

MEDICARE AND MANAGED CARE: FINDING SUCCESSFUL SOLUTIONS

HEARING BEFORE THE COMMITTEE ON FINANCE UNITED STATES SENATE ONE HUNDRED SEVENTH CONGRESS FIRST SESSION

APRIL 3, 2001



Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

73-063—PDF

WASHINGTON : 2001

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MEDICARE AND MANAGED CARE: FINDING SUCCESSFUL SOLUTIONS

TUESDAY, APRIL 3, 2001

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:10 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Snowe, Rockefeller, and Bingaman.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I apologize for starting the hearing 10 minutes late. It is not my practice. I was on the telephone, visiting with people about proposed health amendments on the budget resolution on the floor of the Senate.

Senator Baucus will not be with us right away because he is in the process of offering amendments. So we may have kind of a convoluted sort of hearing today.

But I call the hearing to order and welcome everybody, particularly our witnesses who some go out of their way considerably both for preparation and for coming here to be involved with this hearing, and also to the public that is here to observe and to listen to learn about this issue.

It is the purpose of the committee to take a very fresh look at the troubled relationships between Medicare, on the one hand, and managed care and to explore ways in which we can improve this.

Ever since the 1970's when Medicare began offering managed care to seniors, Congress has in fact wrestled with making Medicare and managed care work better together, all the while with the goal of improving the benefits and controlling high health care costs. Over time, managed care has proved to be a popular alternative to traditional fee-for-service Medicare for many patients, about 14 percent at this point.

Medicare beneficiaries often enroll in managed care options because these plans frequently offer benefits traditional Medicare does not, such as enhanced preventive services, prescription drugs, eyeglasses, and hearing aids. Unlike fee-for-service, managed care plans also provide an integrated benefit package and coordinated care so that services can be administered more efficiently which, of course, contains costs and improves the quality of care for the patients.

In 1997, Congress created the Medicare+Choice program designed to expand health plans to markets where existing access was limited or nonexistent and to offer new types of plans in addition to controlling costs. Now, from the start, achieving the goals of the Medicare+Choice program has not been easy.

The program's aim to control expending combined with increased regulatory burdens and mismanagement of the program have turned many managed care plans away from entering new markets or maintaining their existing markets. When managed care plans leave the Medicare+Choice program, seniors then are forced to choose a new plan.

This might mean giving up a favored physician or paying higher premiums in another plan. If no other plan exists, obviously that is the case in a lot of rural communities, patients must return to the traditional fee-for-service Medicare.

This means that the benefits of a coordinated delivery of care and extra services that seniors need most are at that time lost. Rural America has been and continues to be hit hardest by the lack of planned participation in the Medicare+Choice program.

Now, in my own State of Iowa, out of 99 counties, we only have 1 that offers it. That is for 2,000 and some patients in the county just across the Missouri River because they can affiliate with the program that is in Omaha, Nebraska, a more populous county.

I am pleased that we have Victor Turvey, Regional CEO of the United Healthcare Midwest Region which operates the Iowa Medicare+Choice program here today to speak about his experience in marketing and maintaining a Medicare+Choice plan in a rural community, but obviously not very rural compared to most of Iowa.

Twice since 1997, Congress has listened to plans and listened to patients and stepped in to improve the Medicare+Choice program, but we still have problems remaining. Today's hearing aims to unearth many of those problems and find possible solutions where others have worked.

We have joining us a panel of experts who understand the long and complex relationship between Medicare and managed care and who are prepared to discuss proposals for change. And I thank all of you for participating.

After hearing today's testimony, I hope we will be able to agree that the time is right to strengthen and improve the Medicare+Choice program from the ground up, not by applying some one-time fixes or gift bags, but changing plan design, payment structures, and regulatory requirements. Doing so will preserve this important program for future generations and ensure that seniors have the kind of benefit options that millions of other Americans already enjoy today.

Before I introduce the panel, I would like to call on Senator Rockefeller to speak since Senator Baucus I guess is on the floor and will not be able to here.

You can speak. Just speak as you can speak.

**OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A
U.S. SENATOR FROM WEST VIRGINIA**

Senator ROCKEFELLER. Well, that is what I was hoping.
The CHAIRMAN. Right.

Senator ROCKEFELLER. Thank you, Mr. Chairman, very much. And again, thanks to all the witnesses. These are in fact incredibly important hearings. And this is one that I think we can really learn a lot from.

I have to say that in West Virginia, we have one plan. And you have one in Iowa. And I think I have said on this that 81 percent of all counties in the United States of America do not have plans. I think I was right about it about 2 years ago. I am not sure if I am right on it today, but I will bet that is approximately correct.

And what has been interesting, Mr. Chairman, is that in our two rounds of PBA give-back, so to speak, what we have done is we have increased Medicare+Choice payment levels. And yet, having introduced that competition, there is still only one plan in West Virginia and one in Iowa.

So these increases, unless we hear testimony to the contrary here, are not likely to expand the choices. They are designed to expand the choices, but they do not expand the choices. And all that counts in life with the State that I represent is what works and what does not work.

So in continuing to devote a lot of resources to improving the managed care system is not something that I would be against. Perhaps, if I were from California or some other place, I would be. But being from West Virginia, it gives me a lot of problems because it comes at the expense of fee-for-service. That is where our people are.

That is where our people have no choice but to be. And that is where our people will remain, unless life brings something to West Virginia which it has not before. So the best thing that we can do for Medicare beneficiaries from this Senator's point of view in rural areas like my own is to do a lot focusing on competition and managed care and a lot more focusing on Medicare prescription drug benefit.

The rural beneficiaries are 60 percent more likely to go without prescription medication because of cost concerns than are their urban counterparts, in addition, because rural beneficiaries pay over 25 percent more for out-of-pocket costs of prescription drugs than urban beneficiaries. Rural beneficiaries pay 25 percent more. They obviously therefore spend a greater percentage of their income on these medications on average.

And I go back to what I have said so many times. The average income for Medicare beneficiaries in West Virginia is \$10,800. That is all sources of income from any possible area. And from that, you then automatically deduct \$2,000 for prescription drug expenses.

So that means that the entire gross income for the average Medicare beneficiary in West Virginia is \$8,600. That is not a lot of money. And there is no margin for error at all in West Virginia. And I have to fight and will fight for my people.

So I think we have to work on a prescription drug program that really works, Mr. Chairman, and which really delivers for our people. And I thank you.

The CHAIRMAN. I thank you very much. On these issues of health care, Medicare, and everything, you are very faithful in your participation and work of the committee. And I thank you.

Before I introduce the panel, I want to do some administrative things. First of all, each of you will be able to have your written statement put in the record without your asking that.

Second, both for Senator Rockefeller and me, we not be able to ask all of our questions orally. So you may get questions in writing. And for sure, from some of the people that cannot come, you will get written questions. So we would like to have those responses in two weeks. And for those of you who do not know how that process works, my staff or Senator Baucus' staff would be very happy to help you.

We are privileged to have Dr. Madeleine Smith. She is a Specialist in Social Legislation. And we often call upon her agency, the Congressional Research Service, to present testimony to Congress.

Then, we will hear from Dr. Murray Ross, Executive Director, Medicare Payment Advisory Commission here in Washington, DC. And often, people from that commission appear before our committee.

Victor E. Turvey, President, Midwest Region, United Healthcare of the Midwest, Inc. And that is located in Maryland Heights, Missouri.

Kevin W. McCarthy, Health and Welfare Benefits Consultant, Towers Perrin, Pittsburgh, Pennsylvania.

Dr. Thomas C. Buchmueller, Associate Professor, University of California, Irvine.

And then, Dr. Len M. Nichols, Principal Research Associate, The Urban Institute here in Washington.

So we will just go in that order.

Would you proceed, Dr. Smith?

STATEMENT OF MADELEINE T. SMITH, SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Dr. SMITH. Thank you, Mr. Chairman and Senators, for inviting me to testify about payments under the Medicare+Choice program. My name is Madeleine Smith. I am a Specialist with the Congressional Research Service.

There are two points that I would like to emphasize about the effects of payment reform under Medicare+Choice or M+C.

First, although the number of health maintenance organizations in the program has declined, the proportion of beneficiaries enrolled in managed care has not changed much. In 1997, 14 percent were enrolled. Today, it is about 15 percent. However, enrollment reached almost 17 percent of beneficiaries in 1998. Fewer beneficiaries have access to HMOs, but with the entry of a private fee-for-service plan, a type of Medicare+Choice plan, into the program, access for rural beneficiaries has risen.

Second, variation in payment rates has decreased. In 1997, the highest rate was 3.5 times the lowest rate. Today, it is about 1.75 times. However, benefits offered by Medicare+Choice plans still vary widely across the country.

In the remainder of my testimony, I will briefly review how rates were determined before the Balanced Budget Act of 1997 and the major reasons for reform. Then, I will discuss how rates are currently calculated and the effects of payment reform.

Under the Risk Contract Program created in 1982, an HMO received a payment for each of its enrollees, known as the adjusted average per capita cost or AAPCC. The Health Care Financing Administration, HCFA, calculated a county's AAPCC based on the cost of providing care under traditional fee-for-service Medicare. Basically, HCFA added together all the Medicare fee-for-service expenditures for beneficiaries living in the county and divided this by the number of fee-for-service beneficiaries in the county.

This county-level cost was adjusted for demographic differences between the county's Medicare beneficiaries and average beneficiaries nationwide. The county rate was set equal to 95 percent of the AAPCC to account for savings delivered by managed care organizations through coordination of care.

There were at least three reasons behind reform of the AAPCC under the 1997 Balanced Budget Act: lack of access to a Medicare HMO in many areas, wide variation in the payments and benefits offered by HMOs, and volatility of payment rates over time.

In 1998, almost three-quarters of Medicare beneficiaries had access to at least one risk plan and almost two-thirds had a choice of plans. Still, over one-quarter of beneficiaries nationwide could not choose a risk plan, mostly in rural areas, many with low AAPCCs.

A second perceived problem was wide variation in payments and consequently benefits. Beneficiaries in some areas received additional benefits at no additional cost while others did not.

A third perceived problem was volatility of the AAPCC over time, especially in rural counties. If one beneficiary in a sparsely populated county incurred large Medicare expenditures in 1 year, the average per capita costs would skyrocket. If that beneficiary recovered or died, the next year the average per capita costs could plummet.

In order to address some of these problems, the Balanced Budget Act included a new payment formula. The Medicare+Choice rate in a county was set at the highest of three amounts: a floor or minimum amount, a blend or average of local and national rates, and a minimum update.

The floor and minimum updates alter the immediate effects of blending local and national rates. The floor increased rates in low payment counties more quickly than would occur under blending. The minimum update cushioned effects of blending on high payment counties.

After payment reform, the Medicare+Choice program has experienced three waves of plan withdrawals and service area reductions, effective at the outset of the Medicare+Choice program in 1999 and annually since then. Interspersed between announced withdrawals have come two legislative responses, the Balanced Budget Refinement Act of 1999, BBRA, and the Benefit Improvement and Protection Act of 2000, BIPA.

Why did plans withdraw? Industry representatives believe that inadequate payments are a principal cause. HCFA contends that withdrawals reflect strategic business decisions that transcend payment rate issues.

A recent report from Interstudy, which studies the HMO industry, indicates HMO failures and withdrawals in the general HMO

market in 1999. The industry experienced its first annual decline in enrollment in nearly 30 years, as the boom cycle experienced by HMOs in the mid-1990's came to a close.

In response to plan withdrawals, Congress acted to increase Medicare+Choice payments. The BBRA in 1999 made a few modest changes while the BIPA in 2000 made more substantial changes.

After a little over 2 years, have problems identified with the AAPCC been fixed? Lack of access was seen as a consequence of low payment rates. The payment floor raised rates in many counties.

Today, more beneficiaries in rural areas have access to an M+C plan because of Sterling, the new, private fee-for-service plan in the program. Sterling offers coverage in over half of the States and counties in the country, where over half of beneficiaries living outside metropolitan areas reside.

However, the number of plans has decreased significantly overall, and fewer beneficiaries have the option of choosing an HMO. Although the proportion of beneficiaries enrolled is slightly higher than it was in 1997, it is lower than it was in 1998.

Variation in payments has declined. In 1997, the highest payment rate was 3.5 times the lowest. Today it's 1.75 times. As the payment gap has narrowed, benefits generally have declined. Fewer beneficiaries have access to a zero premium plan, especially one that includes drug coverage.

Differences in benefits persist today. For example, several plans in Miami charge enrollees no additional premium, yet include full coverage of prescription drugs, for drugs on the plan's formulary. In contrast, only one HMO in Minneapolis offers any prescription drug coverage. For a premium of \$81 per month, enrollees are covered for \$100 in total drug expenditures every three months. In both cities, the plans reduce cost sharing and provide additional benefits, such as physical exams and eye care.

Finally, payment reform was intended to reduce volatility in payments over time. Certainly, payments have not decreased, as they did prior to the BBA 1997, but very large increases have occurred in some areas as a result of increases in the payment floor. Some counties saw rates rise over 200 percent between 1997 and 2001.

Thank you. This concludes my testimony.

The CHAIRMAN. Thank you, Dr. Smith.

[The prepared statement of Dr. Smith appears in the appendix.]

The CHAIRMAN. Now, we will go Dr. Ross.

**STATEMENT OF MURRAY N. ROSS, EXECUTIVE DIRECTOR,
MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC**

Dr. ROSS. Good morning, Senator Grassley and Senator Rockefeller. I am Murray Ross, Executive Director of the Medicare Payment Advisory Commission. And I am pleased to be here this morning to discuss the Medicare+Choice program. My testimony draws on the recommendations and analyses in MedPAC's March 2001 report to the Congress.

As you heard from Dr. Smith, prior to the Balanced Budget Act, Medicare's payments to managed care plans were linked to fee-for-service spending in individual counties. Wide variation in fee-for-

service spending among counties meant that managed care payment rates also varied widely.

Because of this and because of market conditions, beneficiaries in some mostly urban areas had access to plans offering much greater benefits than those available to beneficiaries in other mostly rural areas. To address this inequity, the Congress changed the payment mechanism when it enacted the Medicare+Choice program. It put a floor under payments to plans and provided for blending of local and national payment rates. Last year, the Congress raised the floor further.

Reducing the variation in Medicare+Choice payment rates, however, has introduced a different problem by creating the potential for Medicare's payments to plans in some market areas to diverge significantly from fee-for-service spending in those markets.

In counties where payment rates have been increased above fee-for-service costs, Medicare pays Medicare+Choice plans more to provide basic benefits than it would have spent otherwise. In other counties, payments to Medicare+Choice plans may fall below fee-for-service costs, as updates are limited. Over time, plans that paid less than fee-for-service costs will face difficulty in contracting with providers if their payment rates are not competitive.

No matter how much payments to plans are manipulated, achieving parity in payments to Medicare+Choice plans and maintaining local parity between Medicare+Choice and traditional Medicare cannot be accomplished simultaneously as long there is significant underlying variation in fee-for-service spending across market areas.

MedPAC believes that Medicare's payment policies should not steer beneficiaries to either Medicare+Choice plans or the traditional Medicare program. Therefore, the commission recommends making payments for beneficiaries in the two sectors of a local market substantially equal, taking into account differences in risk.

We also recommend that the secretary study variations in spending under traditional Medicare to determine how much reflects differences in input prices and health risk and how much reflects differences in provider practice patterns, the availability of providers and services, and beneficiary preferences. The secretary should report to the Congress and recommend whether and how such differences should be accounted for in fee-for-service payment rates and Medicare+Choice payment rates.

Congress put the floor under Medicare+Choice payment rates to bring new choices and additional benefits to rural areas. The low payment rates are not the only reason that managed care plans do not enter rural areas.

First, the lack of so-called intermediate entities, such as physician group practices in many rural areas makes forming networks more costly. It limits plans' ability to control costs by delegating risk.

Second, lack of competition among hospitals, physicians, and other providers in many rural areas reduces plans' ability to negotiate discounted prices for services. As a result, even with the floor under Medicare+Choice payment rates, few managed care plans have entered rural areas.

In contrast, private fee-for-service plans need not establish networks of providers. In addition, the floor under Medicare+Choice payment rates means they need not negotiate discounts to be profitable.

A private fee-for-service plan whose enrollees' use of services was similar to their use in traditional Medicare could have the same costs for medical care as under the traditional program, but be paid more. This possibility has led one plan to enter over 1,600 counties, three-quarters of them floor counties in 25 States. And another application is pending.

The entry of private fee-for-service plans into floor counties or other counties where Medicare+Choice payment rates substantial exceed local fee-for-service costs raises an important policy issue. On the one hand, such plans represent an alternative to traditional Medicare that the Medicare+Choice program was intended to provide.

On the other hand, because these plans do not manage care, any additional benefits they provide must come not from efficiency, but from higher-than-need payments. Further, higher-than-need payments do not ensure that Medicare beneficiaries will get additional benefits. Some of the excess payments may generate higher profits for insurers and some of it may lead to higher payments to providers from those insurers.

MedPAC recommends that the secretary study how beneficiaries, providers, and insurers each benefit from the additional Medicare+Choice payments in floor counties.

How then can policymakers meet the goals laid out in the BBA of providing more choices of plan options and helping to control the growth of Medicare spending? Making payment rates for Medicare+Choice equal to local fee-for-service costs would help achieve the latter goal, but would not by itself encourage more plans to participate in rural areas. Additional steps will be needed.

One possibility is explore risk sharing. Currently, the financial risk for the cost of health care is assumed fully either by Medicare for beneficiaries in the traditional program or by plans for Medicare+Choice enrollees.

Allowing risk sharing could encourage greater participation by entities unwilling to bear financial risk for services beyond their control. Although the potential to reduce costs and thus provide enhanced benefits might not be as great under shared risk, it might make alternatives to traditional Medicare available in more areas.

Another possibility would be enlarging payment areas to better match local market boundaries and to reduce volatility in local payment rates. Basing Medicare+Choice payments on local fee-for-service spending and risk factors would increase the importance of having the reliable and stable data with which to calculate them.

MedPAC recommends the secretary explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.

I appreciate the opportunity to testify. And I will be happy to answer any questions.

The CHAIRMAN. Thank you, Dr. Ross.

[The prepared statement of Dr. Ross appears in the appendix.]

The CHAIRMAN. Mr. Turvey.

STATEMENT OF VICTOR E. TURVEY, PRESIDENT OF THE MIDWEST REGION, UNITED HEALTHCARE OF THE MIDWEST, INC. MARYLAND HEIGHTS, MO

Mr. TURVEY. Thank you, Mr. Chairman and members of the committee, for the opportunity to testify on our experience in the Medicare+Choice program. I am Victor Turvey, Midwest President of United Healthcare. I am based in St. Louis and responsible for our midwestern health plan operations in Iowa, Nebraska, Missouri, Wisconsin, and Illinois.

United Healthcare and its parent company, United Health Group, have a longstanding commitment to Medicare beneficiaries. In fact, United Health Group is the largest provider of health care services to seniors in America.

Today, over 400,000 beneficiaries are enrolled in our health plans in 25 markets across the country, including over 10,000 members in Pottawattamie County, Iowa and neighboring Douglass County in Nebraska. In addition, through the AARP's Health Care Options program, we provide Medicare supplement insurance to roughly 3.5 million members nationwide.

What we offer is value beyond the traditional Medicare program. We do this by coordinating the fragmented diverse elements of the health care and organizing the delivery of health care around the best interest of the patient.

Our Medicare+Choice members have a very personal relationship with us. They have individually assigned customer service representatives who they get to know quite well. They also have access to a 24-hour nurse line and Internet-based health information. We have programs that track their special health conditions. And we send reminders to get a regularly scheduled diagnostic test.

This is what we call care coordination. And it includes medical doctors and nurses to follow with their hospitalizations and to make sure that the services ordered by their doctor are understood, accessible, and coordinated before, during, and after they are in the hospital. These services are highly valued by members and their physicians, but it takes more than this to succeed in a rural market.

One of the challenges facing rural Medicare+Choice plans is the addition in new members. These days, beneficiaries are becoming increasingly hesitant about Medicare+Choice. We have heard from many seniors about sales calls from Medigap brokers to tell them that they should not take a chance on Medicare+Choice because it will not be around for the long term.

As a result, rural beneficiaries demand more time and information to close a new sale. It is administratively expensive. The sales calls are done in person, usually at the kitchen table, one at a time. But once enrolled, few of our members leave.

Probably though the biggest hurdle in providing quality coverage to rural beneficiaries is the development of the provider network. This is because the limited supply of rural physicians and hospitals mitigates the natural competition for additional patients, such as you would see in urban markets.

Often, a particular hospital is the only game in town. As such, they have little incentive to contract with the Medicare+Choice plan who currently probably cannot afford to compensate them at

the same level as traditional Medicare. In addition, a substandard reimbursement level limits our ability to offer benefits much beyond the standard Medicare offerings.

Our rural counties are all considered floor counties. And thus, they benefitted from the payment increase under last year's BBA legislation. However, the payment increase still lags behind the overall annual medical cost trend. This needs to be addressed quickly, perhaps combined with reasonable incentives for rural physicians to join and learn how to thrive in an M+C program.

For guidance as to what can be done by health plans, let us first look at two real life examples: first, how United Health Group technology is used by a successful provider group in St. Louis, my home territory and then an example of how we have applied the technology to help the rural physicians in southern Illinois.

Now, our success in St. Louis has been primarily with fairly sophisticated provider groups. We provide them at no cost to them information derived from our paid claims data base. It is information which compares the practice patterns of their local physicians to peers in their specialty.

Doctors work with us to mind this data to determine with whom and where the best medical outcomes are found. This helps to make good doctors better doctors. And as a by-product, it helps moderate cost increases. Organized physician groups have the infrastructure to analyze, disseminate, and act on this data.

Unfortunately, this level of sophistication rarely exists in rural areas. It can and should be developed. And United Healthcare and some others can do that, but it will take time and some incentive for rural physicians to want to take the initiative and change the status quo.

In Missouri, we have had success in helping to organize and train a group of southern Illinois physicians in these management tools. And it alone has allowed us to remain in Madison and St. Clare counties, rural counties in southern Illinois. But more widespread efforts are needed. And the capital from those efforts in many rural counties is a necessity.

With respect to administrative issues, we believe that regulation and accountability are important and necessary to ensure fair, quality coverage for Medicare beneficiaries. I was a regulator for my first 6 years in this industry with the State Insurance Department in Illinois. And I was proud of what I did.

But the way the current administrative rules and procedures are established and enforced is burdensome. There is complexity. Coupled with the lack of coordination between States, HCFA, and central HCFA means that plans face conflicting interpretation of rules that are subject to multiple audits. In addition, a number of new rules has grown exponentially since enactment of the BBA.

Based on our experience, the more problematic administrative items are the following. In counter data collection, the current requirements in submitting counter data is time consuming and costly, given questionable returns.

The process for submitting the data to HCFA is cumbersome and resource intensive under the current fee-for-service claims-based system. Additionally, the scope of data required seems excessive, given the more limited data required for risk adjustment.

Regarding the ACR process, the new June filing date, formerly in the fall, makes it considerable more difficult to make accurate financial projections for the following year and thus appropriately price the product. With respect to marketing materials and HCFA's review, the new marketing requirements, particularly the 45-day review time makes it very difficult to get materials finalized in a timely manner.

With respect to regulatory implementation, the frequency and content of new regulatory policy changes has increased considerably. In 2000, HCFA issued 15 new official policy letters, made 2 revisions to another, and the final Medicare+Choice regulation, the "mega reg," and inconsistencies between the regional office and central HCFA are problematic, especially for a national health care organization, such as United Healthcare.

Senator ROCKEFELLER. Mr. Turvey, are you almost through, do you think?

Mr. TURVEY. Yes, I am almost through.

So how do we fix the program and ensure its financial viability? There are four key areas for reform: reimbursement, administrative simplification, provider relations, and evolutionary program design.

Fundamental reform of the reimbursement system is necessary. A fair and competitive payment approach that is more closely aligned with current medical cost trends and which factors in cost variability in rural and urban markets is needed.

Second, a thorough review of current administrative requirements to eliminate items that have negligible benefits would be helpful. Congress should explore the increasing difficulties in the hospital and physician participation in Medicare+Choice, focusing on the lack of competition among rural providers, the need for modest funding of infrastructure for more effective analysis and dissemination of data for improved medical outcomes.

Finally, to reform this system, we must recognize the evolutionary nature of the health care system, developing a program that allows for change as the system warrants. We encourage Congress and HCFA to study successful contract arrangements in the private employer's sector, including non-risk-based alternatives as the basis for its own contracts with private health plans.

Working together, we can help to develop a renewed Medicare program that meets the needs of beneficiaries in rural America across the country. We believe there is great opportunity for positive change.

Thank you for the opportunity to share our thoughts. I would be happy to answer to any questions you may have.

The CHAIRMAN. Thank you, Mr. Turvey.

[The prepared statement of Mr. Turvey appears in the appendix.]

The CHAIRMAN. Now, Mr. McCarthy.

STATEMENT OF KEVIN W. MCCARTHY, HEALTH AND WELFARE BENEFITS CONSULTANT, TOWERS PERRIN, PITTSBURGH, PA

Mr. MCCARTHY. Thank you, Mr. Chairman and Senators. My name is Kevin McCarthy. I am a Health and Welfare Benefits Consultant at Towers Perrin, a global management consulting firm

with nearly 9,000 employees and 70 offices worldwide. I work out of Towers Perrin's Pittsburgh office.

Since 1994, we have sponsored the RetireeCHOICES Coalition which is a group of principally Fortune 500 employers who sponsor post-retirement health care benefits. The coalition has accumulated a great deal of experience in working with Medicare+Choice plans across the country to meet the health benefit needs of retirees.

Over the years, over 100 employers have participated in the coalition, representing over 2.5 million retirees, including salaried, hourly, and collective bargained retirees. While these employers could have a significant impact on the health care market in their own right, their vision has been to foster a competitive retiree medical marketplace, using their collective leverage to improve quality, access, member satisfaction, and efficiency of medical health plans.

Mr. Chairman, in your invitation to testify today, you wrote that the committee wishes to learn about our efforts to develop service, quality, and access criteria for evaluating Medicare+Choice plans, as well as our success in negotiating employer premiums. And also, you asked us to share some lessons we have learned along the way and implications for developing further competition in the Medicare+Choice program.

How do we develop criteria for evaluating Medicare+Choice plans? In our RetireeCHOICES experience, employers consider a variety of factors, but primarily the focus is on the special needs of seniors.

The goal of the typical employer's review process is to select the highest quality, most cost efficient plans in the market for retirees. To do this, employers apply some of the techniques associated with major purchases in their normal business operations, such as a request for proposal, plan interviews, site visits, and negotiations during the selection process.

Those techniques are combined with data from specialized sources, including the National Committee on Quality Assurance and HEDIS, the Health Plan Employer Data and Information Set. Our coalition members receive RetireeCHOICES market data sets which are a compilation of various detailed questionnaires on health plan service area, performance, quality assessment, satisfaction, plan design, pricing, and prescription drug coverage.

Although our main goals are to ensure quality, access, and service, we have also been successful in securing competitive premiums for the employers and the retirees who choose to enroll in Medicare+Choice options.

To foster competition within geographic markets, every Medicare+Choice plan in the country is invited to submit a plan design and premium quote to the coalition for their operational service area. For 2001, our coalition successfully negotiated with Medicare+Choice plans, representing more than 200 health plan and market combinations.

Following these steps, we assist employers in perhaps the most critical phase which is to present the plans to the retirees as they make the voluntary decision whether to enroll in a Medicare+Choice plan or remain in original Medicare and the employer's traditional plan.

The number of lessons along the way that we have learned, there are many, but I would like to talk about four this morning.

One: Communications with retirees are key. Employers have learned the special needs and characteristics of retirees that must be considered in offering Medicare+Choice plans. This includes the need for a coordinated communication program to help retirees understand their choices.

The focal point of the employer communication process is the employer-sponsored retiree meeting. As you know no doubt from your own constituency meeting experiences, these types of sessions are perhaps the most effective way to bring a message to this population.

Two: Negative perceptions of managed care and HMOs must be addressed and balanced. We have learned that it is necessary to present a more balanced perspective of managed care than the negative perception of managed care and HMOs that is often portrayed in the media.

Employer's communication efforts present the pros and cons of joining a HMO. Employers try to remind their retirees of "what makes headlines," is not always the whole story.

Three: HCFA's requirements present operational challenges for HMOs and employers in implementing Medicare+Choice plans.

Four: A marketplace subject to frequent government policy changes and unpredictable pricing can be unstable. Employers have been on the front lines in communicating with retirees who have lost access to their Medicare+Choice coverage or fear they might in the future.

How do we further competition in the Medicare+Choice program? Prior to 1999, we saw the benefits of competition among multiple Medicare+Choice plans in communities across the country.

We know that such competition can work to the benefit of Medicare beneficiaries through improved services and additional benefits. It is key now for Congress to put the Medicare+Choice program on a more equitable and competitive basis with traditional Medicare.

As others on this panel can address in detail, the Balanced Budget Act of 1997 greatly curtailed the annual increase in HCFA payment rates to Medicare+Choice plans. HCFA payment rates in most urban areas have increased by less than 3 percent annually for the last 4 years. As a result, many HMO plans and Medicare+Choice plans have felt the need to reduce service areas, cut benefits, or increase premium rates.

A critical step towards promoting competition in the Medicare+Choice marketplace would be to address the financial inequities between traditional Medicare and HCFA's payments to Medicare+Choice plans. Then, attention can be paid to retiree communications and the operational challenges placed on Medicare+Choice plans.

Thank you, Mr. Chairman and Senators, for the opportunity to testify before you today. Thank you.

The CHAIRMAN. Thank you, Mr. McCarthy.

[The prepared statement of Mr. McCarthy appears in the appendix.]

The CHAIRMAN. Now, Mr. Buchmueller.

STATEMENT OF THOMAS C. BUCHMUELLER, ASSOCIATE PROFESSOR, UNIVERSITY OF CALIFORNIA AT IRVINE, IRVINE, CA

Dr. BUCHMUELLER. Thank you, Mr. Chairman, for the opportunity to testify about the role of consumer choice and competition in Medicare reform. My name is Thomas Buchmueller. I teach economics at the Graduate School of Management, University of California at Irvine. My testimony today will focus on the recent experiences of the health benefits program of the University of California.

The UC program is based on the principles of managed competition and is similar to competitive models proposed for Medicare. In the mid-1990's, the UC adopted a fixed-dollar premium contribution policy whereby the amount it pays for employee health insurance coverage is set at the premium charge by the least costly plan of the program.

Because this change caused employee contributions to increase for some UC plans, but not for others, it created a good, natural experiment for testing the price sensitivity of consumers in a managed competition setting. Because UC retirees are offered the same choice of health plans and face similar price changes as active employees, it is possible to compare the price sensitivity of the groups.

This morning, I would like to provide a brief overview of the UC program, summarize the evidence on the price sensitivity of employees and retirees, discuss the problem of adverse risk selection as it is played out in the UC program, and mention some unique features of the UC population and the UC program which will limit the extent to which this experience generalizes to Medicare.

In the UC program, health plan choices are made during an annual open enrollment period which takes place in November. My analysis is based on the choices made between 1993 and 1998. During that period, the UC menu included several HMOs and two other plans, including Prudential High Option, a traditional fee-for-service plan.

Employees and retirees are required to pay the difference between the premium for their chosen plan and the UC contribution. Until 1994, the UC contribution was based on a weighted average of the four plans with the highest UC enrollment. And because these four included Prudential High Option, the most expensive plan on the menu, the premium contribution exceeded the premium for all the HMOs.

As a result, all the HMOs were free to employees. And the HMOs had no incentive to compete with each other on the basis of price.

In 1994, the UC changed its contribution policy, setting it equal to the premium of the least costly plan available statewide. This caused premium contributions to increase for Prudential High Option and for several of the HMOs. These price changes led to significant shifts in enrollment among active employees.

My analysis indicates that 35 percent of employees facing a price increase of \$20 per month were willing to switch plans rather than pay the higher premium. This compares to a switching rate of only 5 percent for employees in plans that were available for no contribution in both years.

UC retirees were less willing to switch plans in general and less sensitive price. For the retiree population, a \$20 price increase raised the switching rate from 1.4 percent to 3.4 percent.

In the years immediately following the change in the policy, HMOs who participated in the UC program cut premiums to compete for market share. As a result, between 1993 and 1996, average health spending for active UC employees fell by 24 percent.

However, there is an important negative consequence of this price competition. Prudential High Option, the fee-for-service plan, was pushed into an adverse selection death spiral.

Because Prudential could not match the premium cuts of the HMOs, its costs to enrollees increased. Because the people who switched out of Prudential were younger and healthier than the ones who remained, costs from fee-for-service sector increased. Eventually, the plan had to raise premiums which led to further disenrollment and further worsening of the risk floor.

By 1998, employees who had chose Prudential had to pay \$700 a month out-of-pocket on top of the UC contribution. And as a result, the plan enrolled less than one-tenth of 1 percent of all UC active employees.

A comparison with the retiree population suggests a tradeoff between price competition and risk selection. Because UC retirees were so much less price sensitive than active employees, the Prudential Medigap plan did not suffer the same fate as the Prudential plan for active employees. Premiums did increase. And the plan did lose market share somewhat, but the risk floor remained stable.

Now, in thinking about how these results might generalize to Medicare, it is important to keep in mind ways in which the UC retiree population is different from Medicare beneficiaries more generally and also some unique features of the UC program.

First and most importantly, UC locations are in mature managed care markets with high HMO penetration. The most obvious implication is that the UC experience offers no insights for how a competitive approach might be applied to rural areas where there is not sufficient population densities to support competition.

A more subtle point is that the high rate of HMO penetration in the UC program may explain the apparent lack of price sensitivity among retirees. It could be that the people who would be most sensitive to price were already in HMOs at the time that the fee-for-service plan starting increasing in price. And the people who remained in the fee-for-service sector were those with the strongest aversion to managed care.

Also, it is important to keep in mind that even after the cost of the fee-for-service Medigap option increased, the Prudential plan offered comprehensive coverage at a reasonable price. In 1998, the cost of the Prudential for a single individual was \$87 per month. And that includes the part B premium.

When you factor in the fact that the UC has a fairly generous retiree program, it is likely that very few UC retirees found health insurance premiums to be a burden. Retirees in other areas who are less affluent are maybe more sensitive to price and more willing to switch to HMOs.

There are also a couple of features of the UC program that are important. The UC requires HMOs to offer standardized benefits so

that retirees and employees are making apples-to-apples choices. And there is a high degree of provider overlap in the UC program. These factors make the system more price sensitive.

So to summarize, the experience of the UC program provides support for the managed competition approach. Adopting the fixed contribution policy led to considerable savings for the UC to establish a more competitive environment.

However, UC retirees appear to be much less price sensitive than active employees. And it gives reason to be cautious in extrapolating from the working age population to Medicare.

The UC experience also shows how price competition in the health insurance market can lead to fatal adverse selection. Plans that offer consumers a clear freedom of choice are likely to experience severe adverse selection if forced to compete against HMOs.

If Medicare beneficiaries are like UC retirees, this may be less of a problem. However, if restructuring Medicare does increase price competition, this competition may threaten the viability of fee-for-service Medicare.

Thank you very much.

The CHAIRMAN. Thank you very much, Dr. Buchmueller.

[The prepared statement of Dr. Buchmueller appears in the appendix.]

The CHAIRMAN. Now, Dr. Nichols.

**STATEMENT OF LEN M. NICHOLS, PRINCIPAL RESEARCH
ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, DC**

Dr. NICHOLS. Mr. Chairman and members of the committee, I am grateful for the opportunity to discuss with you today the most important lessons that the Competitive Pricing Advisory Committee, or CPAC, learned while trying to help inform the Medicare reform debate. And I am going to focus on those lessons, but I feel compelled to offer you a two-minute history of the Competitive Pricing Advisory Committee so you will know the context.

CPAC was created in 1997 in the Balanced Budget Act. It was created for the purpose of designing and implementing four to seven competitive price demonstration projects in order to inform the larger Medicare reform debate.

Now, CPAC was put in that legislation explicitly so that it would be protected. We had tried the Medicare program a couple of times around competitive price demonstrations, but they were stopped each time by the Congressional delegations of each local community.

So the thought was that if you put the intent of the demonstrations in legislation, then the leadership would not allow these kinds of things to happen because Congress as a whole would have sanctioned the idea of a competitive experiment.

So CPAC was appointed by the secretary of HHS. There were 15 members. John Larson from the private sector, we had physicians, health plan executives, health plan purchasing executives from corporations, actuaries, economists. It was chaired by James Cubbin, the Vice President of Purchasing of Health Care for General Motors, one of the most innovative and creative purchasers of health care in the country.

We began meeting in May of 1998 and finished all the heavy lifting really of the intellectual decisions of how to design this thing by October of 1998. That was because most of the heavy lifting had been done before in the previous design experiments. And we were educating by the staff.

Any way, the hard part was selecting sites where you are going to actually conduct the competition that we all think we may want in theory, but when it comes down to practice, have gotten cold feet. Well, the site selection, we thought, was about as scientific as you could get. We looked at every objective measure one could find. We looked at the payment rates.

We looked at the degree of managed competition, the degree of Medicare, HMO penetration, the competition possible on the ground that was actually going on, etcetera, and chose Phoenix and Kansas City as two representative places in the country where managed care had a foothold and indeed seemed to be working reasonably well in both the non-Medicare and the Medicare markets.

We selected these sites in January of 1999 with the idea that the demonstration would start in January of 2000. It is fair to say that by March of 1999, the opposition in Phoenix had completely galvanized to be virtually unanimous.

Plans opposed it because they thought the competitive experiment would leave them to receive less money per beneficiary. Providers opposed it because if plans get less money per beneficiary, they are not going to do very well in the long run either. Beneficiaries became very nervous because if both plans and providers are nervous, this cannot be a good idea. And they saw fundamentally that they were likely to lose the benefits that exceed the Medicare package in general.

So basically, you had unanimity in Phoenix that this was a bad idea.

In Kansas City, it was not quite as obvious that they opposed it. In fact, the leader of the Kansas City stakeholder's group thought he probably could get them all to vote to do this, but you could not do it in Kansas City alone. It would not be a guinea pig for the country. Thank you very much. You had to get Phoenix to agree or they were not going to go along.

And then, basically by July of 1999, the amendments were being attached and various things that were moving. The Patient Protection Act was the one where the amendments stuck. And the amendments said that we will have no competitive demonstration projects in Arizona or Missouri.

Some people thought of this as a shot across our bow. I think it was more like a torpedo to our whole below the water line because it fundamentally said that the leadership was not going to stop members trying to prevent the competition from going forward.

Some members did try to save the demonstration project. Chairman Thomas on the House side, Senator Graham on the Senate side, Chairman Roth and the Senate finance staff for which we hold a great soft spot in our hearts forever tried to save it. But basically, we are stuck in the water until we were to think about the lessons that I think we need to focus on.

The first lesson which I think is unanimously agreed upon by all members of the committee is that if we are going to learn how to

reform Medicare pricing strategy, we are going to have to invest some money upfront. We are going to have to relax budget neutrality.

What budget neutrality says when you try to run a demonstration is that there is no way any payment can ever exceed what it would have been on the baseline. But the BBA lowered the baseline, the 2 percent that Mr. Turvey talked about.

And therefore, plans said, I cannot do any better. I may do worse. And I am afraid I will do worse. If they are afraid they will do worse, they are afraid they are going to have to cut benefits. So they are going to oppose it. And if beneficiaries think that benefits will be cut, you are never going to get agreement. So you are going to have to relax budget neutrality.

And I would submit to you, you have to give beneficiaries something tangible on the ground. You have to give them either prescription drugs for sure or some kind of reassurance that the benefits that they have now are not going to be taken away.

I would submit, you will get the money back if competition works. If competition does not work, we need to know that, too. So either way, it is worth trying to relax budget neutrality and get the competition started.

The second lesson is without leadership support, no demonstration can withstand sustained local opposition. I would submit to you, maybe we should consider having members of Congress who support the idea of competition agree to meet with stakeholders in their States for their districts and try to figure out what conditions would it take to make them willing to indeed participate in these kinds of experiments.

The third lesson is standard benefit packages are essential to have competitive bidding work. Otherwise, you are never going to get beneficiaries able to compare plans across their options, but they can be determined locally.

We found that local communities, the stakeholders had a great time designing their specific benefit packages to fit their local communities. And that seemed to work very well. And I would submit that we consider that.

The fourth lesson is premium rebates are a very good way to let you compete against fee-for-service in a soft way. That is to say, they allow health plans to offer incentives to beneficiaries to choose managed care without risking having to pay higher premiums on the part fee-for-service beneficiaries who want to stay there. So it is a good way to let competition work without threatening the fee-for-service beneficiaries.

The fifth lesson is postponing these pricing experiments as costly. Why? Because the alternative is if you do not ever allow a demonstration experiment to go forward, it is to basically reform the country simultaneously at the same time everywhere.

I call that going cold turkey. I would submit, cold turkey is for young heroin addicts with very strong hearts. It is not for the Medicare program.

And the sixth lesson is the rural communities present obviously, as we have talked about today, as you well know, very complex problems that are quite different than the problem in the Medicare program in general.

That is to say, we do not see a lot of excess use in rural communities. In fact, the problem is not enough use. There is not enough care being delivered. So competitive pricing is going to have to be designed quite differently there to accommodate our goals.

I would submit, as Senator Rockefeller said in his opening statement, you are never going to get a lot of competition among health plans in rural communities. There may be ways to use pricing strategies to induce one plan to come in which could be good.

But in the meantime, it seems to make obvious sense that if you want to increase the benefits there, put them in the fee-for-service package and deliver them that way, and then think about how you might use competitive pricing elsewhere to get people to join.

Thank you very much. I would be glad to answer any questions.

The CHAIRMAN. Thank you very much, Dr. Nichols.

[The prepared statement of Dr. Nichols appears in the appendix.]

The CHAIRMAN. We will take 5-minute turns. And if either one of my colleagues needs special consideration because of time constraints, I would defer to either one. All right.

I am going to start with Mr. Turvey. How do you compare the regulatory burdens associated with United's commercial plans in Iowa with those imposed in United's Medicare+Choice plan? And is there any way you could quantify if there is a difference in time and/or cost between the two?

Mr. TURVEY. I would say with respect to the comparison, we do have economies of scale on the commercial sector where we have pretty much a standardized format, industry accepted measures for reporting to virtually any large employer. And on a per group or per member basis, it is relatively inexpensive.

And it has standardized our programming of our systems. And our data collection are set up for that standardized approach to reporting. And it allows a much more apples-to-apples comparison over years, one year between employers of their experience.

With our reporting to HCFA, it is much less standardized. There are less volume to amortize it across. And its subject is considerably more changed. So it is much more of a burden. And that is how I would compare the two.

I think it can be streamlined. I think if we actually could look at the private sector, what the major employer groups and coalitions have sought to collect over the past years and take some cues from them.

The CHAIRMAN. Maybe, a following up on just your last sentence. Could you identify any specific regulatory requirement, if it could be liberalized or eliminated altogether that might cause United to expand its participation in Medicare+Choice? And I particularly mean in rural America.

Mr. TURVEY. We have one FTE alone, one full-time equivalent staff person in the Iowa and Nebraska plan just for HCFA regulatory compliance alone.

But while that is a factor, really the greater factor is I think the lack of organization of rural physicians in an individual practice really on a county-wide basis to receive, analyze, understand, and act on data that we can give them to help them reduce clinical variation in their practice and thus improve quality.

What we found is that beyond a certain point or to a certain point, reducing clinical variation and practice patterns improves quality. And when you improve quality, you automatically to a certain degree help maintain cost increases. That, we think, is where the real goal is. That is where we think the opportunity is.

The CHAIRMAN. So it is related more to an organization of doctors and what they would do on their own, as opposed to a specific HCFA. Are you saying this is a result of HCFA requirements?

Mr. TURVEY. It is really not a result of HCFA requirements. We look at what it would take for us to get into more rural counties. It is really, the HCFA administrative burden is there. It is a factor, but it is not a controlling one.

The larger elements are what we believe is too low reimbursement in many of those rural counties even today.

And second, perhaps even a specific funding could be considered, a specific funding to help build infrastructure for physicians to better understand their own practice and how they compare to their peers because when you can do that and provide physicians with information that they have never had, good physicians would want to get better. I mean, they will do that pretty much on their own.

That has been our experience in urban areas. And there is no reason to think that it cannot happen in the rural areas, except in rural areas, physicians are not organized. They are not in physician groups. That has to be sort of artificially built for purposes of looking at their own data and finding ways for them to become better practitioners and more cost effective as a by-product.

The CHAIRMAN. Dr. Ross, you note that in the absence of any change in law, higher Medicare+Choice payments in floor counties raise the potential for plans and providers to earn above-normal profits. To avoid this outcome, MedPAC recommended that Medicare+Choice payments be tied to local fee-for-service spending. Doing so, however, would mean that payment rates will be subject to large swings, as was the case before Medicare+Choice. And going back to the old system further discouraged plans from entering rural markets.

Dr. ROSS. We recognize the possibility of seeing the volatility that we had under the risk contracting program. That is one reason that the commission recommends looking at using a different kind of payment area than making it county based. And one could also look at the details of how you put that payment plan into effect, whether you would use rolling averages or some kind of other provision.

But the goal there would be to get sufficient numbers of beneficiaries in an area that you could get reliable and stable estimates, both for the base payment rate, as well as for risk adjustment.

The CHAIRMAN. Without a floor under Medicare's payment to health plans, you note that something must be done to encourage participation in Medicare+Choice. I think you specifically mention alternatives to full risk capitation and expanding the payment areas as approaches that might increase participation.

So your opinion on which approach or combinations of approaches might best encourage plans to participate?

Dr. ROSS. Well, the commission has not come up with a lot of answers here. The commission has recommended the enlargement of

the payment areas. We are looking at that in conjunction with other work that we are doing on rural areas, looking into alternatives to full risk capitation. There are a variety of ways that could be done.

But I think in my testimony and as Mr. Turvey just alluded, there are some fundamental market conditions that make it difficult for managed care to operate in rural areas. That will require a lot of thinking.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

A question for Dr. Ross. You indicated that MedPAC has recommended that Congress replace the current managed care, managed cost payment system, however you want to refer to it as. And so, they should be paid the same as Medicare fee-for-service in a given area. And then, you say after accounting for risk.

And my question to you is that, is it not kind of understood that risk adjustment has never been achieved? We have told HCFA to do it for the last couple of years. They cannot do it. They are not going to be able to do it. People do not respond to it. Plans do not give you information. Seniors on fee-for-service are too sick or whatever, whatever, whatever.

I mean, what are you saying, if we say, if we account for risk, when we cannot account for risk? We have not been able to do it. We have never been able to do it.

So if that is the case, then where do we set the cost? You say 95 percent fee-for-service, for example. I mean, is that true? You say maybe 100 percent. How do we know an amount? How do you get around risk adjustment when you know we cannot do it?

Dr. ROSS. We cannot do it perfectly. HCFA has been working to improve the old demographic system that we used under the risk contracting program, which was a form of risk adjustment. It just was not a very good one.

The agency started implementing a new system based on hospital admissions and was working to introduce another system that is based more broadly on counters, not just hospital admissions, but all physician and outpatient services.

We will not get perfect risk adjustment. We can get better than what we have had. And I think we can do better than taking an arbitrary 5 percent number and calling that a risk adjustment. The goal here when we are saying—

Senator ROCKEFELLER. What is the goal? We have to pass a bill. So what are you suggesting, what amount? What are paying?

Dr. ROSS. I think you need to leave the development of the risk adjuster to the Health Care Financing Administration. When you say they have been told to do it, they have also been told not to do it in more recent legislation or at least told to—

Senator ROCKEFELLER. Yes, but they have also been unable to do it.

Dr. ROSS. Right.

Senator ROCKEFELLER. So if they cannot do it?

Dr. ROSS. I do not know if they cannot do it. Again, the goal here is not perfect risk adjustment. It is to try and get a better accounting of the factors that we know influence costs.

What we are trying to say here is that Medicare's payments should be financially neutral. When we say accounting for risk, we mean that for a person of a given age and health status, we would like on average to be paying about the same in fee-for-service as we would paying under Medicare+Choice.

Senator ROCKEFELLER. All right.

Dr. ROSS. We recognize the difficulties.

Senator ROCKEFELLER. All right. It just worries me a lot, Mr. Chairman, just because we keep making the assumption that we can do this. And we never can. But then, we pass legislation saying people should do it. And then, we tell them not to. The consequences are pretty high.

Mr. Turvey, approximately 30 percent of Medicare, Medicaid, and S Chip benefits in the protection act last year went to managed care organizations. And yet, as the Chairman and I have indicated, we each have only one Medicare+Choice provider in our States.

Senator SNOWE. I am listening. [Laughter.]

Senator ROCKEFELLER. Now, that might lead some people to say, oh, gee, that means that everybody can take advantage of it. No, it does not work that way. As you know, they are highly geographic within States. So it is like saying a little bit of the State gets services from that one and the rest are nothing. They get nothing. So it is fee-for-service or nothing.

And that 30 percent, of course, could have gone to rural hospitals, but it did not. I mean, at one point, it was at 55 percent. And it came down to 30 percent. And I was grateful for that.

I do not know about Iowa or New Mexico or the State of Maine which is a very wealthy State. [Laughter.] I do not know how much those hospitals are losing. But in West Virginia in the so-called BBA payments, etcetera, which we have not been making sufficiently, last year the average hospital lost \$.5 million. When you talk about West Virginia, you are talking about that is a big, big loss for our small hospitals.

You said in your testimony that in almost half of your Medicare+Choice markets, you are no longer offering coverage for outpatient prescription drugs. And where you do offer coverage, if I am correct, and if I am not tell me, the annual maximum is in the \$200 to \$500 range which stuns me because that is almost like not having a prescription drug benefit. I mean, it is paltry. And you know that. You know that. I mean, average arthritis medicine is \$433 a month.

So why do you want me to agree that we ought to be spending more resources, much less any resources on Medicare+Choice programs, I mean, while you are trying to organize rural doctors which I am really interested in seeing how you can do?

There are swamped by work. They are so discouraged. They are getting out of there so fast because practicing health care in rural America is a very hard thing to do. And getting organized in West Virginia is a very tough thing to do.

But my previous question, why should we commit these resources, a paltry benefit and hospitals that are starving?

Mr. TURVEY. Well, the first thing is hospitals are not starving these days. In fact, we are seeing in our health plans in Ohio and certainly in Missouri, hospitals are finding it today more lucrative

because of reimbursement to have members switch to traditional fee-for-service because they gain a higher margin than they do having members stay in the Medicare+Choice plan.

Senator ROCKEFELLER. All right. So that is making my argument because hospitals still are not making money.

Mr. TURVEY. Well, what you are looking at when you say they are not making money, you are looking at financial data that is a year or two old, as I reported. But I can tell you that the hospital profit margins are definitely on the upswing and in the most of the markets that we do business in.

Senator ROCKEFELLER. The red light is on.

Mr. TURVEY. Yes.

Senator ROCKEFELLER. But will you at least agree with me that \$200 to \$500 is not an overwhelming prescription drug benefit?

Mr. TURVEY. Right. It is not an overwhelming prescription drug benefit. And I think it is reflective of too low a reimbursement over the past year or two. We certainly would like to see it higher.

Senator ROCKEFELLER. Just want more money?

Mr. TURVEY. I think it is to get a better benefit and create a bigger differential between fee-for-service Medicare and Medicare+Choice. It can be a combination of two things. You need some revenue enhancement. You need some investment in infrastructure of physicians, especially rural physicians to utilize data to get better clinical outcomes and maintain cost. So you attack the revenue and the expense side both.

I think if you do that, then you can find a sufficient margin that can come from the program that can then be converted into better benefits. But we think at the moment, we are at that sort of a crossroads where we have not made the investment in the rural side so we can control utilization or physicians can control utilization, improve outcomes.

At the same time historically, revenue has been low enough that we have had to chip away year to year at these benefits differentials. And so at the moment, you do have many markets with Medicare+Choice plans that are not much better benefit wise than Medicare fee-for-service plans.

I do not think that has to stay that way. I think it is a matter of where do we focus our resources to make an improvement?

Senator ROCKEFELLER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Snowe and then Senator Bingaman.

Senator SNOWE. Thank you, Mr. Chairman. I would like to follow up on the questions raised by Senator Rockefeller because obviously a State like Maine being rural, we have no Medicare+Choice programs.

I want to follow up on what Mr. Turvey talked about, how best to make Medicare+Choice feasible? What are the one or two or three things Congress must do to address the problems that many of you have illustrated in your testimony today that could bring about a difference?

I mean, Mr. Turvey, you talked about revenue enhancements and investment and infrastructure. I gather you are talking about payments, number one. Second, how do we make investments in rural areas that can make a difference to the providers who are there?

Obviously, in some areas, we do not have a competition of providers. I do not have a number of providers. We have a singular provider in Maine. In many of the rural areas, we have community health centers. They are the singular provider in some of our rural areas.

So how best do we go about it? If we were to focus on two or three things, what would we focus on?

Mr. TURVEY. I would say with respect to the expense management side of the equation, all the revenue, to be brief about it, I think still we have some rural counties that are probably too low, are definitely too low, maybe in the 5 to 10 percent range despite what has happened over the past year. But on the expense side in terms of policy, I think we need some incentive given to physicians for them to participate in the Medicare+Choice program.

Now, I would say part of the reason some physicians do not want to is because some plans historically have off loaded a full professional capitation to them, in other words, transferred to them significantly more risk than they are equipped to handle. I think that is a bad policy mistake. I think it is just poor business as well.

So I think limiting risk transfer is something that needs to be considered, perhaps limiting it to gain sharing agreements so there is no little—or no downside, but there is potential upside to the physician who participates if they can improve their clinical outcomes. And we have ways to measure that now. So that it can be done. And they can be rewarded for quality.

But I think the two key elements are there needs to be an economic incentive for physicians to move off the status quo and participate without them worrying about a high downside on the financial side.

And second, there needs to be the investment in training and infrastructure so that when they receive data on other practice patterns versus their peers, they can constantly analyze it, act on it, and improve their clinical skills.

Senator SNOWE. Would others care to comment on that? Would you agree, disagree?

Dr. NICHOLS. Senator Snowe.

Senator SNOWE. Dr. Nichols.

Dr. NICHOLS. I would just like to offer an observation that there is not much wrong with Medicare+Choice that competitive pricing would not improve. Fundamentally, we are in this problem because we have managed to choose a price formula that turned not to be accurate.

I mean, it is interesting when you look at the Soviet Union. They gave up on picking 10,000 prices and 3,000. We are still trying to do it in Medicare. And with the competitive pricing experiment, it is not some panacea, Lord knows.

But the idea was to try to let health plans tell us what it cost, let you as Congress and policymakers decide what we are willing to pay for. And then, let us go forth and make life happen just like, I might point out, the rest of the Nation does in virtually every market in the country.

So a lot of what is interesting to me about the rural question in particular, we are looking to health plans to solve the problem of rural beneficiaries not having prescription drugs and other benefits

that we want them to have because they exist through health plans where we pay health plans a lot. But where we pay health plans nothing, they cannot provide drugs either, it turns out. It turns out, you are going to have to pay for it.

So what I am saying is, let us think about competitive pricing and bidding as opposed to administrative pricing.

Senator SNOWE. You are saying let the marketplace—

Dr. NICHOLS. I am saying, let us learn how to let the marketplace work. I think we need to take some baby steps, but I think we can get there.

Senator SNOWE. Would others care to comment?

Dr. Smith.

Dr. SMITH. I would like to add that a new, private fee-for-service plan, Sterling, is available in Maine. And it is also available in Iowa and in West Virginia. This is a Medicare+Choice plan. So while it is true that there are no HMOs available to your constituents, they do have access to an alternative to traditional fee-for-service now.

Senator SNOWE. But obviously have not utilized it.

Dr. SMITH. Well, Sterling just entered the market last year. So enrollment is still low, but the plan is available.

Senator SNOWE. Sterling is not in Maine yet.

Dr. SMITH. Excuse me.

Senator SNOWE. That is all right. But you think that—and what would be the primary attraction for them in the rural areas?

Dr. SMITH. For the Sterling plan?

Senator SNOWE. Sterling.

Dr. SMITH. Well, the attraction for them may be the payment rate, the floor payment rate. Obviously, they believe that they can provide Medicare benefits plus reduce cost sharing for the amount that they are going to be reimbursed from HCFA.

Senator SNOWE. Would others care to comment on what we could be doing?

Dr. Ross.

Dr. ROSS. Well, if I could just follow up on the last point, what is attractive.

Senator SNOWE. Yes.

Dr. ROSS. A private fee-for-service plan by definition provides unmanaged care much like traditional Medicare and does not have to set up the same kind of networks and face some of those barriers that Mr. Turvey had pointed to. And they are essentially providing something comparable to the basic traditional Medicare package, but they are doing so at a floor rate, much higher.

Senator SNOWE. Does anybody care to comment?

[No response.]

Senator SNOWE. And one final question, Dr. Smith, very quickly. You mentioned in your testimony about the number of withdrawals from Medicare+Choice and similar to the experience under the Federal Employees Health Benefit Plan. What is happening with the Medicare+Choice and Medicare? Is it specific to Medicare in this program? Or is it reflective of the broader marketplace and what is occurring in health care in general?

Dr. SMITH. Well, I cannot give a definitive answer, but several studies do suggest that there are withdrawals. There are HMO fail-

ures. There are mergers that are going on not only affecting the Medicare+Choice program, but also affecting the Federal employees program and the private market as well.

The GAO study of the FEHBP withdrawals indicated that many of the same factors appeared to be in play as were behind the withdrawals from the Medicare+Choice program, things like insufficient enrollments in the plans, withdrawals of plans that had recently entered the program and were finding that they could not competitively remain, their inability to offer coverage at a competitive premium. In other words, competition was forcing them to leave the program.

Senator SNOWE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Now, I want to go to Senator Bingaman.

Senator BINGAMAN. Thank you very much, Mr. Chairman. Sorry I was not here to hear all your testimony. But in my State in New Mexico, the problem I have encountered and I think many people have encountered is the volatility that the Medicare+Choice program has brought into the health care delivery system.

I know there is a lot of volatility there at any rate. But a lot of senior Medicare beneficiaries who signed up to the Medicare+Choice plans, one or another of them, they were notified that they are withdrawing from the State. They are no longer providing these services in the part of the State that these people live in. And that, of course, causes substantial anxiety and concern on the part of seniors.

One of the companies sort of ironically advertised for several months there, sign up with us. Our motto was "health care for life." Everybody signs up. Then, they announce that they are leaving the State.

So how do we solve that problem? And I will try to look through your testimony here to discern that.

But are there a few things we could if we want to continue with Medicare+Choice are the things that we could do to ensure that companies that do come in and do make a commitment to beneficiaries under that plan actually stick with it for some period of time? And the beneficiaries, the people who are to receive these services have some level of confidence that the company will continue to provide them?

If any of you have insights into this? Maybe, you all have testified to it.

Dr. Nichols, did you have a thought about it?

Dr. NICHOLS. Well, Senator, I certainly would say that if I understand it correctly, the volatility is pretty much always caused by the payment rate fluctuations relative to their perceptions of what their costs are going to be. I mean, I certainly would defer to Mr. Turvey, but that is a good guess of what is going on. And so, what is wrong is the payment rate system.

Senator BINGAMAN. So if we went to this competitive system that you are advocating, then that would solve it.

Dr. NICHOLS. At a minimum, sir, it would allow us to discern what they think their costs are and would allow competition to work where it can work. In Sante Fe, it could work. In other parts of New Mexico, it is not going to be able to work.

But where it could work, it would allow us to utilize the same kind of competitive forces that work in other markets. So, yes, it would allow us to be more stable. It is not necessarily going to be cheaper.

Senator BINGAMAN. Right.

Dr. NICHOLS. But at least, it will be stable.

Senator BINGAMAN. But even in those cases, even if you go to a competitive system and they come forward and say, this is what we think it is going to cost to provide this service, that is what we bid or we propose, there is nothing in the law now, there is nothing, no requirement that if their chief financial officer tells them 3 months from now that the calculations were wrong, it is going to cost more, they can just pull the plug and send a letter out to everybody saying that we are out here; it is your problem not ours.

Dr. NICHOLS. It is a risk. And I do not mean to minimize it. But I would just offer the observation that if you look at companies like General Motors, you look at places, the Minnesota Buyer's Group, the California Purchasing Cooperatives, you look at those kinds of places.

And they have a little fluctuation around the margins, but nowhere near the magnitude of fluctuations that the Medicare program has experienced because again they are using competitive pricing and not administered pricing. So there is going to be volatility, but it will be minimized if you let them compete.

Senator BINGAMAN. And would any of you advocate that we do something in addition to going to competitive pricing in order to get some of this volatility out of it, that we basically say if a company wants to participate in the Medicare+Choice plan, they have to make certain assurances as to the length of time they will stay in, the length of time they will provide services to people once they sign them up or something to that effect? Is that an unreasonable kind of an imposition on a company? Do any of you have a thought?

Mr. TURVEY. A couple of thoughts. No, I do not think it is. I do not think it is unreasonable under certain conditions. If you look at the private sector for some guidance on this, the way they, the companies on administrative contracts is to go with an ASO or an administrative services only contract so that the carrier or the HMO, in our case, is not taking on a large or at least not a significant underwriting risk in processing claims and doing what it does.

So I think minimizing the financial risk of fluctuations to the health plan is a good way to entice the health plan. It is to say I am going to give you two or three ways to stay in the market. I mean, financial fluctuation is the key thing that we are looking at.

The second thing is oftentimes, it is not the health plan that decides unilaterally it wants to leave the market. Its provider segment has left it and this product line.

I just had a situation two weeks ago in St. Louis where 380 providers or 380 doctors, 75 of them who were employees of a hospital system decided we are not very good at this. We are going to leave. We are giving 90 days notice and we are out of here.

Now, one could debate whether or not that is a breach of a contract to serve through the end of the year, but the question is I could not make them perform through the end of the year. So I have 14,000 members, many of whom are going to be of the 70,000

I have in the market, many of them are going to be looking for new doctors. And there is not much I can do about.

So the commitment kind of trickles down the line. Providers have to commit to the health plan and the health plan commit to the members. But if you can limit the financial fluctuation, the financial exposure to both parties, I think then you can get a lock-in.

Senator BINGAMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bingaman.

Recent evidence from the General Accounting Office and from the MedPAC suggest that some Medicare+Choice plans are overpaid relative to fee-for-service. Yet, since 1998, some Medicare+Choice plans have complained about how low reimbursement relative to fee-for-service is.

How do we reconcile these seemingly opposite points of view?

Dr. SMITH. I believe you can reconcile them by—and I should not speak for the HMO industry. But I believe that you can reconcile the numbers by looking to the benefits that the plans wish to offer to beneficiaries in Medicare+Choice. HMOs entering the Medicare+Choice program, I do not believe, would be satisfied or be in competitive position if all they could offer were Medicare-covered benefits.

Yet, the payment rate that they are receiving from the Medicare+Choice program is predicated on that payment amount. In other words, they cannot provide prescription drug coverage for the payment rate that they are now receiving.

The CHAIRMAN. All right.

Dr. SMITH. And therefore, they are clearly not as attractive to beneficiaries as they were in the past.

The CHAIRMAN. Well, is the increases that we gave in 1999 and 2000 having a beneficial impact on program growth?

Dr. SMITH. The increases post-BBA and the BBA increase in the floor payment rates have expanded at the—

The CHAIRMAN. This gets back to what I said about Iowa and my frustrations.

Dr. SMITH. Right.

The CHAIRMAN. So it does fit in to some extent. We got it up to \$495. We still do not have anymore plans that seem to be interested in going into the other 98 counties.

Dr. SMITH. Right. Access to HMOs has not increased since the BBA. In fact, it has decreased. There are fewer beneficiaries who have a choice of an HMO under the Medicare+Choice program today than did in 1997 or 1998. The one way that access has increased is through the establishment of a private fee-for-service plan that is a Medicare+Choice plan.

And as I mentioned earlier, there is one company that is currently offering a private fee-for-service alternative to traditional Medicare. And this plan is operating, according to them, in half of the States in the country and half of the counties in the country, and is providing access to rural beneficiaries who have no alternative to traditional fee-for-service Medicare.

The CHAIRMAN. All right. Dr. Buchmueller, your testimony shows that active employees in the UC system are especially sensitive to pricing, especially compared to retirees. How sensitive are they then to quality? Does the UC experience tell us anything about the

role quality plays in patient decision making, both for active employees and for retirees?

Dr. BUCHMUELLER. There is not a lot of evidence from the UC program and other programs that employee weigh quality very heavily when choosing their plans. I think part of the problem is that it is very difficult to come up with quality measures that resonate with employees and also reflect what clinicians might think of as quality.

The approach that the UC has taken with respect to quality is to be sort of an active sponsor. Periodically, there is a RFP process where plans bid to be on the menu in the first place. At that point, the UC administrator, its consultants, expert faculty do due diligence and try to evaluate the plans in terms of both customer service aspects of quality and clinical quality.

And so what that effectively does is set a quality floor so that the UC feels comfortable that all the plans that it offers to employees meet a basic standard. But beyond that, there is not a lot that I think has been done very effectively.

There are report cards that are distributed to employees that rank the different plans and the different provider groups, but it is not clear how much they really matter to employees.

The CHAIRMAN. To you also about the fact that patients need adequate information to evaluate their options and to understand change. How does the UC system go about educating its employees and retirees about the new benefit system? How are employees and retirees informed of choices? Was there opposition to change? And if there was opposition to change, what was done to resolve it?

Dr. BUCHMUELLER. Well, in general, there are several channels that the UC uses to inform employees and retirees about changes to the benefit program. There are e-mails. Employee newsletters will feature articles each year about different changes.

There is an annual health benefits fair where the plans on the menu can have tables and promote themselves to employees. And there will be employee brown bags. If there are major changes, like a change in the carrier's handling a certain plan where it is sort of a question and answer session.

At the time the UC changed its contribution policy, there was some misgiving among certain employees that this was going to mean higher out-of-pocket costs. The policy change was something that advocates of managed competition had been promoting for awhile. And it ultimately was the California fiscal crisis that brought it on. So while there was some employee opposition, the imperative was sufficiently strong that the UC went ahead.

And as it turned out, because there was such vigorous price competition, while a number of people did switch plans, average out-of-pocket contributions for employees did not increase very much because there always was, at least on the HMO side, a free plan. And that was the biggest concern by employees. What was going to mean in terms of out-of-pocket costs?

The CHAIRMAN. Now, is it true that for the commercial market as opposed to Medicare+Choice that it is easier for the private commercial markets to be able to give plan options without pressure and time constraints that HCFA imposes through consultants and regulations on Medicare+Choice?

Dr. BUCHMUELLER. I am not sure that I am really expert to comment on that.

The CHAIRMAN. All right. Thank you.

And then, for Dr. Nichols, what role should quality play in competitive pricing environments? Should competitive pricing address only the price of services and not their value? What are some of the ways in which quality can be promoted in a competitive environment?

Dr. NICHOLS. Mr. Chairman, that is an excellent question and one that I think that economists are singularly ill equipped to answer definitively, but I will tell you what we did in the CPAC. We basically said that the local community should be given any savings that occurred from the baseline in the context of demonstration project to be put into a quality pool so that the plans would then get together and decide among themselves how to measure it.

As Tom said, it is very difficult to come to a complete consensus. But there is certain kinds of measures that are fairly well consensus now. And basically, let the plans design their own score card and let the plans decide how to distribute that set of funds.

And we thought that was a very important incentive. And indeed, the plans in both Kansas City and Phoenix thought that it was a good idea. So what I would say is, let us leave quality to the professionals, but let us use competitive pricing to create funds that reward quality as the professionals decide to allocate it.

But we certainly think it is extremely important. And it obviously is going to be extremely important for beneficiaries to understand and indeed to believe that we do care as much about quality as we do about saving money or they are never going to accept reform.

The CHAIRMAN. Thank you.

Does anyone have a last thought that they want to add before I adjourn the hearing?

Mr. MCCARTHY. Senator.

The CHAIRMAN. Please, go ahead.

Mr. MCCARTHY. Yes, Senator. There has been a lot of talk about the lack of availability of plans in rural areas. And that is true. We have talked about it a lot today.

One thing though I would like to say is Medicare+Choice has worked for the most part in the urban areas. And in many cities, including my own city of Pittsburgh, we have three. We even have another Medicare+Choice plan entering the market.

So while Medicare+Choice, the choice as envisioned by the Balanced Budget Act of 1997, has not expanded yet to the rural areas like we wanted them to, Medicare+Choice does work in the urban areas.

I know for about half of the members of the Senate Finance Committee, the choices in their home States are not very good, as we talked about today, but I say we cannot let Medicare+Choice die because we do not have an answer yet for rural areas.

If the current situation continues with Medicare+Choice without some major fundamental change under this system or a new system that offers competition and choice, then I think choice and competition will die in the urban areas, as well as never developing in the rural areas.

Thank you, Senator.

The CHAIRMAN. Thanks to each of you for your participation.

The hearing is adjourned.

[Whereupon, at 11:46 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF THOMAS C. BUCHMUELLER*

Introduction

Thank you, Mr. Chairman and members of the committee, for the opportunity to testify about the role of consumer choice and competition in Medicare reform. My name is Thomas Buchmueller. I teach economics at the Graduate School of Management at the University of California, Irvine. My testimony today will focus on the recent experiences of the employee and retiree health benefits program of the University of California (UC).¹

The UC program is based on the principles of “managed competition” and is quite similar to competitive models proposed for Medicare. In the mid-1990s, the UC adopted a fixed dollar premium contribution policy, whereby the amount it pays for employee health insurance coverage is set at the premium charged by the least costly plan in the program. Because this change caused employee contributions to increase for some UC plans but not others, it created a good natural experiment for testing the price-sensitivity of consumers and the competitive response of health plans in a managed competition setting. Because UC retirees are offered the same choice of health plans and faced similar price changes as active employees, it is possible to compare the price-sensitivity of retirees and active employees. This comparison is important because while there are reasons to suspect Medicare beneficiaries to be less price-sensitive than non-elderly workers, arguments about how a managed competition style Medicare program would work in practice are typically made with reference to employer-sponsored programs covering non-elderly workers.

Results from the UC active employee population show that the competitive approach can be effective in controlling health spending. UC employees have proven to be quite sensitive to out-of-pocket premiums when choosing their health plans, and this has led to vigorous price competition among health plans. In the three years immediately after the UC altered its contribution policy to emphasize price differences among competing health plans, per-employee spending on health benefits fell by 26% in real terms.

However, there are two important caveats to this success story. First, UC retirees were much less price sensitive than active employees in the UC program and workers covered in similar programs elsewhere. This raises questions about how well results from working-aged populations generalize to Medicare. The second caveat is that the shift of enrollment from higher-priced to lower-priced health plans pushed the single fee-for-service (FFS) plan on the UC menu into an “adverse selection death spiral.” Within three years, the FFS plan’s costs and premiums had skyrocketed and its enrollment of active employees was close to zero. This result shows that without effective risk adjustment, plans that are more attractive to higher risk individuals are at a significant disadvantage and may not be viable in a competitive market.

*This testimony is based on research that was supported by grant 030561 from the Robert Wood Johnson Foundation’s Changes in Health Care Financing and Organizations program. Some of that research was done in collaboration with Paul J. Feldstein and Bruce A. Strombom.

¹My research using data from the UC program is summarized in several published articles (Buchmueller and Feldstein 1996, 1997; Buchmueller 1998, 2000; Strombom, Buchmueller and Feldstein 2001).

The University of California Health Benefits Program

The UC offers a choice of health insurance plans to roughly 80,000 employees at 9 campuses located throughout the state and 3 national laboratories, including the Los Alamos National Lab in New Mexico. In addition, a choice of health plans is offered to roughly 30,000 retirees, of whom about half are covered by Medicare.

Employees and retirees choose their health plans during an annual open enrollment period that takes place in November. My analysis focuses on open enrollment decisions made between 1993 and 1998. During that period, the choice of health plans varied somewhat across locations, but at all locations included several HMOs. In nearly every location there were also two other plans: Prudential High Option, a traditional FFS plan, and UC Care, which was designed as a preferred provider organization (PPO) through 1995 and as a point-of-service (POS) plan thereafter. Prudential High Option offered employees the greatest freedom to choose their own providers, including the ability to self-refer to specialists. UC Care fell between the HMOs and Prudential in this respect, offering greater freedom than the HMOs, but less than Prudential. (At the Los Alamos NM location, there was a different FFS plan with a similar design as Prudential, but no PPO/POS option.)

Retirees face the same menu of plans as active employees and the benefits provided by the HMOs are identical for the two groups. For retirees with Medicare, Prudential High Option provides Medigap coverage with a coordination-of-benefits design. The plan covers Medicare deductibles and coinsurance, leaving retirees with essentially no out-of-pocket costs for Medicare-covered services. Prudential's drug benefit has a \$50 annual deductible and a 20 percent coinsurance rate. The coverage under the UC Care Medigap plan is significantly less generous than that of Prudential High Option.

UC employees are required to pay the difference between the premium charged by their chosen plan and the UC's premium contribution. Prior to 1994, the UC's contribution was based on a weighted average of the premiums charged by the four plans with the highest enrollment of UC employees. Because the "big four" included Prudential High Option, the most costly plan on the UC menu, the UC contribution exceeded the premiums of all the HMOs. As a result, all HMOs were available to employees for a zero contribution, which gave them no incentive to compete with each other on the basis of price. Prudential High Option required a monthly premium contribution, but that amount was less than the difference in gross premiums between it and the managed care plans. The way that the UC contribution was pulled up by Prudential's high premium is similar to the way Medicare payments to HMOs are tied to costs in the FFS sector.

In 1994, the UC altered its contribution policy, setting the amount it paid equal to the premium charged by the lowest cost plan available statewide. The adoption of this "fixed dollar" contribution policy caused employee contributions to increase for Prudential High Option as well as for several of the HMOs. Overall, roughly one-third of UC employees faced a price increase between 1993 and 1994. For the HMOs, the price increases ranged from \$4 to \$27, depending on the plan and type of coverage (i.e., single, two-party, family). Monthly premium contributions for Prudential High Option increased by between \$52 (for single coverage) and \$88 (for family coverage). Contributions required for the FFS plan in New Mexico increased by even more. This policy change created a good natural experiment for testing the price-sensitivity of employees in a managed competition setting. The effect of price on health insurance decisions can be inferred by comparing the rate of plan switching by these employees to the rate for employees whose plans did not change in price. Since there were no other significant changes occurring at this time, this comparison provides a "clean" estimate of the effect of price on health insurance choice decisions.

The UC contributes the same amount for retirees' coverage as it does for active employees. For retirees with Medicare, the premiums charged by the plans are substantially below active employee premiums because UC coverage supplements Medicare. The UC allows retirees with Medicare to apply the difference between the UC contribution and the premium for their chosen plan to their Part B premium. After the change in the UC's contribution policy, the same plans that became more expensive for active employees became more expensive for retirees with Medicare. (That is, in 1994 retirees in some plans were required to pay part of their Part B premium.) Thus, it is possible to investigate the effect of price on the health insurance decisions made by UC retirees and to compare their behavior to that of active employees.

The Effect of Price on Switching Among Health Plans

The price increases caused by the change in the UC's premium contribution set off significant shifts in enrollment. Thirty percent of the employees enrolled in

HMOs that increased in price between 1993 and 1994 switched to less costly plans. Half of the employees who had been enrolled in Prudential High Option also switched plans in response to the increase in the price of that plan. In contrast, only 5% of employees in plans that were available for a zero contribution in both 1993 and 1994 switched plans during open enrollment.

The open enrollment results for UC retirees with Medicare reveal a lower propensity to switch plans in general and a lower sensitivity to price. The contrast between active employees and is illustrated in Figure 1, which reports for each group the effect of price changes on the probability of switching plans.² When premiums are constant from one year to the next, 1.4 percent of retirees and 5 percent of active employees will switch plans. For retirees, increasing premiums by \$20 per month raises the switching rate to 3.4 percent. While this effect is statistically significant, it is much smaller than the corresponding effect for active employees for whom a \$20 premium increase results in a switching rate of 34 percent ten times higher than the rate for retirees. Relative to the baseline rates, a price increase of \$20 results in a 240 percent increase in plan switching for retirees ($3.4/1.4 = 2.42$) and nearly a 7-fold increase for active employees ($34/5 = 6.8$).

Additional estimates of the effect of price on health plan choices can be obtained by using more years of data from the UC program. Between 1994 and 1998, the premium contribution for the Prudential Medigap plan increased by roughly 25 percent per year. The plan's market share fell slightly over this period, declining by 1.3 percentage points for every \$10 increase in out-of-pocket premiums. In contrast, an analysis based on active UC employees for the same time period indicates that a price increase of \$10 would lead to a 6-percentage point decline in market share. Estimated price effects from several recent studies using data on active employees in other managed competition programs are similar to those for active UC employees and much larger than the effects found for the UC retirees (Dowd and Feldman 1994/95; Cutler and Reber 1998; Royalty and Solomon 1999).

The Effect of Plan Switching on Risk Selection Among Plans

An important concern regarding health insurance markets where choices are made at the individual level is the potential for adverse risk selection. In the extreme, plans that are particularly attractive to higher cost individuals may suffer an "adverse selection death spiral." A death spiral occurs when premium increases not only reduce a plan's market share but also cause its risk pool to deteriorate, as lower-cost consumers are more likely than higher-cost consumers to switch to less expensive plans. The deterioration of the risk pool requires the plan to raise premiums to cover its now-higher costs, which in turn leads to a further exodus of relatively low-cost consumers, and so on. In the extreme, adverse selection can drive certain plans from the market entirely.

This is essentially the scenario that occurred in the UC program. In response to the change in the UC's contribution policy, participating HMOs cut their premiums to compete for market share. This caused the premium contribution for Prudential High Option to increase despite the fact that the total premium for the plan remained constant. Because the Prudential members who switched out of the plan were younger and healthier than those who remained, the plan ultimately had to increase premiums. Doing so while HMO premiums were continuing to fall worsened Prudential's competitive situation. Between 1993 and 1995, Prudential's single employee contribution more than doubled from \$62 to \$134—and its enrollment fell by 61 percent. By 1998, active employees wishing to enroll in Prudential High Option were required to pay over \$700 per month and the plan covered roughly one-tenth of one percent of all UC employees. The plan was subsequently removed from the menu.

This result is not unique to the UC, but has been replicated in several other health benefits programs where less restrictive plans compete directly with HMOs and plan choices are made by individuals. The main implication for Medicare reform is that if a restructuring of the program does increase the elasticity of demand and induce greater price competition, traditional FFS Medicare is likely to experience even more adverse selection than it does under the current program. Without effective risk adjustment or an explicit policy of holding FFS Medicare harmless, there is a real risk that that option could be driven from the market. This would clearly

²The data in the figure represent the results from multivariate regression models, and thus represent the effect of price controlling for other factors, such as age, gender, salary and location. To maximize comparability the analysis reported in Figure 1 is limited to individuals enrolled in HMOs. When the non-HMO plans are added, the difference between active employees and retirees with Medicare is even more pronounced.

be a major problem, given that the vast majority of beneficiaries are covered by traditional FFS Medicare.

Because UC retirees were so much less price sensitive than active employees, the Prudential Medigap plan did not suffer the same fate as the Prudential plan for active employees. From 1993 to 1996, total premiums for the plan actually fell, though because the UC contribution amount fell even more, the out-of-pocket cost to retirees increased. Gross premiums and premium contributions increased from 1996 to 1998 and, as noted, the Prudential Medigap plan suffered a slight decline in market share as a result. However, the risk pool remained fairly constant. In 1993 the average age of retirees in the Prudential Medigap plan was 5 percent higher than the average age of all UC retirees with Medicare. By 1998, retirees in the Prudential plan were 7 percent older.

How Representative Are UC Retirees?

The UC health benefits program resembles the competitive approach that has been proposed for Medicare. However, in considering what lessons the UC experience has to offer, it is important to keep in mind several ways in which UC retirees are not representative of the entire Medicare population.

First, it is important to note that all UC locations are in mature managed care markets, with some of the highest rates of HMO penetration in the country. One obvious implication is that results from the UC program offer no insights concerning how the managed competition model might be implemented in rural areas where there is not sufficient population density to support multiple managed care organizations.

A more subtle point is that the high rate of HMO penetration in the UC program may help to explain the apparent insensitivity to price among UC retirees. It may be that when the cost of FFS Medigap coverage began to rise, the UC retirees who would be most responsive to price changes were already in HMOs, and the ones with FFS coverage were the ones with the strongest aversion to managed care. In markets where there is some managed care presence but the market is not nearly as saturated, there may be a greater percentage of beneficiaries who would switch from traditional Medicare to an HMO in response to a difference in out-of-pocket costs. Indeed, variation within the UC program offers some suggestion of this. In 1993, HMO penetration among retirees was significantly lower in the UC's one New Mexico location than in any of its California sites. When relative prices changed between 1993 and 1994, retirees in New Mexico showed a greater willingness to switch to less costly plans.

It is also important to keep in mind that even after the cost of the FFS Medigap plan increased, it offered comprehensive coverage at a reasonable price. In 1998, the cost of the plan for a single individual, including the person's Part B premium, was \$87 per month. Considering that the UC has a fairly generous retirement program, it is unlikely that health insurance premiums represented a major burden for many UC retirees. Less affluent beneficiaries are likely to be more sensitive to differences in premiums charged by different plans in a competitive Medicare program.

In addition to these factors that may cause UC retirees to have a less elastic demand than Medicare beneficiaries more generally, there are some features of the UC program that are likely to make the demand for health insurance more elastic. One is that all participating HMOs are required to offer a standard set of benefits, which means that employees and retirees can make clear "apples-to-apples" comparisons. In addition, the plans competing within the UC program have provider panels that were virtually identical in the areas around many UC locations. This further makes health insurance like a commodity. If, in a reformed Medicare program, there were greater differentiation among competing plans, either in terms of benefits or covered providers, the enrollment decisions of beneficiaries would likely be based less on price and more on other differentiating factors.

Summary and Conclusions

The health benefits program of the University of California is similar in many important ways to competitive models proposed for Medicare. The recent experience of the UC program provides support for the argument that this approach can effectively harness the incentives of competitive markets to promote economic efficiency. The decision to restructure the premium contribution policy to emphasize price differences among competing health plans resulted in a considerable one-time savings to the University and established a more competitive environment in which plans that raise premiums face a significant risk of losing a large share of their enrollment.

However, there are two important caveats to this success story. The first is that UC retirees were much less price sensitive than active UC employees and employees

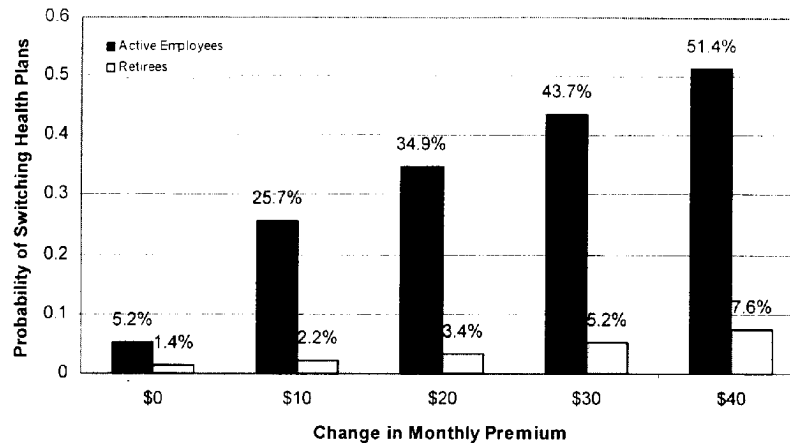
in other similar employer-sponsored programs. In general, the more price-sensitive consumers are, the less will firms be able to increase prices above marginal cost. If Medicare beneficiaries in general are less price-sensitive than younger consumers, health plans will face less pressure to compete on price in Medicare than in other markets. Until more research is available on the price-sensitivity of Medicare beneficiaries, policy analysts should be cautious in extrapolating from the behavior of younger, healthier consumers.

The second caveat is that one by-product of vigorous price competition among HMOs in the UC program was that the single FFS option on the menu suffered serious and fatal adverse selection. As a result, there is currently no option for UC employees who would prefer a plan that places minimal restrictions on their choice of providers. This result is not unique to the UC, but is common in settings where health plan choices are made at the individual level. If Medicare beneficiaries in general are more like UC retirees, biased risk selection is somewhat less of a concern. However, if restructuring Medicare does lead to increased competition on the basis of price, there is a significant potential that plans that are more attractive to higher-risk beneficiaries—in particular, the traditional FFS option—will experience adverse risk selection and may be driven from the market.

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Figure 1
The Effect of Price Changes on the Probability of Switching Health Plans:
Regression Results for UC Employees and Retirees, 1993-94



PREPARED STATEMENT OF KEVIN W. MCCARTHY

Mr. Chairman and Senators, my name is Kevin McCarthy. I am a Health and Welfare Benefits Consultant at Towers Perrin. Towers Perrin is a global management consulting firm with nearly 9,000 employees and offices in over 70 cities worldwide.

Since 1994, Towers Perrin has sponsored the RetireeCHOICES Coalition, a group of principally *Fortune 500* employers who sponsor post-retirement health care plans. The Coalition has accumulated a great deal of experience in working with Medicare+Choice HMOs across the country to meet the health benefit needs of retirees.

Over 100 employers have participated in the Coalition, representing over 2.5 million retirees, including salaried, hourly and collectively bargained retirees. While these employers could have a significant impact on the health care market in their own right, their vision has been to foster a competitive retiree medical marketplace by using their collective leverage to improve quality, access, member satisfaction and efficiency of medical health plans.

Mr. Chairman, in your invitation to testify today you wrote that the Committee wishes to learn about the Coalition's efforts to develop service, quality and access criteria for evaluating Medicare+Choice plans, as well as the Coalition's success in negotiating employer premiums. You also asked us to share lessons we have learned along the way and the implications for developing further competition in the Medicare+Choice program.

I can share a perspective based on our experiences assisting employers in the Medicare+Choice market. In doing so, I do not represent any of the employers who participate in the RetireeCHOICES Coalition, and my views should not be ascribed to them.

As an overview of the current situation, costs for retiree medical plans have risen dramatically in recent years. According to the Towers Perrin 2001 Health Care Cost Survey, employer health benefit costs for retirees aged 65 and over for all types of health plans combined increased an average of 18 percent for between 2000 and 2001. This followed a 24 percent average increase in costs for the year 2000 for this category. The result is a 46 percent compounded increase in plan costs for this segment of the population in a two-year period. Moreover, the responding employers continued to absorb most of these increases. In fact, the average retiree share of total costs actually dropped in this year's survey, with some employers choosing not to pass on a proportionate share of the cost increase to their retirees.

DEVELOPING CRITERIA FOR EVALUATING MEDICARE+CHOICE PLANS.

Employers take their role seriously when selecting health care plans for employees. This is particularly true when it comes to selecting Medicare+Choice programs for their retirees. In our RetireeCHOICES experience, employers consider a variety of factors, but usually focus on two main areas:

- *The Special Needs of Seniors*—how well do the Medicare+Choice entities' organizational structure, procedures and systems reflect the special demands of caring for seniors? The areas that often get specific attention are provider networks, quality assurance, quality improvement, utilization management, health risk management, data reporting, member services, account service, and marketing practices.
- *The Special Needs of Employers*—has the Medicare+Choice entity adapted its organizational structure and systems to meet the needs of employer groups and their retirees? This includes accommodating the employer's plan design and special communication needs. While HMOs are used to working with employers in the market for group coverage, Medicare+Choice is principally an individual product market.

The goal of the typical employer's quality review process is to select the most cost-efficient and highest-quality Medicare HMO in the market for retirees. To do this, employers apply some of the techniques associated with major purchases in their normal business operation, such as a Request for Proposal, request for proposal, plan interviews, site visits and negotiations during the selection process.

Those techniques are combined with data from specialized sources. Attention is given, for example, to National Commission on Quality Assurance (NCQA) accreditation, any past or present investigations by federal or state regulatory bodies, HCFA appeal and grievance reports, and Health Plan Employer Data and Information Set (HEDIS) reporting. Our RetireeCHOICES database provides all of this information and other analysis, including each plan's pharmacy program.

NEGOTIATING EMPLOYER PREMIUMS

Although the Coalition's main goals are to ensure quality, access and service, it has also been successful in securing competitive premiums for the participating employers and the retirees who choose to enroll in Medicare+Choice options.

To foster competition within geographic markets, every Medicare+Choice plan in the country is invited to submit to the Coalition a plan design and premium quote for their operational service areas.

The RetireeCHOICES team then benchmarks the national Medicare+Choice data with employer data and uses this information as the central point for negotiations to secure the best deals for Coalition members.

When negotiations are completed, each coalition member is eligible to offer the negotiated Coalition plan to its retirees. Coalition employers can also enter into individual negotiations with Medicare+Choice plans for alternative rates and benefit arrangements, if they desire.

For 2001, the RetireeCHOICES Coalition successfully negotiated with Medicare+Choice plans, representing more than 200 health plan/market combinations.

Following these steps, we assist employers in perhaps the most critical step, which is to present the plans to their retirees as they make the voluntary decision whether to enroll in a Medicare+Choice plan or remain in traditional Medicare.

LESSONS LEARNED

A number of lessons have emerged from these efforts, but I would like to highlight four of them for your consideration:

1. *Communications With Retirees Are Key.*

Employers have learned the special needs and characteristics of retirees that must be considered in offering Medicare+Choice plans. This includes the need for a coordinated communication program to help retirees understand their choices and guide them through the decision-making process.

The focal point of the employer communication process is the employer-sponsored retiree meeting. As you no doubt know from your own constituent meeting experiences, these types of sessions are perhaps the most effective way to bring a message to this population. The employer's communication campaign is usually the main decision-making factor for retirees; it correlates to success in enrolling more retirees in Medicare+Choice plans and in retiree satisfaction. When considering program changes and budget allocation in the future, I would urge you to keep this in mind.

Even if the financial arrangement for health coverage is compelling, retirees still must understand the program before they will join a Medicare+Choice plan.

2. Negative Perceptions of Managed Care and HMOs Must Be Addressed and Balanced.

We have learned that they must try to balance it is necessary to present a more balanced perspective on managed care than the negative perception of managed care and Medicare HMOs that is sometimes often portrayed in the media. Employers have typically tried presenting a more balanced and objective overview of HMOs, including Medicare HMOs. Employer communication efforts present the pros and cons of joining an HMO. Employers try to remind their retirees that “what makes headlines” is not always representative of the whole story and present the facts about Medicare HMOs.

We know that once a retiree joins a Medicare+Choice plan, he or she usually likes the plan and continues to belong to the plan. This is consistent with HCFA research that shows the same trend. For employer-sponsored Medicare+Choice plans, disenrollment rates have been less than 5%.5 percent.

3. HCFA's Requirements Present Operational Challenges for HMOs and Employers.

We have learned that the annual HCFA process of HCFA's annual process for approval of Medicare+Choice plans' rates and benefits sometimes can make it difficult for the employer to effectively plan the Medicare+Choice offerings to their retirees.

I want to note that we have worked constructively with HCFA and our clients on the National Medicare Education Program and similar initiatives. I have been personally involved in helping HCFA staff achieve practical solutions to administrative problems that don't always involve huge sums of money but make a difference in reaching mutually beneficial objectives. These include issues such as:

- streamlining the Medicare+Choice enrollment and disenrollment process,
- creating more leeway for Medicare+Choice plans to develop custom communications for our clients' enrollment campaigns, and
- addressing inconsistencies that have occurred between HCFA policy on the national and regional office level.

These issues and others can play havoc with a national employer's communication and enrollment processes.

4. A Marketplace Subject to Frequent Government Policy Changes and Unpredictable Pricing Can Be Unstable.

Along with retirees, employers are learning how to deal with the service area reductions and cost increases and to communicate increases. Employers have been on the front lines in communicating with retirees who have lost access to their HMO Medicare+Choice coverage or fear they might in the future. However, it may not be appropriate to draw many conclusions about Medicare and competitive markets since Medicare+Choice coverage from the period that has followed the Balanced Budget Act of 1997, because the law itself has contributed to destabilizing the Medicare+Choice marketplace.

Furthering Competition in the Medicare+Choice Program

Prior to 1999, we saw the benefits of competition among multiple Medicare+Choice plans in communities across the country. We know that such competition can work to the benefit of Medicare beneficiaries through improved services and benefits, such as prescription drug coverage. It is key now for Congress to put the Medicare+Choice program on a more equitable and competitive basis with traditional Medicare.

As others on this panel can address in detail, the Balanced Budget Act of 1997 greatly curtailed the annual increases in HCFA payment rates to Medicare+Choice plans. HCFA payment rates in most urban areas have increased by less than 3 percent annually for the last four years. The relative level of the HCFA payments has declined from 95 percent of traditional Medicare costs to approximately 90 percent for a number of Medicare+Choice plans.

HCFA payments include no revenue for drug coverage since it is not included in traditional Medicare. Most Medicare+Choice plans are experiencing annual cost increases in the 7 percent to 9 percent range. These cost increases are far greater than the HCFA payment rate increases. As a result, most plans have felt the need to reduce service areas, cut benefits, or increase premium rates.

A critical step toward promoting competition in the Medicare+Choice marketplace would be to address the financial inequities between traditional Medicare and HCFA's payments to Medicare+Choice plans. Then, attention can be paid to retiree communications and the operational burdens placed on Medicare+Choice plans.

PREPARED STATEMENT OF LEN M. NICHOLS*

Mr. Chairman and Members of the Committee, I am grateful for the opportunity to discuss with you today the most important lessons that the Competitive Pricing Advisory Committee (CPAC) learned while trying to help inform the Medicare reform debate. As you know, and as the Medicare Trustees just reminded us, the long term financial outlook of Medicare is not rosy, and I applaud you and your Committee's leadership in trying to make sure that we take care to fashion reforms now that will make sense later for our seniors, our taxpayers, and our health system.

History

The CPAC was created by the Balanced Budget Act of 1997, which was passed when reining in Medicare cost growth was of paramount concern. The BBA had many provisions which did help reduce cost growth, and not all have been repealed or rolled back since. Consequently the short-to-intermediate term financial outlook for Medicare has improved considerably. In a way, this financial turnaround, in conjunction with a temporary reduction in general health care cost growth and the near term federal budget surpluses, provides a unique but not everlasting window of opportunity to choose, deliberately and wisely, exactly the kinds of long term reforms that make the most sense for Medicare.

The drafters of the BBA shared the vision of informed reform, and tried to promote it in two separate but related provisions. One created the Bi-Partisan Commission to study and recommend long term reform possibilities, and another provision created the CPAC, which was charged with designing and implementing at least four and up to seven competitive pricing demonstration projects that could inform the larger and longer term reform debate. CPAC's existence was put into legislation because previous attempts to implement competitive pricing demonstrations projects through the usual research arm of the Health Care Financing Administration were stymied by direct Congressional intervention.¹ The theory was that statutory authority would enable a competitive pricing experiment to actually get off the ground, since Congress had already explicitly sanctioned the idea.

CPAC's 15 members were appointed by the Secretary of Health and Human Services and included 2 physicians, 2 actuaries, 3 health plan executives, one corporate purchasing executive, a former Senator (Durenberger, R-Minn) with extensive knowledge of Medicare and health policy generally, a law professor, top executives and lobbyists from the Health Insurance Association of America, the American Association of Retired Persons, and the Service Employees and Industrial Union, and 2 economists, one of whom was a former head of the Congressional Budget Office, Robert Reischauer. The CPAC was ably chaired by James Cubbin, the VP for health purchasing at General Motors, one of the most successful and innovative purchasers of health insurance and health care in the world.

CPAC was charged with designing the pricing demonstrations, selecting sites in which the demonstration projects would take place, and working with local area advisory councils (AACs), which were also called for in the BBA. The very good idea behind the AAC provision was that for Medicare competition to work on the ground, local stakeholders are going to have to be given an opportunity to have input into important design choices. Health care and health insurance markets are inherently local, and no one from outside can possibly know the local situation better than health plans, providers, and beneficiary representatives in the communities selected. This is particularly true for Medicare, since it has been using formulaic instead of competitive pricing for too long. This administered pricing—based on fee-for-service costs—has created very serious inefficiencies which have led to inequities and windfalls in the extra benefits which Medicare payment supports in some areas of the country but not others. One cannot suddenly repeal 15 years of Medicare managed care history and practice and re-impose the statutory benefit package from Washington without engendering significant beneficiary discontent, which is certainly not anyone's intention, and not the way to get Medicare reform off to a popular start.

*Principal Research Associate, Health Policy Center, the Urban Institute; member, Competitive Pricing Advisory Committee; and member, Technical Review Panel for the Medicare Trustees Reports. I am grateful to Marilyn Moon for helpful comments. The views expressed herein are mine alone and should not be attributed to the Urban Institute, its staff, trustees, or sponsors.

¹See Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs* 19(3) (September/October 2000), pp. 9–29, for an illuminating discussion of past failed attempts to implement competitive pricing demonstration projects. Also in the same issue are Len M. Nichols and Robert Reischauer, "Who Really Wants Price Competition in Medicare Managed Care?", and various perspectives on Medicare pricing experiments from Karen Ignani, Barbara Cooper and Bruce Vladek, Rep. Bill Thomas and Linda Fishman, and Nancy-Ann Min DeParle and Robert Berenson.

CPAC began meeting in May of 1998 and completed all the design choices—with the outstanding intellectual assistance of contractors from the University of Minnesota and Abt Associates and timely staff work from the HCFA professionals in Baltimore—by October of 1998. These choices included: (1) whether to include FFS in the demonstration, as many health plans and some CPAC members wanted; (2) how to determine eligibility for plan participation in the demonstration; (3) whether to have a standard benefit package to facilitate comparison shopping; (4) where and how to set the government payment level for health plan enrollees; (5) whether to require more quality reporting by plans competing on price than by those being paid by administrative formula.²

Next came site selection, and the proverbial beginning of the end. Recall one of the main purposes of creating CPAC in the statute was to create a group of knowledgeable and distinguished Americans who could more easily withstand the “political heat” better than the civil servant bureaucracy at HCFA could; heat was expected for creating specific demonstration projects that Congress had asked for in the abstract. This expectation proved prescient.

Moving blithely along, CPAC believed that the Congressional leadership would not allow some Members to stop the demonstrations when a clear majority in Congress had voted for the BBA. So, after reviewing practically all the objective criteria that were obtainable, in January of 1999, CPAC selected two sites—Phoenix and Kansas City—to begin the competitive pricing demonstration projects in January in 2000. Suddenly, in these two communities anyway, a year did not seem to be a very long time at all.

By late March, opposition in Phoenix was united; health plans, providers, and beneficiaries were all correctly convinced that the reform experiment was going to either cost them money or benefits or both. At that point in Kansas City, by contrast, opposition was less bold, except for physicians, who opposed the demonstration project from the first week it was announced. But the leader of the AAC in Kansas City, E. J. Holland, Jr., was in charge of purchasing health insurance for Sprint, a major employer in the area. Prior to that position he had long been a lawyer for local hospitals, so he had clout with plans and credibility with providers, and importantly, he thought competitive pricing for Medicare was not only good for beneficiaries and the country in the long run but would also likely be good for private employers and workers and as they try to make the health care system more accountable and cost effective. However, he was adamant on one point from the beginning: while with a little luck he could deliver the Kansas City AAC and meet all the demonstration project’s rather tight deadlines, the Kansas City AAC would never agree to enter into this kind of experiment alone. Thus, CPAC had to make it happen in Phoenix, or nowhere.

And Phoenix had no constituency on the ground in favor of the project except a few local employers. By July of 1999, opponents of the demonstration projects had attached an amendment to the Patient Protection Act which said that no funds could be expended implementing a competitive pricing demonstration project in Arizona, Kansas, or Missouri. The passage of this amendment signaled that the Senate leadership was not going to deny local Members’ strong desire to serve their constituents and squelch the nascent competitive pricing experiment.

The House health policy leadership, notably Chairman Bill Thomas, as well as Chairman Roth and Senator Bob Graham and senior Finance Committee staff, tried to save the demos somehow, and the Clinton administration also considered it important to try. In the end the Balanced Budget Refinement Act delayed but did not end the CPAC demos, and called for four useful questions to be answered before new demonstrations were designed: (1) how might fee-for-service Medicare best be included in a competitive pricing experiment? (2) what quality reporting requirements should Medicare + Choice plans vs. fee-for-service Medicare? (3) how might a competitive pricing demonstration project be implemented in a rural area? (4) Is benefit package standardization a necessary feature of competitive pricing demonstrations and what are its benefits and costs? CPAC answered these questions in its most recent report, delivered to Congress in January of this year.³

Lessons

There are at least 6 primary lessons from the CPAC experience, and a host of smaller ones that are contained in the cited reports that were submitted to Congress.

²Details about CPAC’s committee members, its meetings’ agendas and minutes, and its reports explaining all of its choices and rationales can be found at www.hcfa.gov/cpac.

³Report to Congress by the Competitive Pricing Advisory Committee of the U.S. Department of Health and Human Services, January 19, 2001 (www.hcfa.gov/cpac).

Lesson #1: To learn about health plan pricing reform in Medicare, the country must invest resources initially

Opposition to competitive pricing is based upon perceived self-interest, which was probably accurate, given the constraints of our design. Budget neutrality requirements, while imminently sensible in most contexts, were simply devastating to CPAC. Forcing each site to be budget neutral each year, as the BBA statute did, guaranteed that no more money could flow into an area than would have under the regular program rules. Since the BBA kept most health plans' revenues per beneficiary growing at 2% per year in areas where Medicare HMOs had substantial market share, plans saw that this constraint would be binding sooner rather than later, especially given their prescription drug cost growth.

Plus, competition alone is likely to lower the average price paid when moving from an administered system to a competitive one, so those savings would also cost the plans. If plans perceive that they are likely to end up with less revenue after competition takes hold, then so are providers and beneficiaries. And the typical Medicare + Choice beneficiary in markets with high managed care penetration is already receiving extra benefits that most Medicare beneficiaries can get only by paying quite a lot out of pocket. The source of these extra benefits is payments to health plans greater than their costs in the current formulaic system. Reducing the excess payments then must reduce the amount of the extra benefits, and so beneficiaries were worried. Thus, with budget neutrality, there was precious little tangible benefit that CPAC could offer stakeholders on the ground in either site.

The way to invest in reform is to relax the budget neutrality constraint, and let bidding run its course. Health plans know they need to offer benefits beyond the current Medicare benefits package if they are to successfully compete with fee-for-service. But budget neutrality and forced competitive bidding threaten the ability to offer extra benefits, the very lifeblood of the Medicare + Choice plans.

Relaxing budget neutrality, however, would restore essential flexibility to the demonstration design. First, just allowing payments to be higher than baseline in year 1 makes it possible to get the competitive process started with much less fear. Second, any savings that do occur could be earmarked for a local quality pool that is paid out to those plans that perform best in agreed upon criteria. This had the added virtue of emphasizing that Medicare pricing reform is ultimately about a lot more than just saving money. Third, relaxing budget neutrality would allow a prescription drugs benefit to be added to the benefit package upon which plans bid. If competition ultimately will save money, these early investments could be recouped in the out years (3–5) of the demonstration. If competitive bidding does not save money in the long run, then Medicare policy makers would be better off knowing that as soon as possible, and why.

Lesson #2: Without the support of Congressional leadership, no demonstration project can withstand sustained constituent fear and opposition

Once local opposition galvanized, CPAC members and HCFA professional staff were not well equipped to solicit defensive support among Members of Congress. If one Member cares a lot, and most other Members are basically indifferent, he can get what he wants, eventually. So, Medicare pricing reform will occur only when the leadership decides it really wants to do that, and prevents amendments like the one that stopped the CPAC demos in their tracks. Perhaps a kind of congressional "ownership" would help. Members of Congress who are leaders in reform efforts could volunteer to work with local stakeholders from their states and with CPAC to discover the conditions under which willing participation in health plan pricing demonstrations might be met in a way that serves the program, beneficiaries, and providers.

Lesson #3: Standard benefit packages are essential for a meaningful comparison of competitive bids to take place

Unless the benefits are the same, price differential are harder to evaluate. But we also learned that the standard benefit does not have to be identical in every area, and that it is best to let local stakeholders design the details of the benefit, given broad federal requirements. Both the Phoenix and the Kansas City AAC got as far as finalizing their benefit packages. Both ended up with drug benefits substantially more generous than CPAC required, and in each case it fit what their local market place had been providing prior to the expected start of the demonstration. In addition, the public process of determining what the drug benefit should be served as a tremendous community education device, wherein all came away with much more understanding of the drug benefits now attached to various Medicare + Choice plans in the marketplace.

Lesson #4: Premium rebates are a relatively low risk way to allow competition between fee-for-service and Medicare + Choice plans

The BBRA gave CPAC the authority to allow plans to use premium rebates in lieu of higher benefits when their costs are below what Medicare pays. In the past, they have been forced to rely on benefit competition, and to fill any gap between costs and payment with benefits. BIPA spread the right to grant a rebate to all plans, not just demo plans, starting in 2003. Health plans were adamant with CPAC that no demonstration project could be fair and fully informative without fee-for-service also competing. Rebates enable Medicare + Choice plans to use price incentives to draw beneficiaries from fee for service, without subjecting those fee-for-service enrollees who remain so to potentially high premium payments, which some Medicare overhaul bills would do.

Lesson #5: Postponing Medicare + choice pricing reform experiments is costly.

The alternative to pricing experiments is to someday implement reform everywhere simultaneously, with no prior experience purchasing health care services in a competitive environment, i.e., to go "cold turkey." Cold turkey is for young heroin addicts with VERY strong hearts. There is much to be learned about how best to meld the best practices from the private sector with the special needs and obligations of the Medicare program. The good news is, new pricing demonstrations could be fit to virtually every serious Medicare reform proposal, so that we might before too long have evidence-based policy disputes, which would surely be an improvement over competing ideologies. Medicare must learn to modernize its purchasing techniques, for while price competition can be a friend to the Medicare program in the long run, the key to beneficiary and citizen acceptance of price competition is to simultaneously enhance our ability to demand accountability for quality outcomes. Policy makers must decide to let Medicare become an efficient purchaser, to use its inherent market power wisely. This will take discretion, like GM and Sprint and other private sector purchasing managers have. For Medicare employees to be granted this essential discretion, they'll need to re-earn Congress' trust. I believe they can, and the time to start is this afternoon.

Lesson #6: The problems of rural Medicare beneficiaries are fundamentally different from the problems with Medicare in urban areas, and the power of competitive pricing per se to help solve them is limited, but potentially useful

Competitive pricing is designed to solve the problem of excess use and cost in the 3/4 of the country with plenty of everything and too much of some things; providers, insurance, utilization of services, and unit charges for those services. The fundamental problem in rural America is low population density, which retards or prevents the economies of scale that make managed care and integrated delivery systems feasible. This low density also leads to fewer providers for they can not make as good a living as in a city. Plus, rural Medicare beneficiaries are more likely to be low income, to have less supplemental insurance, and to face long travel times in order to see a provider than their urban counterparts. The fundamental rural issue is fairness: we are not now providing them with near what urban beneficiaries have come to expect in terms of services, even though they pay the same taxes as everyone else.

There are some options for using competitive pricing to encourage the development of integrated delivery systems that serve rural beneficiaries, explained in the January 2001 CPAC report (one winning bid, geographic capitation, allowing Medicare contributions to be used to buy into Medicaid managed care networks), but there are limits to what health plan pricing policy alone can do to encourage physician location decisions. To improve the geographic distribution problem, direct subsidies may be necessary. There is no doubt that budget neutrality will have to be waived for the competitive pricing demonstration to be of any use to rural Medicare beneficiaries.

I would now be glad to answer any questions my testimony may have provoked.

PREPARED STATEMENT OF MADELEINE SMITH

Thank you, Mr. Chairman, Senator Baucus, Senators, for inviting me to testify about payments under the Medicare+Choice (M+C) program. My name is Madeleine Smith. I am a Specialist with the Congressional Research Service.

There are two points that I would like to emphasize about the effects of payment reform under Medicare+Choice:

1. Although the number of health maintenance organizations (HMOs) in the M+C program has declined, the proportion of Medicare beneficiaries enrolled in managed care has not changed much. In 1997, 14% were enrolled; today, 15% are enrolled. This fairly constant percentage of beneficiaries enrolled in HMOs followed a period of rapid growth in enrollment that has not continued. Fewer beneficiaries have access to HMOs nationwide, but with the entry of a private fee-for-service plan into the program, access to an M+C plan for rural beneficiaries has risen.

2. Variation in payment rates has decreased. In 1997, the highest rate was $3\frac{1}{2}$ times the lowest rate. Today, the highest rate is $1\frac{3}{4}$ times the lowest rate. However, benefits offered by M+C plans still vary widely across the country.

In the remainder of my testimony, I will review how rates were determined before the M+C program, and major reasons for reform of the payment system. Then I will turn to a brief discussion of how rates are currently calculated. Finally, I will summarize one effect of rate reform—plan withdrawals—and changes to the M+C payment rate calculations enacted since 1997.

PRE-BBA

Medicare has included a managed care alternative to traditional fee-for-service for almost 30 years, since the 1970s. Under the risk contract program created in 1982, an HMO participating in the risk contract program (Section 1876 of the Social Security Act) received a single monthly capitation payment for each of its enrollees. This payment was known as the adjusted average per capita cost (AAPCC). In return for the monthly payment, the HMO agreed to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers.

The Health Care Financing Administration (HCFA) calculated the AAPCC for each of the over 3,000 counties in the US. A county's AAPCC was based on the costs of providing care under traditional fee-for-service (FFS) Medicare to a beneficiary in the county. Basically, HCFA determined the average per capita costs by adding together all of the Medicare FFS expenditures for beneficiaries living in the county, and dividing this by the number of FFS beneficiaries in the county. This county-level average per capita cost was adjusted for demographic differences between the county's Medicare beneficiaries and average beneficiaries nationwide. The county rate was set equal to 95% of the AAPCC to account for savings delivered by managed care organizations through coordination of care. Actual payments to HMOs for individual enrollees were adjusted for risk, using demographic characteristics of the enrollees, such as age, gender, and residence in an institution.

Each HMO was required to submit an estimate of its costs of covering Medicare services for its Medicare enrollees. This estimate is known as the adjusted community rate (ACR), and is still submitted today. If the AAPCC was greater than the ACR, the HMO was required to reduce beneficiary cost-sharing, enhance benefits, contribute the excess to a stabilization fund, or return the funds to HCFA. Many HMOs were able to provide additional benefits, such as prescription drug coverage, without charge to an enrollee because the AAPCC exceeded their ACR.

REASONS FOR PAYMENT REFORM

There were at least three main reasons behind reform of the AAPCC payment method under Balanced Budget Act of 1997 (BBA, P.L. 105–33): lack of access to a Medicare HMO in many areas; wide variation in the payments and benefits offered by HMOs; and volatility of payment rates over time.

Lack of access to an alternative to FFS Medicare was the first perceived problem. The risk contract program expanded dramatically between 1993 and 1998, when the number of plans tripled from 110 to 346. In 1998, almost three-fourths of Medicare beneficiaries had access to at least one risk plan, and almost two-thirds had a choice of plans. Still, over one-quarter of Medicare beneficiaries nationwide lacked access to a risk plan, and most of these beneficiaries were in rural areas. Over 90% of Medicare beneficiaries in rural areas lacked access to a risk plan, while all beneficiaries in central urban areas had such access. Many of the counties without plans had low AAPCCs.

A second perceived problem was wide variation in payments and benefits offered by HMOs in different areas. In 1997, the highest payment rate was $3\frac{1}{2}$ times the lowest rate: \$767 versus \$221 monthly for an aged beneficiary. An analysis of ACRs in 1995 showed that HMOs in Miami were required to offer benefits worth over \$100 per month without charging enrollees anything; the payment rate was \$100 per month higher than the HMOs costs of covering Medicare's benefits. In contrast, HMOs in Minneapolis were not required to offer any additional benefits: the pay-

ment rate was equal to the HMOs costs of covering Medicare's benefits. Beneficiaries in the federal Medicare program were receiving benefits that differed across localities.

A third perceived problem was volatility of the AAPCC over time, especially rural counties. This problem occurred because of the relatively small number of Medicare beneficiaries in some counties: today, one county has 18 Medicare beneficiaries. If one beneficiary in a sparsely populated county incurred large Medicare expenditures in one year, the average per capita costs would skyrocket. If that beneficiary recovered or died, the next year the average per capita costs could plummet. Wide variation in payment rates over time was considered one obstacle to risk plan entry into some counties.

Other problems were more technical. The AAPCC was calculated based on average FFS Medicare costs. The costs of care provided to Medicare beneficiaries by Veterans Affairs (VA) or Department of Defense (DOD) facilities were excluded from the calculation. This could depress a county's AAPCC. AAPCCs also included payments for disproportionate-share hospitals (DSH) and graduate medical education (GME) even though some questioned whether HMOs were passing these funds through to hospitals.

PAYMENTS UNDER M+C

In order to address some of these problems, BBA 97 included a new payment rate formula. The M+C rate in a county was set at the highest of 3 amounts:

- a floor, or minimum amount, set at \$367 in 1998;
- a blend, or average, of local and national rates;
- a minimum update representing a 2% increase over the prior year's rate.

The blend calculation used the 1997 AAPCCs as the base local rate. National rates were an average of local rates, adjusted to reflect differences in input prices in each county. A portion of GME payments was excluded from the local rates used to compute the blend, beginning with 20% in 1998 and rising to 100% by 2002. The blend was phased-in. In 1998, 90% was based on local rates and 10% on the national rate; in 2003 and thereafter, 50% will be based on local rates and 50% on the national rate.

The formula included a floor and minimum update to alter the immediate effects of blending local and national rates. The floor increased rates in low payment counties more quickly than would occur through blending of local and national rates. The minimum update was included to cushion the effects of blending on high payment counties. At the time of enactment, analysis projected that over 80% of counties would be receiving blend payment rates by 2003. Among remaining counties, 16% would receive floor rates and 2% would receive minimum updates.

Payment rates were affected by other provisions in BBA 97, including statutory reductions in the national per capita growth percentage used to compute the local rate and the floor, and the budget neutrality provision which requires that aggregate M+C payments equal total payments that would have been made without changes to the formula. Both of these components were meant to guarantee budgetary savings. The M+C payment formula removed funding of GME from the calculation, but left DSH payments in the formula. No adjustments were made to account for care received through VA or DOD facilities. Finally, HCFA was required to implement a new risk adjustment system, based on the health status of beneficiaries, beginning in 2000.

PLAN WITHDRAWALS AND LEGISLATIVE RESPONSES

The M+C program has now experienced three waves of plan withdrawals and service area reductions, effective at the onset of the M+C program in 1999, and annually since then. Interspersed between announced withdrawals have come two legislative responses, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554).

Not all HMOs that had operated under the predecessor program chose to convert to the M+C program in 1999. According to HCFA, the 66 organizations that withdrew or reduced service areas affected slightly more than 400,000 beneficiaries in risk plans in 1998, about 6% of all risk enrollees. Slightly more than 50,000, less than 1% of risk plan enrollees, did not have access to another managed care plan and were forced to return to traditional FFS Medicare.

Plans announced further withdrawals and service area reductions in 1999 and 2000. Of the approximately 300 plans serving Medicare beneficiaries at the end of 1999, 99 plans withdrew or reduced service areas for the 2000 contract year, and 118 withdrew or reduced service areas for the 2001 contract year (GAO, 2000).

These changes affected about 5% of M+C enrollees in 2000 and about 15% in 2001. About one-fourth of affected beneficiaries in 2000, and 15% in 2001, had no other managed care option available.

Why did plans withdraw completely or reduce service areas? Industry representatives believe that inadequate M+C payment rates are a principal cause of plan withdrawals. HCFA contends that withdrawals reflect strategic business decisions by M+C organizations that transcend payment rate issues. Studies of withdrawals by CRS, GAO and others have found that in 2000 M+C plans tended to withdraw from rural counties, where they may have had difficulty maintaining provider networks, and large urban areas, which they had recently entered or where they lacked sufficient enrollment. Similar results were found for 2001, with the added withdrawal of some plans with more extensive program participation. GAO notes that the pattern of M+C withdrawals resembles the experience of the Federal Employees Health Benefits program (FEHBP), with rapid expansion of plan participation between 1994 and 1997, followed by withdrawals of more recent entrants with few enrollees. A recent report from InterStudy indicates similar events in the general HMO market. In 1999, 83 HMOs (12%) ceased operations, many through merger, but 29 HMOs failed. The industry experienced its first annual decline in enrollment in nearly 30 years. Rural areas accounted for the greatest loss in enrollment, and 91% of HMO enrollees now live in urban areas. The boom cycle experienced by HMOs in the mid-1990s came to a close.

Congress acted to increase M+C payment rates. The BBRA in 1999 made a few modest changes to raise future plan payments by decreasing the scheduled reduction in the national per capita M+C growth percentage, and by reducing assessments for beneficiary education. It established bonus payments for plans that enter areas where no other plan is in operation, to encourage participation in rural areas, and it slowed down the Secretary's scheduled phase-in of risk adjustment. The BIPA in 2000 made more substantial changes to increase payments. For 2001, the floor rate was raised to \$475 per month in lower populated areas, and \$525 in areas with population of more than 250,000. The minimum increase in rates was raised from 2% to 3% for 2001. BIPA also extended the current risk adjustment method until 2003 (when a new risk adjustment method will be phased-in), and expanded the new entry bonus payments to encourage participation. Many other provisions with less general impact on payment rates were included. One notable BIPA provision allows M+C plans to offer reductions in the Medicare Part B premium as an additional benefit to enrollees, beginning in 2003.

EFFECTS OF PAYMENT REFORM

After a little over 2 years, have problems identified with the AAPCC been fixed? Lack of access was seen as a consequence of low payment rates. The BBA raised the floor to \$367 per month, and the BIPA raised it again to \$475/\$525. Has access increased? In 1997, there were over 300 risk HMOs, and in 1998, there were 346. Today there are 179 M+C plans. The number of plans has dropped to about half.

Although the number of plans has decreased significantly, the proportion of beneficiaries enrolled has not changed much. In 1997, about 5.2 million Medicare beneficiaries (14%) were enrolled in risk plans. This increased to 6.2 million beneficiaries, or almost 17%, by 1998. In March 2001, there were 5.7 million Medicare+Choice enrollees, representing about 15% of the Medicare population.

Thirty-three percent (33%) of Medicare beneficiaries lacked access to a risk plan in 1997, including 91% of beneficiaries in rural areas. By 2001, 37% overall lacked access to an HMO, including about 85% of beneficiaries in rural areas. With the entry of a private FFS plan, Sterling, into the M+C program, access has increased. Sterling now offers coverage in over half of the states and counties in the country, where 38% of all beneficiaries reside, including 57% of beneficiaries living outside metropolitan areas. Sterling provides access to 18% of beneficiaries who would not otherwise have an M+C option.

Another goal of payment reform was to decrease the variation in payment rates and benefits. This has occurred. In 1997, the highest payment rate was 3½ times the lowest rate. Today, the highest rate is 1 times the lowest rate (\$834 versus \$475), and the spread is even lower across metropolitan areas (about 1.6 times, \$834 versus \$525). This narrowing of differences in payment rates has been achieved by raising the minimum payment, or floor, while restraining growth in the highest paid counties to a 2% (3% in 2001 only) increase per year. (Managed care plans have argued that their costs have risen much more than 2% annually. HCFA projects an increase of 15.4% in nationwide per capita Medicare costs from 1997 to 2001. Plans receiving minimum updates over this period saw rates increase by 9.3%). Additionally, as the payment gap has narrowed, benefits under M+C generally have de-

clined. In 1999, 61% of beneficiaries had access to plans that charged no additional premium, and 54% had access to a plan that charged no additional premium while including drug coverage. By 2001, only 37% of beneficiaries had access to a \$0 premium plan; only 26% had access to a \$0 premium plan with drug coverage.

Recall the difference in benefits available in Miami and Minneapolis in 1997. Differences persist today. Several plans in Miami charge enrollees no additional premium and include full coverage of prescription drugs, both generic and brand name, for drugs on the plan's formulary. Contrast this to Minneapolis. There are four M+C plans, three HMOs and Sterling FFS. Only one HMO offers any prescription drug coverage. For \$81 per month, enrollees are covered for \$100 in total drug expenditures every 3 months, for a total of \$400 of coverage per year. (The HMO provides reduced cost sharing and coverage of other non-Medicare covered services, including routine physicals, eye care, and dental care.)

Finally, payment reform was intended to reduce volatility in payments over time. Certainly payments have not decreased, as they did prior to M+C, but very large increases have occurred in some areas as a result of increases in the payment floor. Some counties saw rates rise over 200% between 1997 and 2001. The most recent rise in floors produced an increase of 14% in rates in non-metropolitan areas (\$415 in 2000 to \$475 in 2001) and 26% in metropolitan areas (\$415 versus \$525). Moreover, some plans are receiving an additional 5% bonus increase in rates because they entered previously unserved areas.

This concludes my testimony. I thank the Committee for this opportunity to discuss M+C payment rates and will be happy to answer your questions to the best of my ability.

PREPARED STATEMENT OF MURRAY N. ROSS, PH.D.

Chairman Grassley, Senator Baucus, members of the committee. I am Murray Ross, executive director of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss the Medicare+Choice (M+C) program. My testimony draws on the recommendations and analysis in MedPAC's March 2001 report to the Congress.

Prior to enactment of the Balanced Budget Act of 1997 (BBA), Medicare's payments to managed care plans were linked to fee-for-service (FFS) spending in individual counties. Wide variation in FFS spending among counties meant that managed care payment rates also varied widely. Because of this and because of market conditions, beneficiaries in some—mostly urban—areas had access to plans offering much greater benefits than those available to beneficiaries in other—mostly rural—areas. To address this inequity, the Congress changed the payment mechanism when it created the Medicare+Choice program. It put a floor under payments to plans, provided for blending of local and national payment rates, and limited increases in payments to higher-paid areas. In the Benefits Improvement and Protection Act of 2000 (BIPA), the Congress raised the floor further.

Reducing the variation in M+C payment rate across the country, however, has introduced a different problem by creating the potential for Medicare's payments to plans in particular market areas to diverge significantly from FFS spending in those markets. In counties where payment rates have been increased above FFS costs, the Medicare program may pay Medicare+Choice plans more to provide the basic benefit package than it would have otherwise, thus increasing program spending. In other counties, payments to Medicare+Choice plans may fall below FFS costs as updates are limited. Over time, plans paid less than FFS costs will face difficulty in contracting with providers if their payment rates are not competitive with those of the traditional program.

No matter how much payments to plans are manipulated, achieving geographic parity in payments to M+C plans and maintaining local parity between Medicare+Choice and traditional Medicare cannot be accomplished simultaneously as long as there is significant underlying variation in fee-for-service spending across market areas.

MedPAC believes that Medicare's payment policies should not steer beneficiaries to either Medicare+Choice plans or the traditional Medicare program. Therefore, the Commission recommends that the Congress make payments for beneficiaries in the two sectors of a local market substantially equal, taking into account differences in risk.

The Commission also recommends that the Secretary study variation in spending under the traditional Medicare program to determine how much reflects differences in input prices and health risk and how much reflects differences in provider practice patterns, the availability of providers and services, and beneficiary preferences.

The Secretary should report to the Congress and make recommendations on whether and how the differences in use of services and preferences should be accounted for in Medicare fee-for-service payments and Medicare+Choice payment rates.

When the Congress put a floor under M+C payment rates, it sought to bring new choices and additional benefits to rural areas. However, low payment rates are not the only reason that managed care plans generally did not enter rural areas. Managed care plans seeking to participate in rural areas face two challenges. First, a lack of so-called intermediate entities (such as physician group practices) in many rural areas makes forming networks more costly and limits plans' ability to delegate risk to control costs. Second, the limited number of hospitals, physicians, and other providers in many rural areas reduces plans' ability to negotiate discounted prices for services because providers lack competition. As a result, even with the floor under Medicare+Choice payments, few managed care plans have entered rural areas.

In contrast to managed care plans, private fee-for-service plans need not establish networks of providers. In addition, the floor under M+C payment rates mean that such plans need not negotiate discounted prices to be profitable. A private fee-for-service plan whose enrollees' use of services was similar to their use in traditional Medicare could have the same costs for medical care as under the traditional program but be paid more.

This possibility has led one plan to enter over 1,600 counties (three-quarters of them floor counties) in 25 states, and another application is pending.

The entry of private fee-for-service plans into floor counties—or other counties where M+C payment rates substantially exceed local FFS costs—raises an important policy issue. On the one hand, such plans represent an alternative to traditional Medicare that the Medicare+Choice program was intended to provide. On the other hand, the lack of care management means that additional benefits provided by such plans come not from efficiency in the provision of medical care, but from higher-than-needed payments. Further, the fact that payments in some floor counties substantially exceed FFS costs does not ensure that Medicare beneficiaries will have access to additional benefits. Some of the excess payment may generate higher profits for insurers and some of the excess payment may lead to higher payments to providers from those insurers. As a result, MedPAC recommends that the Secretary study how beneficiaries, providers, and insurers each benefit from the additional Medicare+Choice payments in floor counties.

How then can policymakers meet the goals laid out in the BBA of providing more choices of plan options and helping to control the growth of Medicare spending? MedPAC's recommendation to make payment rates for Medicare+Choice substantially equal to local FFS costs would help achieve the latter goal, but would not by itself encourage more plans to participate in rural areas. Additional steps will be needed.

One possibility to explore is risk sharing. Under current law, the financial risk for the costs of health care is assumed fully either by Medicare for beneficiaries in the traditional fee-for-service program and or by plans for Medicare+Choice enrollees. Allowing risk sharing could encourage greater participation by entities unwilling to bear risk for services beyond their control. Although the potential to reduce costs (and thus provide enhanced benefits) in a given area might not be as great under a shared-risk arrangement as under full risk, it might make alternatives to traditional Medicare available in more areas.

Another possibility would be to explore alternatives to county-based payments so that payment areas could better match local market boundaries and volatility in payment rates over time could be reduced. Basing Medicare+Choice payments on local FFS spending and risk factors would increase the importance of having reliable and stable data with which to calculate them. MedPAC recommends the Secretary explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.

BACKGROUND

In enacting the Medicare+Choice program in the Balanced Budget Act of 1997, the Congress sought to control the growth in Medicare spending, to provide Medicare beneficiaries with more choice of plan options, and to address a perceived inequity in beneficiaries' access to private plans and the more generous benefits they offered.

The BBA expanded the types of private plans that could participate in Medicare; in addition to health maintenance organizations (HMOs), the law permitted preferred provider organizations (PPOs), provider-sponsored organizations, point-of-

service plans, private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account.

The BBA also introduced a new payment mechanism intended to reduce variability in payment rates across markets. Prior to the BBA, payments to risk plans in a given county were set at 95 percent of the average fee-for-service costs of Medicare beneficiaries in that county, adjusted for demographic characteristics. The BBA set payments at the maximum of a floor rate, a minimum update applied to the previous year's rate and, subject to a so-called budget neutrality factor, a blend of local and national rates. The BBA also directed the Health Care Financing Administration to replace the existing risk adjustment method with one accounted for the health status of M+C enrollees.

Progress towards the Congress's goals has been halting. Although the fraction of Medicare beneficiaries enrolled in Medicare+Choice plans remained roughly constant between 1998 and 1999, this marked a sharp change from the rapid increase in managed care penetration that took place in the mid-1990s. Further, until the recent entry of a private FFS plan, no new types of plans sought to participate and a substantial number of plans withdrew from the program or reduced their service areas. In January 1999, another 41 terminations and 58 service area reductions were announced effective for 2000.

The cumulative effect of these changes is that beneficiaries' access to HMO plans, particularly those offering zero-premium coverage, has declined. The percentage of Medicare beneficiaries having access to a M+C HMO plan fell from 71 percent in 1999 to 69 percent in 2000 and again to 63 percent at the beginning of this year. The percentage of beneficiaries having access to zero-premium plans has been even more pronounced, falling from 61 percent in 1999 to 39 percent in 2001.

The Congress has acted twice in an attempt to maintain participation and stimulate entry by plans. The Balanced Budget Refinement Act of 1999 (BBRA) slowed the phase in of risk adjustment (which would have reduced payments to most plans), provided for bonus payments to plans entering areas without a Medicare+Choice plan, and exempted PPOs from certain quality assurance requirements. The Benefits Improvement and Protection Act of 2000 raised the floor under payments in 2001 from \$415 to \$475 per month and introduced a separate floor of \$525 for counties that are part of Metropolitan Statistical Areas containing more than 250,000 people. The law also provided for a minimum update of 3 percent to 2001 payment rates. In addition, the increases in payment rates to fee-for-service providers enacted in the BBRA and the BIPA feed through to higher updates to M+C payment rates.

It is too early to determine the ultimate impact of these legislative changes. But if the higher floors enacted in the BIPA lead to increased enrollment in floor counties, then updates in high-payment counties will be constrained to the minimum update. This means that plans in high-payment counties will face continuing pressures to reduce additional benefits or increase cost-sharing and premiums for their enrollees.

DIFFERENCES IN FEE-FOR-SERVICE SPENDING

Fee-for-service spending varies widely across the country, with spending in the highest cost counties about triple spending in the lowest cost counties. Some of the variation is attributable to differences among counties in wage rates and in the health risks of their residents, factors that Medicare explicitly takes into account in its prospective payment systems. Some of the variation is attributable to differences in the practice patterns of providers, the availability of providers and services, and the preferences of beneficiaries.

These differences generally went unnoticed in the fee-for-service program. But they became much more visible as Medicare's risk contracting program grew because payments to managed care plans were linked to local fee-for-service spending. Areas with high fee-for-service spending received managed care payments that allowed private insurers to provide generous additional benefits if they could provide Medicare's basic benefits at lower costs. Areas with low FFS spending generally did not attract plans. Although differences in fee-for-service spending were not seen as inequitable, variation in the availability of extra benefits was.

When it enacted the Medicare+Choice program, Congress attempted to address this inequity by serving the link between M+C payment rates and local fee-for-service spending. It put a floor under payment rates and provided for blending of local and national payment rates to bring them closer together. These higher payments were to be financed by limiting updates in payment rates to high-cost counties.

The practical impact of the divergence between M+C payments and local FFS spending was small during the first years of the M+C program because few bene-

ficiaries living in floor counties were enrolled in M+C plans and because slow growth in Medicare FFS spending did not allow blended payments to be made. The increase in floor rates enacted in the BIPA, however, has substantially changed the distribution of payments because about half of Medicare beneficiaries live in the newly expanded set of floor counties. If the higher floors are even moderately successful in attracting new plans and enrollees, then counties with payment rates above the floor are likely to receive the minimum update (rather than a blended rate) for years to come.

The higher floor will compress payment rates. But setting Medicare+Choice payment rates substantially above fee-for-service costs in the floor counties also creates opportunities for insurers to receive much higher payments from Medicare than the program would otherwise spend. If the higher payments do not lead to additional benefits, then Medicare will be spending more than necessary to provide the basic benefit package.

MedPAC is concerned about wide divergences within health care markets between Medicare+Choice payment rates and Medicare spending for beneficiaries in the traditional program because we believe Medicare should be financially neutral as to whether beneficiaries choose the traditional program or a Medicare+Choice plan. This view implies striving to make Medicare+Choice payment rates substantially equal to local per capita fee-for-service costs, adjusted for differences in risk. Failure to do so will encourage financing care in the sector that is most costly to Medicare. Where payments to Medicare+Choice plans exceed FFS costs, beneficiaries are likely to seek out private plans because they will be able to offer additional benefits. Where payments are below FFS costs, plans will be reluctant to enter markets or will have to charge (or increase) premiums to their enrollees.

The underlying geographic differences in spending under traditional Medicare mean that resolving the dilemma of achieving both national equity and local efficiency cannot be done through M+C payment policy alone. Medicare+Choice payment policy is not an effective or appropriate means to address underlying variation in FFS spending. MedPAC recommends that the Secretary study this variation to determine how much is caused by differences in input prices and health risk and how much is caused by differences in providers' practice patterns, the availability of providers and services, and the preferences of beneficiaries. The Commission also recommends that the Secretary report to the Congress on whether and how differences in use and preferences should be incorporated into Medicare FFS payments and M+C payment rates. We recognize that payment policies intended to limit variation in local practice patterns under the FFS program would be difficult to formulate and even more difficult to implement.

In the absence of any change in law, higher M+C payments in floor counties raise the potential for plans and providers to earn above-normal profits. The Secretary should monitor the extent to which payments in those areas result in higher insurer profits, higher provider payments, and extra benefits for enrollees. The focus should be on areas with large divergence between M+C payment rates and FFS spending and on areas with few plans available (because the absence of competition reduces the likelihood that higher payments will yield additional benefits).

MEDICARE+CHOICE AND RURAL AREAS

Even with the introduction of floor payments, Medicare+Choice HMOs have been reluctant to enter rural areas. In 2001, only 14 percent of Medicare beneficiaries living in rural areas have access to an M+C HMO, compared with almost 80 percent of those living in urban areas. The difference between rural and urban areas in the availability of additional benefits is even more striking: 8 percent of beneficiaries living in rural areas have access to a plan offering prescription drug coverage compared with two-thirds of those living in urban areas.

The reluctance of managed care plan to enter rural areas reflects a number of factors, including the difficulty plans face in establishing provider networks that meet regulatory guidelines and the lack of incentives monopoly providers have to negotiate with them. Further, returning to a system that links Medicare+Choice payment rates to local FFS spending would, in the absence of other changes, mean that payment rates were subject to large swings, as was the case under the risk contracting program.

The availability of intermediate entities, such as independent practice associations and large groups practices, can make the formation of networks easier for managed care plans and allow them to pass on risk in the form of capitated payments. Because these intermediate entities are not as commonly available in rural areas as in urban areas, plans seeking to form networks might have to do so provider by provider—a costly method. Also, capitated payment arrangements may not be feasible;

HMOs in rural areas commonly reimburse physicians on a FFS basis, which limits their ability to generate efficiency gains.

In urban areas with large numbers of providers, managed care plans often can negotiate discounts. In rural areas, hospitals and physicians with few competitors have little incentive to accept payment rates below fee-for-service Medicare. Further, even if plans could deliver significantly higher patient volume in exchange for lower payments, many rural physicians would not be in a position to accept them; they already work longer hours and see more patients than their urban counterparts.

That rural areas are not conducive to managed care is not unique to Medicare. Proximity to urban areas correlates with managed care penetration in the commercial insurance market and in Medicaid. HMOs are not available in all counties in the Federal Employees Health Benefits Plan and eight predominantly rural states have no HMO available in any county.

Although managed care plans may be unwilling to enter rural areas, the Medicare+Choice program allows other types of plans to participate. The program has recently seen the entry of a private fee-for-service plan in 25 states (predominantly in floor counties) whose operations are not dependent on establishing networks of providers. Approval of another plan is pending. Under current law Medicare will pay artificially high rates to these plans for the same unmanaged care that the traditional program delivers.

In the absence of a floor under Medicare's payments to health plans, what steps could be taken to encourage participation? MedPAC is examining alternatives to full risk capitation, but makes no recommendations on specific solutions at this time. The Commission does, however, recommend that payment areas be expanded to reduce the volatility in local payment rates that could occur if the floor were removed.

The Medicare+Choice program asks plans to absorb all of the financial risks for beneficiaries' health care. Two alternatives to full-risk capitation are primary care case management (PCCM), which is widely used by the Medicaid program, and split capitation, under which the program could delegate risk for some services while retaining risk for other services.

Under PCCM, primary care providers are paid a small amount per member per month in addition to payments for patient encounters. Over 60 percent of rural counties participating in Medicaid managed care used PCCM in 1997. PCCM is popular among Medicaid beneficiaries, but would be unlikely to generate the extra benefits that Medicare beneficiaries desire.

Under split capitation, entities would bear risk only for the services under their control. For example, a multi-specialty group practice could take full risk for physicians' services and no risk for hospital inpatient services. Much of the efficiency gain that comes from managed care, however, stems from limiting referrals and reducing inpatient admissions. Physicians who were not at risk for those services would have little incentive to reduce them if they did not benefit in some way.

Finally, one step the program could take involves enlarging payment areas to reduce volatility in payment rates and make payment areas correspond more closely to the markets in which beneficiaries receive care. In counties with relatively few Medicare beneficiaries, the presence or absence of a few large claims can lead to swings in average fee-for-service spending at the county level. Under the risk contracting program, swings in FFS spending caused volatility in payment rates to managed care plans; such swings also would be an issue under MedPAC's recommendation to make M+C payment rates comparable to fee-for-service costs. MedPAC recommends that the Secretary explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.

PREPARED STATEMENT OF VICTOR E. TURVEY

Thank you Mr. Chairman and Members of the Committee for the opportunity to testify on our experience in the Medicare+Choice program. I am Vic Turvey, Midwest President of UnitedHealthcare, responsible for our Midwestern health plan operations, including Medicare+Choice offerings in Iowa, Nebraska, Missouri, Wisconsin and Illinois. I am pleased to speak on behalf of our experience in your home state as well as in the other adjoining states where we do business.

UnitedHealthcare, and its parent company UnitedHealth Group, have a long-standing commitment to Medicare beneficiaries. Our participation in the Medicare program is fundamental to our core mission—to support individuals, families, and communities to improve their health and well being at all stages of life. We aim

to facilitate broad and direct access to affordable, high quality health care through a variety of arrangements and to be there when people need us most.

UnitedHealth Group is the largest provider of health care services to seniors in America. For over 20 years, we have provided seniors and disabled individuals a comprehensive alternative to traditional Medicare benefits, now known as the Medicare+Choice program. Today, over 400,000 beneficiaries are enrolled on our health plans in 25 different markets across the country including over 10,000 members in Pottawattamie County in Iowa and neighboring Douglass County in Nebraska. Through our EverCare program, we provide coordinated care services to an additional 20,000 frail elderly individuals in various care settings (under the auspices of Medicare+Choice). In addition, through AARP's Health Care Options program, we provide Medicare Supplement ("Medigap") and Hospital Indemnity insurance to roughly 3.5 million AARP members nationwide.

We bring value beyond the traditional Medicare program by coordinating the fragmented, diverse elements of the health care system and organizing the delivery of care around the best interests of the patient. Since 1996, we have offered Iowa and Nebraska beneficiaries a health plan that requires no additional premium beyond the monthly Part B premium. Beneficiaries who enroll in our plans get comprehensive coverage, much like the commercial coverage that many had through their employers. They benefit from many of our value-based offerings such as individually assigned customer service representatives, access to a 24 hour nurse line and internet-based health information resources, and programs that track their special health conditions and remind them to get regularly scheduled diagnostic tests. They also become a part of our Care Coordination program where dedicated nurses follow their hospitalizations and make sure that services are understood, accessible and coordinated before, during and after they are in the hospital. These services are unavailable outside of the Medicare+Choice program.

The Medicare+Choice product—and program—has undergone considerable change during the past 20 years. One thing that has remained constant is our desire to provide members access to a broad network of providers and comprehensive coverage for benefits. When that cannot, in our opinion, occur we have ceased participating in the particular market.

Issues unique to rural Medicare+Choice offerings

While Pottawattamie County is not exclusively rural (it encompasses the greater Council Bluffs area and some adjacent rural areas), I can share with you some of the unique—and not so unique—experiences we have had in developing, marketing and providing health care coverage in the county's rural areas as well as in other rural counties we serve across the country.

Recruitment of New Beneficiaries: One of the greatest challenges facing rural Medicare+Choice arrangements is the addition of new members. Plans need members to exist and sufficient volume to leverage discounts with hospitals and physicians. These days, beneficiaries are becoming increasingly hesitant about Medicare+Choice. Rural beneficiaries are often not as familiar with managed health care arrangements as their urban and suburban counterparts. Those who are familiar are understandably skeptical, having heard about the many Medicare+Choice exits in rural markets. We have heard from many seniors that they are receiving sales calls from Medigap brokers who tell them that they should not take a chance on Medicare+Choice because it won't be around for the long term. As a result rural beneficiaries demand much more time and information to close a new sale. Agents must first work to establish the plan's reputation in the market, then explain how the Medicare+Choice program works, and then walk the beneficiary through a line-by-line description of the plan and how the coverage improves upon traditional Medicare benefits.

Provider Partnerships: Two of the biggest hurdles in providing quality coverage to beneficiaries is the development of a broad physician and hospital network and the ability to establish a shared philosophy of practice and care coordination throughout the network. Network development is difficult in rural areas, and is becoming increasingly so. The limited supply of physicians and hospitals effectively means there is little incentive to enter into risk-sharing contracts with Medicare+Choice plans who cannot compensate them at the same level as traditional Medicare and cannot assure additional patient volume beyond their current load. To the extent that hospital systems and physicians continue to act this way, rural beneficiaries will face limited choices and coverage options.

Reimbursement: In rural areas, the reimbursement level has a strong effect on our ability to offer benefits beyond the standard Medicare offerings and to contract with physicians and hospitals. Our rural counties are all considered "floor" counties, and thus benefited from the payment increase under the Medicare, Medicaid and SCHIP

Benefits Improvement Protection Act of 2000 (BIPA). However, the payment increase still lags behind overall medical trend. Hospitals also received a considerable Medicare payment increase under BIPA, exacerbating our ability to offer competitive reimbursement, as most physicians in these areas are associated with or employed by a hospital system or physician hospital organization. This, in turn, means that programs with rich benefit coverage—such as coverage for prescription drugs—cannot be offered economically to beneficiaries in these areas.

Issues across all Medicare+Choice offerings

In many parts of the country, our Medicare+Choice members are experiencing the fall-out of many of the same issues that the program is facing in rural areas. They are seeing the richness of benefit coverage decrease and at times, are forced to switch physicians as provider groups end contracts with health plans mid-year.

Reimbursement: In our experience, beneficiaries have seen a deterioration of benefit offerings since enactment of the Balanced Budget Act (BBA) in 1997, as annual payment increases have not kept pace with inflation. We have been able to continue to provide quality coverage to beneficiaries in many markets by streamlining our administrative procedures. We also have had to adjust benefit coverage, increasing copayment amounts for outpatient visits and hospitalizations and reducing or eliminating our coverage for prescription drugs. In almost half of our Medicare+Choice markets we no longer offer coverage for outpatient prescription drugs. Where we do offer coverage, the annual maximum is in the \$200 to \$500 dollar range (with the exception of Dade County, Florida where it is \$1,500) with coverage limited to generic equivalents or steep copayment differentials for generic and brand. While we would like to see additional funding for the program, we believe that fundamental reform of the reimbursement system is necessary to address the many moving parts of the payment system and ensure long-term stability and viability of the program.

Provider Contracts. Hospital systems and provider hospital organizations are demanding increasing reimbursement from our health plans—particularly as the gap between their payment for services under the traditional Medicare program and Medicare+Choice plans grows and they can pick and choose between participation in the two programs. As mentioned above, BIPA served to widen the gap considerably as hospital payment increases generally outpaced Medicare+Choice increases. Consequently, in most markets we were forced to dedicate all BIPA increases to hospital and physician reimbursement to meet their contracting demands. In some markets, physician groups simply can no longer afford to do business with us and have ended their contracts mid-year, inconveniencing our members who often have to find new primary physicians in the remaining network or disenroll from their health plan to maintain their physician relationship.

Our success in urban areas—specifically, St. Louis—has been primarily with sophisticated physician groups who know and understand how to capitalize on the valuable data we can provide to them and accordingly how to manage shared risk effectively. We believe that UnitedHealthcare is unique in its ability to track utilization patterns and outcomes data, and this powerful information makes it possible for physicians to deliver quality care to their patients while sustaining the financial viability of our relationship with them. Unfortunately, this level of sophistication rarely exists in rural areas. It can and should be developed, and UnitedHealthcare can do that, but it will take time and an economic incentive for physicians to invest the time and effort to improve.

Administrative Issues: We believe that regulation and accountability is important and necessary to ensure fair, quality coverage for Medicare beneficiaries. However, the way that current administrative rules and procedures are established and enforced is burdensome and strains health plan resources. The complexity of Medicare+Choice administrative requirements, coupled with the lack of coordination between states, HCFA regions, and central HCFA, means that plans may face conflicting interpretation of rules and be subject to multiple audits. In addition, the number of new rules has grown exponentially since enactment of the BBA. The new HCFA monitoring guide used to evaluate health plans during their biennial site visits includes 279 items for review (not including the BIPA requirements); before BBA, there were 146 items. Our Nebraska and Iowa health plan has had to add one full-time staff person focused exclusively on Medicare+Choice compliance and reporting.

Based on our experience, the more problematic administrative items are:

- Encounter data collection. The current requirement to submit encounter data is very time consuming and costly, given questionable returns. Foremost in our concerns is the process for submitting the data to HCFA, which is cumbersome and resource intensive under the current fee-for-service based claims system.

Additionally, the scope of data required for submission seems excessive, given the more limited data that is required for risk adjustment.

- ACR process. The new June filing deadline (formerly in the fall) makes it very difficult to make accurate financial projections, and thus appropriate benefit decisions, given the limited data available from the current year.
- Marketing materials/HCFR review. The new marketing requirements, particularly the 45-day review time, makes it very difficult to get materials finalized in a timely manner. The 45-day approval time has had a particular impact on our ability to communicate product changes with our members within the required 30 day timeframe, often leading to confusion for our members who hear about changes in media reports, but then fail to receive notice until much later. Moreover, the prescriptive nature of the review often requires the materials to be sanitized, taking away our ability to make sales statements based on our unique attributes. In our Nebraska and Iowa counties, the delay in HCFR approval has had a specific impact on our sales efforts. Direct mail materials that usually are sent out in February are just now being mailed out due to multiple communications with HCFR prior to final approval.
- Regulatory implementation. The frequency and content of new regulatory and policy changes has increased staff time and resources considerably. In 2000, HCFR issued 15 new Official Policy Letters (OPLs), two revisions of one OPL, and the final Medicare+Choice regulation (the "mega reg"). Additionally, new policies have been issued on national coverage of clinical trials, revisions to the standard summary of benefits, and enrollment policies due to Medicare+Choice plan non-renewals. Inconsistencies between regional offices and central HCFR add to the strain of regulatory interpretation, particularly for national health care organizations, such as UnitedHealthcare.
- 2002 Enrollee "Lock-In." The new lock-in requirement, which will be phase-in beginning next year, will likely add to beneficiary confusion and anxiety about the product, placing additional strains on a Medicare+Choice plan's ability to attract and retain members. Currently, one of our greatest selling points is the ability to disenroll at any time throughout the year if members become dissatisfied with the plan and want to switch to a different one.

How do we fix the program and ensure its future viability?

While there clearly are a number of obstacles facing the current Medicare+Choice program, we believe the program continues to have much to offer seniors and disabled individuals and believe there are a number of changes that could significantly enhance the future viability of the program. First and foremost, we believe that the program must undergo fundamental reform to provide beneficiaries broad choices of coverage that best meet their needs and the kind of coverage they will be able to enjoy and count on for years to come. Absent such reform, Medicare+Choice may not be sustainable in rural America.

There are four key areas for reform: reimbursement, administrative simplification, provider relations, and evolutionary program design.

- Fundamental reform of the reimbursement system is necessary to address the many moving parts of the payment system and ensure long-term stability and viability of the program. A fair, competitive payment approach that is more closely aligned with current medical cost trend and factors in cost variability in rural and urban markets is desirable.
- A thorough review of current administrative requirements with an aim to streamline processes, improve coordination and eliminate items that have negligible benefits for members would be advantageous.
- Congress should explore the increasing difficulties with hospital and physician participation in Medicare+Choice, focussing particularly on Medicare+Choice plans' limited provider payment leverage in rural areas.
- Reform of the system must recognize the evolutionary nature of the health care system, developing a program that allows for change as the system warrants. We encourage Congress and HCFR to study successful contracting arrangements in the employer sector, including non-risk-based alternatives, as the basis for its own contracts with private health plans. HCFR could operate like an employer who leverages its assets by self funding employee health coverage and partnering with health plans, like ours, to bring value to their offerings by administering and managing the health and operational aspects of the benefit.

Medicare+Choice has much to offer. We encourage Congress and HCFR to experiment with different types of product offerings within Medicare that are tailored to specific populations and geographic areas. To this end, we already have begun to explore options with HCFR that bring the many unique, value-based attributes of our product offerings to the more traditional Medicare benefits and may be more

sustainable in rural markets. Working together to address many of the items raised today, we can help to develop a renewed Medicare program that meets the needs of today's and tomorrow's beneficiaries in rural America and across the country. The problems with the program are very real, but there is a great opportunity for positive change.

Thank you for the opportunity to share our thoughts. I would be happy to answer any questions you might have.

COMMUNICATIONS

STATEMENT OF ADVAMED (ADVANCED MEDICAL TECHNOLOGY ASSOCIATION)

AdvaMed is pleased to present this testimony on behalf of the world's leading medical technology innovators and the patients we serve. As the largest medical technology trade association in the world, AdvaMed is committed to ensuring that patients have timely access to the advanced medical technologies that can save and improve their lives and help reduce health care costs.

AdvaMed represents more than 800 medical device, diagnostic products, and health information systems manufacturers of all sizes, from small start-ups to global leaders. AdvaMed member firms provide nearly 90 percent of the \$68 billion of health care technology products purchased annually in the U.S. and nearly 50 percent of the \$159 billion purchased annually around the world.

Access to Technology under Medicare

Innovative technologies often are available to working-age Americans covered by private insurance long before they are covered by Medicare. Examples of this include screening tests, positron emission tomography and ultrasound fracture healing. In some of these cases, technologies covered by private insurers for several years still are not available to America's seniors under Medicare.

Medicare faces the dual challenge in the coming decade of containing sharply rising costs and improving access to innovative technologies. This challenge comes as America stands at the dawn of an era of unprecedented medical advances that will enable patients to live longer, healthier lives and help control costs, but Medicare must be fundamentally reformed if we are to meet this challenge.

Congress has taken important steps in the past few years to improve the benefits available to seniors under the Medicare program and increase access to preventive health technologies and other technological innovations. However, the inability of a government-run system to cope with the challenges of the coming decades stems fundamentally from the nature of such a system, no matter how much it is improved.

A Medicare program based on patient choice and competition can achieve financial stability and improve access to high-quality care. When held accountable to consumers' choices through market competition, health plans will quickly adopt the high-quality, innovative products and services that patients need. Legislation that has been crafted by Senators William Frist (R-TN) and John Breaux (D-LA) offers one model for creating such a system.

A competitive Medicare system will foster and reward innovations that improve outcomes, reduce costs and enhance patients' quality of life. However, the traditional fee-for-service Medicare program should be retained and administered by the Health Care Financing Administration as one of the many health plan options available to seniors.

The Role of Innovation in Helping Address the Challenges Facing Medicare

AdvaMed shares the concerns of the Members of Congress, the Administration and seniors across the country about the financial state of the Medicare program. AdvaMed believes that medical technology offers the solution to rising health care costs. Ensuring timely adoption of medical advances by Medicare is crucial not only for the health of America's seniors and people with disabilities covered by the program, but for the fiscal health of the program itself.

America is on the cusp of a revolution in medical technology. Through advances in technology we can detect diseases earlier when they are easier and less costly to treat, provide more effective and less invasive treatment options, reduce recovery times and enable people to return to work much more quickly.

In order to reap these benefits, advanced medical technologies must be rapidly assimilated into the health care system. The Institute of Medicine's recent report, "Crossing the Quality Chasm," underscored this pointing, stating: "Narrowing the quality chasm will make it possible to bring the benefits of medical science and technology to all Americans in every community. . . .and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce."

In a statement on the Trustees' Report, Treasury Secretary and Medicare Trustee Paul O'Neill cited this IOM report in highlighting "tremendous potential for improvements in the health care sector." AdvaMed shares this concern, as well as Secretary O'Neill's understanding of the importance of adopting new technologies and medical practices that can transform the health care sector by improving quality and reducing costs. As Chairman of Alcoa, O'Neill championed the adoption of so-called "disruptive" technologies as the solution to rising health care costs. In a recent *Forbes* article, O'Neill stated: "It is possible to improve the health and medical care value equation by as much as 50%."

Congressional Steps to Improve Patient Access to Technology

The steps Congress took in the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act (BIPA) of 2000 will help ensure that advanced medical technologies are adopted by Medicare in a timely manner. The technology access provisions in these bills help move us into the New Health Economy of higher quality and lower costs.

These bills made important changes to streamline HCFA's coverage, coding and payment procedures, including: requiring HCFA to report annually to Congress on the timeliness of its coverage, coding and payment decisions; streamlining the Medicare Coverage Advisory Committee process; establishing transitional payment mechanisms to support adoption of breakthrough technologies used in the hospital inpatient and outpatient settings; and reducing delays in establishing codes and reimbursement rates for new diagnostic tests.

HCFA should rapidly and fully implement these important measures to improve health care quality by eliminating roadblocks to patient access to innovative medical technologies. The agency and Congress should examine additional steps that should be taken to ensure that Medicare patients have access to 21st century medicine.

The BBRA and BIPA legislation enacted by Congress help move HCFA toward a leadership role in supporting timely patient access to quality-enhancing innovations. AdvaMed believes it is critically important for the agency to take the lead in this area, and can do so by achieving the following goals:

- **Eliminate delays in coverage coding and payment for new technologies.** BBRA and BIPA legislation will help accomplish this goal. HCFA and Congress should take additional steps to reduce access delays, such as issuing codes on quarterly basis and establishing coverage requirements that recognize broad range of reliable data that can support coverage decisions.
- **Establish payment incentives that support quality health care.** BBRA and BIPA help eliminate payment policies that discriminate against advances in care by systematically under-reimbursing for them for two to three years after they are introduced.
- **Support creation of an integrated health care information infrastructure.**
- **Give patients more control over health care decisions.** HCFA should set coverage policies that give doctors and patients flexibility to make their own medical decisions.
- **Develop policies and methodologies that recognize the full benefits of medical technology.**

Again, AdvaMed applauds Congress for recognizing the value of technology in improving the quality and efficiency of the health care system, and taking steps to reduce the barriers patients face to accessing these innovations. Recent reforms continue to improve the system and AdvaMed encourages additional changes to make coverage, coding and payment decisions more predictable, transparent and timely.