is often forgotten that at that time, only half of America's elderly had any health insurance. Millions of elderly Americans lived with the fear that a serious illness could rob them of both their health and their retirement savings.

Today, Medicare pays the doctor and hospital bills of more than 37 million Americans. At a time when the ideas of public purpose and activist government are under attack, Medicare stands as a shining example of how a well-run government program can make a difference in the lives of working families. The program's success is reflected in support that extends across generations. A recent poll conducted by the Daniel Yankelovich Group found that nine out of ten Americans under the age of 65 (including 87 percent of those aged 18 to 29) want Medicare to be there when they retire.

This support for Medicare among younger workers should not be surprising. Medicare is the linchpin of our nation's system of retirement health security. Rapidly rising health care costs have led many employers to drastically scale back their coverage for retirees or eliminate it entirely. Future retirees will be even more dependent on Medicare than current retirees.

In many ways, Medicare is more efficient and effective than private sector health plans. Medicare spends only 2 percent of program costs on administration, less than health plans serving large private employers (5.5%) or small private employers (25%). From 1976 through 1991, the rate of growth in per enrollee costs for Medicare was equal to or even below that of private sector plans. Since 1991, the rate of growth in per enrollee costs for Medicare and private health plans has been roughly equal and this is expected to continue over the next few years. Most of the program's projected growth over the next ten to twenty years comes from increases in the number of eligible individuals because of the aging of the baby boomers.

SEIU does not dispute that the Medicare's current rate of growth of 10 percent a year is unsustainable. We do not object to reforms that will improve the program's efficiency and effectiveness and ensure its ability to provide benefits over the long term. Our position has always been that the rapid increase in Medicare program costs over the last several years mirrors the health care cost crisis in the private sector. What is needed is *system-wide* cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans.

The labor movement knows a great deal about the problem of rising health care costs. Over the last decade, health care has been the number one issue at the bargaining table. While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies. Indeed, many of the private sector innovations that policymakers want to incorporate into the Medicare program, such as managed care, selective contracting, use of centers of excellence and case management, were pioneered by the labor unions and employers over the last decade.

While we are committed to participating in a discussion about how to strengthen the Medicare program for the 21st century, that is not what the debate so far in Congress has been about. It seems clear to us that what happened is that the budget resolution conferees estimated how much they needed to cut from Medicare in order to meet their arbitrary seven-year target for balancing the budget and provide a staggering $245 billion tax cut to wealthy vested interests. The Medicare trustees report is merely an after the fact justification. How else are we to explain that the proposed cuts in Medicare are more than twice the level of what is needed to ensure the adequacy of the trust fund for at least the next ten years.

If we are going to make changes to Medicare, we need to move cautiously and carefully. The goal must be to strengthen the program, not simply to reach an arbitrary budget target or to provide $245 billion in tax cuts for the rich and large corporations. A recent poll by the Kaiser Family Foundation found that this position is shared by most of the public. In that survey, only 28 percent of the public supports major reductions in Medicare if the goal is to provide a tax cut.

In the remainder of my testimony, I want to outline the principles that SEIU believes should guide policymakers as they consider changes to the Medicare program. Finally, I will examine a number of the proposed policy options in light of those principles.

Principles for Medicare Reform

When he put forward the original Medicare legislation in 1961, President Kennedy explicitly linked his proposed health insurance program for the elderly to Social Security and Unemployment Insurance, noting:

> "Twenty-six years ago this Nation adopted the principle that every member of the labor force and his family should be insured against the haunting fear of loss of income caused by retirement, death or unemployment...But there remains a significant gap that denies to all but those with the highest incomes a full measure of security--the high cost of ill health in old age."

With these words in mind, let me outline the principles that SEIU is using to judge any proposed changes to the Medicare program.

- **Universality:** The Medicare program must retain the system where all Americans contribute to the program during their working years and are eligible for the program's benefits when they reach 65 or become disabled.

- **Defined Benefits:** Medicare reform must not lead to any reductions in the scope of benefits that are currently covered.

- **Limits on Premium Share:** Medicare currently pays 100 percent of the Part A "premium" and 75 percent of the Part B premium. Medicare must retain its commitment to pay a certain percentage of a beneficiary's premium and should not limit its premium payment to a flat amount.

- **Choice:** Medicare beneficiaries should be able to obtain coverage from the same range of mainstream health care coverage options that millions of working men and women rely

on, including HMOs, PPOs, and Point-of-Service plans, in addition to the traditional indemnity coverage offered by the Medicare program. Medicare beneficiaries must be able to maintain existing relationships with primary and specialist providers.

- **Quality Standards:** Plans and providers who would provide services to Medicare beneficiaries must be able to meet rigorous quality standards. Providers and plans should be required to report clinical outcomes and this information should be made available to Medicare beneficiaries.

- **Limits on Out-of-Pocket Costs:** Medicare reform must be consistent with the program's original intent of keeping beneficiaries' out-of-pocket payments for health care services within a manageable level. Higher costs should not be used as a bludgeon to force beneficiaries into lower cost plans.

- **Public Accountability:** The debate over the future of Medicare cannot be conducted behind closed doors. It must be a public debate that involves all stakeholders, with a sufficient period of time for research and reflection on the various options. The debate thus far has not conformed to this model.

Evaluating Proposals for Medicare Reform

One of the difficulties in assessing the impact of proposed Medicare reforms is that the Congress has not yet provided the public with a detailed proposal. Instead, as I noted earlier, the budget conferees selected a number designed to help meet an arbitrary goal of balancing the budget by the year 2002 and providing a $245 billion tax cut to the wealthy. Although we are looking forward to examining the Committee's legislation in detail, SEIU wishes to offer comments on some of the proposals that have been floated during the past few weeks.

Increased Premium and Cost Sharing for Medicare Beneficiaries

One proposal that has been put forward is to impose higher premiums for Medicare Part B. In 1990, Congress set the Medicare Part B premium in actual dollar amounts in order to protect beneficiaries from rapidly rising health care costs. But program costs have actually risen more slowly than expected, so beneficiaries are currently paying 31 percent of program costs. Some have suggested making this arrangement permanent, and pegging Part B premiums at 31 percent of program costs.

SEIU members have been down this road before. Over the last ten to fifteen years, employers attempted to reduce their benefit costs by shifting more of the burden to workers. Forcing workers to pay more, however, did nothing to reduce the rate of growth of health care costs.

We are concerned that the result will be the same in this case. Medicare beneficiaries, almost two-thirds of whom have incomes less than $15,000, will be forced to pay higher and higher premiums as Medicare costs continue to spiral upward. Cost shifting should not be confused with cost-control.

Another idea that has been put forward is to impose a new, income-related premium for higher-income beneficiaries. Since, however, 97 percent of Medicare beneficiaries (including couples) earn less than $50,000 a year, the only way that this proposal would raise any revenue would be to set the income threshold quite low. This would hurt millions of low and moderate-income retirees.

Still another revenue raising option that has been proposed is to add 20 percent coinsurance payments for Home Health services, Skilled Nursing Facility care, and laboratory services. While this would raise out-of-pocket costs for beneficiaries, it might not save the Medicare program any money, as beneficiaries might spend additional days in the more

expensive hospital instead of opting for lower cost care in an SNF or at home.

Deep Cuts in Reimbursement to Providers

This is an old Medicare standby and has the potential to generate considerable savings for the program--at an enormous cost. A recent analysis conducted by Lewin-VHI for the American Hospital Association suggested that cutting Medicare by $250 billion could lead to hospital payment rates that are more than 20 percent below costs. Hospitals and other providers would be forced to make up their losses by increasing the rates they charge private pay patients. This would raise the cost of health insurance for millions of working families and lead even more employers to drop coverage.

A 1991 study by Lewin-VHI for the National Association of Manufacturers confirmed the existence of cost shifting, finding that the private sector was already paying close to $11 billion more a year because of underpayment by public programs. The Medicare cuts proposed in the budget resolution are the largest ever considered--several times greater than the $57 billion Congress enacted in 1993. Even if enhanced market competition prevents providers from shifting all of the cuts to private payers, cuts of this magnitude will certainly lead to a significant increase in private health insurance costs. To the extent that providers are unable to shift costs, they will be forced to cut services.

It has been suggested that Congress could avoid this problem if it encouraged more beneficiaries to enroll in managed care plans. But this merely leads to a different set of problems. Since no one seriously believes that the federal government can save $250 billion by moving beneficiaries into these kind of programs, there would still be a need for payment reductions in order to meet the budget targets. But reducing capitation rates to managed care plans will merely reduce the number of managed care plans that want to enroll Medicare beneficiaries, reducing access.

SEIU members work on the front lines of patient care in hospitals, skilled nursing facilities, home care agencies, and other settings. We know first hand what happens to patients when Medicare makes large cuts in reimbursement. Providers begin to cut corners in staffing and look for ways to get people out of the facility earlier--in many cases before they are truly ready to be discharged. The kind of drastic Medicare cuts outlined in the budget resolution will have a negative effect on the quality of care in facilities across the country.

Managed Care

SEIU has supported--and continues to support--allowing Medicare beneficiaries to have a choice of plans that includes health maintenance organizations (HMOs) and other proven managed care entities along with the traditional Medicare fee-for-service plan. In bargaining with our employers, SEIU has tried to ensure that these choices are available to our membership.

However, it would be foolhardy to see managed care as a panacea for the program's cost problem. The truth is that the managed care industry has little experience in serving large numbers of retirees. Given that the magnitude of cost savings associated with managed care for those under the age of 65 is still in dispute, it will be some time before we can come to any definite conclusions about whether Medicare managed care can save money.

There are also special difficulties associated with treating the elderly and disabled, difficulties that many managed care plan may not be prepared for. Those retirees who are enrolled in managed care tend to be younger, on average, than Medicare beneficiaries as a whole. As an individual ages, the development of an established relationship with a physician who is aware of a their medical history becomes much more important, as does access to specialized services. HMOs usually try to limit the use of specialist care and, in some cases, they may not even have an ongoing relationship with certain types of specialist providers.

Vouchers

One of the proposals that has received a great deal of attention is the idea of giving Medicare beneficiaries "vouchers" that they would use to purchase private health insurance. The voucher would be set at a flat dollar amount and would be adjusted every year by an inflation factor set at roughly half of the program's current rate of growth. Beneficiaries would then be free to enroll in any health plan, but would have to pay the difference between the amount of the voucher and the cost of the plan.

While supporters of this plan argue that it would give Medicare beneficiaries greater choice, the truth is that it would resort to financial coercion in order to force beneficiaries into low cost health plans. Millions of retirees would watch helplessly as the value of their vouchers failed to keep pace with the cost of their health insurance.

In order to escape large annual increases in their premium costs, retirees would be forced to shift continually into cheaper plans. This would disrupt their established relationships with primary and specialist providers and put their health at greater risk. The continued movement of a large group of elderly, less healthy individuals into different health plans creates the potential for instability in the system.

SEIU's experience with the CalPERS system, which provides health and retirement benefits to over 100,000 of our members in California, highlights some of the problems. Retirees tend to cluster in plans that give them greater choice of provider, driving up the price of these plans and causing younger and healthier individuals to leave, which drives up the price even higher. While CalPERS has been successful in negotiating rate reductions in 1995-96 of over 5 percent for its HMO plans, the premium for PERSCare (a PPO plan with a large number of retirees) increased by five percent.

Similar problems could result if Congress decides to push Medicare beneficiaries into the Federal Employees Health Benefit Plan (FEHBP). If beneficiaries choose to cluster in a few plans because they provide better choices of providers, those plans could quickly be swamped with more claim activity than they can handle. They may move to restrict provider choices in order to discourage Medicare beneficiaries from joining. Some plans may even go bankrupt. In either case, the quality of care for both federal employees and Medicare beneficiaries will decline.

The potential of Medicare recipients to destabilize a prepaid health plan would likely lead to discrimination against them, either in enrollment or in treatment. Although it is likely that any Medicare reform legislation will require plans to enroll anyone who applies, the history of antidiscrimination legislation suggests some discriminatory practices can escape the definition of the law. A more significant problem is likely to be discrimination in treatment, where the elderly are denied access to clearly beneficial care that is extremely costly. A 1991 study of California HMOs by the Medicare Advocacy Project concluded that "Medicare beneficiaries are extremely vulnerable to misleading marketing by HMOs," and that those who enroll in HMOs "have few meaningful appeal rights" if they disagree with a physician about seeing a specialist.

Because of the potential for discrimination, it is very important that quality standards be developed and that plans be required to report their clinical outcomes. But outcomes and quality research is still in its infancy and it is likely to be several years before we have a workable system that can gain the support of all stakeholders. Large purchasers such as CalPERS have only succeeded in getting premium costs under control. They are just starting the process of trying to evaluating the level of quality they are getting for their money, and they would be the first to tell you that they are a long way off from knowing anything more than just the basics.

While it may be heresy to suggest this in a time of fiscal austerity, Congress needs to consider spending *more* money on outcomes and quality research. The potential payoff in program savings down the road is significant, but only if the federal government is willing to

invest the necessary resources.

Risk Contracts for Private Plan Sponsors

One of the proposals that has been put forward is to allow unions, employers and other health plan sponsors to contract with Medicare to provide coverage for their retirees. The United Mine Workers, for example, has been doing this for several years and the results have been largely positive. SEIU locals across the country operate multiemployer trust funds that provide health and pension benefits to tens of thousands of SEIU members. Our locals are interested in the idea that they would be able to provide "one stop shopping" for all health care benefits for their members.

Financing is, of course, a key concern, both to the government and to the plans. In managing multiemployer plans, for example, the trustees are not running a business in which they are free to take big risks in the hope of achieving big gains. They are nothing more, and nothing less, than fiduciaries of a fund that must be administered in a way that maximizes the benefits of those it covers. Because Medicare has provided the lion's share of health coverage for the over-65 population for so long, multiemployer plans--like other private sector payors--do not have a reliable base of experience from which to estimate the potential cost of folding this age group back into their basic coverage. We are also concerned that the large cuts being contemplated in the Medicare program will require plan sponsors to assume unacceptable levels of risk in covering beneficiaries.

Medical Savings Accounts

Perhaps even more radical than the idea of using vouchers is a proposal to incorporate so-called Medical Savings Accounts into the Medicare system. Under this option, beneficiaries would be allowed the option of enrolling in a high deductible health plan and having the federal government make a contribution to a Medical Savings Account on their behalf. Money in the MSA could be used to pay medical expenses and, depending on how the plan is designed, any money left over at the end of the year can be rolled over into an interest bearing account for future expenses or spent for other purposes.

The principal problem with MSAs, as the Congressional Budget Office has recently noted, is that they exacerbate risk segmentation. In theory, healthier Medicare beneficiaries would tend to gravitate toward the MSAs, with less healthy individuals remaining in the traditional Medicare plan. If this happens, the MSA option is unlikely to save the Medicare program any money, and could actually increase the pressure on the trust fund. Medicare would be making MSA contributions on behalf of healthy individuals who might not need to use the money, and would be unable to use those funds (as it does now) to subsidize the care of the high cost patient that would remain in the traditional program.

Changing the Medicare Eligibility Age

It has been suggested that Medicare's age of eligibility be increased to track the increase in the Social Security age of eligibility for full benefits. Leaving aside the question of whether it was good policy to raise the Social Security age threshold, this proposal ignores significant differences between the two programs. While the majority of retirees have significant sources of retirement income other than Social Security, most rely almost entirely on Medicare to insure them for physician and hospital services. Given that the average age of retirement is actually falling--especially as many companies have downsized over the last few years--raising the age of eligibility could force millions of elderly Americans to go without health insurance for several years.

Conclusion

As I noted earlier, SEIU does not contest the fact that Medicare will require significant changes if it is to be able to cope with the retirement of the baby boomers. However, many of the changes that are currently under consideration pose hazards to beneficiaries--present and future. The cuts required by the budget resolution are so large as to call into question the ability of Medicare to provide its current package of benefits in any form for the money that the federal government will be paying.

Our members see Medicare and Social Security as woven together into a sturdy fabric that they depend on for their retirement security. If "reform" is merely a code word for shifting costs from the federal government to beneficiaries and the private sector, then that fabric will begin to unravel. One of our finest achievements as a nation over the past fifty years--the dramatic reduction in the number of elderly living in poverty--will be put at risk.

SEIU's experience in negotiating and managing health benefit plans in the private sector suggests that there are innovative, but less radical, steps that could turn Medicare from a passive payer of bills into an active purchaser. This is the way that most private plan sponsors are moving. Moving toward a strategy of active purchasing would strengthen the ability of the program to pay benefits for the next ten to fifteen years. This would give us ample time to explore options for more far reaching restructuring if it should become necessary. Reforms of this type could include:

- **Competitive purchasing** of standardized services and supplies, including durable medical equipment, laboratory testing, radiology and outpatient surgery.

- **Establishment of explicit quality and performance standards** and refusal to do business with providers who do not measure up. Medicare needs to move beyond the minimal participation requirements that are now set in legislation. New standards for providers should include the HEDIS-type "report card" and health outcomes measures for which the Medicare program would be accountable.

- **Development and use of centers of excellence and specialized services contracting.** Medicare now uses such concepts in its coverage for transplant services and private sector plans, including union-sponsored Taft-Hartleys, use selective contracting even more widely for many forms of surgery, cancer care, mental health and so forth. A policy of selective contracting, however, needs to take into account the wish of most Medicare beneficiaries to preserve relationships with existing providers.

- **Use of case management** of high cost patients. Most private-sector health plans have the flexibility to work with high-cost patients to develop service packages, such as home care, that can better meet their needs.

- **Improved enforcement** to address fraud and abuse. In recent testimony, a GAO official noted that the Medicare program is "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers." Improved enforcement could yield tens of billions of dollars in savings a year.

In the end, the members of SEIU believe that reform of the Medicare system should be linked to reform of the whole health care system. For years, the private sector has been allowed to insure the young, the healthy, and the financially secure, whereas the public sector has been left with the job of insuring the elderly, the sick, and the poor. Although costs have risen for the private and public sectors alike, the burden of public sector programs has been especially heavy of late, and threatens to bankrupt federal, state, and local governments and drive costs even higher for working families. What is needed is *system-wide* cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans.

Mr. BURR. Doctor, I thank you, and I thank all three. The Chair will exercise the option of the Chair to reverse the direction that we ask questions, which puts me first and last, since I happen to be the only one here. And I apologize for that, but there are a number of things going on on the Hill, as well as some key votes on the House floor and debates right now. But I can assure each of you that it is very valuable to have you in and to have your testimony, because what we are undertaking will probably be one of the most important decisions in my days here in Washington.

Dr. Aghababian—I make a good stab at it. I can say "Bilirakis." I have learned that. But I will have to practice yours a little bit. Let me start with you, if I could.

My health coverage is under an HMO and has been for a number of years. I come from North Carolina, which we are not supposed to know these things until last, but, in fact, this was something that we experienced very early on. There was a savings, and one of the things that you had to do was adjust to a new system. It was a choice for every individual at the company that I worked for.

Unfortunately, while on a vacation in Michigan, I got very ill, went directly to an emergency room. The emergency room never questioned the fact that I was an HMO patient, even though we presented a card, specifically covered it with them. They never stopped what they perceived to be a needed emergency treatment. Fortunately, in a couple of weeks, I was fine.

I guess I would only ask you from my personal experience, am I the exception or am I the norm?

Dr. AGHABABIAN. I can only tell you that on a given day we end up spending several hours on the telephone——

Mr. BURR. Move just a little closer to those mikes, if you could. I never believed it, but it is very difficult up here to hear you folks.

Dr. AGHABABIAN. Understanding that we have perhaps in my department nearly 200 encounters a day, I can tell you that there are several hours spent on the phone trying to get approval for various conditions.

Mr. BURR. I understand and certainly realize that the HMOs have asked all of us to do things a little bit differently. But I think that your testimony really dealt with the potential health of the individuals coming in. And what I would like to really determine: Is your concern with the health of the individuals and the quality of care that they are receiving, or the fact that in the emergency room we are having to shift to a different approval process than the decision by the attending physician, as has been the norm for several years?

Dr. AGHABABIAN. I would just like to begin by saying, Mr. Burr, I would hope that if you came to my emergency department you would have the same—I am sure you would have the same experience of not having your insurance in any way interact with our providing you with appropriate care. We would certainly want that to be the case.

However, I must go on to say that we deal with 30 or 40 different plans in my emergency department, each of which has different rules about payment. And much of what we experience occurs not only at the time of service but retroactively if they decide not to pay for the service. So that you may not have had a problem, and

we certainly would not interrupt the care of someone who we thought was very sick. But a month or two down the line, our hospital and the group that I work with at the university might not be paid for that service they rendered to you.

Mr. BURR. Well, let me ask this, if I could, Doctor. Given that you would not stop what you perceived to be an emergency, are, in fact, the ones that are questioned situations where the individual thought that the emergency room was the appropriate place, but had they placed a call or if a call was made when they walked in the door, that they would have, in fact, been directed to possibly another source?

Dr. AGHABABIAN. There are cases——

Mr. BURR. And I realize we are talking in very broad terms. We are not talking about specific cases. But I think we certainly have to understand the context of what happens daily.

Dr. AGHABABIAN. Right. It is our responsibility, because of the Social Security Act—and, of course, we are happy to do this—to provide an immediate screening exam. The patient who comes in with chest pain may have indigestion or may have a very serious condition, as the one I just described.

I was recently reviewing a case of a 6-month-old child whose parent called because the child was listless and had a fever of 104 and was advised to drive 42 miles to a plan hospital and en route had a cardiac arrest and, as a result of his blood-borne infection, had all four limbs amputated.

Now, how can you tell from the symptoms that a patient describes over the phone if they are having an emergency or not? That takes a lot of experience. So if someone comes to our department complaining of discomfort in the chest, we take it very seriously, and we do whatever has to be done to prepare for a complication that might occur. Then we worry about the health insurance implications.

But what happens is if someone comes with a laceration, which I could easily repair or could be repaired at a doctor's office, or a splinter that has to be removed from their heel that is causing them a great deal of pain, I could assess that problem, and we could try to access the plan, as we often will do. And they may or may not approve the payment for that service.

Now, we still offer the patient the opportunity to have it remedied by us and then to take up the issue of who is going to pay for it with their insurance company. We never delay care. We always take care of the people. But my staff and I will then be on the phone for hours on some cases that are more complex trying to get approval for it.

Now, it is not only approval to treat, but if we elect to admit someone, then we have to get approval to admit. So sometimes we have to make two or three calls to get approval to have a specialist see the patient. So we are constantly on the phone talking about plans, and often we are talking to a nurse or someone with no medical training about what we would like to do to a patient who has an urgent condition.

I would like to defer to Dr. Davis about his experience in Maryland.

Mr. BURR. Let me, if I could, just ask one question of you, though. As an emergency room physician, as one who constantly treats those who are either in an emergency situation or believe that they are, when you deal with seniors, do you find that seniors have a close connection with their primary doctor and, in fact, want notification to them very quickly that there is a problem?

Dr. AGHABABIAN. Not always. There are very stoic individuals who wait until the last minute before they go to the hospital with a symptom, will not call their doctor, who believe they do not want to bother their physician, and will be urged by a family member to come. Seniors are a very diverse lot, and I am glad that is the case. I had a 90-year-old come in with a heart attack recently, and when I was discussing with him the newest approaches of therapy which have risks, he said, "Go for it." He had suffered his heart attack while he was chopping a cord of wood. That is a 90-year-old man chronologically who is physiologically much younger.

I think age is a relevant term these days, and certainly the way they behave to symptoms is very relevant.

Mr. BURR. Well, the individuals that have come before our Commerce Committee who have really opposed the injection of new options, and specifically managed care options, have done so with the contention that seniors are so close currently to their physician that the fear may be that their physician is not listed on that approved list.

One, let me take this opportunity to state that I believe whatever reforms come out of the 104th Congress will protect the existence of the current system for those that would like to stay on it. So I think the debate is about what options we provide, and since I have another Member who has entered the room, I am going to have to watch the clock on myself since I am already over, and I want to go over to Dr. Connerton because I want to go to your conclusion and just ask you a couple of questions, if I could.

I read from your concluding remarks,

> The cuts required by the budget resolution are so large as to call into question the ability of Medicare to provide its current package of benefits in any form for the money that the Federal Government will be paying.

Let me just ask you to define Medicare in that context. Is that HCFA?

Ms. CONNERTON. What?

Mr. BURR. In the sentence that I read where you state that this would "call into question the ability of Medicare to provide its current package of benefits in any form for the money that the Federal Government will be paying." In other words, we pay $4,800 per senior today. We are going to raise it to $6,700. I would assume from that statement that you are saying we cannot supply the same package from HCFA for $6,700 in the future.

Ms. CONNERTON. I think it is clear what we were talking about is the scale of the cut and the impact that that would have on the health delivery system as a whole.

Mr. BURR. Well, I realize that a lot of your statement dealt with the overhaul of the entire system.

Ms. CONNERTON. Yes.

Mr. BURR. I guess this would be a good time to ask you as a representative of your group. Did your group endorse the President's

plan last year? Would that have been—I note your reference to, "What is needed is a system-wide cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans." That is, in fact, what the President offered last year. Was that a plan that you as a representative endorsed?

Ms. CONNERTON. The Clinton health plan was endorsed by all of the unions in the labor movement. That is correct, yes.

Mr. BURR. Very good.

All right. At this time the Chair will recognize Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. It is just amazing how fast your seniority has gone up. I guess if you sit here long enough, why, everyone else leaves.

I want to thank the panelists for staying so long. It is hard being on the third panel because the other ones go longer and you never know what time you are going to be needed, so you sit here the whole day. We appreciate your coming.

I want to reinforce the difficulties that managed care present in the emergency room. Certainly in the life-threatening situations, bound by the Hippocratic oath, we just take care of patients, period. You would agree with that?

Dr. AGHABABIAN. Absolutely, sir.

Mr. GANSKE. I think the quality of care issue arises when you have an acute situation but not a life-threatening situation; that is, a bad hand laceration or something like that. And I can relate from personal experience, because I participated in several HMOs, that the emergency room doctor will make an attempt to get the referring doctor, the primary care doctor on the line. Not infrequently, there is a long delay. So because you have got this bottleneck and you have got all these patients waiting out in the emergency room, you want to try to get these patients taken care of in a reasonable period of time.

You will then phone the specialist, a surgical specialist or whoever is necessary. Is that right?

Dr. AGHABABIAN. Yes.

Mr. GANSKE. And I think probably not infrequently you get an answer from that surgical specialist, well, I will be more than happy to come if you have received authorization. Is that right?

Dr. AGHABABIAN. That is correct.

Mr. GANSKE. The reason for that—correct me if I am wrong—is that if the specialist goes and takes care of the patient but he has not received an authorization from the gatekeeper, then he will receive no payment.

Dr. AGHABABIAN. He will also receive a lot of headache, besides not receiving payment.

Mr. GANSKE. Not only that, but the primary care doctor will get mad at him.

Dr. AGHABABIAN. Correct.

Mr. GANSKE. Because he has now initiated treatment and may not be the choice or on that panel for that particular HMO or PPO; is that right?

Dr. AGHABABIAN. That is correct.

Mr. GANSKE. So what happens? Basically, patients sit there for long periods of time.

Dr. AGHABABIAN. I can think of a classic example that you will appreciate. A middle-aged man came in recently to see me at the front desk; he had broken up a dog fight, and he had several puncture wounds on his hands that were bleeding and open lacerations. He was informed that his insurance company would have to be called. They were called and told the man that, for payment, he would have to go to an urgent care center where I knew on duty was a generalist who did not understand the complication of this injury. I told him that it would be better to be treated here, this was a serious problem. I even called the physician back, who again said, no, send the patient to the center that was manned by someone with minimal experience. It was with great reluctance, because it was the patient's choice, that I let that patient leave with a serious dog bite of both hands, knowing that the incidence of infection and complications could be quite high.

It was heartbreaking to me as a physician because I want to treat my patients as best I can.

Mr. GANSKE. I find it rather paradoxical that those patients that come into the emergency room that have no insurance—I mean, not even title XIX—they will get quicker care than those who have worked hard and have purchased a health insurance plan.

Dr. AGHABABIAN. In our institution, that man would have been seen by a hand or plastic surgeon.

Mr. GANSKE. Thank you very much for your testimony.

Mr. BURR. Thank you, Dr. Ganske.

The Chair would recognize Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Connerton, I would like to address a couple of things in your testimony, and I apologize if I repeat a couple things.

You mention in here about the $245 billion tax cut. Were you aware that the tax cut in the Contract With America was passed without touching Medicare? In other words, it was completely paid for without touching Medicare during the Contract With America. Were you aware of that?

Ms. CONNERTON. I am dealing with the present situation, which is the budget resolution.

Mr. ENSIGN. Were you aware, during the Contract With America, our tax cuts were completely 100 percent paid for without touching Medicare? Purposely without touching Medicare or Social Security?

Ms. CONNERTON. If you say so.

Mr. ENSIGN. Well, it is a matter of fact. It is not a question of anything I say. It is a matter of fact. During the Contract With America, we had 245 billion dollars' worth of tax cuts—actually, more than that—that we did without touching Medicare. We paid for them with cuts in other areas. We did it without touching Medicare.

I think that saying that our tax cuts are being paid for by Medicare or inferring that in your testimony, your written testimony, is very unfair.

Ms. CONNERTON. Well, all I can say is that I am dealing with the budget resolution. I know the Contract With America had some very back-of-the-envelope calculations in it, and I think what is relevant——

Mr. ENSIGN. Back of the envelope? These tax cuts were scored by CBO, and so were all of the spending cuts scored by CBO.

Ms. CONNERTON. Let me just repeat that what we are looking at here is a situation where there is an attempt to balance the Federal budget and achieve tax savings of $245 billion over the next——

Mr. ENSIGN. Correct. We actually had higher tax cuts during the Contract With America without touching Medicare. Repeat, without touching Medicare.

Now, after the Contract With America, the President's own trustees came out with a report that said Medicare will be bankrupt in the year 2002. The President's own trustees, after the Contract With America. After the tax cuts which were paid for without touching Medicare, without the budget proposal that we came out with, without trying to balance the budget, Medicare still goes broke, based on the President's budget that he sent up here that was not balanced in the year 2002. Medicare still goes broke.

Would you agree with that?

Ms. CONNERTON. I would agree that there is a long-term solvency problem with the Medicare Trust Fund.

Mr. ENSIGN. Even without a balanced budget, even without the tax cuts, Medicare still goes broke?

Ms. CONNERTON. That is the current projection. And you have to understand that in——

Mr. ENSIGN. So how can you——

Ms. CONNERTON. Wait——

Mr. ENSIGN. $245 billion in tax cuts to the fact that we are taking that out of Medicare when we did it without it?

Ms. CONNERTON. I am just going back to the arithmetic, and the arithmetic is that you want to balance the budget and achieve $245 billion in tax cuts, and in order to make that all happen, you want to take $270 billion out of the Medicare Program.

Mr. ENSIGN. OK. Let's go to some different line of questioning. Do your recipients have better coverage or worse coverage than Medicare recipients today, your enrollees?

Ms. CONNERTON. Well, we are a service workers union, so it is——

Mr. ENSIGN. On average.

Ms. CONNERTON. On average, I would say "yes" because we have stop loss insurance and prescription drug coverage, better mental health coverage, yes.

Mr. ENSIGN. OK. Why do you think that the private sector has been able to keep up with some of the newer coverages and yet Medicare has not? In other words, a lot of Medicare recipients are not receiving as good a coverage today as people in the private sector. You mentioned prescription drug coverage being a huge part of that.

Ms. CONNERTON. That is correct, but we pay for that as part of our compensation package. And, in fact, we have traded off pay increases in order to get additional benefits at the bargaining table.

Mr. ENSIGN. But even nonunion places are doing that. Even nonunion places without collective bargaining are doing that. I have experience in those areas as well, and even nonunion places—I have worked at union facilities and nonunion facilities, and non-

union places are doing that as well. So I think that we obviously know that, and the point I am making is that we need to improve, we need to provide more service for less money. Your union has been associated with a lot of companies that are doing that not only in their health care plans, but they are building better products for less money. They are providing better services for less money. We are capable of doing that because of better management techniques that your union has been associated with, and you have actually been integrally associated with that. You have seen that happen throughout the eighties, that American companies have become more competitive because of the cooperation and because of the systems that have been put in place.

This is what we are saying that we can do with Medicare, we will slow the rate of growth of spending in Medicare, not as a cut but through efficiency and through strengthening the system.

Ms. CONNERTON. Let me just repeat. My oral testimony really focused on the whole issue of monitoring quality. I mean, we have really been behind a lot of the innovative sort of private sector techniques, managing care. We believe in managed care and see it as a better way to achieve cost-effective care for our employees.

Mr. ENSIGN. Let me just ask one——

Ms. CONNERTON. At the same time—let me just finish what I am saying. At the same time, the private sector is very weak, and they would admit it, and the Jackson Hole meeting which I attended, the whole purpose of the discussion by the purchasers was we do not have a handle around quality at all. All the competition going on there in the marketplace, we are driving down the prices, but we do not know what is happening to the quality of health care that our employees are getting. That is basically where the private sector is at this point. We are a long ways away from determining whether a health plan is a good health plan or a bad——

Mr. ENSIGN. Mr. Chairman, if you will indulge me just for one last question. The savings that have been achieved in the private sector, large employers last year actually had their medical costs go down by about 1.1 percent. Would you classify—if I have a company and I am spending $3,000 on an employee this year, through efficiencies I am able to next year spend $2,900 an employee. Would you call that a cut or would you call that savings?

Ms. CONNERTON. It depends on what happens on the quality.

Mr. ENSIGN. Same quality. Same or maybe better.

Ms. CONNERTON. Well, the way that you have set up the question, the answer obviously would be you would not consider that a cut.

Mr. ENSIGN. If we were able to design a Medicare system, to design a system where we are spending $1,900 more a year per person, providing the same or better quality, would you consider those Medicare cuts?

Ms. CONNERTON. Again, the way the question has been set up, you know, which is the big "if," assuming everything else is constant——

Mr. ENSIGN. Sure, but we do not know that "if," do we?

Ms. CONNERTON. We do not know in the private sector whether we are getting value for our money. We do not know what we are getting.

Mr. ENSIGN. Even though when we do survey our employees——

Ms. CONNERTON. Even though we see cost savings——

Mr. ENSIGN. Even though when we survey our employees, they are every bit as happy or happier with their health care coverage now as before.

Ms. CONNERTON. Well, it is part of the whole question of looking at—if you want to look at the characteristics of the population as a whole or whether you focus your survey on sicker populations. That is one of the reasons why employers are very interested in getting information on health status, because how you view your health plan has a lot to do with your health status. Most employees probably do not use the health plan over the course of the year, but the 10 percent, 20 percent who do, who have the direct interactions with the physicians, with the hospitals and so forth, are the relevant group for interviewing on that end.

There is also the question of health outcomes. Ultimately, is a plan producing a good health outcome? We are very far away from the——

Mr. ENSIGN. I would agree with you there, and I would just encourage your organization to work with us, because Medicare is such an important system. So many people are so dependent on that. Obviously, a lot of your retirees are, and it is such an important system that we have to save it. So instead of just putting out political rhetoric that says that we are cutting Medicare, when, in fact, we may not be cutting Medicare, we may just be achieving cost savings and better quality.

Thank you, Mr. Chairman, for your indulgence.

Mr. BURR. The gentleman's time has expired.

Dr. Davis, I would like to bring you into this for just 1 minute, and I hope that, in fact, this is appropriate to ask you. You have heard part of the debate today. You are in health care. I think you understand the complexity of the issue that we are dealing with. Do you have any suggestions to the Subcommittees, either by what you have seen firsthand or items that you have seen within the medical community that would be prudent for the Subcommittees to look at very seriously that we have not had on the table today?

Dr. DAVIS. Yes, I do. Thank you. I do think that standards are important. I am not willing to turn the oversight over to the private companies. I think Government entities can do that just as well, if not better. I am glad to see the Federal Government taking an interest in this.

Mr. BURR. Well, I can assure you that we hear what you are describing to us. I can only tell you that by every analysis done by an agency of the Federal Government, GAO today—we have had other extensive hearings both in Ways and Means and in Commerce—it is not the opinion of those who do the surveys that, in fact, the Government performs as well as the private sector in this particular case. And HCFA's ability to replicate the successes of the private sector has been slow and sometimes off the mark.

Let me end this hearing today with just a little bit out of the trustees' report, if I may. I quote from the overview of the trustee's report on Medicare.

Under present law, as shown by the projections in this report, the Hospital Insurance Program costs are expected to far exceed revenues over the 75-year long-range period under any reasonable set of assumptions. As a result, the Hospital Insurance Program is severely out of financial balance, and the trustees believe that the Congress must take timely action to establish long-term financial stability for the program. With the magnitude of the projected actuarial deficit in the Hospital Insurance Program and the high probability that the Hospital Insurance Trust Fund will be exhausted in less than 11 years, the trustees urge the Congress to take additional actions designed to control Hospital Insurance Program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of a broad-based health care reform. The trustees believe that prompt, effective, and decisive action is necessary.

I want to take the opportunity to thank all the doctors on this panel, to thank the other panels that preceded you, and to take this opportunity to thank the Subcommittee Members of Ways and Means and of the Commerce Committee. Congress is in a position to exert the responsibility that the trustees have asked us to do, and that is to investigate every option, to talk to everybody concerned—those that agree, those that disagree—to make sure that, in fact, we have the highest quality of health care delivery for our seniors in this country. I am certain over the next several months working with you and others who are willing to come and testify and share with us your feelings on that, in fact, we will reach something that assures all of us of a high quality of care for the seniors in America.

This hearing is now adjourned.

[Whereupon, at 2:27 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

OF THE

AMERICAN ACADEMY OF NURSE PRACTITIONERS
AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
AMERICAN COLLEGE OF NURSE-MIDWIVES
AMERICAN COLLEGE OF NURSE PRACTITIONERS
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PHYSICAL THERAPY ASSOCIATION
AMERICAN PODIATRIC MEDICAL ASSOCIATION
AMERICAN PSYCHOLOGICAL ASSOCIATION
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH

TO THE

HOUSE WAYS AND MEANS COMMITTEE
AND
HOUSE COMMERCE COMMITTEE

ON

JULY 27, 1995

The undersigned associations representing the interests of over 500,000 health professionals appreciate the opportunity to submit written testimony to the House Ways and Means and Commerce Committees to share our views on issues related to the health care delivery system. These non-MD health professional associations share the concern that all Americans should have the opportunity to obtain services from all types of health care providers who are licensed or certified to provide those services. Based on this concern, we would like to describe how this can be accomplished.

RELATIONSHIP BETWEEN HEALTH PLANS AND HEALTH PROFESSIONALS

Our associations believe it is necessary that reasonable access to all health professionals be guaranteed to ensure consumer health care needs are met. Barriers continue to exist in the health care marketplace preventing non-MD health professionals from competing with physicians and practicing to the fullest extent of their education and training.

An essential first step for creating equitable access to all health professionals is to incorporate into health care legislation, antidiscrimination requirements that prohibit health plans from discriminating on the basis of the category of licensure or certification of the health professional. Our health professional associations succeeded in securing provisions in all major health care reform legislation of the 103rd Congress prohibiting health plans from discriminating against health professionals on the basis of their licensure or certification. This success illustrates the understanding by policymakers of the need to ensure the public's access to appropriate health care services.

By preventing discrimination against qualified health care professionals, consumers will have access to necessary primary and specialty care and will be able to choose among a variety of qualified health professionals. Non-MD health professionals are particularly important to meeting the accessibility needs of consumers in rural and underserved areas. In many situations, these are the only qualified health professionals available to provide care. Therefore, antidiscrimination language should be applied to all types of health plans. Even though limited fee-for-service plans and HMO point-of-service options with higher premiums and additional copays provide some choice, they do not go far enough to guarantee consumer choice.

This antidiscrimination language is not "any willing provider" language. It does not require a health plan to enter into a contract with every individual practitioner, but rather would require the plan to have representatives of a variety of health professions in its network. Antidiscrimination language is intended to give health plans more flexibility than "any willing provider" requirements by allowing health plans the discretion to contract selectively on the basis of an individual health professional's reputation, professional qualifications, etc, while preventing health plans from refusing to contract with entire health professions.

During the last Congress, our associations worked with representatives of the managed care industry to negotiate a compromise approach to preventing arbitrary discrimination against health professionals based solely on their license or certification. This concept of antidiscrimination, supported by non-MD health professional associations and managed care organizations, was included in all major health care reform legislation last year. This language prohibits a state, certified health plan, or certified health plan sponsor from discriminating in the participation of, or denying reimbursement or indemnification to a health care provider who is acting within the scope of the provider's license or certification under applicable State or Federal law, solely on the basis of such license or certification.

An increasing number of states, including California, Michigan and Minnesota, have undertaken or are considering affirmative measures to prevent plans from discriminating against health professionals on the basis of category of licensure. Typically, under these statutes, health plans may specify terms and conditions of affiliation to assure cost efficiency, qualification of providers, appropriate utilization of services, accessibility, convenience to consumers, and consistency with the plan's method of operation. This, of course, is not to say that inclusion of all providers of a certain category is mandated.

We urge the Committees to support this reasonable approach to the issue of discrimination against classes of health professionals. This approach was endorsed not only by several health professional associations, but also by representatives of the managed care industry.

CAPACITY OF HEALTH PLANS TO SERVE CONSUMERS

All of the major health care reform proposals of the 103rd Congress recognized the importance of assuring that health plans have the resources and capacity to meet the needs of plan enrollees in a reasonable and adequate manner. Under these proposals, health plans must be certified and demonstrate this ability to provide appropriate care.

Any health care legislation of the 104th Congress should include specific criteria that health plans must meet to demonstrate their capacity to serve the health care needs of enrollees. Our health professional associations and the managed care organizations had agreed to specific criteria that was incorporated into major health care reform legislation last year. This legislative language requires that health plans:

- provide a sufficient number, distribution and variety of health providers to meet the needs of enrollees;
- meet the needs of enrollees with reasonable promptness and in a manner that assures continuity of care;
- appropriately serve the diverse needs of the population including the special resource problems of a designated medically underserved area that is part of the plan's network service area;
- ensure that health services are accessible in the communities and plan service areas in which people live and work; and
- provide information to consumers upon request regarding the plan's certification status, benefits offered, premium cost-sharing and administrative charges under the plan, risk and referral arrangements under the plan, and the number, distribution and variety of health care providers under the plan and the availability of such providers.

We urge the Ways and Means and Commerce Committees to recommend to Congress that every type of health plan be prohibited from discriminating in participation of, or denying reimbursement or indemnification to a health professional who is acting within the scope of the health professional's license under applicable State law solely on the basis of such license or certification. Plans should also be required, at a minimum, to meet certain conditions demonstrating that they have the capacity to serve the enrollees of their plan.

American Academy of Nurse Practitioners
American Association of Marriage and Family Therapy
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American College of Nurse Practitioners
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychological Association
American Speech-Language-Hearing Association
National Association of Nurse Practitioners in Reproductive Health



American Association of PPOs
601 13th Street, N.W. ● Suite 370S ● Washington, D.C. 20005☎ (202)347-7600 ☎ FAX (202)347-7601

July 28, 1995

The Honorable William M. Thomas
Chairman
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The American Association of Preferred Provider Organizations (AAPPO) has delivered or submitted testimony to both the Ways & Means and Commerce health subcommittees on the advantages in both cost-containment and beneficiary satisfaction of adding a PPO option to Medicare. We would like to comment further on the subject of qualification and quality standards, the subject of your July 27 joint hearing, and we ask to have this communication included in the record of that hearing.

AAPPO agrees with the prevailing thought that Medicare choices should be expanded, giving Medicare beneficiaries the same options available to those insured in the private market. We are concerned, however, by some proposals now being discussed that would limit those choices to state-licensed, risk-bearing entities.

As discussed in our earlier testimony, most PPOs are not licensed as insurers or HMOs, and do not bear insurance risk. To require them to do so is to bar most PPOs from Medicare participation, thereby barring beneficiaries from an option that would offer both cost savings and provider choice.

AAPPO believes strongly that Medicare must build on the successes of the private sector, including PPOs. PPOs have charted impressive growth and popularity not by trying to replicate HMOs' structure, but by applying utilization and quality management to a fee-for-service base. In essence, PPOs represent *managed fee for service*. Given that 90% of Medicare beneficiaries currently are enrolled in a fee-for-service arrangement, it clearly would be advantageous to encourage this population to move into a more efficient and cost-effective variation. PPOs have the capacity to enroll large numbers of beneficiaries quickly -- but not if they must first undergo the laborious process of obtaining state insurance licensure.

AAPPO by no means suggests that PPOs seek to escape oversight and accountability. Indeed,

we have proposed the development and implementation of federal-level standards to demonstrate PPOs' ability to deliver high-quality care and to protect beneficiary interests. Under the current scenario, we are prepared to work with the Health Care Financing Administration to develop standards appropriate to PPOs' unique structure; however -- as suggested by several witnesses as well as members of the Subcommittees -- it certainly makes sense to suggest that private organizations could fulfill the role of arbiter.

As we have discussed with you, PPOs seek direct contractor status under the Medicare program. As we envision the process, an interested PPO would first demonstrate its qualification by complying with formal standards. It then would contract with Medicare just as it now does with a self-insured employer, i.e., the employer bears the insurance risk, and compensates the PPO via an administrative fee for network access, provider credentialing, quality and utilization management, etc. AAPPO has suggested that negotiated performance targets could form part of this contract, e.g., that average claims would not exceed the level payable under the standard Medicare payment methodology.

AAPPO urges you to allow PPOs to bring their unique strengths to Medicare's assistance. We look forward to working with you to develop standards and contracts that will promote high-quality care, cost savings, and beneficiary satisfaction.

Sincerely,

Gordon B. Wheeler

Gordon B. Wheeler
President and Chief Operating Officer

STATEMENT BY
THE AMERICAN FARM BUREAU FEDERATION
TO THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE WAYS AND MEANS COMMITTEE
AND THE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
OF THE
HOUSE COMMITTEE ON COMMERCE
ON
STANDARDS FOR THE MEDICARE PROGRAM

July 27, 1995

The American Farm Bureau Federation, the nation's largest general farm organization, representing over 4.4 million member families in every state and Puerto Rico, appreciates this opportunity to comment on standards for various private health insurance plans seeking to participate in and provide coverage to beneficiaries under the Medicare program.

Medicare is a vital part of the rural health care delivery system. It is not uncommon for rural health care delivery systems to have Medicare recipients account for 60-70 percent of their patient count. Medicare money is critical to the cash flow of rural health care delivery systems. At the same time, Medicare regulations determine whether or not the payments for health care delivered to Medicare recipients is sufficient to pay for the actual cost of care.

The first standard for Medicare in rural areas should be to do no harm. Rural health care delivery systems are fragile because of limited patient loads, long travel for care and the limited availability of health care professionals. The cost of Medicare regulations is an added burden on rural systems that may cause quality of care to suffer or the entire system to shut down.

Two factors are critical in determining the impact that Medicare has on rural health care delivery systems. The first one is that Medicare payments must cover the actual cost of delivering care. Cost shifting between payers of care is rampant throughout the health care delivery industry. That is a well established fact. In rural areas often there are few, if any, segments of the market to shift costs to from Medicare.

As was noted earlier, 60-70 percent of the patient load may be Medicare recipients. Another 10-20 percent may be Medicaid recipients. That leaves 20-30 percent of the patients as private pay or insurance payers. Fewer rural families have health care plans than the population as a whole and the plans are often less generous that those of higher paid urban/ suburban residents. In short, rural areas have few "deep pockets" to pay for the shortfalls in Medicare reimbursements.

In addition, there is the issue of complexity. Each time the Medicare system attempts to "fine tune" the payment system to catch potential excess reimbursements, it makes it harder for rural providers to track the changes and respond. They often lack the administrative support staff and electronic systems to handle the additional details.

The second critical factor for rural health care delivery systems is regulatory flexibility. Rural systems often do not have the support staffs necessary to keep up with the never-ending stream of regulations that must be followed to qualify for Medicare payments. The issue is not the quality of care. The issue is meeting a regulatory definition of what is necessary to provide high quality health care.

The size and location of rural health care delivery systems often prevent them from meeting regulations that are often taken as a matter of course in urban/suburban settings. Patient demand

flows are more variable. Maintaining 24-hours-per-day, 365-days-per-year coverage for certain types of care may be prohibitively expensive when patient loads only require coverage for a third or half that time.

Health care professionals need the flexibility to be cross-trained to do more than one job. Mid-level practitioners need more opportunities to perform activities that may be done by physicians in other settings. The many regulations that focus on equipment requirements rather than on patient outcomes need to be reviewed.

In reality, Medicare is a one-size-fits-all, centralized system, managed from Washington, D.C. It assumes that all recipients are the same, all providers are the same and all portions of the country are the same. Medicare must respond to the needs of rural areas.

The current policy debate on allowing more flexibility under managed care and the use of vouchers for Medicare recipients may be good news for rural providers and recipients. Both policy approaches would move decision making-closer to the providers and recipients of care. If managed care providers are given wide discretion in providing care, they could choose a mix of care-givers consistent with the local delivery systems. The managed care payments per recipient may need to be adjusted for the fact that rural systems do not have as even a spread of risks as urban/suburban delivery systems.

A voucher system would provide some of the same flexibility. In this case the recipients would choose a payment system and a delivery system. They would be more likely to choose one consistent with the currently available rural delivery system. The competition encouraged by the voucher approach would also produce new payment and delivery options.

The current focus on the cost of the Medicare program may be a potent force in making changes in the system. If increased payment and delivery flexibility is the result, it will be good news for taxpayers, recipients and providers in rural areas.

STATEMENT OF AMERICAN LUNG ASSOCIATION AND AMERICAN THORACIC SOCIETY

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 12,500 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

The ALA/ATS would like to take this opportunity to bring to the attention of the Committee its concerns regarding access to specialty care for the chronic lung disease patient. Under the proposed Medicare reform plan, which focusses principally on enrolling Medicare recipients into managed care plans, the access to specialty care question is paramount for our constituents who suffer from lung disease. In addition to including access to specialty care in Medicare reform, we would also like to see included a provision to end restrictive insurance industry policies that limit Medicare patients' access to the latest pharmaceutical products and medical devices. Furthermore, lifetime monetary caps on prescription drugs and medical devices should be eliminated.

LUNG DISEASE AMONG THE MEDICARE POPULATION

The prevalence of chronic lung disease varies with age, but for most categories chronic lung disease hits hardest in individuals 65 years of age and older. For instance, the prevalence of chronic bronchitis is the highest in those over 65, where 61.7 persons per 1,000 are affected. The prevalence of emphysema increases steeply with age, affecting 15.6 people per 1,000 in the 45-to 64-year-old group and nearly doubling to 29.8 per 1,000 after age 65. In addition, those over age 65 experience the second highest prevalence of asthma -- 48.2 per 1,000.

With these statistics in mind, it is only natural that the ALA/ATS be concerned with how Medicare recipients with chronic lung disease are treated under Medicare reform. If current proposals prevail, there will be an increasing number of Medicare recipients enrolled in managed care. The ALA/ATS wants to make sure that those with chronic lung disease will receive the same quality care and access to specialty care they receive under the present Medicare system.

THE NEED FOR ACCESS TO SPECIALTY CARE

In order to maintain optimal functioning in the face of a disabling condition such as chronic lung disease, patients require a wide range of health-related services. Medical treatment is, of course, primary. In terms of physician care, the patient's family physician usually makes a tentative diagnosis of chronic lung disease. In most instances, a consultation with a pulmonary specialist is suggested. In some cases, because of the extent of the patient's disease, referral to a pulmonary specialist is necessary.

Specialists serve a dual role in clinical practice: as a primary physician for a person with chronic disease and as a consultant for acute illness where the patient has been referred to the specialist. A gatekeeper system that too strictly requires permission or referral for every visit to a specialist would be a large detractor to access for people with chronic lung problems. Appropriate management of moderate to severe asthma by a specialist, for example, is more likely to result in fewer costly hospitalizations than care of those same cases by a general internist or family practioner who does not have the extensive training to work with asthma. Further, pulmonary physicians are generally able to assume full care for the patient whose primary problem is lung related and more often do so at the patient's request.

Just as there is a need to include specialty care access in Medicare reform, there also remains the need to train specialists to perform those services. The ALA/ATS is concerned that every effort be made to continue funding of Graduate Medical Education (GME) through a Medicare set-aside. Although the trend of the medical profession is to produce more primary care physicians, the fact remains that with a growing elderly population, the need for specialized services, such as critical care/pulmonology, will continue to grow well into the next century.

The American Lung Association and the American Thoracic Society are dedicated to ensuring that

lung disease patients on Medicare have access to the appropriate specialty care. Unless there is specific language in the Medicare reform bill mandating an out-of-service option for managed health care plans, access to providers who are specialists for individuals with chronic diseases (e.g. a specialist acting in the primary care provider role) may be denied, or severely restricted in the interest of cost savings. Financial disincentives for specialty referral also must be eliminated. Referrals always must be based on the best interest of the patient, not the financial interests of the health plan.

MEDICARE RECIPIENT ACCESS TO LATEST PRESCRIPTION DRUGS AND DEVICES

A variety of oral, parenteral and aerosolized medications are required to treat chronic pulmonary disease. In addition, some patients require oxygen and durable medical equipment, such as nebulizers, humidifiers, suctioning equipment and mechanical ventilators. New drugs and devices that can better control and add improve the quality of life for lung disease patients are being made available daily. Unfortunately, Medicare recipients cannot receive the latest/experimental drugs or devices because of restrictive Medicare payment policies. As a result, these patients, who are often in most need of advanced drugs and devices, are being denied access to a series of new products and therapies.

Compounding this already stifling situation are lifetime caps on prescription drugs and medical devices. The cost of treating chronic diseases is very expensive. Lifetime monetary caps on these therapies cruelly postpone the inevitable for those with chronic conditions. For patients who have exceeded their lifetime cap, finding other cost-effective health insurance to help pay for their ongoing medical costs is a nightmare, if not impossible.

Studies have been conducted indicating that the eradication of lifetime caps would result in minimal increases in insurance premiums. Insurance companies can effectively spread their risk of having patients with catastrophic illnesses through reinsurance. From an actuarial view, there is a trivial increase in premium costs from raising the lifetime cap from half a million or a million dollars to six million dollars or eliminating it altogether -- the difference for the patient who has a chronic and costly disease, however, is tremendous.

CONCLUSION

With the ever increasing number of Medicare recipients enrolling in managed care plans and considering proposed legislative plans to encourage this trend, Congress should make sure that the issues of access to specialty care, the ending of restrictive Medicare drug and medical device policies, and the elimination of lifetime caps on prescription drugs and medical devices are thoroughly reviewed.

Continued access to specialty care, prescription drugs, medical devices and the elimination of lifetime monetary caps are of extreme importance to those with chronic diseases, especially chronic lung disease. It is the hope of the American Lung Association and the American Thoracic Society that the committee will seriously and carefully consider these options when formalizing its final plan for Medicare reform.

STATEMENT OF AMERICAN REHABILITATION ASSOCIATION

BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

AND

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
COMMITTEE ON COMMERCE

FOR THE RECORD OF THE HEARING ON STANDARDS FOR HEALTH PLANS
PROVIDING COVERAGE IN THE MEDICARE PROGRAM

July 27, 1995

This testimony is being submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on standards for health plans providing coverage in the Medicare program.

The American Rehabilitation Association (formerly the National Association of Rehabilitation Facilities) is the largest not-for-profit organization serving vocational, residential and medical providers in the United States. The established leader in the field of rehabilitation for more than a quarter century, American Rehab serves its more than 800 member facilities by effecting changes in public policy, developing educational and training programs, and promoting research. In addition, it provides networking and communications opportunities, all of which help to ensure quality care and access to services to more than four million persons with disabilities.

This testimony will provide background on rehabilitation, discuss the impact that managed care has had on rehabilitation, and outline standards for plans providing care to Medicare beneficiaries.

BACKGROUND ON REHABILITATION

Medical rehabilitation addresses itself to a single end--the elimination or mitigation of disability. Rehabilitation restores a person's ability to live, work and enjoy life after an illness, trauma, stroke or similar event has impaired his or her physical or mental abilities. Most patients enter rehabilitation after an acute hospital stay. In 1994 about 400,000 people per year received such services as inpatients in rehabilitation hospitals or rehabilitation units of general hospitals. Many more receive such services as outpatients. There are now about 200 rehabilitation hospitals and 800 rehabilitation units in general hospitals.

Many of the conditions requiring rehabilitation are associated with advancing age, particularly strokes, arthritis and orthopedic conditions. Accordingly, a relatively high percentage of the persons who need rehabilitation are covered by Medicare. In 1994 about 71% of discharges from rehabilitation hospitals and units and 66% of total days of care were covered by the Medicare program. These figures do not include Medicare beneficiaries who have chosen to enroll in managed care plans. Thus, rehabilitation facilities are perhaps more affected by Medicare policy than any other element of health care.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts. The team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person has had a stroke which impairs the ability to walk, see, swallow and creates weakness on the left side. The goals include walking again independently, swallowing without aid, seeing well enough to read, strengthening the left side so the arm and leg can be used, and being able to dress independently again. Over 80% of the 4 million people receiving rehabilitation services return to their homes,

work, schools, or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, skilled nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

The rehabilitation field is responding to the changes in the health care field. It is becoming more cost effective through the use of critical pathways, decision rules and constant examination of the use of resources and outcomes. All of these practices help make decisions about the appropriate use of resources and help cut costs.

EFFECTIVENESS OF REHABILITATION

If rehabilitation services are delivered, they are most effective if delivered early after trauma or illness. For example, rehabilitation is one of the evaluations done right in the trauma center. If an appropriate referral is not made the person remains dependent, the family suffers and society, the individual and the family pay more than just financially. In a study of the cost benefits of stroke, the investigators found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus in a nursing home setting saved $13,248 per year in 1981 dollars, or $21,599.54 in 1994 dollars per year. Given that the average stroke patient lives over 5 years this is a savings of $107,997.70 in 1994 dollars.

An article in the 1994 October/November/December issue of TQM magazine, "Judging the Cost-Effectiveness of Rehabilitation", discussed the cost effectiveness of rehabilitation. Pulmonary rehabilitation improves patient function and reduces the use of medical services. Early rehabilitation in a rehabilitation unit for stroke patients is more effective than for patients treated on general medical wards. Twice as many of the patients who did not receive rehabilitation went to nursing homes and the mean time in an institution in the first year, including nursing homes was 75 days for the rehabilitation patients and 123 days for the patients who did not get the rehab program.

For traumatic brain injury (TBI) early initiation of rehabilitation can save costs. A recent study compared patients from one hospital with an aggressive early rehabilitation program for TBI with those from 11 other hospitals without organized programs. Patients from the formal program experienced one third the time in a coma. Also the rehabilitation length of stay averaged 54 days vs. 106 days for those coming from routine care. Ninety-four percent (94%) were discharged home in the early intervention program compared to 57% of the others. Again, there is an enormous amount of money saved simply by calculating the cost of days **not** spent in the hospital.

MEDICARE, REHABILITATION AND HMOs

As noted previously, the Medicare program impacts the medical rehabilitation industry significantly in accounting for 66% of inpatient days. It has been suggested that one means of reducing the rate of increase in overall Medicare expenditures is to encourage more Medicare patients to enroll in plans other than the traditional fee for service plan. Options being considered include managed care, medical savings accounts and employer plans. We are most familiar with managed care and raise some issues related to medical savings accounts as well.

At present only about 9% of Medicare beneficiaries have chosen to move from fee for service Medicare to HMOs and other managed care plans. This relatively low rate of enrollment obscures the fact that managed care enrollment is much higher in certain parts of the country, particularly on the west coast. In California, for example over 20% of Medicare patients are enrolled in managed care plans.

In concept there are two reasons why managed care plans can provide care at lower cost than traditional forms of insurance and health care delivery. First, it is assumed that by hiring or contracting with providers of services to significant patient populations, HMOs and other managed care plans can achieve economies of scale (or drive hard bargains). Second, through "management" of care through gatekeeper physicians and other controlling mechanisms, they can avoid delivery of ineffective or superfluous services and, thereby, avoid the associated costs.

In fact, there is a third factor, denial of services. Enrollees may find that certain services are not provided, either because they are deemed to be unnecessary or because of contract limitations, the effects of which are not appreciated until it is too late. This observation is not to suggest that HMOs and other managed care plans seek to deceive enrollees, but rather that certain specialty services needed by a relatively small number of people do not receive adequate consideration by either the plan or the enrollee until the service is needed.

About four million people annually receive some type of therapy service. Of these about 400,000 are admitted to a rehabilitation hospital or a rehabilitation unit in a general hospital. Thus, the chance that any given individual will need rehabilitation services is slight.
This means that it is unlikely that a person shopping for HMO coverage will anticipate the need for and coverage of rehabilitation services.

Rehabilitation services are intense and of longer duration than acute care. By their very nature managed care plans seek to avoid or minimize the cost of such services. Our association recently surveyed member facilities. Sixty nine percent (69%) of the rehabilitation hospitals and units to which HMOs referred Medicare patients reported that the HMO limits the numbers of days of therapy, with an average limit of 51 days. We find this information about Medicare beneficiaries particularly disconcerting because it is our understanding that the Medicare package of benefits is to be available to Medicare rehabilitation patients. Under Medicare there are no day limits on therapies or programs. Medical necessity is determined by the Medicare inpatient rehabilitation hospital guidelines.

The Medicare Advocacy Project, Los Angeles, California, in its January 1993 report, "Medicare Risk Contract HMOs in California: A Study of Marketing, Quality and Due Process Rights" noted the noted the following problems:

* Failure to refer for needed specialty care. The decision may not be made by the gatekeeper physician but by the medical group manager, utilization review coordinator or medical director. They also cited the physician financial incentive issues mentioned above.

* Not having enough contracting specialty physicians available or when the financial incentives delay referrals to specialty physicians.

* Failure to refer for rehabilitation. The frequency with which HMOs deny access to home health care and inpatient rehabilitation services... "raises questions about the financial incentives under which HMOs and their subcontracting provider groups operate." The report questions the HMOs determinations that cases that appear to meet the Medicare coverage guidelines were denied the care as not medically necessary.

The quality of care given to many HMO Medicare enrollees is also a big concern. This is a difficult issue to quantify. As noted, we have heard about problems with people either not being referred at all for rehabilitation or being referred but with a limit on the number of days. Quality goes to the setting to which the patient is referred for services and the duration, frequency and type of treatment they receive. Our members have told us about enrollees, both Medicare and non-Medicare, being sent to what we characterize as a custodial institutional setting that provides either no or periodic skilled nursing and rehabilitation therapies as required under OBRA '90, but not a comprehensive rehabilitation program. Our members do not believe many of these patients obtain their maximum outcomes and the rates of return to home, work, school and an active retirement are not as high as possible. This is a tragic personal, professional, familial, social and financial loss and burden.

The Medicare Advocacy Project Report cited above noted several cases where the HMOs approved less care than needed. The report states the "survey also points to possible systemic bias by some HMOs against referrals for in-patient rehabilitation services. All five of the southern California in-patient rehabilitation hospitals responding to MAP's survey felt that some Medicare HMOs denied medically necessary rehabilitation services to a greater extent than occurred in FFS [fee for service]. " The report further states "some HMOs appear to use arbitrary standards to deny or discontinue rehabilitation care." These standards include the patient's age even when a patient was improving.

The Mathematica study released in December, 1993 also raised concerns about quality of care. Mathematica looked at rates of death, hospital readmission and post admission complications as gross outcomes" measures but did not make any adverse findings. However it did state," ...a few differences do indicate that HMOs may be providing less adequate care in some situations. ...HMO stroke patients received significantly less physical therapy while in the hospital and had greater motor and speech deficits at discharge, yet were not more likely to have a post discharge speech or physical therapy plan. This pattern suggests that HMOs may economize on rehabilitation care...Although there is no evidence that these differences in care led to poorer patient outcomes, they cause some concern because of their potential adverse effect on outcomes."

The study noted that HMOs discharge a higher proportion of stroke patients to nursing homes and a lower proportion to rehabilitation hospitals. While it did not have follow up data, this practice raised concerns about whether this pattern was leading to poorer care.

Managed care should not be used to deny rehabilitation and other specialty services from which patients can profit. Denial of such services in the name of economy is an illusion. The managed care plan or society as a whole will end up paying higher acute medical and/or social costs.

RECOMMENDATIONS ON PLAN STANDARDS

As this committee looks for ways to bring Medicare into the next century and ensure its financial viability, it will look to assure that any health plan serving Medicare beneficiaries meet certain standards. The movement to restructure Medicare and focus on multiple options, including managed care, must assure that any kind of plan meets certain criteria regarding benefits, marketing practices, solvency, reporting, quality of care delivered and quality of outcomes, plus grievances and sanctions, at a minimum. To that end we suggest the following be included. Furthermore, we recommend that any national accrediting body's standards relied upon must also cover these points.

1. Plan Information

Plans should provide uniform written descriptions of their benefits, services and procedures that clearly and fully disclose coverage of benefits, exclusions, limitations on coverage, and out-of-pocket costs, including copayments, deductibles, coinsurance, and established aggregate maximums on out-of-pocket costs.

2. Evaluation

Patients who have impaired functional abilities should receive a rehabilitation evaluation by a specialist in physical medicine and rehabilitation as quickly as possible once they experience an illness or injury. Studies have shown that the earlier a patient is evaluated and receives rehabilitation services, the more successful the outcome. If an enrollee is a candidate for rehabilitation he or she should have access to, and be referred for, those services.

This evaluation would be for individuals a) with one of the conditions usually requiring rehabilitation services, b) with a congenital disability, and/or c) with a specific functional level based on a functional assessment and occur within 72 hours upon seeing a primary

care provider or other gatekeeper. The conditions in question include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and pulmonary diseases and pain.

3. Coverage

Any plan offered to Medicare beneficiaries should offer those benefits for rehabilitation services from rehabilitation providers which are currently covered in the Medicare program. Additionally, there are coverage guidelines for inpatient rehabilitation hospitals and unit services and outpatient services. They are based on the patient's need and progress, not an arbitrary limit. The current Medicare inpatient and outpatient guidelines should be used by plans while options are examined.

4. Incentives

Financial and other incentives for physicians to refer to physician and nonphysician specialists should be based on the needs of the patient and the patients' outcomes. All financial and other incentives should be disclosed to patients, employers and other purchasers of the plan's services.

5. Quality

Managed care plans should be accountable for the quality of care provided. They should ensure adequate access to services for all their enrollees. Outcomes, both medical and functional, should be reported by insurers to employers, government payers and enrollees. Quality criteria by which to determine plan approval of rehabilitation services to Medicare beneficiaries should include (a) patient outcomes, including but not limited to, death, pressure sores, discharge status, and change in functional motor and cognitive function, and others; and (b) readmission to the hospital. Additionally, with respect to access, plan standards must address maximum waiting periods for appointments, for referrals to specialists as wee as initial and follow up appointments to nonspecialists and maximum travel distances. All this information should be available to the public.

6. Specialists as Gatekeepers

Enrollees who require ongoing, specialized health services should be able to choose a specialist as a gatekeeper in order to effectively manage the services appropriate to their conditions. Relevant specialists should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated. Persons requiring rehabilitation services and persons with disabilities in particular should be able to select a primary care provider or gatekeeper who is a physiatrist, an otherwise qualified rehabilitation physician or a specialist in the medical management of their particular condition.

7. Consumer and Provider Due Process

Plans should set forth procedures to be followed in the resolution of disputes with enrollees about required services and the adequacy of those provided by the plan. Grievance mechanisms should be timely and fair.

Grievance and appeals procedures should:

a) be available to both enrollees and providers, including timely review of a service denial;

b) be clearly communicated to all parties;

c) require independent second opinions to be obtained promptly when covered benefits

are denied for any reason;

d) require an expedited appeals process leading to a decision within 72 hours of the initial complaint.

8. Arrangements with Providers

Plans should enter into agreements and other arrangements to ensure an appropriate mix, number and distribution of qualified health professionals to adequately provide for the plan's benefit package.

9. Utilization Management Protocols

Utilization review should be performed by qualified personnel knowledgeable in the field in which a coverage decision is being made. Qualified health professionals, including rehabilitation providers and other specialists, should be involved in the development and implementation of utilization review procedures and practice guidelines.

10. Ability to Opt Out

Ultimately, it may be impossible to adequately protect the interests of severely disabled persons requiring intensive rehabilitation services through the types of procedural requirements outlined in this testimony. We recommend that if such an enrollee is dissatisfied with the type or quality of rehabilitation service provided, then he or she have the option to return to Medicare fee for service coverage promptly, as enrollees can do now by disenrolling from the managed care plan within a month. We recommend that this process be made simpler, be clarified and be included in all plan literature.

11. HCFA's Responsibilities

HCFA should direct HMOs now and plans in the future that they cannot use arbitrary rules of thumb to deny rehabilitation care to Medicare beneficiaries, e.g. age or deny any Medicare benefits to beneficiaries. If an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines, he or she should be referred for those services.

HCFA should increase its review of Medicare risk contractors' practices in referring patients who require rehabilitation to less intense levels of services which may result in decreased positive outcomes.

12. Consistency

Plans should be consistent in the information required, i.e., data elements and methods of analysis, evaluation criteria, assurance of non-discrimination among classes of providers, uniform quality and utilization standards, outcomes assessment, assurance of access, fair and adequate reimbursement, consistency of record-keeping requirements.

13. Point-of-Service Option

HMO enrollees should have the right to obtain care from out-of-network providers, assuming they opt to pay the any extra costs. It retains the ability of closed-panel HMOs to contain costs, but also allows enrollees the flexibility to opt out of the provider network if they pay a little more for this option.

MEDICAL SAVINGS ACCOUNTS

We have examined some descriptions of medical savings accounts. Several issues arise that are of concern for persons in need of rehabilitation services and providers of those services. First the catastrophic health plans should not be allowed to impose preexisting condition limitations nor to refuse to cover persons based on health status, especially persons with disabilities. Second such plans must be required to provide comprehensive coverage for persons with serious illnesses or injuries requiring rehabilitation services. Third, there should be no lifetime or per condition limits for persons experiencing a catastrophic injury or illness which requires rehabilitation. Fourth, such plans should be required to include rehabilitation services in their benefits package since the majority of conditions considered catastrophic, e.g. stroke, head injury, brain injury, etc., require rehabilitation services in order to restore the person to their prior functional level.

We would be pleased to discuss these critical issues with you Mr. Chairman.

Respectfully submitted,

Carolyn C. Zollar
Vice President for Public Policy and General Counsel

STATEMENT OF JAMES W. PATTON
ON BEHALF OF COMPREHENSIVE HEALTH SERVICES OF DETROIT

We commend Chairman Thomas and Chairman Bilirakis for taking on the task of reviewing standards for health plans providing coverage in the Medicare program. Congress has the opportunity to replace multilayered standards with uniform standards for comparable health care systems.

Issue - 50/50 Rule

Health Maintenance Organizations which serve the Medicaid population are often precluded from serving the Medicare population because of the Medicare requirement that at least 50 percent of their members must be covered other than through Medicare or Medicaid (the 50/50 rule). The intended purpose of this rule is to ensure quality in Medicare HMOs through limiting member composition to no greater than 50% Medicare and Medicaid. The goal of this Congress to encourage more Medicare beneficiaries to receive their health care in managed care settings is being impeded by the 50/50 rule. To achieve its goal, Congress should at a minimum require the Secretary of Health and Human Services to automatically waive the 50/50 rule for plans which meet certain quality and financial standards.

Background on CHS

Comprehensive Health Services (CHS) of Detroit, known as The Wellness Plan, is a 501(c)(3) federally qualified health maintenance organization ("HMO") operating since 1972 and serving the Detroit metropolitan area. Currently, CHS has over 140,000 enrollees, approximately 90 percent of whom are enrolled through the state of Michigan Medicaid program. CHS currently has roughly 2,000 Medicare enrollees with marketing plans to reach 15,000 enrollees in the next few years.

CHS has over 200 commercial accounts with medium and small businesses, enrolls nearly 10 percent of the federal employee health benefit plan participants in Detroit, and has accounts with major companies. However, CHS has a disproportionate percentage of Medicaid members from sectors of the city of Detroit with the greatest preponderance of minority and low income populations. In practice, it is not realistic for an inner-city HMO like CHS that serves a significant number of Medicaid beneficiaries to meet the 50/50 rule.

CHS is a well established HMO that has been recognized as a model quality Medicaid managed care program by such national leaders as Dr. Otis Bowen, former Secretary of the Department of Health and Human Services. Based on its stellar performance, CHS is as qualified as any other HMO in serving Medicare patients. Indeed, despite the fact that it often serves the sickest and most vulnerable population in the city of Detroit, including many dual eligible persons (with Medicare and Medicaid coverage), its costs to the Medicare program are far below the average adjusted per capita cost rates paid to Medicare risk contractors.

CHS has had a Health Care Prepayment Plan (HCPP) contract with Medicare since 1993. While CHS would have preferred to have a risk contract, it was and remains ineligible to participate in these contracts because of the 50/50 rule.

Under the Medicare technical corrections legislation enacted last year, HCPPs must comply with State Medigap requirements as of January 1, 1996. However, Medigap rules prohibit activities which are fundamental to HMO operations such as imposition of reasonable copayments and coverage of preventative care. Further, CHS cannot comply with Medigap because it is not licensed as an insurance company. Because compliance with Medigap is impossible, CHS would like to convert its HCPP contract to a Medicare risk contract, but again, this is impossible because of the 50/50 rule.

Standards for Automatic Waiver of 50/50 Rule for Medicaid Plans

The Secretary of HHS should be required to automatically grant waivers for plans that cannot meet the 50/50 rule due to significant Medicaid enrollment if they meet the following criteria:

- Operational Medicaid risk contract for at least three consecutive years;
- Enrollment of at least 25,000 Medicaid recipients;
- Financial Soundness as documented by at least one of the following:
  - a net surplus of income over expenses over the past three years
  - net worth equal or exceeding two months of medical expenses
  - medical loss ratio of not less than 75% over the past two years
- Quality plan as documented by meeting at least one of the following:
  - federal qualification
  - satisfactory disenrollment for cause rates, beneficiary appeal rates, and track record of state/federal compliance actions or other measures of consumer satisfaction (e.g., independent customer satisfaction surveys documenting favorable ratings from a high percentage of respondents)
  - accreditation by a private accreditation body.

The Secretary should also have authority to grant waivers on a case by case basis for other Medicaid plans not meeting the above standards.

Further Specific Concern of CHS

At the end of the 103rd Congress a law was enacted known as the Social Security and Technical Corrections Act of 1994, H.R. 5252 (dated October 7, 1994). Section 171(f) would subject an HCPP contractor to Medigap laws and regulations as of January 1, 1996. Because these provisions are inherently contrary to the operations of HCPPs, Section 171(f) would make it impossible for an HCPP contractor to offer a "gap policy" to any of its individually enrolled Medicare members. This is critical because, without a gap policy Medicare beneficiaries would have no reason to enroll or remain enrolled in an HCPP contractor. Rather, HCPPs would have to limit offers of gap policies to persons enrolled in a group contract (e.g. Medicaid dually enrolled Medicare beneficiaries, retirees of union trust plans and employer group retiree plans), who do not fall under the scope of Section 171(f).

Historically, HCPP contractors generally, and all federally qualified HMOs, were exempt from the federal Medigap laws. HCFA apparently interprets Section 171(f) as restricting an HCPP contractor from offering a gap policy unless it is in conformance with requirements for a Medicare Supplement Policy ("Medigap policy"). Because Medigap policies are indemnity policies and because most federally qualified HMOs and most other state licensed HMOs are not licensed insurers, it is impossible for them to offer such policies solely through an HCPP.

Moreover, under federal law, a Medigap policy must reimburse benefits regardless of which provider or physician offers the care. Congress has provided an exception to the Medigap requirements enabling insurers and Blue Cross Blue Shield plans to offer Medicare Select, a Medicare PPO product. Even though Medicare Select allows for differences in reimbursement between in-network and out-of-network providers, it does not address most of the conflicts for HCPPs attempting to comply with Section 171(f). Specifically, by requiring an HCPP contractor to conform to

Medicare Select, Section 171(f) would preclude an HCPP from offering its own unique version of covered benefits and require instead that the HCPP gap policy conform to 1 of 10 standard Medigap policies. None of these policies permit an HCPP contractor to use modest copayments (i.e., $5 to $10 for office visits and $25 to $50 for use of a hospital emergency room) to help manage usage of services by Medicare enrolled members of the HCPP. Nor does Medicare Select allow an HCPP to offer more comprehensive or more generous benefits, including extensive preventative care services that are not covered by Medicare or by Medigap policies.

Moreover, even for provisions that do not directly conflict with the obligations of an HCPP contractor, some requirements of Medicare Select, if implemented, could increase dramatically the administrative costs of operating an HCPP program. For example, even though the HCPP is paid its costs in lieu of the billed fees from a Medicare carrier, Section 171(f) would require an HCPP to submit bills to a Medicare carrier. Accordingly, the framework created by Section 171(f) is contrary to the framework of operating as an HCPP.

It is ironic that Congress, by adopting Section 171(f), could undermine the HCPP program when it has been a source of long term stable participation of HMOs with Medicare. Unlike the HMO risk program, HCPPs have not been criticized for having financial incentives to favorably select only healthy patients. Yet, HCPPs have served as an important feeder program that enables HMOs to shift to risk contracts once they gain experience in managing Medicare population. Few HCPPs have dropped out of the Medicare program and since the inception of the risk contract program 14 of the largest and most successful risk contractors were previously HCPPs. By contrast, in the first eight years of the risk contract program approximately 300 out of 400 contracts (or 75 percent) were terminated or non-renewed. **Accordingly, if Congress does not provide for a waiver of the 50/50 rule for Medicaid plans, it will be impossible for HCPP contractors such as CHS to expand coverage to additional Medicare beneficiaries. In the absence of a 50/50 waiver, CHS finds it necessary to seek a solution to its specific problem.**

Alternatives (all of which are budget neutral) might include:

- Specifically waive the applicability of the 50/50 rule to CHS;
- Postpone the effective date of the requirement that HCPP contractors comply with Medigap rules for those HMOs that cannot meet the 50/50 rule (and therefore cannot otherwise serve the Medicare population on a managed care basis) until such plans can qualify for a risk contract;
- Delete the requirement that HCPP contractors comply with Medigap rules and instead impose quality standards on HCPP contractors.

At a time when the Congress is looking toward managed care as one option for reducing the rate of growth in the Medicare program, destroying the ability of CHS to serve the Medicare population on a managed care basis would be truly counterproductive.

* * *

If you have any questions or wish to obtain additional information regarding this statement, please call our Washington Counsel, Wendy Krasner at (202) 778-8064 or Kathleen Black at (202) 778-8342 of the firm of McDermott, Will & Emery in Washington, D.C.

STATEMENT OF D.C. CHARTERED HEALTH PLAN, INC.

Issue

Health Maintenance Organizations which serve the Medicaid population are often prohibited from serving the Medicare population because of the Medicare requirement that at least 50 percent of their members must have insurance coverage other than through Medicare or Medicaid (the 50/50 rule). The intended purpose of this rule is to ensure quality in Medicare HMOs through limiting member composition to no greater than 50% Medicare and Medicaid. The goal of this Congress to encourage more Medicare beneficiaries to receive their health care in managed care settings is being impeded by the 50/50 rule. To achieve this goal, Congress should, at a minimum, require the Secretary of Health and Human Services to automatically waive the 50/50 rule for established plans which primarily serve Medicaid recipients and meet certain quality and financial standards.

Background on Chartered Health Plan

Chartered Health Plan ("Chartered") is a prepaid health care plan under contract with the District of Columbia Government (the District) to provide health care services since fiscal year 1988. It began this contract when all other HMOs in the District were unwilling to serve Medicaid recipients.

Chartered has a proven track record of dealing effectively with the hard core Medicaid population in the District. Indeed, Chartered is currently establishing state of the art primary health care centers in the two most under-served, crime ridden, and economically challenged areas of the city. Chartered is committed to serving the Medicaid population with adequate access to high quality care. During the course of serving the Medicaid population, it has found that many of its services are needed and sought by Medicare beneficiaries who reside in the inner city. However, Chartered is unable to enroll these persons in its plan because of the 50/50 rule.

In addition to supporting automatic waivers of the 50/50 rule, Chartered is seeking similar requirements for the Secretary with regard to the Medicaid 75/25 waiver.

Background on Medicare/Medicaid Dual Eligibles

Even though the District of Columbia Government has embraced managed care as a cost saving alternative to traditional Medicaid coverage, it is currently limited to Medicaid beneficiaries entitled due to coverage under Aid to Families with Dependant Children ("AFDC"). The sickest and most expensive Medicaid patients are those who are also entitled to coverage under the federal Supplemental Security Income ("SSI") program -- "dual eligibles". Typically, insurance companies and HMOs have avoided underwriting this population.

Chartered is now seeking to work with the District to develop a program for joint coverage of SSI beneficiaries with the Medicaid program. To expand the scope of its services to SSI beneficiaries, Chartered would need both a waiver of the 75/25 Medicaid composition rule and a waiver of the 50/50 Medicare enrollment composition rule.

In order to serve this segment of the population, Chartered is willing to become a federally qualified HMO or federally approved Competitive Medical Plan ("CMP"). Chartered also plans to become approved by NCQA, the private HMO accreditation organization and has recently been licensed as an HMO in the state of Virginia.

Dual eligibles are cumbersome to handle because they require two separate contracts, one with the Medicaid program and a second with the Medicare program. A critical factor in

explaining why this population remains untargeted by managed care programs is that these beneficiaries have chronic and acute medical problems that pose substantial costs to both the Medicare and Medicaid programs. Accordingly, these beneficiaries are often unattractive to HMOs because they are difficult to manage and have adverse medical histories. Medicaid agencies are beginning to encourage these populations to join Medicare risk or cost contractors because they are required by federal law to cover the gaps in Medicare and because the Medicare program provides primary coverage and the Medicaid program provides secondary coverage. Yet, few HMOs are ready to serve these populations.

Standards for Automatic Waiver of 50/50 for Medicaid Plans

The Secretary of Health and Human Services should be required to automatically waive the 50/50 rule for a plan with significant Medicaid enrollment if the plan meets the following criteria:

- Operational Medicaid risk contract for at least three consecutive years;
- Enrollment of at least 25,000 Medicaid recipients;
- Financial Soundness as documented by at least one of the following:
  - a net surplus of income over expenses over the past three years
  - net worth equal or exceeding two months of medical expenses
  - medical loss ratio of not less than 75% over the past two years
- Quality plan as documented by meeting at least one of the following:
  - federal qualification
  - satisfactory disenrollment for cause rates, beneficiary appeal rates, and track record of state/federal compliance actions or other measures of consumer satisfaction (e.g., independent customer satisfaction surveys documenting favorable ratings from a high percentage of respondents)
  - accreditation by a private accreditation body.

Further, the Secretary would also have authority to grant waivers on a case by case basis for other Medicaid plans not meeting above standards.

Precedent for a waiver of the Medicare enrollment composition rule already exists for individual health plans that were targeted to the Medicaid population. We believe it is now time for other urban based HMOs with significant experience in serving Medicaid patients to be allowed to operate as Medicare contractors.

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If you have any questions or wish to obtain additional information regarding this statement, please call our General Counsel, Jerrold Hercenberg at 703 758-3604 or call Wendy Krasner at 202 778-8064 or Kathleen Black at 202-778-8342 of the firm of McDermott, Will & Emery in Washington, D.C.

STATEMENT OF JOINT COMMITTEE FOR PATIENTS IN PAIN

MEDICARE REFORM AND THE FEDERAL BUDGET

The American Pain Society, the American Academy of Pain Medicine, and the American Association for the Study of Headache have formed the **Joint Committee for Patients in Pain** to advocate responsible public policy and private sector action for the benefit of millions of Americans who suffer from intractable pain.

While pain affects patients of all ages, it is closely associated with many illnesses that afflict the elderly, including cancer, diabetes, and arthritis. Chronic pain is also closely associated with disability; in fact, intractable pain is frequently the cause of disability. Thus, access to appropriate treatment for pain is a core issue for Medicare beneficiaries, particularly those with serious illness and disability who by necessity are disproportionately large consumers of Medicare financed health care services.

The 104th Congress is considering changes to the Medicare program which are more fundamental than any considered since the original enactment of Medicare in 1965. Most proposed changes would move more Medicare patients towards private sector health plans, or bring managed care practices from the private sector more fully into the public plan. As Congress considers these dramatic changes, caution must be taken to ensure that Medicare patients in pain do not lose access to appropriate care.

As with certain other illnesses, complex pain cases are not effectively treated in tightly controlled systems emphasizing primary care services. Pain and its underlying causes are frequently misdiagnosed - or undiagnosed. Patients are frequently mistreated, under treated, or untreated. "Gatekeepers" impede rather than facilitate appropriate early intervention. These cases stand out. They are not "routine," but they are widespread, and often become very high cost. They require special consideration in a reformed Medicare program.

Intractable pain can be intolerable to the patient. It impacts so dramatically on the quality of life and the ability to function as to prompt desperate searches for relief in and out of a patient's primary health network, and in and out of proven treatment modalities. At some point, it even becomes unbearable. Though often lost in the rancorous debate over assisted suicide, it is a fact that most of Dr. Jack Kevorkian's patients have been sufferers of intractable pain.

Medicare reforms must deal fairly and effectively with the special needs of patients in pain. The Joint Committee for Patients in Pain urges Congress to consider the following protections for patients afflicted with intractable pain:

JOINT COMMITTEE FOR PATIENTS IN PAIN

I. MEDICARE BENEFICIARIES SHOULD HAVE A FEE-FOR-SERVICE AND A POINT OF SERVICE OPTION AVAILABLE AT ALL TIMES OF MEDICARE ENROLLMENT. THESE OPTIONS SHOULD BE REAL - NOT SUBJECT TO INORDINATELY HIGH PREMIUM OR CO-PAY DIFFERENTIALS, OR UNDUE RESTRICTIONS ON THE ABILITY TO SWITCH PLANS.

II. QUALIFIED MEDICARE PLANS THAT UTILIZE RESTRICTED PROVIDER NETWORKS MUST BE REQUIRED TO DEMONSTRATE CAPACITY TO EFFECTIVELY TREAT INTRACTABLE PAIN WITHIN THE NETWORK, OR THROUGH REFERRAL ARRANGEMENTS OUTSIDE THE NETWORK, AND PROVIDE OUTCOME DATA TO PROVE EFFECTIVENESS.

III. GATEKEEPERS EMPLOYED IN QUALIFIED MEDICARE PLANS MUST:

- Be properly trained for the clinical judgements they are asked to make, e.g. where prior authorization is required for specialty referral or treatment;
- Not have financial incentives to under-treat or under-refer;
- Perform a contemporaneous evaluation of the patient before overriding another physician's clinical judgement; and
- Be accountable for the clinical judgements made in their capacity as gatekeepers.

IV. REFERRAL ARRANGEMENTS MUST BE TARGETED TO PROPERLY TRAINED PRACTITIONERS, ACADEMIC CENTERS, AND "CENTERS OF EXCELLENCE" WHICH SPECIALIZE IN THE TREATMENT OF INTRACTABLE PAIN AND SIMILAR ILLNESSES.

V. MEDICARE FEE SCHEDULES MUST RECOGNIZE THE SCOPE AND INTENSITY OF SERVICES DELIVERED BY PRACTITIONERS WITH ADVANCED TRAINING AND MULTI-DISCIPLINARY TEAMS IN CENTERS OF EXCELLENCE TO PATIENTS IN PAIN WHO HAVE FAILED TO RESPOND TO CUSTOMARY AND USUAL CARE.

July 1995

JOINT COMMITTEE FOR PATIENTS IN PAIN

THE FACTS ON INTRACTABLE PAIN

- Pain is a major public health problem in the United States
- **50 million** Americans are partially or totally disabled by pain
- **45%** of all Americans seek care for persistent pain at some point in their lives
- **Headache** and **low back pain** are the most prevalent forms of intractable pain
- Pain accompanies a wide range of other clinical conditions, including:
  - **cancer**
  - **diabetes**
  - **arthritis**
- **22%** of work-related injuries involve back pain
- **150 million** workdays are lost annually to head pain alone
- Children lose **1 million** school days annually due to pain
- Intractable pain is frequently **untreated or mistreated**
- Mismanagement of pain has tragic and costly consequences:
  - disability
  - depression
  - over-utilization of diagnostic services and procedures
  - unnecessary hospitalizations and surgery
- Pain can be effectively treated:
  - with early intervention
  - by appropriately trained specialists
  - frequently in ambulatory settings
  - at reasonable cost

STATEMENT OF PATIENT ACCESS TO SPECIALTY CARE COALITION

Mr. Chairman: This statement is made on behalf of the Patient Access to Specialty Care Coalition ("Coalition"), consisting of nearly 100 patient, physician, and non-physician health care professional organizations dedicated to ensuring the right of patients to consult and be treated at a reasonable cost by the health care provider or specialist of their own choice, regardless of the health plan in which they are enrolled.

As Congress considers changes in the Medicare program to encourage more seniors to join managed care health plans, we believe that several patient protections must be included in any legislative proposal to ensure that seniors continue to be able to access the health care providers of their own choosing.

THE CORNERSTONE OF THE CURRENT MEDICARE LAW IS CHOICE OF HEALTH CARE PROVIDER

Title 42 of the U.S. Code, Section 1395a clearly states: "Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services."

Proposals to increase the choices of the type of health care plans offered to Medicare enrollees do **not** necessarily ensure choice of health care provider. In fact, they may limit it. In order to encourage people to move into managed care plans, current Medicare enrollees will be required to pay additional copayments, deductibles and out-of-pocket expenses to maintain their current status under Medicare fee-for-service. If the Medicare population enrolls in managed care plans, they will discover that many of these plans may take away their choice of provider and may not permit them to see the health care providers that they have been seeing all along.

The Patient Access to Specialty Care Coalition is proposing a simple quality assurance check on managed health care delivery systems to ensure that patients receive the full range of health care services to which they are entitled, and that patients will continue to have the freedom to choose any health care provider, as currently is provided under the Medicare laws.

PATIENT CHOICE MUST REMAIN PARAMOUNT IN HEALTH CARE DELIVERY

Many major changes are now taking place in the way people purchase health insurance and receive medical care. The pressures to reduce health spending continue to be intense, and health plans and providers have become more aggressive in their cost containment activities. While many health plans have developed a number of effective techniques to achieve economy and maintain quality of care, others have not always achieved that balance. Since Medicare is a Federal government funded program, we should make sure that these tax dollars result in appropriate patient care.

The Medicare market is open to many different health plans, and there is no guarantee that health care plans would not discriminate against a sicker elderly population. Right now, some health care plans are "cherry-picking" senior citizens by offering aerobics classes, sponsoring "socials," and developing other promotional activities which are targeted at healthy, active Medicare enrollees. Are these added options more choice, or a coercive policy to force seniors into lower cost health care plans which will provide less than the full range of health care services, which are now obtainable under the Medicare program? The most vulnerable population, the elderly, will be flung into a fiercely competitive marketplace where access to appropriate medical services may take a "back seat."

In this rapidly changing health care delivery environment, the Patient Access to Specialty Care Coalition believes that consumers of medical services must have effective protection against the potential that their access to medically necessary health care services will be inappropriately limited.

The most effective check against this potential restraint is the patient's power to seek and obtain medical services outside the provider network established by the health plan. Health plans that provide good service to their enrollees should not be

troubled by this point-of-service feature. Only health plans that fail to meet the needs of their subscribers should be concerned.

SURVEY DEMONSTRATES THAT CHOICE OF HEALTH CARE PROVIDER IS MOST IMPORTANT TO ELDERLY POPULATION

The Coalition had the firm of ICR Research poll a nationally representative sample of Americans age 50 and over on their views concerning Medicare reform. (The results of the survey carried a plus or minus 3.2 margin of error). The results of this poll demonstrated that roughly three out of four Americans age 50 and older would not join a Medicare managed care program without the freedom to continue seeing their current doctor or choose a specialist when they became ill.

The poll results indicated that older Americans view their freedom to choose a health care provider as a fundamental personal right that is much more important than other principles, such as the right to bear arms or imposing term limits for Members of Congress.

Eighty-two percent of the respondents said that whether a prospective Medicare managed care program allowed them the freedom to choose out-of-network physicians and specialists would be "critically important/important" to their decision to join one. Even among lower-income seniors (those making less than $15,000 a year), 64 percent said they would choose a Medicare managed care program with the freedom-to-choose feature (for a reasonable co-payment) over a Medicare managed care program that covers the cost of prescription medications. Eighty-three percent of respondents making over $50,000 gave the same response.

The results of this poll are consistent with those released this month by Louis Harris and Associates for the Commonwealth Fund. It found that managed care enrollees were more likely to rate their health plans as fair or poor than enrollees in traditional fee-for-service plans. The polling, which covered families in Boston, Los Angeles, and Miami demonstrated that choice of health care plan and choice of physician were key issues, and that those individuals who were forced into managed care because it was the only health care coverage provided by their employer were twice as likely to rate their plan negatively as those who choose managed care from a list of options.

THE POINT-OF-SERVICE FEATURE

The Coalition is deeply concerned that there are a number of current practices, especially in managed care settings, which impede patient access to treatment, particularly specialty care.

True freedom of choice for patients can only be achieved by making out-of-network medically necessary treatment and services available for all health care plans. All patients should have the option, at an additional but not prohibitive copayment, to seek the out-of-network treatment they desire. This feature should be built into every health care plan, and not just offered at the time of enrollment.

While offering a point-of-service feature at the time of enrollment is a good first step in preserving consumer choice, patients sometimes act with less than perfect information when choosing a health care plan. Many times healthy patients are unable to assess their health care needs, until they actually get sick or need specialty care. Consequently, the broadest possible patient protection is to build choice of health care provider into every health care plan.

Real Medicare reform will maintain the freedom for patients to choose their own health care providers or specialty care provider, and then to continue to access these same caregivers regardless of a change of jobs or health care plans.

As Congress explores the role of managed care in controlling health care costs, it also has the opportunity to guarantee the patients' right to choose, and to make consumers secure in knowing that the health care provider of their own choice will always be there.

Making out-of-network treatment and services available for enrollees in all health care plans provides a very good quality assurance check. It ensures that all health care plans provide the health care that their enrollees need and deserve. The ability of all Americans to seek out-of-network coverage provides consumer protection as well. If a patient is not satisfied with care, he or she could pursue other treatment for a reasonable, but not cost-prohibitive price.

Today, one of the more popular health insurance products among consumers is a closed panel managed care plan with the availability of out-of-network coverage. Patients have been demanding this freedom to choose, and the marketplace has responded. This point-of-service feature for all health plans, therefore, is not intrusive, but rather advances a developing trend, ensuring consistency and predictability for consumers.

THIS POINT-OF-SERVICE FEATURE IS NOT COSTLY

Building a point-of-service feature into all health plans under Medicare will not affect any health plans' ability to be aggressive in their cost containment activities, nor will it limit their efforts to encourage providers and consumers to use health care resources wisely. It will simply put pressure on health plans to keep the patient's welfare uppermost on their agenda, ahead of dividends and the bottom line.

Consumers expect to bear some additional cost for this point-of-service feature. However, this cost is not great, and it is a simple actuarial calculation to determine a reasonable copayment. There is also no financial burden placed on the HMO.

The Patient Access to Specialty Care Coalition retained the firm of Milliman & Robertson, Inc. to study the cost impact on HMOs, if all closed-panel HMOs had to offer a point-of-service to their enrollees. A closed-panel HMO only allows patients to receive care from its own contracted providers. When a closed panel HMO has a point-of-service feature, patients have an opportunity to "opt-out" of the managed care network of providers, and seek "out-of-network" care.

The managed care industry has consistently claimed that a point-of-service feature in all health plans would greatly increase the cost of doing business. This assertion is contradicted by the Milliman and Robertson findings.

According to this study, a built-in point-of-service feature for all managed care plans would not greatly change the cost of managed care or HMO benefits. In fact the study demonstrates that this point-of-service feature, in some instances, can actually lower the costs to an HMO.

The Milliman and Robertson study estimated the "net claim cost" for two typical health care plans in today's marketplace. These plans were developed from existing data in the HMO Industry Study, 1994 of the Group Health Association of America. Milliman and Robertson concluded that when it compared a point-of-service feature to a pure HMO (a closed panel), the expected cost ranged from a decrease of about 5 percent for a typical HMO plan to an increase of about 10 percent for a more generous HMO plan.

Analysis of this data demonstrates that the inclusion of out-of-network coverage within an HMO design does not, in itself, either increase or decrease claims costs incurred by the HMO. Instead, claims costs are increased or decreased depending upon the HMO's selection of factors (deductibles, copayments, and out-of-pocket limits) that encourage or discourage utilization of out-of-network coverage and the nature of the discounts negotiated with network providers. (For the Committees' use, the Coalition has shared a copy of the complete Milliman and Robertson study).

Again, the Patient Access to Specialty Care Coalition maintains that a built-in point-of-service feature provides a good safety valve for the unhappy or dissatisfied members of the closed panel HMO. Under the point-of-service feature, patients are able to go to a non-network provider of their choice. In doing so, however, the patient would incur a higher copayment for the opportunity to go "out-of-network."

This point-of-service feature provides the patient with an out when they question the quality of care they are receiving by the network's limited providers. It also provides an opportunity for the patient to seek an additional opinion from a non-partisan provider when the patient or family disagrees with the decision made by the closed panel HMO or the primary care gatekeeper to withhold treatment or deny an appropriate referral to a specialist.

EXPANSION OF MANAGED CARE IN THE MEDICARE PROGRAM

The Coalition is not opposed to managed care. It is concerned, however, that Congress may be embracing a concept of cost savings of managed care in the Medicare population without sufficient data.

Should Congress choose to go forward with expanding managed care in the Medicare program, the Coalition maintains that its recommended point-of-service feature will:

a) End the uncertainty and unpredictability of seniors moving in and out of health plans through open enrollment and disenrollment--the feature will always be there, and actuaries could easily calculate utilization of out-of-network services.

b) Give the Medicare patient effective protection against the potential for restricting access to medically necessary health care services.

c) Provide a quality assurance check on all health care plans to make sure that they are providing the full range of health care services to their enrollees.

THE POINT-OF-SERVICE FEATURE IS NOT AN "ANY WILLING PROVIDER" PROVISION

The point-of-service feature endorsed by the Patient Access to Specialty Care Coalition differs substantially from "any willing provider" proposals. "Any willing provider" provisions deal with the contractual relationships between health plans and providers of medical services. The focus of the Patient Access to Specialty Care Coalition is on patient choice and the health care access rights of consumers and patients.

THE COALITION IS NOT AGAINST MANAGED CARE, AND WE HAVE TAKEN NO POSITION ON THE REPUBLICAN LEADERSHIP'S PROPOSAL TO EXPAND MANAGED CARE IN THE MEDICARE PROGRAM

There have been several misconceptions about the Patient Access to Specialty Care Coalition. Contrary to comments which have appeared in the press, the Coalition is not anti-managed care, and we are not trying to interfere with, or slow-down, the rate of growth in managed care plans. We have not taken any position for or against the House Republican Leadership proposal on Medicare reform. We are not against the gatekeeper concept, and we do not take issue with the important role that primary care providers play in offering quality health care to their patients.

Instead, our message is very simple. We believe that in this rapid changing health care marketplace, patients should be afforded a few basic protections. If the Congress desires to shift the elderly population more toward managed care health care

delivery, all that we asked is that provisions be included to ensure that patient choice of health care provider is preserved, so that Medicare enrollees will be able to continue to have timely access to the full range of appropriate medical services.

OTHER PROVISIONS TO ENHANCE PATIENT CHOICE AND ACCESS SHOULD ALSO BE INCLUDED

The Coalition believes that additional provisions should be included in Medicare reform legislation to enhance patient choice and access. Medicare reform legislation should include: a patient bill of rights ensuring timely access to specialty care; a streamlined appeals process for denial of care or copayment for out-of-network care; a ban on financial incentives which result in the withholding of care or the denial of a referral; and a requirement that health care plans return to patient policyholders, in the form of aggregate benefits provided under the policy, at least 85 percent of the aggregate amount of premiums.

Mr. Chairman, the Patient Access to Specialty Care Coalition's point-of-service feature allowing patients to access out-of-network medically necessary care ensures real choice and real consumer protection, and is a sound quality assurance check to make certain that all plans offer the full range of quality health care.

In your continuing deliberations on managed care and the expansion of managed care in the Medicare program, we urge the House Ways and Means Committee and the House Commerce Committee to ensure adequate patient protection and safeguards in this changing marketplace by instituting a point-of-service feature in all health plans.

A listing of the current membership of the Patient Access to Specialty Care Coalition follows:

(as of 7/7/95)

Organizations in the

PATIENT ACCESS TO SPECIALTY CARE COALITION

Allergy and Asthma Network•Mothers of Asthmatics, Inc.
American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for the Study of Headache
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Private Practice Psychiatrists
American College of Cardiology
American College of Foot and Ankle Surgeons
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians & Gynecologists
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American Diabetes Association
American EEG Society
American Gastroenterological Association
American Lung Association
American Orthopaedic Society for Sports Medicine
American Osteopathic Academy of Orthopedics
American Pain Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Rehabilitation Association
American Sleep Disorders Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Dermatology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society of Transplant Physicians
American Thoracic Society
American Liver Foundation
American Urological Association
Amputee Coalition of America
Arthritis Foundation
Arthroscopy Association of North America
Association of Subspecialty Professors
Asthma & Allergy Foundation of America
California Access to Specialty Care Coalition
California Congress of Dermatological Societies
College of American Pathologists
Congress of Neurological Surgeons
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Eye Bank Association of America
Federated Ambulatory Surgery Association
Joint Council of Allergy and Immunology
Lupus Foundation of America, Inc.
National Association for the Advancement of Orthotics and Prosthetics
National Association of Epilepsy Centers
National Association of Medical Directors of Respiratory Care
National Committee to Preserve Social Security and Medicare
National Foundation for Ectodermal Dysplasias
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Psoriasis Foundation
North American Society of Pacing and Electrophysiology
Oregon Dermatology Society
Orthopaedic Trauma Association
Patient Advocates for Skin Disease Research
Pediatric Orthopaedic Society of North America
Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists
Renal Physicians Association
Scoliosis Research Society
Society for Vascular Surgery
Society of Cardiovascular & Interventional Radiology
Society of Gynecologic Oncologists
Society of Nuclear Medicine
Society of Thoracic Surgeons
The Alexander Graham Bell Association for the Deaf, Inc.
The American Society of Dermatophathology
The Endocrine Society
The Paget Foundation For Paget's Disease of Bone and Related Disorders
The TMJ Association, Ltd.

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