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NEW DIRECTIONS IN MEDICARE

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BEFORE THE

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UNITED STATES SENATE

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NEW DIRECTIONS IN MEDICARE

TUESDAY, JULY 25, 1995

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

The hearing was convened, pursuant to notice, at 9:35 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Roth, Chafee, Grassley, Hatch, Simpson, Moynihan, Baucus, Rockefeller, Breaux, and Moseley-Braun.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, Senator Kerrey.

Senator KERREY. I see I have specific instructions to limit my testimony to 10 minutes.

The CHAIRMAN. We knew that you are normally able to do it in 3 or 4, and we did not want to so constrain you.

Senator KERREY. Well, Mr. Chairman, I have testimony that I will submit for the record, and I have some notes. I hope it does not take longer than 10. If it does, you can——

The CHAIRMAN. I have just read it. Why do you not go right ahead and start.

STATEMENT OF HON. J. ROBERT KERREY, A U.S. SENATOR FROM NEBRASKA

Senator KERREY. First of all, there is no question that this committee has the toughest one of all the budget problems. And it is clear to me that the reason we are doing this is that we are genuinely set about the task of eliminating this Nation's deficit, the fiscal deficit that has troubled us for so many years.

Your task under the budget resolution is larger than all the other committees combined. Again, I say for emphasis, I do not believe this committee would be about this business if the only challenge was to do something about the trustees warning us that Medicare is going to be insolvent in the year 2002.

This committee has this task before it because we are trying to get rid of the deficit. And we are trying because we believe that eliminating the deficit will increase savings, and it will also increase economic growth. I think it is very important to lay that out in front. I believe that that will occur, that $1 trillion of new savings which will come as a result of deficit reduction, will stimulate economic growth and, as a consequence of the stimulation of eco-

nomic growth, the Federal Government will take in more money. There is an economic argument to do this.

I would like to help in this task. I voted for the first budget resolution; I did not vote for the second because I thought the tax cuts were unwise. I still believe that they are unwise. I voted for the first one sort of reluctantly. I think that we should not, and do not, need to be doing this at this particular time.

I understand the political dynamics of it. The 70 or so House members who campaigned on the Contract of America have that out there, and it is a difficult political problem.

I hope for, and indeed see, a way for this entire exercise to be bipartisan by the end of the year, and would like for it to be. I would like to be on board. In particular, I would like to enthusiastically support the work of this committee.

In order to do it, Mr. Chairman and members of the committee, one of the things I think is important to do is shift our attention a little to a problem that, in my judgment, is more troubling than the deficit itself. There are trends that are more troubling than the forecasts of where our fiscal deficits are going.

The first trend is this inexorable growth of entitlements, as a percent of our total budget. Under the budget resolution, the entitlements will grow from 66 percent of this year's budget to 75 percent of the budget in the year 2002. Imagine what would happen if we were allocating $400 billion of appropriations for defense and non-defense this year. That is basically the job. And I do not think any of us would have a ready proposal to be able to do that.

So the first problem with the trend of the growth in entitlements is that we are seeing a reduction of our capacity to make collective investments. I benefited, made a lot of money before I got into politics, as a result of my parents building the interstate highway system with cash, as a result of the GI bill and lots of other things. We could not build the interstate highway system or do a GI bill today because our domestic discretionary accounts continue to be eroded.

The second problem is that we have this huge unfunded liability. We look at our income statement; we do not like to talk about our balance sheet. On our balance sheet, we have about $11 trillion just in Medicare and Social Security, with about $2 trillion of assets, if we were lucky enough to find a buyer for everything that we own.

The third problem is that we have—it is a little difficult to say this—when I put a promise to pay somebody's bills, at some point in the future, on the table, that reduces the incentive that individual has got to save, to put money aside for the future.

There is another trend I would call to the committee's attention that I consider to be a real threat, both to free enterprise capitalism and a liberal democracy. And that is a widening economic gap between the economic haves and have-nots, both in income and in wealth. There is a concentration of wealth, and widening gap of incomes, that I think it is fair to say jeopardizes and threatens both free enterprise capitalism and liberal democracy.

Looking at those trends, the question occurred to me as I was preparing my testimony, do the laws this committee addresses itself to have anything to do with those trends?

Is there anything this committee could do, as far as changing our laws, that would have an impact upon those trends in a positive way? And my answer is yes—at least in five ways. I will eventually get to health care here, Mr. Chairman. I appreciate your indulgence, if that is what I am getting at the moment.

The first is, as I indicated, entitlement growth reduces our ability to make collective investments. There is still a lot of waste in Government, but there are a lot of areas where Republicans and Democrats unquestionably agree that, if we can collect some tax money and make this investment, it will undoubtedly increase both our current and future productive capacity.

Second, retirement programs are not savings programs. So, as a result, we are not generating incremental wealth for individuals. We are creating a pool of resources to be distributed at the moment of retirement.

Third, our tax system penalizes savings and discourages this incremental accumulation of wealth that is so necessary if we are going to deal with this concentration of wealth issue.

Fourth, our pension laws make it difficult for people to save.

Fifth, this is a rather difficult proposition, but I believe it to be true. Anytime I put a promise to pay on the table, that is unquestionably going to have an impact. It is going to say to somebody that they do not need to save or worry about that, because somebody else is going to take care of that for them.

Mr. Chairman, and members of the committee, as I thought about how we can break out of this grid we are in right now, where we are basically going to give the President a bill that he is threatening to veto in the fall, I came up with some ways that I think we could break out.

First, I hope this committee considers writing a bill that prohibits mandatory spending and interest from exceeding 70 percent of our total Federal budget.

Second, I hope that this committee considers writing a bill that converts our retirement programs into a savings program, or at least a piece of our retirement programs into savings programs.

Third, I hope this committee will consider writing a law that moves us from the progressive taxation of income to a progressive taxation of consumption.

And, fourth, I hope that this committee considers writing a law that changes the Government's promise to pay our health care bills, which brings me now to the subject that you asked me to come here for today.

There are going to be a lot of people say that we cannot do those things. There is not enough time, we have 90 days, it cannot be done. I argue, not only can it be done, but it should be done. Because, Mr. Chairman, members of the committee, when you look at the negative impacts of compounding interest when they are working against you, time is unquestionably not on our side.

You asked me about Medicare and Medicaid. Please note that, for my purposes, I framed the question somewhat differently than what do we do about Medicare and Medicaid? My question is, what kind of promise do we want to make? What kind of promise to pay bills do we want to make?

Current law says that we promise to pay the bills if your kidneys malfunction. We promise to pay the bills once you reach age 65. We promise to pay the bills if it can be determined that you are poor. We promise to pay the bills if it can be determined that you are disabled. And we promise to pay the bills if you get blown up in a war.

No effort is required on the part of individuals, beyond merely proving that you have met one of those categories, and other categories besides. Those are the main categories that are in place.

I argue that one of the principal problems that condition creates is that no effort is required, no effort on the part of the individual, other than proving that they have met that categorical requirement.

In addition, there are other problems, such as an open-ended payment system and little use of the market force. People are taking earlier retirements, working shorter work lives. They are living longer than before. We have 75 million baby boomers that are coming on line in the year 2008, which is the biggest problem of all.

Technology and science continue to make discoveries that are typically quite expensive. And, finally, there is still a substantial amount of fraud in the system.

I would recommend three courses of action to this committee in the area of health care, in what I would consider descending order of preference.

The first preference is that I would prefer to see you write a bill that says the following: Title I, abolish all previous Government programs, clean the slate. We have about $400 billion in subsidies of Medicare, Medicaid, tax deductions, VA. Take it all, put it all together and say all right, how do you become eligible?

I would say in Title II, if you are an American, or a legal resident, you are eligible and in the system.

There is a continuing problem of access in America. In 1994, 2 million Americans were added to the insurance rolls, as a consequence of getting private insurance at the workplace. Four and a half million Americans lost their insurance as a consequence of where they work. That is a 2½ million net decline in the number of insured Americans.

Fortunately, State and local governments added 1.4 million Americans to the rolls of the insured, leaving 1.1 million Americans exposed as a consequence of that dynamic.

So I would start Title II saying, if you are an American or a legal resident, if you are on Medicare today, the best way to get Medicare security, in my judgment, is to abolish the current system and start with a clean slate, saying if you are an American or legal resident, you are in.

In Title III, I would say that you should pay according to your capacity to pay. And there should be incentives, as well, to acquire the capacity to pay for that rainy day.

Title IV, I would say that all subsidies ought to be funded in the current year. We should do no deficit reduction. Whatever we decide we want to put out there in the way of subsidies, whatever we decide we want to put out there in order to help people pay the bills, we ought to have to pay for them in the current year.

Title V, I would let the price that is paid to the providers be determined in negotiations between private payers and private providers. I apologize. That last title is a bit vague, but I just wanted to generally state my philosophical belief that it is going to be impossible for Congress in an economical fashion, let alone a moral fashion, to be able to set those prices.

Second choice for me would be to write a bill that phases in changes, so that the Federal health expenditures do not grow as a percentage of our budget. Senator Danforth and I have details in the Bipartisan Commission on Entitlements. Only he and I supported the recommendations. You can see the kinds of recommendations we had to do in order to get the Federal expenditures for health care fixed as a percentage of our budget.

They are not terribly popular. I suspect that is the reason only Jack and I supported them, although Senator Simpson had a proposal that was nearly as ugly as ours. There is no question that, in general terms, you have to ask people to pay more. You have to ask some providers to take less.

There is no magic formula in here. We do believe that providing choice to individuals and using the market forces would provide some savings. But it is very significant, and I am sure you will learn it as well, that the new CBO is not likely to be any more generous than the old one was. When it looks at managed care, it is not likely to give us much in the way of savings, so you are apt to have to look at asking people to pay more.

An important objective of option number 2, that is not currently being planned, is that you fix the cost of entitlements. You fix the cost of that Federal entitlement as a percent of the overall budget.

I know you all have looked at this thing. But, when we say that the budget nose ends in the year 2002, we are conveniently ignoring what happens when 75 million Americans, an unprecedented move from working to retired, move into the ranks of retired, starting sometime roughly in the year 2008.

The third option is sort of nature takes it course, or political nature takes its course. Follow the instructions of the non-binding budget resolution. I would recommend that you use the vouchers and the market that you regulate to prevent the kind of skimming that will unquestionably occur. If you do not, I would recommend that you put some kind of test of means or affluence, so that people have to make a contribution according to their capacity to pay. Focus upon fraud.

And, most importantly of all, you say to us baby boomers that we are going to have to start to phase in a different kind of promise. We may not be able to resolve it this year, but for God's sake let us begin to plan for what happens when this unprecedented number of people move into the ranks of retired.

I hope you do not do number 3. I would prefer number 1. I prefer that we do some kind of a break-out option this year. I think the political landscape is right for it. It seems to me that there is a lot of enthusiasm out there to do things differently. And I believe there is a lot more bipartisan consensus than typically meets the eye.

As a Democrat, I support progressivity. And I support less concentration of wealth and power. I support incomes that grow with productivity, and I support taking care of the poor.

However, Mr. Chairman and members of the committee, I also support economic growth through deficit reduction. I support programs that increase savings and investment. And I support programs that provide rewards for individual initiative.

I indeed hope—and, for what it is worth, I also pray—that this committee is able to come up with a blueprint that will actually run a bit away from the budget resolution, and say that if we really want to solve not just the problem of the deficit, but the problem of declining savings and concentration of wealth, and widening economic gaps, we have to do things much differently than this nonbinding resolution provides.

I thank the Chair. I thank the members of the committee.

The CHAIRMAN. In the non-medical part of your comments, you made some reference to progressive taxation of consumption. I did not get it that this was in lieu of progressive taxation of income, but in addition to it. Tell me what it was that you said.

Senator KERREY. It would be in lieu of. I support the Nunn-Domenici U.S.A. tax as a replacement for the current income tax system. And the four general things that does, it says that if I save money I am not taxed on it.

It says that I can deduct the cost of my payroll tax, the most regressive tax that we currently have in place. It says that if I am an exporter, I am not taxed on that export. If you are an importer, you are going to be. It allows for that.

And it says as well that, if I am a business, it is investing in capital. If I am making a capital investment, I am not going to be taxed on that capital investment.

The CHAIRMAN. It also says that you therefore can have great accumulations of income untaxed, as long as you do not consume it.

Senator KERREY. That is correct.

The CHAIRMAN. That would fly in the face of the theory of progressive income tax.

Senator KERREY. No. It actually maintains progressivity. Frankly, I would prefer that the tax on consumption be steeply progressive. I would prefer a steeply progressive consumption tax. But the Nunn-Domenici proposal does maintain progressivity.

The CHAIRMAN. Point 2, under Medicare, I believe people ought to pay for Medicare according to their capacity. Where do you draw the line?

Senator KERREY. Well, under the Kerrey-Danforth proposal, which again is option 2, is nowhere near as attractive to me as option 1, to be clear on this.

I would prefer a system that said, if you are an American or a legal resident, you are in.

The CHAIRMAN. You are in, but you have to pay for part of your own care if you can afford it.

Senator KERREY. That is right.

Not only should you have to pay, according to your capacity to pay, but there should be incentives that enable you to acquire that capacity to pay.

I do not like the idea that we have a basically open-ended promise to pay on the table, which says that no effort is required at all, not only in terms of income, but in terms of wealth that you generate.

In our proposal which, as I said, is option number 2, we start the test at $40,000 income.

The CHAIRMAN. Individual?

Senator KERREY. Individual. And the target we have, the problem that we tried to solve, which I think is a bigger problem than the deficit, is this growing cost of entitlements as a percentage of our budget. We did not even get to balance. We did not balance our budget.

And one of the principles we had is that we have time. If you trying to fix the cost as a percentage, you have time to plan, and you ought to give people time to do their own individual planning.

So we phased the changes in. Some of them took effect immediately, but some of them were phased in.

The CHAIRMAN. As a matter of fact, it is only a modest few of the entitlements. We have 410 entitlements, but the bottom 400, collectively, cost about plus or minus $50 billion a year. And top four, plus interest, cost $900 billion a year.

Senator KERREY. That is right.

The CHAIRMAN. And we can wipe out the bottom 400, and each year we would eat up the increase in the top four unless we did something about it.

Senator KERREY. That is correct. That is correct. And the two biggest ones are health care and retirement.

The CHAIRMAN. Those are the big four—Medicare, Medicaid, Social Security and then other Government retirement, military or civilian, plus interest.

Senator KERREY. And to be clear on retirement—perhaps not to be clear, to state it and you be the judge of whether it is clear—there are two problems with the retirement accounts. One is an unfunded liability that we have on the table, a liability that is going to be awfully difficult for us to fund. We have a promise to pay that I think is going to be difficult for us to pay. By the way, I think we need to maintain that contract.

The second problem is, because it is not a savings program, individuals do not have the opportunity to accumulate wealth. In the proposal Senator Simpson and I put in, by taking 2 percent of the individual payroll tax, and allowing that to go into a personal investment plan that would be run by Social Security, very much like our Federal retirement program, the individual has something that they own. Admittedly, it is 2 percent.

I have been toying with a proposal that would make it more progressive, so that you would have a minimum of $1,200 being contributed. This means you would have to allow 12 percent to flow at $10,000 and 2 percent at the $60,000 cap. But if you have a $1,200 contribution over a 45-year working life, and let us say that you put in S&P 500's top 100 capitalized stocks, you are going to get 8 percent real rate of return. Over 45 years, you are going to get a compound of six or seven times. And six or seven times, compounded at $1,200 a year, enables that individual to actually become wealthy, even at $10,000 a year. A person at $10,000 a

year can become wealthy if we change our retirement system. It is far better to have that individual become wealthy and have the resources to retire. Then Social Security continues as it was intended to be, a supplement for retirement income.

The CHAIRMAN. Would you limit what they can invest in?

Senator KERREY. I would put limitations on what they invest in, yes. I would not let them invest in Orange County, for example. [Laughter.]

Yes, I would limit it, very much like the Federal Employee Retirement System is limited. There are limitations on that.

When I say that the Social Security Administration would operate it, they are private sector investment pools. Federal employees are making private sector investments. It is not a Government investment strategy. It is just that they have a much more exciting rate of return than a non-negotiable Treasury bond.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Wow. We have our work cut out for us, do we not?

The CHAIRMAN. Well, we have got 2 weeks.

Senator KERREY. You have what, 2 weeks?

Senator MOYNIHAN. The only question I have never understood is, why is it that Senator Kerrey has never asked to be on this committee, since he thinks this is where all the work gets done?

Senator KERREY. I have asked.

Senator MOYNIHAN. To make a point in much agreement, you remarked that you voted for the budget reconciliation legislation in 1993. And that brought us a deficit decline of $500 billion.

Just last Friday, the Deputy Secretary of the Treasury Designate, Dr. Summers, was here for his confirmation hearing. And we spoke of the reduction in what they called the deficit premium on interest payments. He said that interest costs are now down 100 basis points in the aftermath of that 1993 legislation. In terms of managing the Federal debt portfolio, that is an enormous amount of money, just there. We got that just for doing what we ought to have done, and done more, as you stated.

Senator KERREY. You also pushed back the due date of Medicare insolvency by a couple of years.

Senator MOYNIHAN. That is right. That is right.

Just to share with you, although you know it, but to make a point for the record, entitlements are——

Senator KERREY. It should be pointed out that, since you persuaded me to vote for that thing, you can take some satisfaction in——

Senator MOYNIHAN. Well, I want you to think it was not as bad as you thought at the time.

On the future of entitlements, I do not know if it is going to help or not, but there is a little bit of history here.

In 1977, in the Social Security Amendments of that year, we made the decision to move away from the pay-as-you-go basis that had been put in place in 1935, in the middle of a depression, which probably helped trigger the 1937 crash, even as it was. But we decided to go in a more stable setting to a partially funded system.

We put in place a surplus which would buy the New York Stock Exchange. But the only way you could actually save it would be to

have a balanced Federal operating budget so that the surplus from the trust fund brought down the Treasury debt held by the public. And the exact inverse is an increase in private savings.

We do not do it. We are coming to the end of that surplus. We have spent it all on current consumption, and have not saved a penny. But, even so, those trust funds are still in surplus.

Mr. Chairman, we have to increase the debt ceiling pretty soon now, or all of this will be a very theoretical discussion anyway. But, for the next 2 years, we have to increase the debt ceiling by $600 billion. Four hundred billion represents true deficit, $200 billion represents the Treasury debt that is exchanged for the income of the trust funds, which are still in surplus. They are still in surplus. We are living off of what was meant to be saved, but has not been.

But one other comment, I do think there is some good news in all this. A year ago, Dr. Ellwood, who is going to be among our distinguished witnesses this morning, told us that medical care prices were beginning to moderate. That was at a time when the official view was that they were going completely out of control. And they have indeed moderated, as I think we will hear from Dr. Ellwood later on.

But we had a note from the Chairman of the Council of Economic Advisers just a few days ago. On an annualized basis, taking off from the last 6 months, the general price index has gone up 3.2 percent. The medical care price index has gone up 3.7 percent, a difference of one-half a percentage point. This is quite a different experience from the last 20 or 30 years.

So I say, be of good cheer. You are of good cheer.

Senator KERREY. Of course.

We may get something done here yet because some of the tides are running with us.

Senator KERREY. Yes. It is easier for me to be of good cheer because it is going to be easier to keep the promises that were made to me than it will to keep the promises made to my kids. That is one of the problems I have got.

Senator, had we taken that surplus and put it into an investment account, similar to what States would do, if it was a State pension fund, rather than basically using the money to keep our deficit looking smaller—as you once said, requiring those who get paid by the hour to shoulder a disproportionate share of deficit reduction—then we would unquestionably have a larger collective pool.

That still would not deal with the other side of it, which I think is a need for individuals to acquire wealth for their own future.

I just do not believe it is possible, let alone desirable, for us to make a promise that we are going to redistribute wealth. It is far better for us to have retirement programs and a tax system that enables people to accumulate that wealth a little bit at a time, over the course of their working lives.

Senator MOYNIHAN. Thank you, Senator. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Simpson?

Senator SIMPSON. Thank you, Mr. Chairman.

I have very much enjoyed working with Bob Kerrey on many things. We are trying to do some—we think—important things in

a bipartisan way, such as a silly little thing of trying to assure the solvency of Social Security in the year 2031. It is the trustees of this marvelous program telling us exactly what is going to happen, and the trustees are not partisan Republicans or partisan Democrats. They are people who are charged by law to tell us about this system.

So those are some things we are dealing with, and the issues of the Entitlements Commission, of which Senator Moynihan was a member. Also, another Member of this panel, Senator Moseley-Braun, was a member.

So I do think that we must be paying attention. Even though we might have extended the doomsday date by 2 years, or 3, or 5, or 10, people between 18 and 34 are going to get hammered flat. That is the real issue. No one over 50 is going to get hammered at all.

The trust funds, as Senator Moynihan says, are in surplus. And that is true, except that they are really not trust funds. They are just kind of floating IOU's. If we ever found a kitty of several billions lying around like that, which could reach $2 trillion in surplus, we will blow that if we could ever find such a stable figure somewhere. But it is not; it is floating IOU's.

And in that year 2013, according to the trustees, the income will not meet the outgo. Then we will go and begin to cash the bonds, which are part of the surplus, and the Treasury securities, which are stabilized by the full faith and credit of the United States.

But I wanted to ask you, do you feel, since you started your work on the Entitlements Commission, and do you see in a cheerful way—because you are that way, a man of good cheer, as is our colleague from New York—do you think Americans are finally understanding what is happening in this arena, as to the entitlements and Medicare going broke? I mean, that is what we are told.

Senator KERREY. Yes, Senator, I do. I think, in particular, I am cheered by a willingness, if it is fair and balanced. They are going to want our retirement to be affected; they are going to want nothing to be left off the table. But I think Americans are prepared, both for the truth and for the consequences of that truth.

Senator SIMPSON. And one of the things you continue to speak of is, in a sense, affluence testing in various arenas. Do you feel that in Medicare, any time you go to the doctor, you should pay something?

Senator KERREY. Yes.

Senator SIMPSON. Regardless of who you are.

Senator KERREY. Yes. Unless you are absolutely flat broke, and have nothing. I do not think you should be turned away, but my answer is yes.

Senator SIMPSON. Five bucks, 10 bucks, 15 bucks?

Senator KERREY. Some sort of a contribution, so that you know there are costs attached to the visit, yes.

Senator SIMPSON. And then copayments increased also?

Senator KERREY. Yes.

Senator SIMPSON. Across the board, whatever they may be?

Senator KERREY. Yes again.

One of the fundamental problems we have got with our current system is, because we make no distinction on means, what we have in place right now—and I will try to say this slow enough—we are

subsidizing people who do not need it. And, as a consequence, we do not have the money to subsidize people who do. All of us, to a certain extent, are being subsidized beyond what is reasonable, what we need.

And I just think, as you look at the implications of people not getting well baby care, not getting that preventive care, you must look at the costs attached to rationing that care at the lower end.

We have 40 million Americans now. We added 1.1 million this past year who are not insured, who cannot afford to make the purchase. The market just is not getting the job done.

So, if you look at the implications of that kind of rationing, Senator, I think there is an urgency attached to doing precisely what you are describing, which is to make sure that those with the capacity to pay, pay for it.

Senator SIMPSON. Well, you can imagine, can you not hear the debate already, when we charge somebody $15 for a doctor's visit, that we are tearing apart the very fabric of America by someone paying two movie theater tickets, $7, two of those $15. And we will listen to some pretty heavy slashing, will we not?

Senator KERREY. Yes.

Senator SIMPSON. And, without that, what will happen?

Senator KERREY. We will get no savings.

Senator SIMPSON. And what will happen to Medicare?

Senator KERREY. You are leading me down through the valley of the shadow of death here. [Laughter.]

Senator SIMPSON. I know, but I am with you.

Senator KERREY. I fear no evil.

Senator SIMPSON. We are going with you. We are going together through the valley.

Senator KERREY. Well, it will not fix the problem, Senator. And, as a consequence, people that do not get care today are not going to get it. That is the trade off, it seems to me.

Senator SIMPSON. Well, it is serious business, and this is where the work will be done. And it is a great pleasure to be part of it.

Thank you. I always enjoy hearing from you, and the things you share with us.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Thanks for holding this hearing, particularly today, the 30-year anniversary of Medicare.

I am delighted to have our lead-off witness, Senator Kerrey. He has really done a great deal of work, and sort of damn the political consequences. He has been willing to say what I think is needed, and that is necessary. We have had some good suggestions from him today.

As I think back over the history of this program, the fact is that today we have 37 million Americans who get health insurance through this program. Virtually all senior citizens have universal coverage. Last year, we thought a lot about universal coverage and how we can bring it about. Well, the only group in America that essentially has universal coverage is our senior citizens, because of a program that this committee worked on.

My predecessor, Russell Long, in particular, had so much to do with bringing this program into reality. I was reading an article in the New York Times where I first picked up the quote by my predecessor. And I want to read it because I think it really talks about what they were doing 30 years ago. He said that, "This program is much more than just another Government program. The spirit in which this law is written draws deeply upon the ancient dreams of all mankind. In Leviticus, it is written, 'Thou shalt rise up before the hoary head, and honor the face of an old man.'"

And, Mr. Chairman and my colleagues, I do not know if we had any idea about how successful this program was going to be 30 years ago, not only for the seniors, but for an awful lot of children who worry about their parents. And they know that, if their parents got sick, and we did not have Medicare, they would not be financially able to take care of their parents.

So it has been a very successful program, but it is on the brink of bankruptcy. And we have to do something to fix it. We have been there before. This program has been on the brink of bankruptcy before. And this committee and this Congress have been able to assure its stability. And that is the challenge.

My question and my concern, which I will ask Senator Kerrey to comment on, is that we are instructed to do much more than just save Medicare. We are instructed to cut Medicare $270 billion, not just to save Medicare, but to pay for tax cuts.

I think that we have extremely strong support from the American public to do what is necessary to save Medicare, even if it means cuts, but not if we are cutting in order to pay for tax cuts for other people, where it is questionable whether they need it or not.

That is what I would like to ask Senator Kerrey. The numbers that I have seen, in order to fix Medicare, to put it on a sound footing for the next 10 years, are what, $165 billion, $160 billion? But we are going to cut it $270 billion maybe, because that is what the budget reconciliation bill tells us to do, and we are going to take all that extra money and pass tax cuts. What is your thought about that?

Senator KERREY. Well, as I said earlier, Senator, I think that the tax cuts are the worst parts of this proposal. Not only are they unnecessary, but I think they undercut our ability to reduce spending sufficiently to get our budget in balance.

And you are highlighting one area. There are many other areas. There is no question that it is difficult to make the sale if I am doing a tax cut at the same time that I am getting that kind of savings.

Further, $270 billion is a big number. I would urge you to look at the recommendations that Senator Danforth and I have in this Bipartisan Commission on Entitlements. There were not a lot of people walk up the line saying, gee, let us do that. That did not get $270 billion over 7 years.

I mean all these ugly choices—we have a premium on Part A in here. We means-test Part A and Part B. We change the eligibility age to 70, phased in over a period of time. I mean these are the kinds of choices that we ended up having to make because, if you

go to CBO and say I want to do managed care, they are not going to give you much of a score.

Senator BREAUX. But none of your recommendations, as tough as they were, were in an effort to try to achieve greater savings in order to pay for a tax cut?

Senator KERREY. No sir, they were not. I think it is a mistake to do that. In addition to that, Senator, none of ours tried to balance the budget in 7 years.

What we dealt with is, I think, a problem larger than the deficit, and that is that entitlements grow as a percentage of our budget. And we said, as a consequence of the long-term problem, let us fix the long-term problem, and give people a chance over time to plan. So we had a lot of ours phased in. We were not faced with a 7-year window, where we had to get everything done in that period of time.

Senator BREAUX. We thank you for your contribution.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. Senator Kerrey, thank you for being here.

In West Virginia, the average Medicare recipient's income is about $10,700 a year. And I think that 75 percent of all Medicare recipients are below $25,000.

I think you mentioned earlier in your testimony that you would start your means testing at about $40,000?

Senator KERREY. That is what we did. In the recommendations that our Entitlements Commission made, I said that I see three options to fix this thing. One is to extend eligibility to all Americans, which would be my preference, and decide that everybody is going to be in, and they are going to contribute according to their capacity to pay.

The second option would be to fix the cost, the percent, of health care as a percent of the total budget, which is what we did with the Entitlements Commission. We did not have a 7-year window to do that.

The third one would be to take the constraints of the budget resolution, and try to accomplish that 7-year objective.

The $40,000 test we had in the Entitlements Commission recommendation, and we did phase that in.

Senator ROCKEFELLER. Well, two of the three suggestions that you make are not being considered by this committee. And we have to deal with the one that is left—the means testing.

If we did means testing as a way of trying to cut Medicare by $270 billion and we wanted to get at those cuts in a fair way—it would add up to about $10 billion out of the $270 billion. Am I not approximately correct?

Senator KERREY. It is a relatively small amount.

Senator ROCKEFELLER. Yes.

Senator KERREY. That is correct.

Senator ROCKEFELLER. So the means testing, which is often used rhetorically as kind of the catch-all approach, and the fairness approach—and I cannot and do not argue with that—would in fact do very little to solve the problem?

Senator KERREY. That is correct.

Senator ROCKEFELLER. Yes.

Senator KERREY. We have most of our savings, Senator, from a choice that is about as unpopular as one could make. And that is to phase in an increase in the eligibility age.

Senator ROCKEFELLER. Right. I understand that. I understand that.

I just have an observation I would like to make to you, Senator Kerrey. You have testified that you favor a system that would make all Americans eligible for health care, and you worked very hard at this, especially in Nebraska——

Senator KERREY. After beginning with the elimination of all current entitlements. I think you have to restructure the program. If you try to extend a new entitlement on top of the current entitlements, I do not think you can afford it.

Senator ROCKEFELLER. I know. I am not trying to make that comparison. I am just simply saying that universal health care is something that you have vigorously espoused in various forms for some time now.And you tested an idea in your own State, which you found to be well received there.

The observation I would make is that one of the things that worries me very much is that we are talking about Medicare, and we are talking very little about Medicaid. This is not a Medicaid hearing; it is a Medicare hearing. It may be our last one.

We do not know where the cuts are going to come. I could ask the Chairman when we would know when the cuts are going to come, and what the cuts are going to be, so we can adjust ourselves to those and make comments on them. I suspect that we will get them a day or two before they actually happen.

The CHAIRMAN. We are actually waiting for the administration.

Senator ROCKEFELLER. That is what the Ranking Member says, but that is not necessarily what the rest of us say.

The safety net for the poor bothers me a lot. I think it is very much in danger of being eliminated by this committee. I think the block grant program, when that comes, is going to have a devastating effect on Nebraska and West Virginia, and on most States.

And it is interesting, and I think it should be said clearly, that children accounted for the largest proportion of increases in the uninsured in health care. Between 1992 and 1993, it increased by a full percent. Goodness knows what has happened since then, as employers have tended to diminish benefits by eliminating health insurance for dependents, even those that maintain it for those who actually work.

Now I think the figure that is projected for the year 2000 is 54 percent of those who work will have job-based coverage. For many of those, however, their dependents will not be covered. Even the 54 percent is down from 63 percent in 1992.

I remember, a few years ago, we specifically worked on pregnant women and children, in terms of trying to get them covered over a 10-year period ending in the year 2002.

So I would just observe to you that this Senator is extremely worried. On the one hand, we are talking about means testing, which is not going to save a lot of money. In the meantime, we are not talking about kids who are getting massacred out there. That

is a strong word, but not for those who are affected by this. I worry about that a lot.

Senator KERREY. Senator, I agree with you. Of the two categories, Medicare and Medicaid, Medicaid is the more troublesome program.

What I was trying to do here this morning is suggest an alternative to merely considering that the non-binding budget resolution instructions are gospel, that we have to do it this way.

I think, in the interest of our country, we need to find a way to break out of what appears to me to be an inevitable course taking us to a Presidential veto and a continuing resolution, and all that sort of thing, which looks like it may happen.

But I would mention, Senator, one of the principles that I have when it comes to health care for the poor. First of all, if you are disabled, I am prepared to take care of you, I am prepared to help you. If you have no capacity to work, and you are disabled in some fashion, as a large percentage of the Medicaid recipients are, I am prepared to provide assistance.

However, beyond that, when you have an able-bodied person, the principle that I believe Senator Breaux and Senator Mikulski put into their welfare reform proposal, someone who is poor should have to work as hard to become middle-class as people who are middle-class are working to stay middle-class. I find this to be quite solid and correct.

And I am very concerned about 20 million or so people who are in the work force, working like mad, trying to figure out how they are going to pay for health care, and their attitude towards people who are not working and on Medicaid, having all their health care bills paid for.

So, somehow, we have got to find a way to provide people with an incentive to work. And, again, I get back to what I said at the beginning. Yes, I am willing to go universal coverage on health care. But, in order to do that, I am proposing to start by saying let us abolish the old—not permanently—let us abolish the old and start with Title II and say that everybody is in.

It is not based upon whether or not you can prove that you are poor, or prove you are old, or prove you got blown up in a war, or prove anything at all, other than that you are an American or legal resident.

But let us require people, not only to pay according to their capacity to pay. Let us provide a real incentive, an incentive for them to save money and acquire the resources for that rainy day. And let them make the decision about how they are going to use it in the end.

So I share your concern about the Medicaid cuts. I think, in many ways, they are apt to produce a more painful impact upon the American people.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I very much appreciate your words for many reasons. I think I speak for all of us in the Senate when I say that we very much appreciate the often provocative nature of your words. It forces us to think, going somewhat against the grain, but against the grain

in a way that is very constructive and very positive. I very much appreciate that.

Too often, we are caught up in the traditional, ordinary way of doing things. And you are always very refreshing with new ideas, forcing people to think. And I know I can speak not only for the Senate, but for the country, to thank you for that.

What this really gets to is who we are as Americans. What is America? On one hand, we want to take care of people who need to be taken care of. On the other hand, we want to be self-reliant, encourage the work ethic, live within our means, and so forth. And it is difficult trying to find a way to do that.

Frankly, I am quite distressed, as I think you are from your words, that the values we do not want in our country are hurting a lot of people who really need help. And using that hurt, if you will, to help a lot of people who do not need help—that is, cutting Medicare drastically, particularly for those who are not wealthy, and using those cuts to pay for a big tax break. I just do not think that is what America is, and that is not what we want to do.

Now we still have to solve the Medicare problem. And I would like your reaction to setting up a commission to deal with Medicare. It is not a new idea. I frankly think——

Senator KERREY. I am not volunteering, I can tell you that.

Senator BAUCUS. I know you are not. I think the Entitlements Commission served a very useful purpose. But, in my view, I think the Entitlements Commission was a little too ambitious. It tried to take on too much. It tried to take on all the entitlements. And the entitlements are so different, one from the other. They are not all the same. It is a much more complex issue than just entitlements.

As we know, there was another commission that worked. It was the Commission on Social Security. And our Senator from New York, a distinguished Member of this panel, did a terrific job helping to guide that commission. It was bipartisan, and included in the public and private sectors.

Senator MOYNIHAN. Senator Dole.

Senator BAUCUS. Yes, Senator Dole was on it. As I recall, I think Alan Greenspan was chairman of that commission. And it was a thoughtful effort on the part of a lot of very intelligent, public-spirited people to find a solution to Social Security. Nobody assumed that it would be a permanent solution, but at least a pretty good solution for the indefinite future.

And it worked. The President and the Congress came together, and essentially agreed upon and implemented the recommendations of the commission. And that is why I think that Social Security today is in significantly better shape than Medicare or Medicaid.

So, why not cut Medicare a little bit in this budget resolution, but not near as much as is contemplated? Because I think it hurts too many people? For example, in my State, 70 percent of seniors have an income of $15,000 or less—70 percent. And one-eighth of the population in my State are seniors. So that is a big chunk of people who just cannot stand this. It is not fair to ask them to take greater cuts.

So my question is, why not enact some modest cuts in Medicare, here in this budget resolution, budget reconciliation, because every-

thing has got to be cut a bit if we are going to get the budget balanced? But then put the bigger question off onto a commission along the lines of the commission that Senator Moynihan, Senator Dole and others participated in.

Senator KERREY. Senator, it may be that the proposal is meritorious. One thing that I would say is different about today is that the Social Security Commission had kind of a high noon quality about it. They were looking at insolvency, not being able to write checks, within a span of a year, or a relatively short period of time. They had checks to write, and an insufficient amount of income to be able to write the checks. So that had that moment of time approaching very rapidly, which created a different sense of urgency, whereas we are looking at 2002.

It may be that you are dead right. It may be that is exactly what we ought to do is to empanel a group of people. If it is structured properly, and there is a commitment on the part of the President and the leadership in both Houses to take the legislation up, as opposed to saying, gee, thank you very much, Senator, and put it in the out box, it may be that the format you are describing would, in fact, work.

One of the points that I have tried to emphasize, and I would like to indulge the committee with a numerical example, is this idea that compounding interest rates does not bless you with time. If you have them working for you, the longer the time period that you are working on, the more you accumulate as a consequence. If it is working against you, just the opposite happens. And we have compounding interest rates working against us right now.

I confess that the reason I am knowledgeable about compounding interest rates is a consequence of Warren Buffett being a Nebraskan. He learned it at age 11; I learned it at 51. That is basically an illustration of compounding interest rates right there.

But there is a rule of 72. And I would urge you to play with this thing because it is a very powerful concept, and has a big impact upon what we are doing, and ought to create an urgency to change our retirement system, and to act.

The rule of 72 is that you divide 72 by your real rate of return. Whatever number you have got, that is the number of years it takes for your investment to double. So, if it is 10 percent, that means it doubles every 7 years. Well, the implications of that are, if you put $1,000 away the day the child is born, it will double 10 times by age 70. And that child will have a million dollars at age 70 to spend on health care, to spend on anything else they want.

But, if they do not start it, if you start at age 20, you miss three turns, and the difference is $100,000 to a million. And most of us wake up at about age 50 and say, oh my God, I am going to retire in 15 years, I had better start figuring out what I am going to do. You have $100,000 with 7 turns. And with 10 turns, you have a million.

What I am trying to emphasize is that, for that $15,000 a year individual, who needs to have us help them pay their bills, in addition to helping them pay their bills for the current moment, we need to be thinking about people whc are 20 years of age now. Help them acquire the wealth, so they need less assistance when they reach the age of 65. Because the numbers that are retiring in be-

tween—the baby boomers, you and I, Senator, and somewhat younger—will overwhelm the system. That is the real problem.

The real problem for us is not the so-called insolvency in the year 2002, which is hardly as devastating a moment as it is sometimes made out to be. The devastating moment occurs in the year 2008, when those baby boomers start to move into the ranks of retired, saying all right, now it is time for you to pay my bills as well, because that is a 75-million person cohort.

Senator BAUCUS. Maybe there is the same urgency as in Social Security then.

Senator KERREY. Maybe there is.

Thank you.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

The statistics, where Senator Baucus and Senator Rockefeller each indicated that the average income of those over 65 in their States is very modest. Does that figure include Social Security into the income?

Senator BAUCUS. I do not—I would——

Senator CHAFEE. I am not trying to pin you down, but the income cited seems so low. Social Security, with a husband and wife, at the top bracket, could give you approximately $18,000 a year. So I am curious about those figures and also, in West Virginia, whether it included black lung benefits.

Senator BAUCUS. I do not know. I actually got my data from the Department of Labor.

Senator CHAFEE. I think it would be interesting because it certainly——

Senator BAUCUS. It is Government data, but I do not know whether it includes Social Security or not.

Senator CHAFEE. Let me just go through a couple of points here. One of the problems in connection with Medicare, is that beneficiaries will say look, we paid for Medicare, and we are entitled to get it back. Now, in Part A, that is true. In Part B, however, this is not true at all because in Part B the beneficiaries are currently paying 30 percent of what they receive, the other 70 percent comes from the general Treasury.

And, in this year, the general Treasury taking from all taxpayers—you, me, the fellow who sweeps the halls out here—from his and her income taxes, all of this money is going into the general fund, and $47 billion is coming out this year to pay for Part B. It pays the doctors' bills. And it goes up next year to 14 percent, then up 12 percent, 11 percent, 12 percent, 12 percent. So, over the next 7 years, that averages a 12-percent increase per year in what the Federal Government is putting into this program.

So I think every point you or others make about having this means-tested is absolutely fair. Why should some very rich person have the general taxpayers paying for his or her doctors' bills? It does not make any sense at all.

However, the argument for cutting Part A which is the hospital part, paid for by the payroll tax, is harder to make would anyone care comment?

Senator KERREY. Well, Senator, what I have generally tried to say here today, as I have said on other occasions, is that I see two

problems with an open-ended promise, regardless of how I collect the money to pay for it.

As I said, the first problem is basically that I really do not have to set aside any reserve because I know that, once I hit the age of 65, that is going to be taken care of. So I am relieved of any responsibility or concern about what happens. So I think this unquestionably has an impact on people's savings behavior, what they do to plan for their retirement.

The second problem that I have is that I do think, regardless of what your contribution is, if you have the capacity to pay, you should pay. And I personally see the Medicare system as very similar to the Social Security system. In fact, it is part of the Social Security Act. It is an extension on the part of the American people to say that we want to make sure that when somebody gets to the age of 65, when they get to the ranks of old—and, arguably, it is not as old as when these programs began—you ought not to have to sit and worry about whether or not you are going to have to go and live in a poorhouse someplace.

Senator Baucus earlier used the number of people who are below $15,000 a year in Montana. It is roughly 12 percent of the American people over the age of 65 who are now in poverty. And it would be well over 40 percent without Social Security and Medicare. So I think it is a successful and worthy gesture to try to make sure that people do not find themselves living in misery when they are no longer able to produce.

So I certainly do not see Part A as a system where I am saying that you have to pay in, in a straight insurance actuarial form, and I am going to pay out according to the reserves that I have built up for Senator Chafee. You built up the reserve, you paid in and, thus, I am going to pay back out. I do not see Part A being operated in that fashion at all. Indeed, I do not think that individual would really like us to say all right, is that what you want, Senator? You would like us to give you what you have paid in? I do not think people over the age of 65 would want that for either Part A or Part B.

Senator CHAFEE. All right. Well, I see my time is up.

Thank you very much.

Senator KERREY. I do understand the point you are making. A and B are different, but there just is no way humanly for us to fund the kinds of growth we have got without saying to Americans, if you have the ability to pay, you need to make a contribution.

Senator CHAFEE. Well, it is astonishing to me that Part B, which is what pays physicians under Medicare, is forecasted to go up at 12 percent a year. By the end of this century, it will not be $47 billion the Federal Government is putting in; it will be $83 billion.

Senator KERREY. Well, Senator, you have led the so-called Mainstream Coalition last year.

Senator CHAFEE. I had some superb members in that group too, such as——

Senator KERREY. Well, the boat went over the waterfall.

I think one of the principles we had in that was that, so long as you have a system where people are shielded from the real costs of care, it is unlikely that we are going to get broad enthusiasm for actually controlling costs.

One of the reasons that managed care is producing cost savings out in the private sector is that people have been shown the real cost of care and encouraged, as a consequence, to be more efficient in their consumption.

Senator CHAFEE. Thank you.

The CHAIRMAN. I hope that is not a second round of questions because we have another panel coming on.

Do not underestimate means-testing. The $10 million figure that Senator Rockefeller talks about is if you start means-testing at $100,000 single and $125,000 joint.

If they are going to start it at $40,000, and they are going to apply it to Part A and Part B, on a top-of-the-head guess, you are talking about closer to $45 billion to $60 billion than you are $10 billion. But you are at a comparatively low threshold in relation to what anybody else has talked about. I do not mean that critically, but there is a fair amount of money when you get that low.

Senator KERREY. Yes. Again, for emphasis, Senator, look at the three proposals that I put up on health care. The one that I prefer, I understand that we cannot do, but I still think it is the best.

The second one, which we addressed in the Entitlements Commission, is the problem of the growing percentage of entitlements as a bigger problem than the deficit. And we said, as a consequence, we can see it being a long-term problem that we can phase in. So the recommendations we made are phased in. They are not even inside that 7-year window.

The CHAIRMAN. Thank you very much, Senator, for coming this morning, and spending this much time with us.

[The prepared statement of Senator Kerrey appears in the appendix.]

The CHAIRMAN. Next we will take a panel of Dr. Paul Ellwood, Lynn Etheredge and Joseph Martingale.

Senator ROCKEFELLER. Mr. Chairman, while they are taking their seats, could I just make an observation that about 60 percent of the elderly—and this is in response to Senator Chafee's question—rely on Social Security benefits for 50 percent or more of their income. And 32 percent of the elderly rely on Social Security benefits for 80 percent or more of their income, which I think is instructive.

Thank you.

Senator MOYNIHAN. Mr. Chairman, in the general proposition, may I offer some wise words of Herbert Stein, who has written that, "If a trend is unsustainable, presumably it will stop."

The CHAIRMAN. I think that is what Dr. Ellwood said last year.

Doctor, why do you not go first?

STATEMENT OF PAUL M. ELLWOOD, M.D., PRESIDENT, JACKSON HOLE GROUP, TETON VILLAGE, WY

Dr. ELLWOOD. Thank you, Mr. Chairman, and members of the committee.

In preparing for this testimony today, I had occasion to review my testimony before Senator Breaux's colleague, Mr. Long, in 1970 on this same subject. On that occasion, I urged that we adopt a series of reforms very similar to those that I am going to urge you to adopt today, except that I wanted to use Medicare to reform the

health care system, to become a wise buyer and encourage competition.

We failed in that regard. But, luckily enough, the private sector did not. And the private sector has become a very effective buyer of health care. In fact, thank goodness, they were nice to gurus. You know, gurus are not accountable. And I indicated here in March that health care costs were moderating, and we expected them to continue to do so.

As Senator Moynihan had pointed out, all-item CPI and the medical CPI are converging. And, in fact, private health insurance is not included in the CPI. And, if we were to look at private health insurance, and the experience of organizations like CalPERS, we can see that the medical costs are actually deflationary. They are now actually falling for private purchasers of health care.

Now the smartest buyers of health care encourage competition between multiple health plans. They try to motivate——

Senator MOYNIHAN. If I could interrupt, doctor, we have not seen such a chart in my 19 years on this committee.

Do you project that CalPERS premium rate will drop 5.2 percent for the year 1995–1996?

Dr. ELLWOOD. Well, that is their actual premiums. They are going to be 5.2 percent below what they were.

The CHAIRMAN. Those are already set?

Dr. ELLWOOD. Yes. And I just saw some premiums for another large buying group today, and they are going to drop 4.3 percent for several million people. There are a million people in this particular one.

Senator CHAFEE. I think you ought to point out the zero line there. In other words, if inflation is 3.5 percent, or whatever it is, that would be normal. Instead, what you are saying is that CalPERS is giving a 5.2 percent reduction in the premiums this year?

Dr. ELLWOOD. Yes. And the head of CalPERS told me that their premiums now are lower than they were several years ago.

Senator CHAFEE. In actual dollars?

Dr. ELLWOOD. Yes.

Senator CHAFEE. That is a startling statistic.

Dr. ELLWOOD. As I will point out, they have done three things. They have pitted health care plans against each other. In this case, they have 19 that are competing.

They try to make employees be wiser buyers by setting a defined amount of money that they are prepared to pay for each employee who is purchasing health care, so that they are motivated to seek out the less costly sources of care.

And they have improved the quality of these choices by having uniform benefits and giving them significant information about the quality of the health care that each of these plans provides. And, in my view, that is what Medicare should do.

Now there are a number of questions you are struggling with, as you try to make this transition. One is, how do you move to a defined contribution program from one which offers and open set of benefits without controlling the amount of the contribution?

Second, you have been struggling with huge regional differences in what Medicare pays for health care in various parts of the country.

And, third, you are wondering whether or not trends like I have just shown you here are sustainable, or whether this is just a one-time phenomenon.

Now, where market forces are exploited in a program, like the Federal Employees Health Benefit Program, the range of premiums from one area to another is very narrow. You might refer to this chart. You see that black line; that is the Federal Employees Health Benefits range of premiums for each of the cities that are identified on the chart. It is almost flat. That is market forces at work.

On the other hand, with Medicare, the premiums vary all over the lot, up and down around that average. Now, in New York City, for instance, or New York, Medicare's per-capita costs are 25 percent above the national average. Their Federal Employees Health Benefits difference is only 2 percent above the national average.

The extreme case is Miami, where the average premium for Medicare is 35 percent above the national average, and where their premium in a competitive Federal Health Benefits Program is 5 percent below the national average. So there is no rationale, in terms of factor prices and that sort of thing, that justifies these huge differences in what you are paying.

My impression is that, as Medicare attempts to micromanage doctors' fees and hospital reimbursement, the providers in high-cost areas simply raise volume. If you compare Oregon, let us say, to Florida, the providers of health care in Oregon have many fewer doctor visits, many fewer operations, many fewer tests than they do in Florida. This is a volume-driven phenomena.

So, thinking in terms of deductibles, Senator Chafee, that is not going to change doctor behavior and the amount of services they provide. Deductibles are designed to discourage consumers from using health care.

Let me describe what I would like to suggest that you do. We propose using the first 4 years of a new program we will call the new Medicare, to put in place the necessary health plan choices and quality assurance systems to get health plans competing with each other.

Now, depending on when it is enacted, a new Medicare approach can produce potential savings of $270 billion in 7 years, if that is what your objective is. In 10 years, it will produce $670 billion in savings. Again, this is dealing with exponential growth curves, as Senator Kerrey referred to.

The past experience in Medicare in the private sector is that raising deductibles and coinsurance really does not make much difference. If you review the experience of this committee in tinkering with Medicare, every year you tinker around with raising this or lowering that, in an effort to get this thing under control. And it still continues to increase at about 10 percent a year, therefore doubling every 7 years.

I think it is probably worth while for you to continue that process, though I would not plan on it saving a lot of money, because

people buy Medigap policies, and employers are committed to make up the difference if you do not decide to pay it yourself.

I would give the HCFA Director more discretion in managing care, so that he can manage this program very much the way a Blue Cross director, or any other individual trying to control health care costs, would do.

We have five suggestions: One——

Senator CHAFEE. Paul, before you get into this, I am not sure I understand that chart. Does everybody else understand it?

Dr. ELLWOOD. Wait a minute. You would think, after being here for 25 years before this committee, you would not get nervous. But I skipped over this, and it is an interesting point on this matter of whether or not these savings are sustainable.

What we see here is the experience of Minnesota with surgery, whether it is performed in the hospital or out of the hospital. The green line is surgery that was performed in the hospital. The red line is 24-hour surgery—surgery that is performed out of the hospital. And you can see that, over a 10-year period, the amount of surgery that is done in the hospital has been steadily declining. The amount of surgery that is done out of the hospital has been steadily rising.

But the other thing that strikes me about this is the absolute quantity of surgery has not changed. It is pretty much the same. And the reason for that is Medicare. Medicare, by failing to control the volume of surgery, has led to this persistence of high surgical rates.

Senator GRASSLEY. Does that basically mean that, if Medicare will pay for it, the surgery will be done? Is that the basic principle?

Senator KERREY. That is a good characterization.

Senator CHAFEE. Well, maybe it is needed.

Dr. ELLWOOD. In some instances, of course it is needed.

Senator CHAFEE. What are those figures on the lines?

Dr. ELLWOOD. That is the actual number of operations.

Senator CHAFEE. If you add them both up, you would find that they would be the same?

Dr. ELLWOOD. They are about the same.

Senator CHAFEE. I see. One hundred sixty and 212.

Dr. ELLWOOD. Yes, incidentally, Senator, the mix of operations is not the same. Some things like hip replacements have become more common. Some things like tonsillectomies have become obsolete.

Senator MOYNIHAN. Gastrointestinal might be.

Dr. ELLWOOD. Right.

Senator GRASSLEY. Well, from that standpoint, it is the practice of medicine, it is not just because Medicare would pay for it.

Dr. ELLWOOD. That is right. But the way Medicare pays for things, especially if they cut doctors' fees, leads to a greater volume of services. That is such a well-known phenomena that we even have formulas for predicting how much volume will go up when you cut their fees. It is not a one-to-one ratio, but it is real.

Senator GRASSLEY. Do you save some money?

Dr. ELLWOOD. Yes. You save some. And, in places like Minnesota and Oregon, you will notice from the previous diagram that their Medicare costs were actually below the average. There I feel that the physicians, for some reason, are less likely to practice two

brands of medicine. But, in other places, that is not necessarily so, particularly in places that are oversupplied with physicians.

Senator CHAFEE. This is a pretty severe indictment you are making, doctor. Are you saying that if you pay a doctor or surgeon less, he will go out and operate on you more? Is that it?

Dr. ELLWOOD. Some of them will.

Senator CHAFEE. It seems as if that is what your statistics are showing and, you indicated you could predict it.

Dr. ELLWOOD. Yes. When the PPRC sits down to recommend to you that surgical fees be raised, they build into that an increase in the amount of surgery performed when they make their forecast.

Senator ROTH. Mr. Chairman, could I urge that we——

The CHAIRMAN. Go ahead and finish up. We will take the other two witnesses first.

Dr. ELLWOOD. First, we would separate health plan payments from the rate of increase in traditional Medicare plans. You might look at the next chart here. The blue line on this chart indicates what is anticipated will happen to Medicare costs if you do nothing. This is from Senator Kerrey's commission, the Entitlements Commission.

What we are suggesting is that you follow the red line on this chart. Now the way you would do that is limit the rate at which the Government would pay health plans to 5 percent. But, you would say to the health plan, we want you to deliver a greater scope of benefits, prescription drugs, and minimize the deductibles and coinsurance, so that it is not necessary for people to purchase Medigap policies.

Senator MOYNIHAN. Doctor, this is a voucher system you are describing.

Dr. ELLWOOD. We call it a defined contribution system. The Government decides how much it is prepared to spend on medical care. And, each year, it specifies what that sum of money is going to be. It says to the health plans, that is what we will pay you. You go out and compete to provide a greater scope of benefits. If you can be below that number, we believe that the money should be given back to the beneficiary for having made a wise choice. If you are above it, the beneficiary would be expected to pay the difference.

Now the dilemma is, how do you make the transition in regular Medicare which, as I suggested, is a program that is essentially out of control?

What I would suggest is that, each year, you reduce the payment to regular Medicare by 1 percent below this trajectory that we see. But, in the year 2000, if nothing happens to traditional Medicare, and the new Medicare has been rising at 5 percent per year, the difference in cost to the Government between those two programs, open-ended Medicare and the new Medicare, will be $1,290 per beneficiary, per year.

Now that is what has happened with corporations. Then the CEO looks at those numbers and says, no way can we go on with this. And, at that point, they say that the traditional health insurance plan that the company has been buying is going to pay the same amount as we are paying to the new health insurance plan.

By that time, 5 years have elapsed. People have had an opportunity to get used to the new approach to Medicare.

Now, Lynn Etheredge is going to suggest to you some methods for helping the manager of Medicare, the manager of HCFA, to act more like a private insurer. I think that is a good idea. However, if that is the case and, in effect, HCFA is competing with the private sector to retain enrollees, then I believe the two programs need to be separated from each other.

The experience in both the private sector and the public sector is that anyone running an insurance company does not want to change it. And they are reluctant to move into managed care. I think you could expect the same thing with the managers of HCFA. They would not want to see their large insurance company grow smaller. And the most persistent problem that we have had in getting managed care introduced to HCFA has been the reticence on the part of the leader of HCFA to see their program move into the private sector.

So, if you intend to emulate the private sector in reforming Medicare, you are going to have to make some internal changes, so that people are actually encouraged to join health plans in the same way employers do.

In conclusion, one of the things that really worries me about the debate that is going on right now over vouchers, and all this sort of thing, is that every time anybody raises any questions about this, we reduce the likelihood that we are going to be able to do it.

I cannot imagine the president of IBM trying to get to a more economical health program and, at the same time, saying we are going to be taking things away from you, and you are going to be getting poorer care as a result of these changes we are making.

And, really, the longer this debate goes on, the more discouraged I personally become about our ability to achieve this really achievable objective. We can get more health care to people, at vastly lower cost, with no sacrifice in quality, and with plenty of choice of health plans, and certainly a lot more information about the quality of the health care being made available to consumers.

The CHAIRMAN. Doctor, thank you.

Mr. Etheredge?

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

STATEMENT OF LYNN ETHEREDGE, CONSULTANT, CHEVY CHASE, MD

Mr. ETHEREDGE. Thank you, Mr. Chairman, members of the committee. It is an honor to be invited to appear before you this morning.

Much of the recent Medicare policy debate is centered on making more private health plan options available for Medicare enrollees, like the Federal Employees Health Benefits model.

I support those efforts, as they have been described by Dr. Ellwood. But my testimony this morning will focus on another aspect of needed Medicare reform. What should be done to improve the basic Medicare program? How can it be modernized, be brought up to date, to incorporate the best practices in health benefits management, to the benefit of Medicare's 37 million elderly and disabled?

Why should we be concerned about reengineering the basic Medicare program? Most importantly, because that is where 90 percent of Medicare's enrollees and expenditures are, still in the basic Medicare program, not in the private plans.

In most States, it is even more. In 32 States, as of January 1, 99 percent or more of Medicare enrollees were still in the basic Medicare program.

The second major reason to update the basic Medicare program is that it is now far behind the state of the art in private sector health benefits management. Thirty years ago, Medicare was the leading edge of health sector management. Based on the private sector's health insurance models at that time, it was established as a bill-paying program. Today, Medicare is still primarily a bill-paying insurance program, with some national formulas for hospital and physician payments.

In contrast, as this committee knows, the private sector has moved far beyond simply bill paying. Private sector payers and benefit managers now use a variety of purchasing techniques, in a very competitive marketplace, to restrain costs and to improve quality and service.

Among those kinds of purchasing strategies are many forms of selective contracting; risk-sharing arrangements, provider performance standards with incentives, penalties and continuous quality improvement goals; management of high-cost cases; centers of excellence for heart surgery, cancer care and other treatment; prevention and chronic care; disease management initiatives, and many others.

Employers are also trying to hold the health system of their contractors accountable, through report card initiatives like NCQA's HEDIS measures.

Anywhere you look in Medicare today, you can see the problems of a 30-year-old system, and the need to update the statutes, to give the administrators more authority.

Medicare does not have the tools it needs to deal with the complexity and pace of change in today's health system. A 3-year-long rulemaking process, that takes longer for HCFA to implement your laws than it does for you to write them. There are wide regional variations in patterns of care, volume increases, and explosive service growth in different areas and services that really are the program's cost drivers. In addition, there is widespread fraud and abuse, and the budget costs with which you have to continue to deal.

Just having national price controls and rulemaking authority for Medicare is like trying to build a house with only a hammer and a saw. The plumbing would not work very well, nor would the lights. In the same way, Medicare needs more tools to be well managed.

Similarly, the current tools this committee has to manage that growth are largely across-the-board cuts in provider payments, and across-the-board cuts for all beneficiaries in the country. In contrast, with selective tools, Medicare could deal more fairly and effectively with the specific problems in the specific areas in which it needs to deal with cost and quality. New tools are needed so that Medicare does not have to cut beneficiaries and providers across

the country. And you will also have more options to deal with the problems you have to deal with.

So what I am suggesting, Mr. Chairman, is that the Congress consider new statutory authorities that allow the Medicare program more discretion to go beyond the limits of national price-setting and rule-making. Allow Medicare to become a prudent purchaser, to incorporate the best practices from the private sector.

My written statement outlines a number of specific suggestions and studies that would be needed to develop this kind of management plan. Ideas such as report cards on quality, a new emphasis on patient outcome, high-cost case management, a wide use of preferred provider arrangements, and other measures. These could all be done incrementally, targeted to deal with Medicare's most pressing problems.

In summary, Mr. Chairman, my suggestion is that the committee consider a two-track Medicare reform strategy this year. One track would be the new statutory authorities for the basic Medicare program that I have outlined earlier, the other track would be an FEHBP-type choice arrangement for selection of private plans.

If you adopted this approach, Medicare's 37 million elderly would be able to enroll either in a modernized Medicare that is working hard to provide the best economy, quality and service the Government can provide, or in competing private health care plans.

One might expect that both taxpayers and Medicare-eligible persons would benefit by such competition.

Thank you.

The CHAIRMAN. Thank you.

Mr. Martingale?

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

STATEMENT OF JOSEPH J. MARTINGALE, PRINCIPAL, TOWERS PERRIN, NEW YORK, NY

Mr. MARTINGALE. Thank you. My name is Joseph Martingale. I am with Towers Perrin. Towers Perrin, as you may know, is a human resources and employee benefits consulting firm.

In particular, with respect to your interest, we have been working with employers for decades, especially within the last 10 years, helping them manage their health care costs, largely through moving their populations, their employees and dependents, from traditional indemnity programs—fee-for-service programs like Medicare—into managed care organizations and organized delivery systems.

Another way of stating it is that they have converted from becoming passive reimbursers for health care to active purchasers of health care.

I have personally worked with dozens of large organizations who have made such a move. And Towers Perrin has worked with hundreds.

I think the reason you have asked me to speak to you today is because of an initiative that we have underway right now, which has more than 60 large employers banding together in order to address the health care concerns of their retirees, particularly their retirees 65 years of age and over.

So these 60 employers have, for the first time really, taken this initiative with respect to a population that they pay a lot of money for, which is probably the last hold-out in terms of populations that have already made the move into managed care.

The reason that employers have been reluctant or slow to adapt managed care strategies for their older retirees is because what they pay for is Medicare supplemental coverage. And, unless Medicare is involved in managed care in some sensible way, it is difficult or impossible for them to encourage these people into managed care programs.

Now, perhaps for the first time in the marketplace, it is possible to engage managed care organizations, HMO's, to have a contract with Medicare that allows retirees to select a managed care alternative, and to encourage their populations to at least consider that alternative for themselves.

So what we are doing on behalf of this group is evaluating and negotiating with every HMO in America that has such an arrangement with Medicare, in the hopes of presenting to these organizations information about those HMO's, their quality and access, how they treat their customers, and the financial aspects of these arrangements. These organizations, in turn, can present these HMO's, or those they are willing to present, to their retirees for serious consideration about their movement into managed care, into HMO's.

This group of 60 pays for benefits for somewhat more than a million and a half senior citizens, post-65 retirees and spouses. And we are evaluating in excess of a hundred managed care organizations, HMO's, in over 60 markets, in over 30 States throughout the country.

What we hope to do is very much in line with what Dr. Ellwood has been talking about for many years. We are hoping to create a competitive environment for the health care delivery to senior citizens every place it is possible to do.

And we will really do that in three ways. We will, over time, standardize the assessment of patient satisfaction. We will ask identical questions through surveys to each enrollee who joins. So a year from now, or 2 years from now, we will begin to develop a real base of information about how these HMO's treat their customers, their patients.

We have taken our best shot for the moment at the statistical measure of quality itself, building on some of the programs and report card technologies that are out there, including Towers Perrin's own, but focusing for the first time really on some special issues that have to do with the treatment of senior citizens.

And we will then put the spotlight on efficiency—that is, the level of benefits that these HMO's provide, and the premiums that they charge.

By creating the appropriate environment, by creating these three major themes, around which HMO's will compete for potential enrollees, they will really compete twice. They will compete, first, to be offered by each of these 60 large organizations and, second, to be chosen by the retirees themselves.

By making information more and more available to the retirees and the employers about patient satisfaction and quality, and obvi-

ously about benefits and cost, we hope to transform the marketplace as best we can, given the current state of affairs.

We will do that, I believe. We have already seen significant movement, even before the first of these employers offers these programs, movement in terms of more willingness to develop programs that are especially attractive to senior citizens, special attention on the coverage of prescription drugs, and lowering of premiums in markets across the country.

In closing, what I would hope we would do that would be helpful to you is that there will be—there already is, by the way—a great deal of information about how the non-elderly have reacted to their movement into managed care, and the quality of care they are receiving. We have a wealth of information about that.

To the extent that skepticism remains about whether senior citizens will react similarly, we hope that our program, our initiative, will provide you with some information that will perhaps make your jobs, and the difficult choices you have to make, a little bit easier. I hope that we will have even more information for you a year from now.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Dr. Ellwood, you presume a standard benefit package in your Medicare plan. Would it be the existing Medicare package?

Dr. ELLWOOD. No. It would be a typical HMO package, which contains a minimum of deductibles and no coinsurance, prescription drugs, and most things that people need for medical care.

I defy anybody to understand the existing Medicare program. I was uncovered with physician services under Medicare for the first year I was on it, because I did not know that there was this separate payment and application that I had to make for Part B.

In the case of managed care programs, you cover everything, you pay one premium, and that is it. And you place the burden on the managed care organization to manage your health, and to motivate you to manage it yourself. And it works.

The CHAIRMAN. In your judgment, tell me how we normalize the high cost versus the low cost areas. Minneapolis and Portland are low-cost. Miami and Los Angeles are high-cost. How, over the 5, 6 or 7 years, does that reach a norm, in your judgment?

Dr. ELLWOOD. May I have that first chart, that FEHB chart?

What I would like to suggest, Senator——

The CHAIRMAN. I did not understand this chart when you put it up.

Dr. ELLWOOD. All right. The dotted line is what FEHB pays for Federal employees in HMO's in those various cities that have a dot above them. The dots are what——

The CHAIRMAN. There is where I am confused.

I see the dotted line going down, and I see the dots above and below, but I do not understand what they represent. I see cities, but I do not understand it.

Dr. ELLWOOD. The middle there is average, average for Medicare, or average for FEHB.

The CHAIRMAN. All right.

Dr. ELLWOOD. And you can see that the FEHB line, the dotted line, is very close to the average all across the country. The dots represent various cities, and what Medicare pays in those cities. So, if you will take the dot for Portland there, you can see it?

The CHAIRMAN. Yes.

Dr. ELLWOOD. You can see that, for Medicare, Portland is below the national average.

Well, if you follow that up from that dot to the white space on the almost straight line——

The CHAIRMAN. Right.

Dr. ELLWOOD. That is what the Federal Employees Health Benefits Program pays for health care in Portland. So, the Portland case——

The CHAIRMAN. They are paying more.

Dr. ELLWOOD. They are below average on both programs.

The CHAIRMAN. Yes, but the Federal Employees plan is above Portland on Medicare, both of them below average.

But I want to know what is going to——

Dr. ELLWOOD. Excuse me. In equalizing things here——

The CHAIRMAN. That is what I want to know.

Dr. ELLWOOD. It seems to me that this Federal Employees program——

The CHAIRMAN. How do you get the Miami, Southern California costs down?

Dr. ELLWOOD [continuing]. Gives us a very good clue as to what an appropriate range is. It is about 5 percent above and below the national average, without taking into account a whole bunch of elaborate factor pricing——

The CHAIRMAN. All right.

Dr. ELLWOOD [continuing]. On what the cost of living is in those areas.

The CHAIRMAN. Does it come to down HMO's bidding nationally?

Dr. ELLWOOD. What we suggest that you do is, in the aggregate, the HMO premiums, the Federal Government's payment, be permitted to go up by 5 percent per year.

The CHAIRMAN. Total.

Dr. ELLWOOD. So, in a community like Portland, which is well below the national average, we would suggest that the premium go up by 7 percent per year.

In Miami, which is well above the national average, the premium would be permitted to go up by 3 percent per year, until you get to this logical band. And my testimony contains a little chart of how these things would be equalized.

The CHAIRMAN. Now, does the market determine this, or is this set by the Government?

Dr. ELLWOOD. The Government is a buyer here.

The CHAIRMAN. Right.

Dr. ELLWOOD. And the Government can decide what it intends to pay on behalf of its beneficiaries. The market will determine what the actual price is that the health plan proposes to charge the Government.

The CHAIRMAN. So, in Miami, we say you are going to go up only 3 percent this year. And the HMO's that serve Miami are going to have to live within that 3 percent increase?

Dr. ELLWOOD. Well, they are going to receive from the Government a 3 percent increase. They can charge more than that.

The CHAIRMAN. I understand that.

Dr. ELLWOOD. And, if they are successful in attracting beneficiaries by doing so, they can.

But I just came across this particular piece of research, and it is really quite fascinating. And it is the first evidence I have seen that, in a competitive market, these things will equalize themselves.

Now, in the year 2000, or thereabout, when you have had about 5 years of experience with the Federal Government, in effect fixing its premiums, I would suggest that you do move to competitive bidding, because I think we can beat the 5 percent up per year. But CBO is never going to score anything that says, well we will let the market decide, and see how effective it is as a competitor. We learned that last year, that it just does not work.

So I am suggesting, during the first 5 years, that you fix the premium that the Federal Government is prepared to pay, get it scored, and then, when you are sure that it works and you know more about how people behave, then go to a competitive bidding arrangement. And I bet you that will come down below the 5 percent per year.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, I do not know if I have ever been to a more important hearing in this committee, or one with more promise. I think we are in a situation in which we have research evidence being presented to us. The experiment has been going on, the data is in, and it works.

And there is kind of a paradigm shift taking place here. We began Medicare 30 years ago this day, which reflected exactly the medical practices of the time. Thirty years have passed, and it no longer does. Either we move into the present, or we are left with a program that is clearly not working. I see Mr. Etheredge agreeing.

Dr. Ellwood called my attention to an article that appeared in "The Public Interest" in 1968, just 3 years after Medicare had begun. And it was called "Rethinking Our Social Strategies", written by Robert Levine. And he said, "As one reflects on the troubled history of the War on Poverty and other social programs of the Great Society, it becomes clear that the problem is not so much the nature of the programs as it is the difficulties of administration."

This is pretty good, 3 years into the program. Nobody knew there was a sea of troubles in the War on Poverty. But he could already sense it, and said the key, in his view, is to design a system in which people make decisions for themselves, in their own best interests, but in which the sum total comes out as a net increment to the social good.

And I think that we have here a model of people making decisions for themselves, in their own best interests, finding the HMO that suits their interests or needs, however best they can judge them. And, in the end, there is a net increment to the social good, not least because the costs are not as high. Is that not what our experience is, seeing that first dramatic chart of CalPERS? CalPERS is a model of such individual choice, is it not? And you

see that their medical costs are going to be below what they were 5 years ago.

Remember, just last year, we were talking about a system out of control. And, obviously, it was out of control in the way it was being administered. But, if you reconceive that, you have a different picture altogether.

I speak oracles. I mean I think it is wonderful what you have done here.

Dr. Ellwood?

Dr. ELLWOOD. We have not done it with Medicare.

Senator MOYNIHAN. But you say we could. You say that we could change that administrative paradigm, and you can get the same results you get elsewhere.

Dr. ELLWOOD. We certainly can. But, right now, Medicare HMO's are going right along that blue line. Because, the way we have Medicare fixed, we say that HMO's can charge 5 percent less than what traditional Medicare does. So the same driver that traditional Medicare has is driving the HMO premiums.

So the first thing you have to do, without even any political trauma, is disconnect this attachment of the HMO premiums to traditional Medicare, and say you set the number. But, say you are willing to pay 5 percent more per year, and let them go out and sell themselves to the public. If you do that, you will produce large savings immediately. Right now, you are not saving anything.

Senator MOYNIHAN. But those savings are to be had because those plans are in place.

Dr. ELLWOOD. Exactly.

Senator MOYNIHAN. And there are HMO's——

Dr. ELLWOOD. When I last checked, HMO's are now available to 74 percent of the people on Medicare. We even have them in Wyoming now, Senator Simpson. And I presume that figure is closer to 90 percent now, but I do not know.

Senator MOYNIHAN. Mr. Etheredge, would you like to comment on that?

Mr. ETHEREDGE. They are available, but this committee in 1965, and since then, has made Medicare a very popular program. The elderly in most States really like Medicare. They also have Medigap insurance. So it is hard for HMO's, particularly in low expenditures areas, to compete with Medicare.

Senator MOYNIHAN. But they will not like Medicare very much if it stops.

Mr. ETHEREDGE. No, they will not.

Senator MOYNIHAN. And that is a subject that very much concerns Senator Simpson.

Dr. ELLWOOD. I do not know why it is so popular. I got bucked off a horse a month ago, broke a bunch of ribs and punctured a lung, and ended up in the local hospital. And I did not have a clue who the good doctors were. I just did not have a clue. And there was no information available to me to help me make my choice, so I said give me the youngest surgeon. That is really the way I made that choice.

Then, a week ago, I got this huge bill from St. John's hospital in Jackson. It did not say that Medicare was going to pay it, or that

the Blue Cross supplemental policy I have is going to pay it. I thought I was going to have to pay it.

I do not know how anybody can think of this as a reasonable form of insurance. Sure, it is protection. If you can talk to your kids, they will explain what all this means to you, that somebody is going to pay it, or pay most of it. But it really is a very awkward, poor insurance policy.

Senator MOYNIHAN. It is a time for coming forward, as you have done, in this confessional mode.

I had to run for a fourth term in the Senate, because I could not possibly figure out Medicare. [Laughter.]

Senator Simpson?

Senator SIMPSON. Is it my turn? Well, thank you, Senator Moynihan.

Senator CHAFEE. I think Senator Simpson should tell his story about how to get the best doctor in Cody. Tell them that one, Al.

Senator SIMPSON. Well, that was not in Cody, John. That was the one where the fellow moved to this community, a little town. He asked who is the best doctor here? And they said Dr. Jones, when he is sober. So he said, who is second? And they said, Dr. Jones, when he is drunk. [Laughter.]

I think it was something like that. But it is not worth taking it anywhere.

Nevertheless, thank you. I agree with Senator Moynihan. I did not intend to stay, but I have been very intrigued and very fascinated by what you are saying to us, and what could be. I have had the feeling that, if we do not do something reasonable, the Congress will be goaded by our constituents, in their terrible frustration—that is, if they do figure out what is happening. But 85 percent of them are not worried at all because they are getting the best care at the moment they want it, and somebody else if paying for it. So they are not stirred up out in the land.

But when we are told by the trustees that Medicare will go broke—and these trustees are not partisan, evil people—and, if we are really good, we can extend the death day by 2 years or 3, that will just be thrill for all of us. It certainly will for all of us over 60.

But again, the people between 18 and 40 are headed for a rocky, rocky experience. So I have always felt that they will eventually lash out at doctors, lawyers, hospitals, durable goods producers, and really let them have it. They will just say there, we solved it. Those guys were all making big bucks, and we stopped them. That is a typical American response, I might add. And that is not going to do it for us.

Mr. Martingale and others have said that there has been a dramatic——

And you too, Dr. Ellwood. It is good to see you. How are things in Jackson Hole? I was there just a week ago—officially, of course, not for any recreational pursuit. [Laughter.]

Things are going better. Managed care has been clearly shown to be effective in controlling the growth of health care costs. Is one reason for that the fact that they know Congress is going to cut back on the amount of money in the money pot? Has that been a

driving force here, as we came to that tremendous debate 2 years ago?

Dr. ELLWOOD. Not at all.

Senator SIMPSON. Not at all?

Dr. ELLWOOD. Whoever runs Sony or Toyota were more of a driver here than you were. The private sector, trying to compete in a global economy, faced with all sorts of downsizing, finally decided they had to deal with health benefits, just as much as we deal with everything else we purchase and sell.

And the real driving factor here was the basic change in the American economy, unrelated to Medicare.

Senator SIMPSON. Unrelated to the fact that they felt we were going to do something dramatic.

Dr. ELLWOOD. That is what I hoped in 1970. That was the proposal, that Medicare be capitated, and let it be the driver. It was not. Instead, the private sector, faced with worldwide competition, became the driver. They use the same techniques. There is no great change.

Senator SIMPSON. Dr. Ellwood, you certainly have been an innovator and a facilitator in this National debate. And the charts have been interesting, but the big one is that that blue one is just going to keep going unless we do something. That is what you have said, and that is what I keep saying.

People say we cannot do anything, we do not dare send these people out into the streets. We cannot do this, and we cannot allow Medicare to go up only 6.7 percent a year. That would be evil. We will let it go up 10½ percent, which would be charitable. And so that is the debate we are caught in right now. By letting it go up 6.7 percent, we have had that described to us as a savage cut in Medicare, while 7 years from now are facing what is not my idea of doomsday—I did not make that up.

You say that one of the steps to improve and move Medicare into this managed care, which is going to be its salvation, you are advising us is "beneficiary education". Now what would you suggest that HCFA do to ensure that seniors are educated on the choices that will be available to them under the Medicare program?

Dr. ELLWOOD. Well, one, they could let the health plans know who their potential customers are. They do not even do that. They do not even get a post card saying they are eligible to join a health plan now.

Second, they could do the sort of thing shown on this chart. They could show you that you have a number of health plan choices, and they can give you comparisons between the effectiveness of these various health plans. In this case, Super Health Plan is a better-than-average health plan, when it comes to screening for cancer of the cervix. They catch it when it is localized, and they have a higher survival rate. Incidentally though, people report that their quality of life has deteriorated some because they are being so intensely treated.

But, at any rate, we could give people just vastly better information than we do now. When I arrived at that emergency room, those doctors were just doctors who decided to practice in Jackson, Wyoming. They were not selected by anybody, other than their na-

tional boards or whatever. And HCFA ought to make this kind of information available.

But my other suggestion is, I think the two things are going to have to be separated. I really do believe that the manager of HCFA, in trying to do the best possible job, to do the kind of things Lynn has suggested, will find it difficult to promote some other competing health program.

Those are the things I would do—add benefits, make it clear to them what is there, make sure that the sellers know who their potential customers are, and separate the two of them.

Senator SIMPSON. Thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you very much, Mr. Chairman. And thanks once again for this panel. This is a terrific panel. We are actually talking about what we need to do with Medicare to reform it, not just find a way to come up with $270 billion of cuts, but actually structurally talking about what needs to be done. And I think it is terrific.

Mr. Etheredge, what I hear from you about Medicare is that Medicare is a wonderful program, but it was built in 1965. The comparison I get is that it is like taking a 1965 car, driving it down an interstate highway, and trying to keep up with a 1995 model. That 1965 car is likely to spewing oil, backfiring, stalling and practically falling apart because it was built in 1965, and has not kept up with new technology.

It seems to me that is what Medicare's problem is. It was wonderful when we built it in 1965, but the technology, the rules and the marketplace have all changed, and Medicare has not.

So I think what we are really looking at is to figure out how to make it into a 1995 model. Is that consistent with what you are telling us?

Mr. ETHEREDGE. Exactly right. You see, if we stay on the current course, those CBO projections are where we are going. If we do not change the structure of Medicare, we are looking at bankruptcy of the program. In your metaphor, the car is going to fall apart.

Senator BREAUX. Let me get some of the suggestions on the table, like the CalPERS, Paul. I see Senator Chafee here. We have talked about this managed care before. This is not the first impression about what managed care can do to help solve this problem. I think we have talked extensively about it over the last couple of years.

First, let me respond to Senator Chafee. It is not new that doctors will do more procedures when we limit the reimbursement per procedure. That is not new information; we have always known that to be one of the defects in Medicare.

But tell me more about CalPERS and the great reductions in cost. It works well in California, which is a fairly urbanized area. I am concerned about managed care not working nearly as well in rural areas. Interestingly enough, Louisiana is the highest—we rank number 50—in the sense of reimbursements per enrollee in the Medicare program—$5,412 per person.

In Oregon, Mr. Chairman, you rank number 1. You have the least amount of money spent per Medicare enrollee. There is com-

petition out there, and they do it less expensively. You are first; we are last.

The CalPERS thing is a fine example, but how does it work in areas that are not like California?

Mr. Martingale, I would like you also to participate in this because I take it that the 60 companies that you represent are not all located in just urbanized areas and cities. They operate all over the United States. And yet, through managed care, you have been able to reduce those employee costs as well. So just give me some discussion. Can it work throughout the country, not just in urbanized areas?

Dr. ELLWOOD. Well, CalPERS, of course, applies to both large and small communities in California. It is a big buying pool, with multiple employers. And that is something we discussed last year too.

The other thing is that this stuff is coming to small towns. I hate to keep citing Jackson, but the big surprise in health care in Jackson this last year was when the school board signed up for a health plan. And there was a lot of grousing on the part of the providers in that community, until it came out that this school board in a town of 5,000 is going to save $30,000 a month, and the teachers are going to be able to get a raise, we are going to be able to hire some more teachers.

It has been slower coming to certain parts of the country. It is slower in coming to small communities. But the technology that Mr. Martingale and others have worked on is now known to everybody, and it is no big technological or economic breakthrough to do it.

Senator BREAUX. Mr. Martingale?

Mr. MARTINGALE. I guess what I would add is that, when we first started doing this with large populations about 10 years ago, it was typical for multi-State companies to have maybe 50 or 60 percent of their population in areas where managed care was possible. But, nevertheless, we did it anyway, and probably preserved the current level of benefits in those non-managed-care areas, or cut them back modestly.

But the reality was then that those tended to be the less expensive areas because they were non-urban and, therefore, they were not where the big problem was.

So we went about our business, and did what we could, not waiting for the perfect solution. Today, it is more typical that we get for similar organizations 80 percent or more of their population. Because, as Dr. Ellwood said, these programs are expanding. So I think competition is hitting even the more rural areas, although it has a ways to go.

Senator BREAUX. Let me ask a question then, Dr. Ellwood. What about the argument that Medicare is for older people? They are going to have different health problems, more severe. Managed care can work with a younger population with less severe problems. Can you comment on that?

Dr. ELLWOOD. The goal is to deliver medical care more efficiently. So the sickest people are the ones where you need the greatest degree of efficiency, the best selection of treatment.

Incidentally, on your automobile analogy, General Motors is now smaller than Medicare. General Motors is a $154 billion company. Medicare is a $165 billion company.

Imagine running that with a new administrator every 3 or 4 years.

The CHAIRMAN. They might have done better, General Motors, that is.

We have two votes back to back at 12:00 o'clock. And I am hoping we will be able to finish our questions, so we do not have to keep the witnesses here.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I guess I would address this to all three of you, and I am really just seeking your thinking on this.

Up until recently, CBO, companies, everybody was saying that managed care got you a pretty good saving in the first year or year and a half but, after that, things began to go back.

Now CBO appears to be saying that managed care has the potential to sustain those savings over longer periods of time because of the nature and proliferation, or at least the emphasis on the competition, at least at this point.

On the other hand, there is anecdotal evidence that managed care is spotty and so forth, that some of this going up process could start again.

It seems to me the projections for savings under managed care are an incredibly important part of this debate. CBO has been very definitive in the past. They seem to have changed rather quickly, and have not really made definitive statements. But I would be interested in how you all react to that.

Mr. ETHEREDGE. I think Senator Moynihan said it well when he said we are shifting paradigms. We are shifting from an insurance, bill-paying paradigm to purchasing and managed care paradigms.

When you shift paradigms, and start doing something wholly new, you do not have a statistical base for projection, which is what CBO relies on. I think CBO is doing its job that it is asked to do. It is asked to look at the hard evidence. What is the money you can put in the bank? When you go off in a new direction, the evidence comes in slowly. But the evidence we are seeing so far is very positive.

And if you analyze the situation, if you start looking at all the areas where the health system is overspending, compared to the national average, overspending compared to other countries, the fact that we have a major oversupply of hospitals and specialists, these are conditions where markets can be effective for the longer term.

I do not know if you can convince CBO to score managed care savings much better than they have in the past, but I am confident there will be more savings there than they would credit at the moment.

Senator ROCKEFELLER. Dr. Ellwood?

Dr. ELLWOOD. Well, medicine is a technologically-driven industry now. In every other industry that is driven by technology, we have seen remarkable savings. And in medicine, for instance, surgery is now done without making a big incision. The surgeon is still paid

the same amount of money to do surgery like it is a Nintendo game.

So I feel that it is a paradigm shift. We have moved from a cost-plus-driven industry to one that is competing on price. The cost of CT scanners has come down. Before, if you bought an expensive CT scanner, you paid off the CT scanner and added something on top of it. So it seems to me that, with the exception of the effect of medicine on the aging of the population, if we all get to be 100, of course costs are going to increase.

But, other than that, the factor of growth of the number of people who are dependent, the structure of medicine and the directions in which science is moving are to reduce costs.

Mr. MARTINGALE. All that I would add is that the history, which is relatively short, has demonstrated that, as long as competition is in place, managed care continues to do well, relative to non-managed care. And part of that comparison is getting the advantage of how what is left in non-managed care is more and more out of control. So the bogey becomes easier and easier to beat.

I would just add one word of caution. When we make presentations to management groups, looking well out into the future about health care costs, we always feel compelled to point out the cyclical nature of these costs.

And we are all tempted to assume, because costs have performed so well in the last 18 months, that this is what the future holds. But there is a distinct possibility you need to be mindful of, as we do, that another surge looms around some corner. And I would not want my clients making long-term projections without at least being mindful of that risk.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Ellwood, I thought the first chart you put up there, what is happening with CalPERS, was an astonishing chart.

If I understand what the panel is saying here, you go into managed care, and you have got tremendous potential savings.

Mr. Etheredge, perhaps you could address this. Well, Mr. Martingale, you had this, but a little differently. There is a new generation coming along that has experience with managed care, but how do you get a person who is on Medicare, who has not had experience with managed care to go into these plans?

Mr. Martingale, under your situation, I assume that U.S. Steel is paying the Medigap, or paying the deductibles and copayments.

So, therefore, if U.S. Steel says to an individual retiree, you go into managed care or we will not pay your deductibles any more, that is a high incentive to do it. Is that they way you get them to do it?

Mr. MARTINGALE. Well, no.

Senator CHAFEE. Just briefly, because I do not have——

Mr. MARTINGALE. Probably all of the employers that I am involved with will make this optional, available. And then the challenge is to educate and convince.

Senator CHAFEE. But you have got to put a sweetener in there. The sweetener I think Dr. Ellwood was talking about is that they will get prescription drugs.

Mr. MARTINGALE. The sweetener is almost always enhanced benefits, and significantly so.

Senator CHAFEE. Producing enhanced benefits seems difficult for areas such as automotive industry where they are paying everything anyway.

Mr. MARTINGALE. It becomes more difficult, the more generous the program that they are leaving.

Senator CHAFEE. But, in any event, the objective is to get these folks in managed care.

Now I agree with what is said here. This has been a wonderful hearing. Any hearing where we think we can save a lot of money, we classify as a wonderful hearing.

When Dr. Greenspan came in and told us for the first time about how the CPI has been overpriced, that rated as a wonderful hearing.

And this one likewise, can be rated as wonderful because of the potential out there for saving. And one of the interesting points you made, Dr. Ellwood, was that under the current system, we everything we pay for Medicare less 5 percent.

We have always thought that was pretty good because we are getting it for 5 percent less. What you are telling us is that we could get it for a whale of a lot less than 5 percent. And you echoed that, Mr. Martingale, and Dr. Etheredge too.

So we are waking up here, I believe. But, again, how would you suggest we get more of these folks? What is the inducement, Mr. Etheredge, to get them on managed care? They are leery of it.

Mr. ETHEREDGE. Yes. Absolutely. I tried convincing my 96-year-old grandmother to join a Medicare HMO when she was living in Detroit several years ago. I visited her, and she had a shopping bag of claims and explanations of Medicare benefits, and she had pills all over the place. So I said, "Why not join an HMO? You would not have any paperwork, your prescription drugs would be covered." And she said, "Well, I guess I have just one question. Would the Government want me to join an HMO so it could save money?" I said, "Yes, that is one of the reasons we are doing it. And she said, "Well, then I figure it is not in my best interest." [Laughter.]

So I think we have to convince my grandmother, and people who worry about all of this reform being tied to budget savings.

The expansion of HMO's and managed care, and its general acceptance by the under 65 and the over 65 really is the most important element. If you look at where HMO enrollment is by State, it is 42 percent of total Medicare enrollees in California, 17 percent of Medicare enrollees in Florida. In these areas, HMOs enrollment is growing very nicely because people now know that these plans know how to serve Medicare beneficiaries, and it is accepted.

Second, it is important to do report cards.

Senator CHAFEE. Who would do those report cards?

Mr. ETHEREDGE. That could be done by the private sector, or by Government.

Senator CHAFEE. Well, Dr. Ellwood, you had a system of report cards.

Dr. ELLWOOD. We had a meeting at my home a couple of weeks ago, where people who purchase health care for 80 million people, including Medicare, joined together and said, let us start doing this

collectively. One of the things that really pleased me about that meeting was that Medicare was prepared to use the same system as the private sector.

Mr. ETHEREDGE. We have to show people what the quality is in the basic Medicare program—so they can see what they get currently, and they can see if it is going to be better quality and more satisfaction in the alternatives. I think that kind of reassurance and good information is important for people choosing a plan.

Second, a kind of Federal employees' open season is important. Medicare enrollees now do not get a choice once a year. They do not get a selection of plans. They do not get brochures telling them here are the additional benefits and quality measures.

I think if we actually told Medicare enrollees once a year that these are the Medicare HMO options in the community, people are satisfied with the quality measures, and gave them a chance to sign up, many more would sign up. Today, you have to really want to sign up, or have you employer sign you up.

Senator CHAFEE. All right. Thank you.

Mr. Chairman, I think this is excellent. I appreciate your having this hearing. My time is up. Thank you. It is nice to see you all again.

The CHAIRMAN. Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman. I want to add my thanks for your convening this hearing. It is an important hearing, and gives us a chance to talk about the new paradigm, and approaches to reform here.

We are looking at some $270 billion in Medicare and $182 billion in Medicaid cuts over the next 7 years respectively. And the question that many people are raising is whether or not these cuts represent a meat axe approach to the issue of reform, and whether or not the cuts alone, the meat axe we are taking which, by the way, is the largest cut we have ever taken in Medicare and Medicaid. OBRA 93 cut Medicare by $56 billion, and that was considered to be extraordinary.

But the point is whether this meat axe approach fails altogether to take advantage of the experience of the last 30 years. Thirty years ago, when Medicare was first started, Medicare and Medicaid were seen as kind of the pillars of the system, and that there would be an eventual inclusion of just about everybody. And we would have something like universal health coverage for the American people. Everybody would be covered.

We are here in 1995, looking at some 40 or 41—depending on whose numbers you listen to—million Americans with no health coverage at all. And we failed last year, unfortunately, to reform health care and try to address that issue.

We are also looking at the continuation of cost-shifting in the system. I was just asking my staff to take a look at the numbers for uncompensated care, care that does not get paid for, either by subsidy or insurance. And the estimate from the green book is that 13 percent of the care provided is uncompensated care.

So, with this meat axe, with the approach we are taking, I think we are looking at a potential increase in uncompensated care on the one hand, and certainly a diminishing of care for people on the other.

I know this is kind of a long preface to my question, but those are some of my assumptions. But my question is, when you talk about a new paradigm for Medicare, are you talking about just a better insurance plan? Is that the cine quo non of reform? Or does the reform to which you refer go further than just saying we are going to change the insurance forms and we are going to change the financial practices, as opposed to something more, in terms of how we approach this issue? I think that is a critically important question. If we just focus in on the dollars, I think we are going to miss the point in terms of the impacts.

Dr. ELLWOOD. Well, Senator Moseley-Braun, I really think it is a fundamental change in the way we practice medicine, and what our objectives are. And I will give you just one example.

When someone joins a health plan, let us say it is an elderly woman who has just had a cataract operation, and who you know has osteoporosis, you know that woman is a pushover for falling down, tripping over a rug or something on the way to the bathroom, and breaking her hip. So what you do is go out to her home, and you check this pathway to the bathroom to make sure that will not happen.

Under the old system, we would say, well, we know how to fix your hip. When she breaks her hip, we will do the best possible job, we will replace it, and she will be on her feet in no time.

But this paradigm shift is not just a matter of going out and trying to save money. It is a completely different view of the way you practice medicine. Incidentally, Nelson Mandela, when he got out of prison, I gather that the White House in South Africa was a duplicate of the cottage that he lived in when he was in prison. Do you know why he did it? So he would not trip and fall over things on the way to the bathroom during the night. He knew where things were. I think we have got to do the same kind of thing in dealing with a problem like Medicare. We have to just completely change the way in which we view people and their health, and anticipate what can go wrong.

And the present way of paying for things does not do that; it pays you after they go wrong.

Senator MOSELEY-BRAUN. Right.

Mr. MARTINGALE. I guess, Senator, to the extent that you focus on the delivery of health care itself, and garnering efficiencies through an enhanced system, the opportunity is there—and this is really the private sector experience—to enhance the benefits that individuals are eligible for at the same time you bring down costs.

Most especially, that enhancement takes place at the preventive end of the spectrum, where Medicare and fee-for-service indemnity insurance generally does not cover anything. And health maintenance organizations and organized systems really have to be profitable, have to reach out to people. The opportunity to do it with respect to the elderly is far greater than it is to the non-elderly population, because of situations like Dr. Ellwood described.

Mr. ETHEREDGE. Let me add one cautionary note. I think when people hear from the visionaries and about the best practices, the way Paul and others describe them, it is important to know that Congress needs to structure an entire system for economic incentives to produce such good results.

If Congress just gives people vouchers, and leaves them to purchase for themselves, that will encourage all kinds of risk skimming, fly-by-night companies and bad practices, which we have seen before when we tried to bring managed care into Medicare.

Legislative action needs to carry through to a complete system restructuring, which includes open seasons and report cards, so that people can make an informed choice. And then government needs to oversee the new system, and make sure that the people who are trying to provide worse care to make a profit, or skimming off the healthy people, are not allowed to do that.

If this committee can deal with the possible abuses system by designing the system so it weeds those out, then I think the elderly can get a lot more of the advantages that Paul and others are talking about.

Senator MOSELEY-BRAUN. Thank you. Thank you, Mr. Chairman.

Senator MOYNIHAN. Thank you, Senator.

Senator Roth?

Senator ROTH. Yes. Dr. Ellwood, in your statement you talked about having standard benefits. There would not be competition as to what benefits.

Under the Federal Employees Health Plan, there is a choice as to benefits. And, as you stated, I think that plan has worked reasonably well.

My question is, how important do you see it to be that we have standard benefits, or can we go another direction and let the participant have a choice?

Dr. ELLWOOD. I think there can be some choices. But I would restrict these choices to some degree. The reason for that is that you can really manipulate who it is you appeal to in your health plan by manipulating benefits. If you do not want diabetics, you have a poor set of diabetic benefits. And one of the real abuses in health insurance has been the manipulation of benefits for risk selection.

And CalPERS has found that, even with the best actuaries, they were not able to differentiate between these subtle differences in policies. So the average person cannot do that. So, sure, we ought to have a point-of-service plan and a PPO plan, and two or three variations. But the chart that I used for the Federal Employees Health Benefits Plan was a comparison of HMO prices, where benefits are standardized.

Senator ROTH. So the further you move the direction of choice, you run into what is called cherry picking. Is that right?

Dr. ELLWOOD. That is one of the expressions that is used, yes.

Senator ROTH. I do not know if any of you have seen the editorial in the New York Times this morning, but one of the statements——

Senator MOYNIHAN. I certainly would not want that moment to pass without stating for the record that of course, I have. [Laughter.]

Senator ROTH. I was certain of that, Mr. Chairman.

But, in the editorial, it questions that there are significant savings. If I understood you, Dr. Ellwood, you said that, if we went the direction proposed by you, there would be something like $270 billion savings in the 7 years. And, over a 10-year period, I do not recall the figure.

Dr. ELLWOOD. Six hundred and some billion.

Senator ROTH. Six hundred and some.

The New York Times said that, "The larger threat to Medicare reform comes from the gargantuan target of $270 billion, about 15 percent that the Republicans have set for Medicare savings by 2002."

Who is right?

Dr. ELLWOOD. I do not know who wrote that one.

Senator ROTH. Well, where are the savings made?

Dr. ELLWOOD. There is just a difference in the slope of the growth curve. In that one chart, we are still talking about a 5 percent annual increase. That is a substantial increase in expenditures for Medicare.

Senator ROTH. But, if I understand you, it does not depend on the beneficiary receiving the savings. It is the savings that result from the general approach. Is that not right?

Dr. ELLWOOD. Yes. It is the savings that result from greater efficiency. As far as I am concerned, the beneficiaries will get a greater scope of benefits.

Senator ROTH. Over the long term, sure.

Dr. ELLWOOD. Well, immediately, just as soon as they join a health plan.

Senator ROTH. Yes.

One of the concerns I have heard about HMO's is, are there areas, States, where it will work negatively—for example, the State of Alaska, which is somewhat isolated from the 48 below? Are there special problems?

Dr. ELLWOOD. I really think that they work better in rural areas.

Information flows in medicine as money flows. By that I mean, you refer patients to a doctor that gives you advice over the telephone. And, when you integrate medical care, where information can very readily flow, and everybody is part of the same financial network, you facilitate delivery of medical care at a distance.

Senator ROTH. Would the other two gentlemen agree with that? Do you have any comment on whether HMO's would give particular problems to some States, some regions?

Mr. ETHEREDGE. Yes, HOMs have been slower to develop in rural areas.

What HMO's and managed care are about is trying to change the practice of medicine. Prices are under control in Medicare. It is the volume differences from area to area, the rate of service increases in the future, which drives the costs.

What Medicare needs is a way to rationalize, and get professional and patient agreement on, a better way of practicing medicine—better in terms of quality, and better in terms of cost and service.

So I would urge more emphasis on outcomes research to influence areas with less HMO enrollment. Once Medicare can get the information base, that there is a better way to practice medicine, that in itself can be a major driver, whether it is a rural area or urban area. In fact, if you look at the two services that are declining in Medicare—cataracts and prostate surgery—those are both procedure in which we had good solid research that indicated to patients and clinicians that there was too much being done.

So I have hopes that, if HMO can provide good research that a more resource conservative clinical style can produce equal or better outcomes, that can be broadcast around the country and influence both rural and urban areas.

Dr. ELLWOOD. The one positive and then negative that I can think of, Senator Roth, is that we are now starting to see migrations of physicians out of California and some of the States where managed care has really taken over.

We expect a surplus of physicians of somewhere between 100,000 and 150,000 as a result of this. And those physicians are moving into States that do not have enough doctors right now, or communities that do not have enough doctors. Now that will be fine for a while, until they have too many.

One of the reasons why Medicare is such a time bomb is not just because of the nature of these projections, but because Medicare is now the court of last resort if you are a doctor who cannot find a job.

So, instead of Medicare cost-shifting to everybody else, everybody else is, in effect, resource shifting to Medicare.

Mr. ETHEREDGE. Senator, there is a risk of the CBO projections being too conservative. If providers who are driven out of managed care start moving into Medicare, and try to make up their lower incomes by serving Medicare patients, Medicare has no volume control. The administrator has very little authority to deal with this. We could see an acceleration of those Medicare baseline costs if we do not put more management tools in the basic program to protect against that.

Senator ROTH. Thank you.

Senator MOYNIHAN. Thank you, Senator.

If I could just read a line from this, which says it is a bold, imperfect Medicare plan. The Times this morning says, "If competition is to work, the GOP must let beneficiaries, rather than the Government, pocket most of the savings from choosing low-cost policies." But then the Treasury will not save much money. I do not think that follows, does it?

Dr. ELLWOOD. As I testified, you can have it both ways. You can save money and give them better benefits.

Senator MOYNIHAN. If the trajectory is lowered, the fact that you give a small payment to people who buy the cheaper plan does not mean you are giving up anything. You are not realizing any savings.

Dr. ELLWOOD. You have more extensive benefits.

Senator MOYNIHAN. Yes. At the risk of emptying the hall, could I say that we are talking about public administration here, as much as about medicine.

I know, they are almost rushing for the door. [Laughter.]

But the mode of public administration is profoundly important. Mr. Etheredge, who has worked in OMB, knows that very well.

Senator Packwood was commenting that it took me 15 years to persuade the Social Security Administration to send out an annual statement to persons who are paying into the system, reporting how much they paid that year, how much they had paid over the years, what they could expect in benefits at age 65, what their survivor's benefit would be, and such like.

The document costs less than the stamp it takes to mail it. They have the data, but they did not think it was anybody's business. They wondered why anybody would want to know. And we gradually got them to those over 60; pretty soon it will be 55.

They look up after 50 years, knowing the system is in good shape, and that is all they needed to know. The majority of nonretired adults do not think they will get Social Security. They never kept in touch with anybody, and they did not see why they should have to.

We tried to get a tamper-proof card, which I have on some legislation for an immigration bill. And, after a year, the tamper-proof card came back. It was a nice piece of plastic. You know, a Mexican could walk in to an employer in San Francisco and say here is my Social Security card. Just run it through and it will ring a bell back there and tell you to hire him. After a year's time, back came the same damn piece of pasteboard, but with fibers which are instantly detectable by an FBI lab that could spot a forgery made in Tiajuana. But no employer would. That is the one that was given out in 1935.

Dr. ELLWOOD. Remember last year, they showed those nice plastic cards. They were going to give you free health care.

Senator MOYNIHAN. Right.

Dr. ELLWOOD. This is a Medicare card. I cannot even read it any more.

Senator MOYNIHAN. That is right. They were very scared of those. You had an institutional fright. In 1935, when they started Social Security, they said Roosevelt wanted to have an identity card, so he can round up everybody to put them in the Army, send them here, send them there. So it said, "Not to be used for identification purposes". It literally said so. But they wanted the least card they could get. And these institutional organizational patterns carry on.

Well, we are hugely in your debt. We have to do something. And it seems clear to me that it ought to be something along the lines you have proposed.

Thank you very much. The Chairman is necessarily absent, so I will close the hearing with our great gratitude.

And you, Dr. Ellwood, seem to have recovered nicely. It shows that——

Dr. ELLWOOD. I chose the right doctor.

Senator MOYNIHAN. Thank you all.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

NEW DIRECTIONS IN MEDICARE

WEDNESDAY, JULY 26, 1995

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

The hearing was convened, pursuant to notice, at 2:50 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Simpson, Pressler, Moynihan, Baucus, Rockefeller, Conrad, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Folks, I apologize. If all the witnesses want to come up and take their place. I apologize. We have been having votes. Senator Moynihan said he will be a little bit late. I just saw him on the Floor. I apologize for rescheduling this morning. We did not know about the joint session of Congress at the time.

Have we got everybody here? We will start, going in order on the list, with Jordan Cohen, the president of the Association of American Medical Colleges.

Doctor?

STATEMENT OF JORDAN J. COHEN, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Dr. COHEN. Good morning, Mr. Chairman. Good afternoon, I should say.

The CHAIRMAN. Yes. Again, I apologize for it being afternoon.

Dr. COHEN. I want to also give my salutations to the members of the committee. I am Jordan Cohen, president and CEO of the Association of American Medical Colleges, and former dean of the Medical College at the State University of New York at Stoneybrook.

First, I would like to say how much the AAMC appreciates Senator Hatch's leadership in introducing S. 955. We look forward to working with all of you on this critical legislation so that Medicare beneficiaries continue to have access to the latest technologies.

Teaching hospitals and medical schools are struggling for their very survival in the new competitive world of health care delivery. Reports about how the competitive environment is threatening academic medicine abound in the media.

Despite these threats, the July 21 issue of U.S. News and World Report about America's best hospitals documents what I think most people know full well. Of the 128 best hospitals, according to U.S. News and World Report, virtually all are teaching hospitals. Teaching hospitals and medical schools are perfectly able to compete in the new environment, on the condition that a level playing field exists between teaching and non-teaching hospitals.

Unfortunately, a level playing field requires the participation of all payors in financing the unique education and research missions carried out by teaching hospitals and medical schools. The AAMC is committed to the fundamental principle that support for these social goods is a shared responsibility.

We understand the need to address the Federal deficit, as well as a need to scrutinize the Medicare program in the process. We also understand how difficult it will be to reach decisions. But, at the end of the day, such decisions must be informed and they must be fair.

In the current environment, the Medicare program's explicit payments to teaching hospitals are of crucial importance. Cuts in either the IME or the DME will make it more difficult for teaching hospitals to compete in a free market and to sustain their special missions.

Medicare payments to teaching hospitals and teaching physicians play a decisive role in allowing my colleagues across the country to provide the best medical care in the world.

We also are deeply concerned about how the rate for Medicare risk contractor plans is calculated. This rate, the average adjusted per capita cost, includes all Medicare expenditures, including DME, IME, and DSH payments. However, there is no assurance under the present arrangements that the teaching hospital receives these dollars as Congress intended. In most cases, in fact, it does not.

We believe that these mission-related payments should be excluded from the AAPCC and paid directly to teaching hospitals. This change would direct payments appropriately, as intended by Congress.

Our written testimony explains in some detail how this could be accomplished and the AAMC urges the committee to make such a change as part of its proposals to reform the Medicare program.

The AAMC supports the formation of graduate medical education consortia. The AAMC urges Congress to scrutinize the current statutory requirements that permits only hospitals to receive Medicare DME payments and to consider allowing other entities, such as ambulatory training sites, to receive payments if they incur the costs of the training.

In closing, I would like to underscore the fragile nature of medical school financing. Revenues earned by clinical faculty in the patient care arena now accounts for 44 percent of total medical school revenues.

As the health care environment becomes more price competitive, it is inevitable that less money will be available from this source to support education and research. Now is the time to begin thinking seriously about how best to ensure the continued financial viability and integrity of medical schools.

Mr. Chairman, medical schools and teaching hospitals are ready, willing, and able to do their fair share. Given the crucial importance of Medicare payments, we urge caution as you consider Medicare reform and the ways to address the program's level of spending.

I am very happy to answer your questions, Mr. Chairman.

The CHAIRMAN. Doctor, thank you. We will take the entire panel, first.

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

The CHAIRMAN. We will take next Dr. John Goodman next, who is the president of the National Center for Policy Analysis in Dallas.

Doctor?

STATEMENT OF JOHN C. GOODMAN, PH.D., PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS, DALLAS, TX

Dr. GOODMAN. Thank you, Mr. Chairman, members of the committee.

The CHAIRMAN. Let me interrupt for just a minute. Mr. Lee, you have got to catch a plane back?

Mr. LEE. No, I am all right.

The CHAIRMAN. You are all right. Thank you. All right.

Go ahead, Doctor.

Dr. GOODMAN. Thank you. I have become convinced that the traditional fee-for-service health insurance policy, the one that allows you to go into the market and see any doctor, and order any test, and send the bill to someone else simply cannot survive. It is becoming too expensive. I am not sure I can buy such a policy for our employees at the NCPA in Dallas right now.

What is happening in the market, even without legislation, is that people are being pushed in one of two directions. Either people have to enter a managed care organization that limits choice of doctors and limits access to tests and other services, or if people want to be able to exercise all those options for themselves they have to agree to manage their own health care dollars through what today we are calling a medical savings account.

Now, when we presented these options to our own employees, the vote was unanimous: they voted for the medical savings account.

This first chart shows what we were able to do. At no extra cost to the employer we went from a traditional fee-for-service plan to a plan that created the $2,000 deductible for our families. We were able to put $1,500 in a medical savings account. So the first $1,500 they pay out of the account, the next $500 they pay out of pocket, and when they hit $2,000 the plan pays everything above that.

Now, the next chart contrasts where we are this year with where we were last year. It immediatly answers one of the objections that we hear so frequently about medical savings accounts, that it is good for healthy people, bad for sick people. In fact, what we were able to do is great for any employee that is sick, or family member who is sick.

Under last year's plan, that family would have faced a $500 deductible and a 20 percent co-payment for another $1,000, so they would have been out $1,500. This year, we are able to limit the total exposure to just $500. So moving to a medical savings account

for our employees is equivalent to a $1,000 gift to a family that knows it is going to max out on deductibles and co-payments.

Now, we have been working with Milliman & Robertson on options for Medicare. If I could see the next chart. This is an actuarial consulting firm that actually is quite favorable to managed care; but we asked them to look at some options for medical savings accounts.

They began with the money that we are now spending and asked, what would happen if we created a $4,000 deductible? This completely caps all the Part A hospital expenses and all but about $2,000 of the patient's exposure under Part B, and they are able to put $2,000 in a medical savings account.

Now, this was before we used any Medigap money. Most of the elderly buy Medigap policies. I think the average cost right now is about $1,200 a year. I do not have final numbers yet; but it looks as though if we had access to that money we could create a $2,000 deductible and $2,000 in a medical savings account with no gap. Or if you wanted to expand coverage to drugs and some other items you could create, say, a $3,000 deductible and a $2,000 medical savings account. In any event, you could move from the current system, which is very inefficient and quite irrational, in my opinion, to something which is more efficient and more attractive.

If I could have the final chart. Milliman & Robertson has done some projections to see what these kinds of options would do in terms of meeting the budget goals that Congress has set for itself. They are projecting that you could have about $200 billion-plus of savings with medical savings accounts alone. Gary and Aldona Robbins, using our own health care model, which is a dynamic model, are estimating about $230 billion of savings with this kind of approach.

Then Milliman & Robertson asked, what if we combined medical savings accounts with managed care, because, as a practical matter, every medical savings account plan that I know of right now is combined with managed care, including our own plan for our own employees, and they found that you could have savings possibly as high as $300 billion.

So at this point, and these numbers are still preliminary, we are optimistic. It looks like the kinds of options that people are talking about are consistent with the budget goals that Congress wants to meet.

Thank you.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Next, we will have Karen Ignagni, who represents Group Health, who has appeared here before, as I believe, on an occasion or two.

Go right ahead.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC., WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman, Senator Rockefeller. We are delighted to be here this afternoon to contribute to your process of considering the options before you with respect to Medicare.

At GHAA we have presented for your consideration a plan for preserving Medicare for another 30 years. We have thought long and hard about the contribution that Medicare has made with respect to access to care for senior citizens and with respect to health security for senior citizens, and have tried to offer you our thoughts on how to preserve those qualities, but yet go forward into the future.

We have offered six specific recommendations. The first would allow a number of different types of delivery systems to provide services to beneficiaries and, in fact, compete with each other within the Medicare program. That would include the traditional Medicare program.

Second, we have offered some suggestions about improving information to beneficiaries. I would like to specifically direct your attention to the situation we have now with respect to an individual retiring and going into Medicare for the first time.

Right now, the information that is received is fairly minimal. What we hear from many of our beneficiaries is that, in fact, they would like to have more information and they would like to have a better sense of what is out there so they can make their own decisions.

I would remind you that GHAA feels very strongly that Medicare beneficiaries, as all beneficiaries, should be making their own decisions with respect to health care delivery.

I think the point of the informational observations, however, is that we should set up a structure which puts in their hands information prior to retirement so that they can have plenty of opportunity to consider that before they actually become Medicare eligible.

The third observation we make, is that any proposal for change in Medicare that contemplates setting up more competition in the system will not work without equitable standards across all participating plans. I have already talked about information. In our view, that includes quality assurance, solvency, and payment. I will come back to payment in a moment.

The fourth observation we make, is that some of the proposals that we have offered, and others have offered, would definitely transition the role of government in the system to that of a standard setter versus the type of point of service payment regulation we have today. I think that we are prepared to offer some suggestions in that area and would be very much delighted to engage in a dialogue about that.

The fifth, is a transition to an improved payment methodology. I might comment that there have been a lot of observations recently about an FEHBP structure and FEHBP-like systems. We think it may be very useful to explore those models for the long term, but that will take time and study. What we have tried to do is offer you some suggestions that will allow you to begin making

changes now, building off the current system; in other words, a road map of how to begin.

We would start from expenditures, where they are today, translate that into a per capita payment for fee-for-service and for non-fee-for-service plans. On the fee-for-service, that would provide the incentive to integrate Part A and B and, in fact, pick up and implement many of the proposals that this committee, and others, have talked about over time in terms of improving coordination of care to beneficiaries in the traditional Medicare program.

On the managed care side, there would be a budget much like AAPCC. That would be a beginning point. That environment, I think on both sides, would put this committee and others into the discussion of, in fact, discussing the specifics of growth levels, and you would have a mechanism to begin to make that change.

The sixth point we offer is probably self-evident, but let me say it anyway. We think that it is terribly important to put in place a process that continuously monitors what we are doing and the effect of what we are doing.

I do not think anyone can contemplate now, as, indeed, no employer can exactly contemplate the extent of changes that are going on in health care delivery, and what the delivery system is going to be looking like in the next 10 years.

What we have tried to do is offer suggestions based on what is, in fact, working for the under-65 market and begin to give you a road map or a critical path in terms of implementing them with Medicare.

We hope this proposal is a helpful contribution to the debate and would be delighted to discuss it. Thank you.

[The prepared statement of Ms. Ignagni appears in the appendix.]

The CHAIRMAN. Now, Dennis Kasselman, who is the senior vice president of Marketing and Development for the Mid-America Health Partners. But today he is appearing on behalf of the American Association of Preferred Provider Organizations. Mr. Kasselman?

STATEMENT OF DENNIS G. KASSELMAN, SENIOR VICE PRESIDENT OF MARKETING AND DEVELOPMENT, MID-AMERICA HEALTH PARTNERS, INC., KANSAS CITY, MO, ON BEHALF OF THE AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS

Mr. KASSELMAN. Thank you, Mr. Chairman, and thank you, committee, for inviting the AAPPO to participate in this very important hearing.

The AAPPO is a national trade association for PPOs, Preferred Provider Organizations. Since the early 1980's, PPOs have been available to the under-65 population. They became a marketplace response to health plan sponsors seeking to reduce the rate of medical cost inflation without reducing benefits and while retaining the freedom for patients to choose their providers, both hospitals and physicians.

As we look at the success in the private sector we find that PPO membership has grown to over 79 million people in 802 plans across the Nation. This compares to an HMO membership of 55

million in 564 plans. This impressive growth of PPOs reflects the acceptance by patients, providers, and plan sponsors and purchasers of PPOs within our communities.

A recent major health benefit study by an international consulting firm reported that PPO plans had the lowest average annual cost increase amongst all health plan types in 1994.

When we look at Medicare, we find that currently less than 10 percent of those Medicare-eligibles are in HMOs, and that is over a 10-year period. Over 90 percent have no other managed care options. The absence of PPOs, one might say, could explain in part why Medicare cost increases have exceeded private sector increases.

It is our strong recommendation that Congress legislatively enable PPOs to be direct contractors with HCFA and that PPOs be offered to Medicare beneficiaries in order to achieve the dual goal of both reducing the growth in Medicare expenditures, as well as providing beneficiary satisfaction by way of offering them a major choice.

PPOs are corporate entities which contract with providers at reduced rates. The PPOs then in turn take this network of providers to the health plan sponsored by insurers or employers to offer these networks and a medical management system to control costs.

PPOs use a number of methods now not employed by HCFA to help control these costs. First of all, by agreement with their contracting physicians, PPOs work closely with these physicians to manage the necessity, appropriateness, and level of health care services. This utilization management program results in significant savings for the members and for the purchaser.

PPOs also utilize a different method for payment on the Part A hospital side, as well as Part B diagnostic services, which often results in costs less than Medicare now pays. For example, hospital payment is often on a per diem or maximum daily charge basis. When you then reduce the lengths of stay you have less cost than you would with the DRG payment system. PPOs are available now and they are a means to introduce Medicare beneficiaries into an effective and desirable managed care system.

The AAPPO has the following recommendations for Congressional legislation that will build upon successful innovations in the marketplace. First, enable direct contracts between HCFA and PPOs, as is done currently with major self-insured employers within our community.

Second, modify the Federal law and regulations to permit PPOs to assume full or partial risk in contract with HCFA. Third, require accountability of all managed care plan types to protect the interest of the Medicare beneficiaries.

The AAPPO, its board, and staff stand ready to assist Congress and HCFA in the implementation of our recommendations. With your permission, Mr. Chairman, I would like to submit the official PPO definition for the record. Thank you.

The CHAIRMAN. Absolutely.

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

The CHAIRMAN. Last, we will conclude with John Lee, who is the regional vice president for Oregon and California for the Sisters of

Providence Health System, a man I have known for almost a generation. He has been in the health business all of that time, and I am glad that you could stay.

Mr. Lee?

STATEMENT OF JOHN P. LEE, REGIONAL VICE PRESIDENT FOR OREGON AND CALIFORNIA, SISTERS OF PROVIDENCE HEALTH SYSTEM, PORTLAND, OR, ON BEHALF OF THE FAIRNESS COALITION

Mr. LEE. Good afternoon, Mr. Chairman, other members of the committee. My name is John Lee. On behalf of the Sisters of Providence Health System and our 33,000 Providence Good Health Plan Medicare beneficiaries, I appreciate the opportunity to appear before you today.

The CHAIRMAN. Let me ask you a quick question. You are representing the Fairness Coalition.

Mr. LEE. That is correct.

The CHAIRMAN. But I am not quite sure what that is.

Mr. LEE. All right.

The CHAIRMAN. Or who that is.

Mr. LEE. It is a coalition of not-for-profit managed care plans that are based in Washington, Minnesota, Oregon, Utah, and Idaho.

The CHAIRMAN. Thank you.

Mr. LEE. Separate from the record, there is a position statement that has been submitted to the committee.

The CHAIRMAN. Thank you.

Mr. LEE. I want to make four points this afternoon. One, is that HMOs work, capitated HMOs, have a proven record of being able to positively address the triple threats of cost, quality, and access for Medicare beneficiaries. We believe that any reform of Medicare should preserve the opportunity for HMOs to offer incentives for beneficiaries to choose managed care plans.

Two, the current Medicare HMO payment methodology is seriously flawed. As you know, HMO payments are based on AAPCC rates. In 1995, this payment rate for the same course services varied geographically, from a low of $167 per month in the lowest-paid county in the United States to a high of $615 per month in the highest. This is a variance of 367 percent from the lowest county to the highest county.

As a result of this enormous disparity, few or no HMOs exist to serve Medicare beneficiaries in those parts of the country with a very low Medicare per capita spending. If we want to encourage more choices among competing health plans, we have to address payment disparity.

Three, Medicare beneficiaries are not being treated fairly across the United States. Medicare HMO members in high payment areas have often received more benefits and pay less out of pocket than similar beneficiaries who happen to live in low-payment areas.

Fourth, we would like to propose a solution, an excellent methodology that had its origins in this committee, and has to do with the development of DRGs. Currently, as you are aware, DRG rates only vary from a high to a low of 14 percent throughout the United

States. Keep in mind, that compares to 367 percent variance for HMO AAPCC rates.

Now, I would like to take a couple of minutes to explain these four points further. The problem with the current Medicare HMO payment. At the present time, payment to Medicare HMOs is tied to the fee-for-service spending in their local community.

Using a complicated formula that very few people understand, HCFA calculates for each county in the United States what is known as the AAPCC. The AAPCC rate in each county reflects various demographic adjusters and the local fee-for-service cost for hospital, physician, and out-patient services. HMOs are then paid 95 percent of that rate.

With a compelling need to save the Medicare trust fund, it is time to reform the way in which the Federal Government purchases services for Medicare recipients. As Congress implements a limited Medicare budget, communities that are better able to manage their health care resources will be forced to subsidize those less efficient areas of the United States unless some change is made.

The situation is especially pronounced in rural areas. Per capita spending in rural areas lags well behind urban areas, and the Medicare AAPCC rates are too low to make HMO options economically viable in these communities. We have prepared maps for every State represented on this committee. As Chart 1 illustrates, the situation in our own State of Oregon, where all the counties in the State receive less than the national average AAPCC rate. You will note that the colors are reflected on where the AAPCC rates fall by county. Other States in a similar situation that all fall below the national average include Nebraska, North Dakota, South Dakota, Montana, Iowa, and Oklahoma.

In States like Illinois and New York, you see wide variations in the AAPCC rates between neighboring counties. For example, in New York State, the 1995 AAPCC for Putnam County was $518 per month, which is well above the national average, while the Olster County payment, which is right next to it, was $383, or a full $135 difference per enrollee, per month. Do seniors in Olster County deserve less than their neighbors in Putnam County?

As you can see, the most important impact of these enormous geographic variations is that our seniors are not receiving equal benefits across the country for their comparable contributions.

In highly-paid counties in which Medicare HMOs flourish, it is not unusual for beneficiaries to pay zero premium and receive significant additional benefits, including prescription drugs, eyeglasses, and dental coverage. However, HMO plans in lesser-paid counties must charge monthly premiums and cannot afford to include additional benefits.

So what are the implications for Medicare budget decisions? As Graph 1 shows, if nothing is done, the disparity between the top 10 percent of AAPCC counties and the bottom half of AAPCC counties will increase. If across-the-board cuts are made in Medicare payment rates, the disparity gets even worse and you almost certainly eliminate Medicare HMO options in low-cost areas.

Graph 2, on the other hand, shows how you can reduce the disparity between high and low AAPCC counties and achieve the 2002 expenditure target in the Budget Agreement, which is a U.S. aver-

age of $6,700 per beneficiary, per year. Some health plans already receive some exceeding $6,700. Plans in Dade County, for example, currently receive $7,380 per year.

So how could equity in Medicare HMO payments be accomplished? We suggest that the approach developed by HCFA to normalize DRG rates to hospitals is a fair method for accomplishing the same equity for HMO rates. HCFA DRGs do now allow regional variations based on legitimate differences in labor rates and supply costs.

To close, clearly Congress must reduce the crippling inflation rate in the Medicare program that we have experienced in recent years. However, across-the-board cuts will threaten the continuation of Medicare HMOs in efficient markets and prohibit their expansion to rural communities.

We thus believe that Congress must address the issue of the gross disparity between Medicare HMO payments if it hopes to achieve significant Medicare savings, as well as increase choice of health plans for seniors.

Thank you very much.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Dr. Goodman, are the medical savings accounts you described similar to those described by Mr. Rooney of Golden Rule Insurance Company?

Dr. GOODMAN. Yes, sir. Our deductible is lower. For his own employees——

The CHAIRMAN. Same idea, though.

Dr. GOODMAN. Same idea.

The CHAIRMAN. Now, you indicate that—you estimate that—beneficiaries can save over $200 billion over 7 years.

Dr. GOODMAN. That is the Federal Government can save that money.

The CHAIRMAN. Well, that is what I thought. I thought you said beneficiaries. You think with just medical savings accounts we can save $200 billion in Medicare?

Dr. GOODMAN. Yes.

Senator CHAFEE. Over how many years?

The CHAIRMAN. Seven years.

Dr. GOODMAN. Seven years.

The CHAIRMAN. Just kind of run the numbers by me again.

Dr. GOODMAN. Well, I do not have the full report, and these are preliminary, but we have two separate groups looking at this. One is Milliman & Robertson, which is a very highly-respected actuarial consulting firm. Basically they assume a high deductible. The incentives created by a high deductible will cut 30 percent into Part B spending and about 10 percent into Part A spending. That is roughly what the assumptions are. There is more to it than that. Within about a week we will have a full report.

The CHAIRMAN. Well, explain to me mechanically how it works. I understand how a medical savings account can save money for the beneficiary, assuming the beneficiary does not spend all of the set-aside, and their tax on part of it, and keep part of it. Tell me how Medicare is going to save this money. Obviously, we are going

to pay out $200 billion less somehow. Technically, how does it work?

Dr. GOODMAN. Well, the assumption here is that we could induce the private sector to create a reasonable plan of the type that we have described earlier for, say, 95 percent, or something less than that, of what we are now paying. So the government saves money by paying the private plan less than what it otherwise would pay.

The CHAIRMAN. And we would pay them $200 billion less than we would otherwise pay of the 7 years.

Dr. GOODMAN. That is right.

The CHAIRMAN. Those are stunning figures.

Dr. GOODMAN. Well, they are encouraging, yes.

The CHAIRMAN. Encouraging. Yes, they are encouraging. I mean, our problem is solved.

Dr. GOODMAN. Well, I am not going to say that.

The CHAIRMAN. Would you mind coming back to testify once more in about a week?

Dr. GOODMAN. I will do that.

The CHAIRMAN. I did not realize how easy it was going to be.

Dr. GOODMAN. I did not say it was going to be easy, but it looks like we can be in the ballpark.

The CHAIRMAN. Ms. Ignagni, what does your association think of medical savings accounts?

Ms. IGNAGNI. Well, we have actually have done quite a lot of work looking at the literature in terms of what the track record and accomplishment of coordinated systems have been.

The literature is beginning to tell a very compelling story, basically, to suggest what we already know, that in terms of many of the catastrophic illnesses that many Americans experience, there is a very high value in coordinated care which emphasizes early intervention. That does not exactly fit with the MSA concept.

The CHAIRMAN. Now, translate that again.

Ms. IGNAGNI. Yes. What we found is that our track record in terms of performance and quality in HMO-style of care is very directly related to early intervention and attention to prevention and health care maintenance.

The CHAIRMAN. Therefore, lowering catastrophic costs.

Ms. IGNAGNI. Yes, sir.

The CHAIRMAN. And your feeling is that individuals will not do this preventive care if they have to pay the first $500, $1,000, or $1,500?

Ms. IGNAGNI. Well, we do not know, simply. I think that this is a question that remains unanswered. So, in evaluating MSA proposals, many of which are keyed, as you know, to catastrophic, coverage we have been raising concerns about that in terms of how they would fit with what we seem to have learned.

Dr. Cohen and I have talked quite a lot about the value of prevention, and there is a whole body of very persuasive evidence that suggests our whole educational approach to how we are training physicians and other health care practitioners really needs to emphasize more front-end kinds of services and prevention. So we are looking forward to engaging in some discussions about how all this fits together, but that has been our experience.

The CHAIRMAN. Now, Dr. Goodman, in your testimony you more or less refute that. You say this does not stop preventive care.

Dr. GOODMAN. No, I do not think it does. But let me just say, in most of the academic studies have found that preventive medicine does not save money. It does not mean we should not have it and should not encourage it, but it simply does not save money. The studies do not show that that is how HMOs save money. HMOs save money by keeping people out of hospitals and by substituting less-costly therapies for more-costly therapies. There is a lot of literature on this.

Let me make one other point, Mr. Chairman.

The CHAIRMAN. Yes.

Dr. GOODMAN. The Milliman & Robertson studies also suggest you can achieve this kind of savings by managed care alone. But what we recommend is that managed care and medical savings accounts, and medical savings accounts combined with managed care, all be options that are available to the elderly.

The CHAIRMAN. Let me ask you about the statement, preventive care does not save money. It reminds me of the testimony we had, it must have been a year ago, from a doctor who was talking about mammograms. He said, for women under 50 it does not save money.

The amount of money that you would spend to do the mammograms for women under 50 and the slight discovery you would find for the cost, you would be spending more for the mammograms than you would save in the preventive care. Again, he was not necessarily saying, do not do it, he just said, do not expect to save money on it. Is that what you are saying?

Dr. GOODMAN. That is correct. It is also true of women over 50 years of age. Roughly, women in the 50's, if you give regular mammograms to healthy women, you are going to spend about $186,000 for every year of life you save. That is not paying for itself, that is very expensive.

I am sorry. For women in their 50's, it is about $100,000 you spend for every year of life you save, and for women in their 40's you spend about $186,000 for every year of life you save. Again, it does not mean you should not do it, it just means it is expensive.

The CHAIRMAN. Do not assume you are going to save money.

Dr. GOODMAN. It does not pay for itself.

Dr. COHEN. Mr. Chairman, if I might add a comment to that, if I could.

The CHAIRMAN. Yes.

Dr. COHEN. I think it is certainly true, if one looks at a single kind of preventive activity, like mammograms, one can come up with a calculus like that, but I think what Ms. Ignagni was referring to was the whole spate of preventive services, including childhood immunization, including blood pressure checks and prevention of hypertension once it is detected and treated properly, things that we know have tremendous impact on potential avoidance of catastrophic illness later on. I think when all of those aggregated preventive services are taken in toto, I believe the evidence shows that it is, in fact, cost saving.

The CHAIRMAN. I am reminded, and I have used this with the committee several times, of 30 years ago when I was in the legisla-

ture. Even in those days Kaiser was a significant factor in health care in Oregon because they had come up with the shipyards in World War II. And they would testify at the legislature that their hospital costs were not that much cheaper than anybody else's, they just did not hospital as many people. They would do the best they could, in a rather primitive fashion, to do preventive medicine.

They had a number of large employers under contract and they would do what they could with trying to run physicals, and screenings, and catch people, and they did. Their costs were lower. That is why a lot of employers were signing up.

Then the ultimate thing that was always intriguing, because I was a labor lawyer and represented some of these employers, the employees seemed to like the service. I did not find any great complaint about, why do I have to go to Kaiser? In those days, you had to go to the Kaiser clinic. There was no significant opt-out, but nobody seemed to complain much.

Jay?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Jordan, let me ask you just a general question. You are hoping that Medicare medical education spending is not going to be eliminated with cuts in Medicare. Most people in this Congress have no idea that graduate medical education is paid for by Medicare in the first place, much less international medical school graduates, plus those who teach them, plus anything in health care they do—I would suspect that they probably will be eliminated because of the nature of this particular Congress. I do not think they are going to be very friendly towards people who do not come from America.

Now, given that for a moment, you and I have talked in the past and we have discussed in this committee, although not very constructively in past years—not this year, but in past years—that, one, there were far too many specialists in this country. Probably too many doctors, but certainly far too many specialists. One argument was there was 80,000, another that there was 100,000, but there was no question that there was too many, and that the system was causing that to happen.

There is no question that radiologists, anesthesiologists, and other specialties are living in terror as they contemplate a large reduction in their income.

My question to you is, as you look at the condition of specialists now, do you see them accepting the reality of what appears to be happening, or do you see them only in, pathologists, radiologists, anesthesiologists, maybe one or two more categories, accepting that reality because it is so dramatically already being shown?

In other words, that the evening out between the generalist and the specialist that most of us have been trying to get in this country is going to happen, is now happening, through non-legislative private mechanisms?

Dr. COHEN. Well, thank you for the question, Senator Rockefeller. You have touched on many issues in that comment. Let me say the following. I think American medical students are clearly getting the message that the career opportunities of the future are going to be different than they have been in the past and they are going to be much more open in the generalist disciplines and in the specialist disciplines.

We have seen in the past 3 years really quite a remarkable change, considering the relatively short time frame, in the choices that American medical student graduates are making in terms of their career options.

As recently as 3 years ago, less than 15 percent of graduates of U.S. medical schools were electing one of the generalist careers. Last year, the figure was almost 25 percent. Preliminary numbers from this current graduating class just a couple of months ago suggest it is going to be in the 27–28 percent rate.

So we have had virtually a doubling in the number of U.S. graduates who are selecting one of the generalist careers over just a very few years ago. I think the evidence is that that is going to continue to ramp up, in response to a whole spate of different things.

Market forces, undoubtedly, are a part of it. The stories about the anesthesiologists and the radiologists are certainly being heard by medical students and they are making choices, in part, as a result of that.

On the other hand, we still are faced with a very large excess in the training capacity in our country. We graduate about 17,000 U.S. graduates, both allopathic and osteopathic graduates a year, but we accept 25,000 new physicians every year into training in our country.

So there is a very large additional group of individuals who are coming into the graduate medical education arena that are adding ultimately to the physician work force because most of those individuals who are coming from medical schools abroad do stay in this country to practice medicine. That group, as far as I can tell, is continuing to select disproportionately more specialty options than generalist options.

In the final analysis, the total number of physicians that we are turning out as a result of that large capacity to train in the graduate medical education arena far exceeds what I think most scholars who have looked at this question think we have a need for in the future, particularly if managed care continues to grow.

Senator ROCKEFELLER. Thank you. I want to ask one more quick question. I would have never believed 2 years ago, 4 months ago, that there would be something in this county called a for-profit HMO. I just would not have believed it, because HMOs were based upon, you put down your money once all the incentive is on the physician to bring you in for check-ups. I find for-profit HMOs personally offensive as a kind of medical vehicle.

I would like somebody to explain to me how they came to be all of a sudden, that nobody had thought about this several years ago, and all of a sudden there are so many. It is 50 percent, and seems to be growing. I mean, money seems to be ruling everywhere.

Ms. IGNAGNI. I think, Senator, as you know, there has been a real issue with respect to, in the system of the 1990's health care delivery and looking forward to the turn of the century, the ability to have first-rate information systems and to provide the kind of accountability——

Senator ROCKEFELLER. Karen, you answered that. That was your answer to an earlier question. I am asking a different question.

Ms. IGNAGNI. No. I am actually going to give you a rationale for why a number of not-for-profit HMOs have transitioned into for-profit status because of an access to capital issue.

The CHAIRMAN. Because of a what?

Ms. IGNAGNI. Access to capital issue. The only other source for capital, as you know, in the not-for-profit world is through the bond market, and there are limitations there. So that is one issue.

There has been quite a growth on the for-profit side, as you indicated. I think, as you investigate some of the reasons for that, you will find, particularly with some of the conversions, that that has been a major factor.

Also, with respect to any plan, whether it is an HMO, a PPO, or some delivery system we have yet to invent, I think the compelling issue is how we judge performance. I think the bottom-line performance should be scrutinized. We have now data and the ability to look at performance across all kinds of systems and all kinds of plans. I think that is the issue, how are plans performing, are patients satisfied.

Senator ROCKEFELLER. I do not think that is necessarily the entire issue, Karen. I think that is a convenient answer for you, but I do not think that is the entire issue.

My time is up, and we maybe can continue this. I think there is a moral matter here, and a money matter here.

The CHAIRMAN. Are those two in conflict?

Senator ROCKEFELLER. I think, potentially, yes.

The CHAIRMAN. Only in medicine, hopefully, then.

Senator Graham?

OPENING STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman. Mr. Chairman, I arrived a little late. I apologize. But I heard most of the panelists' remarks. To me, it underscores a message for this committee. That is, we are about to make some of the most important decisions that will affect the 35 million plus Americans who depend upon Medicare for their health and much of the quality of their life.

We have heard in some interesting but often relatively vague statements of both facts and policy what different alternatives to reforming this system might mean to that 35 million beneficiaries.

Speaking of a moral responsibility, I think this committee has a moral responsibility to move from the generality to the specific as rapidly as possible so that, as we perform our legislative surgery on Medicare, we will do so from the most informed base and with the greatest degree of public participation.

If we come with a midnight Medicare reform plan that the experts, such as those here with us today, have had little opportunity to review in its specifics, much less the lay person who depends upon this program, I believe we are going to sow the seeds of great public apprehension, anxiety, and additional distrust of the political system.

So I would urge that at the earliest possible date we start having legislative hearings on a specific plan, with specific consequences, numbers that can be evaluated, and that we can start the process

of public involvement, public participation, expert critique and commentary.

If we put this off until the second week in September, as I have seen some precedent indications might be some person's intentions, I think we will do a disservice to this Congress, a disservice to this important program that we now celebrate its 30th anniversary, and a disservice to the American people.

So, Mr. Chairman, that is my opening statement, is a strong plea that we move from generality to specific and, therefore, to the ability to make more informed and more democratic decisions.

Having said that, my question is, Dr. Goodman suggested that the medical savings account proposal could save in the range of $200 billion plus. We have the responsibility in this committee of recommending to our colleagues a plan which will save $270 billion. Dr. Goodman has given us his number.

Those of you who are familiar with other alternatives, such as the PPO or HMO, what do you think a reasonably, but aggressively applied, utilization of your methodology would result in reductions of Medicare expenditures below those that are currently contemplated if the status quo were to stay in place over the next 7 years? Yes.

Mr. LEE. Let me respond. If HMOs currently being paid over 120 percent of the national median would receive 1.5 percent annual increase until they fell within range——

The CHAIRMAN. Wait a minute. Let me get that. They are now getting 1.2?

Mr. LEE. Let me start all over again. Increase HMO payments by 5 percent a year rather than being based on AAPCC. So uncouple HMO payments from AAPCCs. Then HMOs currently being paid over 120 percent of the national median might receive maybe 1.5 percent annual increase until they fell within range. This idea would save $9.9 billion. That is a long ways from where you need to go.

Senator GRAHAM. That is $9.9. billion over seven years.

Mr. LEE. Over 7 years.

The CHAIRMAN. How much, $9.9 billion?

Mr. LEE. Right. But, more importantly, it would lure HMOs into those areas that may not be appealing because of low AAPCCs. For some of the committee members who came in later, there is a chart for each of your States that shows how your counties look.

Senator GRAHAM. I want to get the numbers from the other folks. So do you have a cumulative number that you think can be achieved by reasonable but aggressive application of HMO to Medicare?

Mr. LEE. This is just one small part of it.

The CHAIRMAN. Counting Dr. Goodman, we are at $210 billion now.

Senator GRAHAM. Mr. Kasselman?

Mr. KASSELMAN. Unfortunately, I am a single plan in a region in Kansas City. I think it would be inappropriate for me to give you a figure at this point in time. I would be glad to go back and talk with the APPO organization and prepare a response as far as numbers.

Senator GRAHAM. Thank you.

Ms. Ignagni?

Ms. IGNAGNI. Senator, our membership has focused very much on the policy construct, not the number. In proposing the specific policy alternative that we have, what we have tried to do is create an environment in which you can make choices about growth rates across various systems, and thus back into various numbers that have been laid upon the table.

Senator GRAHAM. So the answer is, you do not have a number as to what you think your proposal would contribute toward the $270 billion?

Ms. IGNAGNI. Our proposal is contingent upon this and other committees engaging in discussion about targeted growth rates and making those decisions.

Senator GRAHAM. Dr. Cohen, I know this is somewhat outside of the range of your testimony. Would you care to make any suggestions?

Dr. COHEN. Thank you, Senator, no. [Laughter.]

The CHAIRMAN. We are still at $210 billion.

Bob, let me say this. I do not want to spring something on the committee 2 days before a mark-up. I would rather do this on a bipartisan basis, as we did tax reform a decade ago, than not.

My mind is open for any suggestions from any members that will get us to $270 billion. But that is the figure I am aiming for, because that is what we were instructed to do. I do not think we can say, well, we are only going to do half of that, let some other committee pick up something else. That is my only hesitancy.

Senator GRAHAM. I think we are obligated to meet this number. There are a number of ways in which that can be done, both in terms of specific services, transfer of cost to beneficiaries, or other alternatives. Then within those, there are some other important issues. One of those is the issue of regressivity.

Are we going to ask the 75 percent of the 35 million Medicare beneficiaries who are receiving less than $25,000 a year to pay the same additional amount, in terms of additional premiums, co-payments, or deductibles, as we do the more affluent elderly?

You could argue either side of that case, but I think it is an issue that we need to have before us in a concrete form that would elicit the kind of debate, discussion, and hopefully enhanced understanding that will lead to a better decision.

The CHAIRMAN. Well, here is a good example, then we will take Senator Chafee. Affluence testing, as we now call it, or means testing. For several years, President Bush tried to do it at $100,000 for singles, $125,000 for couples.

Congress just turned thumbs down on it all the time. Very frankly, while it saved money—it saved about $7–10 billion—the Concord Coalition says, let us start at $40,000. They do it on Part A and Part B. This was just Part B means testing.

I estimated the other day, just top of the head, then you are talking about maybe $45–60 billion if you want to start means testing at $40,000. Now, that is all means testing, it is just a question of where you want to set the threshold. But then you can get real money.

Senator GRAHAM. Another issue that is very important that has not gotten much discussion in this debate is that, if we increase the

cost of Medicare for a significant number of that 35 million beneficiaries, they are also Medicaid beneficiaries. The States, under their Medicaid programs, pick up those costs.

We are about to have a significant intergovernmental transfer as we ask the States to pay a bigger share of the cost of the indigent elderly. At least out of respect to our brethren at the States, we ought to let them in on what we are proposing to do so that they can have the opportunity to comment as to what the implications of this will be in their financial situations, and to be able to prepare, because a typical state is going to be preparing itsfiscal year 1997 budget in the weeks immediately after we make this decision.

So, Mr. Chairman, I see nothing that argues that the public interest would be served by putting off coming to closure, at least on an initial suggestion of how we are going to reach this $270 billion, and let us have a serious debate so that our ultimate judgments are as educated by the participation of other good Americans as possible.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I just want to go on record as stating that I believe that achieving this $270 billion is going to be an incredibly difficult job; likewise, the $182 billion of Medicaid. That is one of the reasons I have been unenthusiastic about the tax cuts in trying to make up the revenue we have got to make there. However, we have been ordered to do these different things, and we will do our very best to do so.

Let me ask a question to the panel, and maybe this is more in Mr. Lee's territory than others. Medicare reimburses at different rates across the country. Yesterday we had a chart that showed an average line. Florida and New York City are considerably above this line. Below this line, as less than the average reimbursement, would be Oregon, and, Rhode Island, et cetera.

Now, let us address HMO's. Yesterday's testimony affirmed the cost-saving features of HMO's. The problem at hand, however, si how to encourage people to utilize these facilities.

I have noticed that one of the main points that Republicans in the House leadership are saying on Medicare is that they are going to preserve choice. They extol the sanctity of the doctor-patient relationship. In other words, if you want to be in a fee-for-service, three cheers, you can be in it.

Therefore, there have got to be some real inducements to encourage people to join HMO's. Presumably it is not the political will around here for us, even if it were right, for us to mandate that, everybody in Medicare will now be in a managed care plan. We are not going to do that.

A perfect example is Oregon. This State has the lowest costs per Medicare beneficiary, you have the fourth highest health status, and the highest HMO enrollment.

The CHAIRMAN. And we have voluntarily, just in the Portland metropolitan area, passed 50 percent on Medicare HMO enrollment.

Senator CHAFEE. Well, this is all Medicare. It seems difficult for an HMO to persuade Medicare beneficiaries to join if the State's reimbursement of Medicare is lower than the national average. They

are cutting it pretty close anyway. In addition to this, they get 5 percent less.

On the other hand, if it is Florida, let us say, where let us say they are getting $5,000 per beneficiary and the average in the Nation is $4,000. In a situation like that, an HMO that enters Florida can do things more efficiently, because there are more inducements such as prescription drugs and no co-payments.

Now, what is the answer to that; how can they do it in Oregon? For the benefit of the record, whenever I mention that word O-R-E-G-O-N, it is pronounced Oregon, in case I deviate on occasion. [Laughter.]

Mr. LEE. I think there are many lessons out of this, in that each market is really different. The Portland market is different than the Medford market, which is Southern Oregon. And to try to take an Oregon solution and pose it somewhere else is the wrong answer.

But I can tell you that things are alive and well in Portland. It is a very competitive environment. We have three competing health care systems, all of which integrate the provider system with the insurance function. Where this is going on in other places, you find similar success stories.

Senator CHAFEE. Let me present to you a typical problem that occurs when the government encourages HMO's. We had one witness yesterday whose 95-year-old mother did not want to switch. She figured, anything that is good for the U.S. Government must be bad for her. She was not entirely wrong, maybe. Now, why should I, in Portland, switch to an HMO? They must provide some sort of encouragement.

Mr. LEE. Right. They do. You have much simpler paperwork, you have less out-of-pocket costs. We have now just added a prescription benefit in some of the HMOs.

Senator CHAFEE. Now, if you were in Florida, you could really give them something.

Mr. LEE. Absolutely.

Senator CHAFEE. You could give them a lot.

Mr. LEE. There is no question about it. That is why we think there needs to be some kind of narrowing of the corridor between——

Senator CHAFEE. In your testimony did you suggest that across the Nation we get rid of these tremendous disparities.

Mr. LEE. Reduce them.

Senator CHAFEE. Well, my time is up here.

The CHAIRMAN. As long as you are asking about Oregon, why, go ahead.

Senator CHAFEE. It seems to me that these plans, these HMOs that are getting into these business, why do they not get heavily into risk selection, for example?

Mr. LEE. We are. Ours is.

Senator CHAFEE. I mean, only take the healthy people.

Mr. LEE. Oh.

Senator CHAFEE. Why not?

Mr. LEE. There are ways to prohibit that.

Senator CHAFEE. Ways for who, the Federal Government to prohibit it?

Mr. LEE. Well, I think HMOs get accused all the time of only choosing the healthy. But I think the more the market grows, the less that you are going to find those kind of variances. Studies do show that. Group Health has some studies that show that.

Senator CHAFEE. Let us take for example, Florida which is as in my illustration, 20 percent above the national average for reimbursement for Medicare beneficiaries.

This is a tremendous incentive for an HMO to come in there——

Mr. LEE. No question about it.

Senator CHAFEE Offer a lot of juicy things, solely to the healthy people.

Mr. LEE. Right.

Senator CHAFEE. And make a lot of money.

Mr. LEE. That is right.

Senator CHAFEE. This would leave the Federal Government with just the sick people.

Mr. LEE. I think it is happening as we speak. I think the for-profit HMOs that Senator Rockefeller probably spoke about are targeting and figuring out how, if they are not already in the Florida market, do it. But what happens over time is, as your HMOs grow and you get beyond certain thresholds, this idea of being able to pick only the well, I think, goes away rapidly, and our group can give you some data to support that.

Ms. IGNAGNI. Senator, can I comment on that? Several points, quickly. First, absent any changes that you may or may not make, last year there was a 28-percent increase in the number of Medicare beneficiaries going into HMO risk, number one.

Senator CHAFEE. Yes. However, 28 percent may not be very many people because you are not sure at what base you started, so 28 percent, I do not know if that is a lot of people.

Ms. IGNAGNI. That is a considerable amount of people in a particular year. I can compare it to the private sector, where we have 12 percent average annual growth rates. We also have very high satisfaction statistics, members speaking for themselves about HMO-style of practice.

This issue of geographic distribution, the point that Mr. Lee makes, is a terribly compelling one. I might remind the committee that you were in this position approximately 10 years ago when you were debating and discussing the DRG PPS payment.

The decision that was made, which I believe Mr. Lee referred to as a potential model for consideration, was to start where we are today, 100 percent State-based, and then the next year go to 75/25, then 50/50, and then flip 75/25 until you phased into a national rate.

I would second Mr. Lee's point that that would be a model that has a proven track record that you might look at to deal with the geographic inequity, and I believe that most groups that have been working hard to submit proposals in this area have very seriously talked about similar kinds of proposals, and we certainly have, and many of Mr. Lee's members are members of our association as well, but it is an issue that needs to be attended to.

In terms of positive risk selection, the only study was a 1987–1988 study done by the Mathematica Corporation, which suggested

that HMOs were somehow skimming in the Medicare market, and they had seen it.

We were pleased to direct to your attention in our testimony a 1994 study which puts to bed, I hope, the myth that HMOs are doing positive risk selection. We submit data on particular disease categories, as well as overall rates, that suggest that the HMO-type of patient is mirroring almost exactly the fee-for-service patient. I think that is a major step forward and would be worthy of your consideration.

Senator CHAFEE. Well, thank you very much. I will look at your testimony, and Mr. Lee's. I regret that I was not here.

I do not know how the Chairman managed to attend four roll call votes and be here at the same time. That is why he is Chairman, I suppose. [Laughter.]

The CHAIRMAN. Senator Baucus, then Senator Grassley, then Senator Pressler.

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Chairman, I want to echo graciously the points of Senator Graham about trying to work this out together. We are talking about very significant changes here; $270 billion is, by any definition, very significant.

For the sake of good government, we are all here to serve people. Whatever we do here is more likely to be a lot better if it is open; if it is debated, and if it is given time to air so that people around the country can see what it is we are talking about rather than rammed through. I have, unfortunately, been here sometimes when things have been rammed through. It is just not good practice, and I very much hope we can not do that.

The CHAIRMAN. I hope we can. Needless to say, I have been occupying myself on welfare recently, where I cannot even, at the moment, reach a consensus position among the Republicans, let alone try to get bipartisan consensus. I have not yet gotten a majority on our side for anything.

Senator BAUCUS. Well, I understand that, but that is another issue. We are talking now about Medicare. I just hope that, whenever we tackle Medicare, that it is done on an open basis.

I apologize I was not here for the testimony, but I would like the ask the panelists, a few general questions. Here is what concerns me. In my State of Montana, about one-eighth of our population is age 65 or older. I mentioned this the other day. Seventy percent of our seniors have incomes of $15,000 or less. That includes Social Security.

I was asked yesterday whether that $15,000 figure includes Social Security or not. I checked, and it does include Social Security. Health care costs are going up for seniors. They live mostly on fixed incomes, most of them.

If the Budget Resolution requires us to cut Medicare $270 billion over the next 7 years, and even if we come up with, as I understand it, some kind of a voucher system for Medicare patients; or a senior could opt for Medicare if he or she wants; or go to an HMO with this voucher—some kind of capitated system. I think it calculates to, I heard, a 15-percent cut over 7 years. With drug prices and other prices going up, how in the world is this going to work?

Dr. GOODMAN. I would just point out, Senator, that every other health care plan in the economy has gone through major change.

Every employer plan that I know of has instituted managed care, medical savings accounts, or some other radical change to induce people to more efficiency in the way they purchase health care. A 15 percent cut over 7 years is not at all unreasonable.

Senator BAUCUS. Why are costs going up?

Dr. GOODMAN. Not in light of the changes that we are seeing right now in the private sector.

Senator BAUCUS. What do you say to that senior citizen, that elderly women or man, who has $12,000 in income a year, and no chance of increase? What are you going to say to that person when her costs are going up and we are talking about a big cut?

Dr. GOODMAN. Well, I am not talking about their costs going up.

Senator BAUCUS. Well, I am. I am talking about that person, that individual who is looking to see what we are doing here, wondering what in the heck these guys or gals are going to come up with.

Dr. GOODMAN. What I am talking about is moving from an inefficient way to purchase health care to one that is considerably more efficient, be it managed care, HMO, medical savings accounts. Any of these options, properly implemented, would save a great deal of money and leave the elderly better off.

Senator BAUCUS. Now, those are all nice-sounding words. I do not think they are very persuasive to that senior citizen watching you utter them right now. He or she is wondering, what does he mean; what evidence does he have; how am I going to trust this or believe this? What are you going to tell him or her, other than those fancy-sounding words?

Dr. GOODMAN. Well, we have a great deal of experience in the private sector; we have employers all over the country trying out different things, finding out what works and what does not. I think everyone at this table can cite examples of where money is there to be saved, and Medicare has just been totally out of this process and it is time to bring Medicare into the modern age.

Senator BAUCUS. One of you mentioned that HMOs are not indulging in, is it, positive risk——

Ms. IGNAGNI. Selection.

Senator BAUCUS. Selection. Why would an HMO, in providing service to an elderly person, not engage in positive risk selection? I mean, these are outfits that want to make money. They want to cut down their costs. So why would they not?

Dr. GOODMAN. I think all things being equal many will, and that is why I think it is important to have a risk adjusted payment so that you pay more for sicker people, less for healthy people, so that the HMO does not have financial incentives to avoid the healthy and go only for the sick.

Ms. IGNAGNI. Two responses to that. Our plans are measured by what they do, they are measured by their track record, they are measured by patient satisfaction, and they are measured by accountability.

In fact, we are the only systems that have report cards now and have data that you can get in under what is, in fact, going on. I think that is a major step forward. The point about what you could tell your constituent that is very properly concerned about the burden is, I would turn that around, Senator, and say the following.

The people who are not standing still in this debate are, in fact, Medicare beneficiaries. The deductible keeps going up, we have a 20 percent co-pay obligation, there is no catastrophic protection.

So we have a problem on the front end, we have a problem on the back end. As you know, about 75 percent of Medicare beneficiaries now, as a result of that, have bought Medigap insurance and are spending, on average, about $1,000 a year for it. So we have a problem in the system itself, and if you take apart the Medigap insurance the problem becomes more stark.

In a coordinated care environment, the one that we are speaking to on behalf of GHAA, what you have is a system where you have preventive care, you have health maintenance, and you have catastrophic coordinated in a system where teams of professionals are working together to keep the patient well. It is a very different orientation.

Senator BAUCUS. How many seniors today are now not in an HMO, what percent are not?

Ms. IGNAGNI. A considerable percent.

Senator BAUCUS. I am sorry?

Ms. IGNAGNI. Ninety percent are not.

Senator BAUCUS. Ninety percent are not.

Ms. IGNAGNI. And the growth has been quite heavy over the last couple of years.

Senator BAUCUS. I understand the growth. I understand the growth, that is from a lower base.

I would assume, and I do not know if this is the case, that seniors tend—well, I know it is the case, our health care bills show they are a more costly population.

Ms. IGNAGNI. Yes, sir. That is right.

Senator BAUCUS. I imagine there are some seniors who are lot more unhealthy than some others.

Ms. IGNAGNI. As there are people under 65 unhealthy.

Senator BAUCUS. Correct.

Ms. IGNAGNI. We would not want to volunteer which one of us would be in that category.

Senator BAUCUS. I understand. But I just cannot see, if we are going to cut $270 billion over 7 years, how that is going to help their plight.

Ms. IGNAGNI. I would say, Senator, I would make it very clear, as I observed earlier, that we are trying, on behalf of GHAA, to provide and make suggestions about an environment in which you can make decisions, number one.

Number two, I would also suggest, however, that there is compelling evidence about the effectiveness of coordinated care systems for this population, as well as for the under-65 population.

Arguably, given the track record and the experience, it is even a more compelling case for people who need early intervention, who need health maintenance, and who need systems.

I have repeatedly heard people bragging about the wonder of being able to go to any specialist or any physician you want, but that is picked through the phone book. It is a very different system.

Senator BAUCUS. Let me ask another question, and it is not related. At a certain level, I think it raises some moral issues. I would ask, if there are public funds, taxpayers' dollars, a capitation

payment or something that goes to seniors and they shop around, and so forth, and some seniors who buy their services from an HMO here, or something there, the question that comes to my mind, and it gets a little into what Senator Rockefeller was driving at, is just the propriety or the seemliness, or the unseemliness of people making a heck of a lot of money, big salaries, millions of bucks, palatial mansions, largely financed by the taxpayer because of the capitation payments that go to this HMO. I mean, is there a credibility question there, is there a moral question there, or not? I am just wondering.

Mr. LEE. I think there definitely is. Health care has to be more than a business. I think, when Karen talked earlier about publishing some data so that you have informed choice on behalf of the consumer to choose, and they can choose either traditional Medicare program or an HMO A, B, or C, or a PPO, if we have that, or whatever. But having good data and informing seniors so they can make choices is critical to reforming the health care system.

Senator BAUCUS. Well, my time has expired. I just raised the issue.

Mr. LEE. Part of that would be giving the data, how much profits are made by the health insurance industry, and how does it compare to other industries.

Senator BAUCUS. That gets awfully complicated, and it is hard to tell. I worked at the SEC years ago. I used to go through all these 10(k)s and these annual reports, and so forth. I mean, they mean something, but they do not mean a heck of a lot, either. There is just a lot of stuff there.

Mr. LEE. Maybe there is another way.

Senator BAUCUS. Yes. Right. I appreciate it. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Dr. Goodman, I would ask you the first question. I think these are your words, that there is evidence suggesting that premature discharges have harmed some patients. I do not find fault with you making that statement, but that is a pretty serious charge.

Could you tell the committee the evidence you have about that? The reason I ask it is because our director of ProPAC, albeit admitting that we do not have recent statistics, maybe back 3–5 years, said that quality is not a problem.

Dr. GOODMAN. Well, this is controversial, but there have been a series of studies that have been published in The New England Journal of Medicine and in the Journal of the American Medical Association that suggests there is a problem here.

Now, it is something that people debate about. I am not going to say that all the evidence comes down on one side or the other, but there is enough there, it seems to me, to give us all reason for concern.

Senator GRASSLEY. So then the answer is, and I will be glad to hear from you, is basically that there are plenty of studies on this we can look at to back it up. That is what you are basing your statement on, other people's studies.

Dr. GOODMAN. It is not a study I have done, but there have been several studies published in the New England Journal and elsewhere that suggests this is a problem.

Senator GRASSLEY. All right.

Mr. LEE. What I would say is, you can find examples on both ends of the spectrum. You can find lots of examples where there has been under-treatment, and lots of examples where there is over-treatment.

The question is, how is the industry going to be held accountable, is it through organized groups of providers that come together under health plans, or whatever? The point is, you can find all kinds of examples on this subject on both ends of the spectrum, both of which are bad.

Senator GRASSLEY. Also, Dr. Goodman, you mentioned that there is no incompatibility between managed care and medical savings accounts. For elaboration, how does it work with your organization? For instance, does the same insurer who provides the catastrophic coverage have a network of providers that the MSA holders in your organization can use if they want to, paying from the MSA when they see those providers?

Dr. GOODMAN. Yes. We have a network. Our employees do not have to go to the network, but if they do go into the network then every dollar they spend counts toward the deductible. And when they get above the deductible, the plan pays for every dollar spent, as long as they are seeing network physicians and going to network hospitals.

Now, if they go outside the network we only count 75 percent of reasonable and customary fees, and above the $2,000 deductible we only pay 75 percent. So it works like a point-of-service plan. It is very, very common. What we have done is we have integrated that idea with the medical savings account.

Senator GRASSLEY. I want to give you criticism of medical savings accounts for you to respond to. This is in regard to the high deductible, whether or not it saves enough in premium costs to allow an employer to deposit the full amount up to the deductible limit in the MSA.

If this would be true, the employee could then be at risk until the entire amount is deposited in the MSA, and this could take about 3–4 years, if I understand it right, to build up, where you might, as an individual, be able to cover the difference between what you have to pay until you get up to your deductible.

Dr. GOODMAN. Well, we made our decisions based on consultation with employees, whereas a lot of employers choose a $3,000 deductible, we happen to choose a $2,000 deductible for our employees. There are a wide range of deductibles and, depending upon what you save, you can make different deposits to the medical savings accounts.

If it is not attractive, then people are not going to do it. We found that the most attractive of all the options we looked at was a $2,000 deductible and a $1,500 deposit. In different parts of the country you might be able to do better than that, you might do worse than that, but the market should make the decision. If it is not attractive, then people should and would not do it.

Senator GRASSLEY. I would ask you, Karen, a question. I am sorry. I could not pronounce your last name, that is why I called you Karen.

Ms. IGNAGNI. That is fine.

Senator GRASSLEY. You stressed in your statement the need for standards. Could you elaborate on how this should work, and your association's views? Should a health plan have to be qualified in order to enroll Medicare beneficiaries, in your view? If so, who should do the qualifying? Would this be a governmental entity or some private entity like, for instance, a National Commission on Quality Assurance?

Ms. IGNAGNI. To the direct question, we believe, yes. As far as the entity, we have actually been exploring a number of different models: a Federal model, where it would be a governmental decision; a quasi-governmental private sector body; and we are presently involved in discussions on a range of alternatives and hope to submit a proposal to the committee on the entity itself.

Let me say that this is a important issue that I think you put your finger on because, as we talk about expanding participation in the system, we have seen that, based on what has been going on at the State level and what is, in part, going on at the National Association of Insurance Commissioners, they are observing the need for similar kinds of standards that we are talking about in terms of leveling the playing field.

So if you want to come to the Medicare program, then there ought to be some standards with respect to data, disclosure, quality assurance, solvency, that could be common—that is just the beginning, but just to flag a few for you—to all health plans so that, in the end, senior citizens would be assured that there would be some comparability. I might also say that the same standards should apply in the traditional Medicare program as well.

Senator GRASSLEY. Mr. Chairman, I am done asking questions. The committee has heard me ask several questions over the last several weeks on quality as it relates to managed care, and I think some of the things that Senator Baucus had, if they get too rampant, what he said about salaries and profits, if that gets too rampant and it looks like there is not quality care, if we are not cognizant of quality before we go into these programs, then down the road, maybe 2–3, who knows, maybe it is even 5–6 years, but if there is not quality in the delivery, then we are going to have Congress stepping in with consumer protection sorts of approaches.

Maybe consumer protection is not the right word to use. But where there is adequate concern about when money drives something to too great of an extent that the consumers are forgotten about, then I think the bottom line is that Congress or governmental agencies are going to step in to be concerned about that.

The CHAIRMAN. Well, Chuck, I would say this. If Ms. Ignagni and Dr. Goodman can figure out a way to save us $100--200 billion, I am willing to let them build a $500 million mansion if we have not been able to figure it out before. I will make that trade-off.

Senator GRASSLEY. Well, first of all, my comment was not related to just what Senator Baucus was saying, because I have been asking questions on this subject over a long period of time. But I would just say, obviously what Senator Baucus said is one of those things that really drives Congress to act, right or wrong. It does drive Congress to act.

Ms. IGNAGNI. Senator, all the members of the GHAA believe that quality ought to drive this discussion, and we have offered some

specific proposals for your consideration and would be delighted to pursue that discussion. You are absolutely right about the quality issue.

Senator GRASSLEY. There is probably a condition in that offer that Senator Packwood made. I can guess where that house has to be built. [Laughter.]

The CHAIRMAN. We are going to limit their mortgage interest deduction, however, to somewhat less than $500 million.

Senator Simpson, you ready?

Senator SIMPSON. Yes. Well, I am sorry I was not able to be here for the presentation, but have looked at the material and stay vitally interested in the issue. I admire so what the Chairman and the Ranking Member are doing in forcing us to confront the issue of, what are we going to do on an issue which is filled with high drama and emotion.

Some of us get accused—I know I do—of being told, you are being too dramatic when you say Medicare will go broke in the year 2002, and I said, I did not say that; it was told to us by the trustees of the system.

So then we are to be heartened every once in awhile when somebody says, we have something solved where Medicare will only go broke in the year 2004, which is supposed to be a cheerful thing for us. Maybe next time they will tell us that we are very fortunate that Medicare will not go broke until 2006. I think that is a total abrogation of legislative response, that we should be doing something now to make it work, or at least try to see that there is something there.

So, in looking at the summaries, I had a question for John Goodman, if I may. Under your medical savings account proposal, you assume that patients will be knowledgeable enough to go out and find "the best deal" for themselves and their family members, that they will shop around for the highest quality of care at the best price.

My question is, how can you be assured that patients will talk to a number of physicians before undergoing a procedure, and how do we equip patients with information that will assist them in making well-educated decisions?

My experience is that this is very difficult, even when we are dealing with the Congress when we come up for the open season or we are asked to pick what program we are going to do. We just dump it on the administrative assistants and say, what is this? So, where are we with that, in reality?

Dr. GOODMAN. Well, even if we do nothing more than what we have done for our own employees at the National Center for Policy Analysis, it would be a big improvement over the current system because in the current system the elderly are sort of on their own in the marketplace. They have large out-of-pocket payments which, for some, are very, very large.

What our medical savings account plan does is combine a network with a medical savings account. The network is where we recommend that our employees go, but they do not have to go there. The medical savings account does empower them, and allows them to go elsewhere.

More and more information is getting to patients, and I think they are going to get on the Internet and get information from all kinds of sources that we cannot even predict how the information is going to flow. I am concerned about it, and I think one of the things that you would want a private plan to do is to help individuals make those decisions.

Senator SIMPSON. Well, my experience, again, warped as it is, is that a lot of people really do not get on the Internet and play around too much, unless it is people on my staff, and they are very young, and they love it. Those of us who are 63 still do not know what the hell it is all about.

So I just do not think that that is very reasonable at all because the people that I know in this age group are not on the Internet, they are working, they are confounded, they are hearing that we are going to do something with Medicare, and that Medicare is going broke, and Medicare is not going broke; and it is going to be cut, and it is not going to be cut; and we are trying to slow the increase; no, we are not, we are cutting it. They are really not paying much attention, except to their own anguish, about what we are doing, which to them is confusing.

Dr. GOODMAN. Well, as I said, in our plan we not only have a medical savings account but we also have a list of doctors that we recommend, and a list of hospitals. So we implicitly, by contracting with that network, have done some quality assurance. We could probably do an even better job, but what we are doing now is better than what Medicare does.

Senator SIMPSON. It was interesting yesterday, when Dr. Ellwood spoke, from the Jackson Hole Group, my native State, and talked about the medical facilities in Jackson. Well, they are tremendous because doctors love to go to Jackson. But that will not take care of anything else in a rural State like Wyoming; it is just unrealistic. I did not get an opportunity to share that with him.

I have just a few moments. But, Dr. Cohen, if I could ask you, obviously from reading your testimony about teaching hospitals and the dependency—total dependency—of these hospitals upon Medicare for meeting the graduate medical education expenses, my question there is, to see the tremendous depth of being beholden to this money for your existence, how did these hospitals handle their expenses before Medicare came along?

Dr. COHEN. Well, we are talking about 30 years ago.

Senator SIMPSON. I know.

Dr. COHEN. There has been a long time since the inception of the Medicare program for this current system to have evolved and developed. I do not think that there is any doubt about the fact that the system we have now in play is not the ideal system.

First of all, it is becoming excessively dependent upon Medicare payments, particularly as the price competitive marketplace has driven down the reimbursements that teaching hospitals receive from non-Medicare payors of health care as the price competitive market has led to reduced reimbursements. Medicare support for the special missions of teaching hospitals has become disproportionately more important. That is not a healthy situation to preserve.

What we need to do is to recognize that the traditional way of funding, not only graduate medical education but the other social goods that are produced by the teaching hospitals, has been eroded by this competitive market that we are now in and we need to develop an alternative system to replace those supports that had been in the system before with something that is more explicit, more understandable, and better calibrated to the ultimate need.

Until we can craft such an all-payor system to support these missions of teaching hospitals, we are unfortunately very dependent upon the Medicare program.

The worry that we have is that, as aggressively and as actively as teaching hospitals are, in fact, making adaptations to this new environment, there must be time in order for this adaptation to take hold.

Our fear is that if there is an abrupt or very serious reduction in the supports that Medicare is providing for these crucial functions we will lose important institutions that have taken decades to create and we will have a very hard time replacing them.

Senator SIMPSON. It would be even harder if the system went broke in 7 years, would it not?

Dr. COHEN. I am sorry. I did not hear that.

Senator SIMPSON. It would be even harder if the system went broke in 7 years.

Dr. COHEN. There is no question about the fact that we have to address the impending problems in Medicare and the deficit reduction issues that you all are contending with. It is a very difficult issue.

Our plea is that the teaching hospital and the academic medicine community in general not be treated disproportionately harshly in this problem-solving that everybody is going to have to contribute to. We are just asking for a fair and equitable solution to the problem that does not inadvertently injure academic medicine.

Senator SIMPSON. Mr. Chairman, I thank you very much. Thank you to the panel, too.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. With apologies to the rest of the panel, I have to discuss with Dr. Cohen, who is a former dean at Stoneybrook, this whole question which has troubled me a very great deal, in any event, about the proposals to limit the number of residents to 110 percent of the graduates of American medical schools.

This was part of the administration proposal last year. It is the nearest thing to a black project that I have seen in the area of social policy. It was never mentioned in any of the President's speeches, the platform, the big program, all that shining material that came out.

But it was in the three House bills, three House committees dealt with this. The Committee on Labor and Human Resources talked about it, but we never debated it. It was a secret proposal, very much in the mode of medicine when prescriptions were in illegible Latin and that sort of guild exclusiveness. It would have devastating effects in New York City, New York State, in New Jersey. I do not know.

A very distinguished physician, Dr. Reich, then at the Woodrow Wilson Center, referred to the "dumbing down" of American medicine. He wanted to cut the number of residents from 110 percent of graduates of American medical schools and cut the number of specialists in half.

Richard Cooper has pointed out that the number of general practitioners is a function of demography, you need about 85,000–100,000 persons. The number of specialists is a function of science. Science comes along with some new information, some new technology, you get a new specialty.

We are in the great age of American medical science; the first time scientific transformation is taking place from the United States. We have always followed Europe for the last two centuries. We have had some things, from the transit of Venus in 1765, but in the main, not many things. We observed the transit of Venus in Philadelphia in Rittenhouse Square.

Two things. One, is this something about not wanting any foreigners in our country? I have a very strong feeling that it was not ever mentioned in the debates from the materials from the White House, and so forth. It is not very politically correct to say we do not want any more Indians, Filipinos, or Pakistanis in our country, so you do it without saying it.

In New York City, 50 percent of our residents took their medical training abroad. A good number of them are persons who are coming here and will stay here. A considerable number—I have never been able to quite find out—are simply people coming from around the world to do their residency at New York Hospital, Columbia Presbyterian, or Sloan-Kettering.

Dr. COHEN. Or Stoneybrook.

Senator MOYNIHAN. Or Stoneybrook, which is a State University in New York. And then go back to Glasgow and be the best oncologist in Glasgow because you did your residency, as one did it in Paris in the 19th century, and London, but they do it in New York now, and in Houston, and in Los Angeles, and other places.

Why would you want to limit the number of doctors so, and why would you want to devastate a place such as New York, which is certainly the epicenter? We have more of the great medical schools in New York, we have the oldest ones. New York Hospital was chartered by George the II, not just a few decades ago, but a few centuries ago. They would close down. Now, what kind of association is yours, and what do they think about this at Cornell? Help me.

Dr. COHEN. Well, you have raised some exceedingly important issues, Senator Moynihan. Let me say a couple of things, several things if I have the time. First of all, our association is not in favor of a regulated approach to reducing the number of residents in this country. In the course of the debate last fall with the health care reform issues, we were in a position to consider some trade-offs in terms of an all-payor fund for graduate education and for the medical school needs in the context of that health care reform debate, and we made a political calculus at that time that that was not part of the policy positions of the association that we would have preferred.

We had been on record and are now on record in favoring a commission to study the issue of the future work force needs of the country, and to provide better advice based upon better data than we now have, which is, I think, appallingly limited. So that is point number one.

Number two, there is no question that we have evolved a system that is extraordinarily complicated and for which certain institutions have become exceptionally dependent upon the services of foreign-trained physicians, and that is a system we must respect and we must be sure that as we change things we do not do violence to those institutions that are so important to the communities that they are serving that we do not do something that is injurious to those institutions' social mission.

If there were to be a need, or felt need, or some other mechanisms that the marketplace determined that there would be a reduction in the number of residents training, something would have to be done in order to accommodate the service needs of these institutions. We cannot leave them bereft of the expertise that they now have to deliver their missions.

Senator MOYNIHAN. May I just say, my time is up and I thank you for your open response. But the notion that we will cut off the supply and then think about what to do it about it——

Dr. COHEN. It cannot be done in sequence. If there is going to be anything done about this, it has got to be done——

Senator MOYNIHAN. In the last Congress, it was just going to be done. That is what worries me.

The CHAIRMAN. And we were going to allocate them around the country.

Senator MOYNIHAN. Yes. Yes.

The CHAIRMAN. What was the name of that county in West Virginia that you said nobody wanted to go to? I cannot remember.

Senator MOYNIHAN.

Well, no. It was Mingo County, West Virginia.

The CHAIRMAN. Mingo County. That was it.

Senator MOYNIHAN. Nobody wanted to practice osteopathy.

The CHAIRMAN. Dr. Goodman, in your testimony your studies presumed a $4,000 deductible and a $2,000 savings account contribution. What would a policy like that cost for an average Medicare beneficiary? I do not know. Do the studies indicate?

Dr. GOODMAN. Well, we just assumed we use the current amount that we are spending now, the $4,800 per beneficiary, and that, plus the Part B premium that the elderly are paying would buy this policy. Now, this does not include the Medigap money.

The CHAIRMAN. No, I understand that. But you would use all of the $4,800, plus the beneficiary's Part B payment.

Dr. GOODMAN. That is right. Now, what would that do? That would create a $4,000 deductible and cap all the hospital expenses, so no longer would a person be exposed past the 60th day, and so forth, in the hospital. It caps all but $2,000 of exposure over on the Part B, whereas now the patient is exposed forever.

The CHAIRMAN. Because the first $2,000 is covered with the deposit to the medical savings account. You can use that for the first $2,000. Is that what you are saying?

Dr. GOODMAN. No, I am saying something different, that this $4,000 deductible——

The CHAIRMAN. Deductible.

Dr. GOODMAN. Caps everything except $2,000 worth of exposure over on Part B.

The CHAIRMAN. But you put the $2,000 in the savings account also.

Dr. GOODMAN. That is right.

The CHAIRMAN. And if the beneficiary does not spend it, they get to keep it and pay taxes on it?

Dr. GOODMAN. Yes.

The CHAIRMAN. But they can roll it over from year to year, as you propose.

Dr. GOODMAN. Absolutely.

The CHAIRMAN. All right.

Ms. Ignagni, Dr. Ellwood suggests that HMOs be established and they go through a competitive bidding process rather than the way we now pay them. What is your view on it?

Ms. IGNAGNI. I think that is a meritorious suggestion, but the truth is, we do not know how to do that right now. So the question, I think, before the committee is, if you want to begin to make changes in Medicare that takes advantage of some of the advances we have seen in the market and give beneficiaries more choice, then we have tried to offer you some suggestions about how you begin now in transition while we explore some of the longer-term issues that Dr. Ellwood and others have suggested. So this is not a negative comment, in principle. I think that there is just quite a lot to learn about exactly how we do that.

The CHAIRMAN. Let me ask you and Mr. Lee, because Dr. Ellwood, both publicly and then privately in talking with me, thinks initially you might want to put a cap in Florida on what you are going to pay an HMO, and you might want to raise it a bit in Portland. But he thinks, given 4–5 years, the market with nationwide HMOs is pretty much going to level out around the Nation, within reason. Do either of you think that is true?

Ms. IGNAGNI. I do actually think that the proposals that have been offered to take that question first are very worthy of consideration and would go a long way, as Mr. Lee has so eloquently described, to deal with this issue.

I also think that it is wise to look back to the PPS model, where you began where you were, which is the analog here, to begin where we are, and then look at differentials here in terms of shrinking the gap from one market to another.

I also see that there is quite a lot of interest on the part of a number of plans around the country to begin looking at broadening networks now that they have learned about how to provide care to the senior population.

As you know, we have not yet talked about enabling services, we have not yet talked about support services, that are very much part of our systems of care.

I might give you one observation. One of our colleagues of mine and Mr. Lee was before a House committee recently. He made the observation that an elderly person in their Medicare risk contract, they noted, was not coming in to meet scheduled appointments.

They got on the phone and they called the individual and were very chagrined to find out that the individual was not coming in for appointments because she did not have a pair of shoes.

This is the kind of system where you can detect those kinds of problems. So we are not just talking about the direct provision of medical care, we are talking about a support network that is quite of value to this population.

The CHAIRMAN. Mr. Lee?

Mr. LEE. What I would add is, right now it appears that the problem with increases in cost is in the non-HMO environment, it is traditional Medicare. And until we figure out how to create some other experiments, whether it is HMOs, PPOs, or savings accounts that we can run side-by-side, we are not going to deal with the problem on the other side.

So, assuming you can move people into a managed care environment, I think that if you had enough market, I think it is possible that you could say to the qualified HMOs in a certain area, what will you offer as your services, what will be your benefits, what will be your price, and you publish that maybe through some governmental enrollment process, so you do not have adverse selection or get low-risk, you might try to funnel then people into the HMOs, for those that choose to go in there, whether you call that a bid or not.

In many ways, there is a bidding process now because we determine the amount that we are going to charge per month and we figure out what kind of benefits we are going to offer. We do not know what our competitors are going to do, and we then have to file that rate. So in many ways, we are building on that kind of a theme now, but I think you can take it further.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

The first comments I am going to make are not intended to be totally parochial, but really to lead to a policy question. Yes, it is true that Florida Medicare beneficiaries receive above the national average in terms of their per capita resources for their health care.

On the other hand, it is also true that Florida has 20 percent higher than the national average in terms of older persons who are below the poverty line. Florida has over 50 percent the national average of persons over the age of 85 who are Medicare beneficiaries.

In sad contrast to Oregon, in which its citizens rank fourth in the Nation in terms of their overall health status, Floridians rank, in spite of Ponce de Leon's Fountain of Youth, only 29th in their overall health status. So we have some significant real differences in the composition of the population, which have implications in terms of intensity of services that are required.

Having said that, I am a little discouraged, Mrs.——

Ms. IGNAGNI. Ignagni.

Senator GRAHAM [continuing]. Ignagni, about your comment that you think we are some distance away from being able to go to a competitive marketplace determination of what HMO Medicare contracts should be.

One of the reasons that the private sector has been able to get some of the cost reductions that have been alluded to is the fact that they are aggressively using the marketplace as a means of se-

curing the most cost-effective managed care contracts for their employees.

In a community like South Florida where there is a well-developed system of managed care organizations, why do you not think we could go fairly quickly towards a marketplace-based determination of what these providers of care would charge in order to do that to Medicare beneficiaries?

Ms. IGNAGNI. Let me begin, Senator, by saying that, in my effort to be very clear, perhaps I was not. So let me step back and say that what we have proposed is very definitely adopting the techniques and the experiences, what we have learned in the private sector, to the Medicare program: expanding choice, allowing quite a lot of delivery systems to offer services to beneficiaries, and having quite a lot of competition, beginning with the Medicare benefit package as a basic, core set of benefits and allowing plans to compete over that in terms of additional benefits, wrapping in the supplemental should they choose, et cetera. So we envision quite a lot of competition in that regard on services, on prices, et cetera.

What I was commenting on, and I apologize for not being clear, is I was directing my comment to the Chairman's question about the issue of how you set the reimbursement, namely the competitive bid.

And I was suggesting that we might now start from what we have learned in Medicare risk in terms of paying and reimbursing plans as a baseline, making some of the appropriate policy decisions with respect to the issues that others have talked about, and then going on to explore the issue of competitive bidding as a pricing mechanism.

One begins from the top down where we are now, the other begins from the bottom up. I think that there is quite a lot to learn from systems that are out there right now. I am not sure we know enough to implement it today in terms of the bidding proposal.

You can have quite a lot of competition, which is why we have talked about a per capita payment, beginning from where we are today, translating that into a per capita payment mechanism, and having the kind of competition that I have described. So it is a technical issue, but I think will be quite relevant as the committee fashions its proposal. I apologize for not being clear about the difference between the two.

Mr. KASSELMAN. Senator Graham?

Senator GRAHAM. Yes.

Mr. KASSELMAN. May I comment on that? We have been talking about the private sector initiatives that have created quite a difference in the rising medical costs. I believe it is important to continue to look at that and the success factors that relate to the expanded choices of HMOs and the addition of PPOs in that.

As Karen has indicated, I believe that as we begin to expand those choices and introduce more managed care choices, along with MSAs and other things, to the senior group, that we find that their understanding of the quality of choices and their ability to make decisions will improve significantly.

As we found in markets where we have had a major saturation, that understanding of how these things work—and it is not a black

box—is that there are really significant choices, and PPOs and HMOs, I think, will be greatly improved.

Senator GRAHAM. I would like to ask two questions, and my time is close to being up. The Congressional Budget Office has projected that the private health care spending per insured persons from 1996 to the year 2002 will grow at an annual rate of 7.1 percent.

I think that is the percentage upon which our Federal health program is also predicated. The proposal that is before us would cause the average Medicare insured beneficiaries' resources to grow at 4.9 percent per year. What is the basis for expecting that the over-65-year-old population will have a lower rate of increase of health care resources over the next 7 years than the under-65?

Ms. IGNAGNI. I would take a crack at that, Senator, if you think it is appropriate. I think one of the issues that you need to begin to get your hands around is the differential rates of growth in various systems. As you look at the data and disaggregate—I can speak only for our systems—you find very different growth paths, so the average mixes all kinds of systems up and attains that average.

What we are talking about is taking advantage of what has been going on in the employed sector, which is showing a very, very different growth rate in our systems, for example, and there is strong reason to believe that there would be tremendous cost savings in the Medicare population as well, under similar systems in savings.

Senator GRAHAM. So you are saying the savings are not going to be a function of the health status or the requirement of the populations, but rather the more intensive application of the most cost-effective systems to the Medicare population, a significantly more intensive application to that population than to the under-65 population.

Ms. IGNAGNI. I was following you until you said the last thing.

Senator GRAHAM. Well, I just have to accept at face value the validity of these numbers, and specifically the first number, which is the Congressional Budget Office projection that the under-65 insured population will have an annual increase in its health care costs between 1996 and 2002 of 7.1 percent.

Ms. IGNAGNI. And I would say back to you that——

Senator GRAHAM. Excuse me. Let me just finish.

Ms. IGNAGNI. Sure. I am sorry.

Senator GRAHAM. Now, an arithmetic calculation of what is in the current budget resolution produces an average increase of the over-65 Medicare-covered population of 4.9 percent. The question is, what explains these two differences in the per capita increase in health care resources required, the under-65, whose rates are largely set in a marketplace, and the Medicare population whose prices are set in a controlled government program?

You are suggesting that the explanation is that you are going to apply more cost-effective delivery systems at greater levels of intensity to the over-65-year-old population?

Ms. IGNAGNI. No. That is why I said I was tracking you up to the last observation. In fact, if you disaggregate that 7.3 percent, you will find in our systems the health care premiums are increasing at just about zero percent. In fact, there is no rate of increase.

So that 7.3 is an average that masks quite a lot of what is going on in the current system.

I am sure my colleagues would like to talk about that from their very specific experiences. That is the problem with any kind of arithmetic averaging process, you cannot get your hands in under what is going on in specific systems.

Senator GRAHAM. But we have had testimony that something on the order of 20–30 percent of the under-65 population is in a managed care plan.

Ms. IGNAGNI. It is actually 62–63 percent now.

Senator GRAHAM. Then that makes my argument even more a question. We know that in Medicare, slightly less than 10 percent is in managed care. Is that right?

Ms. IGNAGNI. That is right.

Senator GRAHAM. Now, you are saying that you have got one population, of which 63 percent is in the more efficient system. It is going to have that segment of the population, according to the Congressional Budget Office, is going to grow, on average, at 7.1 percent.

Ms. IGNAGNI. That is not what is happening in our system.

Senator GRAHAM. I know that. I know you said that is now what is happening in your system. But the Congressional Budget Office says that the average private health care spending, per person, will grow at 7.1 percent. That includes the 63 percent who are in managed care, assumedly.

Ms. IGNAGNI. That are paying very little by way of increasing premiums.

Senator GRAHAM. So I guess I had difficulty seeing how you are going to get a population which is only 10 percent in managed care to a point that it is going to have roughly 70 percent of the per capita annual growth rate as the population that, today, is 63 percent in managed care.

Ms. IGNAGNI. Well, if we are at zero for the under 65, Medicare is at 10.3, then what you need to look at is the performance. Admittedly, you probably want to make some adjustments, and we have talked about that in our testimony, for changes in population and intensity for this population.

The CHAIRMAN. Let me ask. I think this is what he is saying. You have got roughly 60 percent of the population in managed care and you have got zero premiums.

Ms. IGNAGNI. Roughly.

The CHAIRMAN. The Congressional Budget Office says, for your 60 percent and the other 40 percent, costs are going to go up, on average, 7 percent. Yours are not going to go up at all, or very little, so that one-third must be going up 15 percent.

Now, he then says, all right, now we have only got 10 percent of people in Medicare in managed care, we have 90 percent that are not in. How are we going to get those 90 percent, which are down to an average of 4.8 percent, if so few of them are in managed care now? Is that roughly it, Bob?

Senator GRAHAM. I would like to see a business plan that will result in the Medicare population having an annual rate of increase of 4.9 percent against the rest of the population, 7.1 percent.

Dr. GOODMAN. Senator, the Milliman & Robertson study assumes there is a phase-in, that options are given to all of the elderly. They do not immediately take the options.They are phased in, so that by the end of the period, by 2002, you still only have 80 percent of them who have accepted an option. I cannot speak to the 4.9 percent, but they are assuming that, over the period, you can cut the rate of growth by 2 percentage points.

Senator MOYNIHAN. Well, can we not entertain the possibility, horrible as it may be, that the Congressional Budget Office wrong? [Laughter.]

Yes, I know. I know. Easy, easy. We have a dispensary. The attending physician will be with you momentarily, sir.

Senator GRAHAM. Where I might say the increase in cost is very controlled.

Senator MOYNIHAN. Something has changed. Do you say Ignagni?

Ms. IGNAGNI. Yes. Yes, sir.

Senator MOYNIHAN. Could you give us a little more detail on your zero growth?

Ms. IGNAGNI. Yes. In the under-65 population, as you know, in many markets, Senator, the rate of increase is at zero.

Senator MOYNIHAN. We are going to have to run.

Ms. IGNAGNI. I would be delighted to supply it.

Senator MOYNIHAN. Could you give us that on a table?

Ms. IGNAGNI. Yes.

Senator MOYNIHAN. Because you are not saying anything different than what Paul Ellwood said yesterday.

Ms. IGNAGNI. That is right.

Senator MOYNIHAN. I mean, you are bringing in information from substantially the same set of experience. This happens to be good news.

Ms. IGNAGNI. Yes. Senator, one thing that I find very encouraging is that the data suggest that our systems, it is running, over a period of time, at approximately 40 percent less than the fee-for-service, so we will supply those trend lines. It is not just a one-time savings.

Senator MOYNIHAN. Good.

Well, thank you, Mr. Chairman.

The CHAIRMAN. We have to run. Thank you. Sorry to cut you off. We have about 6 minutes left to make our vote. Thank you very much.

Mr. Lee, good to see you again.

Mr. LEE. Thank you.

The CHAIRMAN. Are you going back tonight or are you going to wait till tomorrow morning?

Mr. LEE. Tonight.

The CHAIRMAN. Good luck.

[Whereupon, at 4:48 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JORDAN J. COHEN, M.D.

Mr. Chairman and members of the Committee, I am Jordan J. Cohen, M.D., President and Chief Executive Officer of the Association of American Medical Colleges. The AAMC welcomes the opportunity to testify on the importance of Medicare payments to teaching hospitals and their associated medical schools and faculty in providing the best medical care in the world. The Association represents all of the nation's 125 accredited medical schools, approximately 300 major teaching hospitals that participate in the Medicare program, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents.

The health care delivery system is evolving as both public and private payers struggle to control health care expenditures, and academic medicine is prepared and willing to meet the delivery system's new imperatives. Teaching hospitals, medical schools and faculty practice plans have recognized the need for change within their own organizations and are actively engaged in reformulating the health delivery system, finding ways to reduce the rate of increase in health care costs, improving accountability, and enhancing the quality of care.

Academic medicine is adapting to a market-driven health care delivery system, but is concerned about proposals that would jeopardize its ability to fulfill its core missions. There are three fundamental principles which the AAMC believes should guide changes in the delivery system and the Medicare program:

1. **The AAMC believes in a "shared responsibility" approach to financing the special missions of academic medicine. All payers should recognize and pay for the costs associated with these missions.** Teaching hospitals and their associated medical schools and faculty are important components of the health care system because they:

- provide all levels of patient care--from preventive to tertiary services--often to the most disadvantaged members of our society;
- ensure the availability of trained health care providers, including physicians, nurses and allied health professionals, by serving as principal sites for clinical education; and
- provide the environment for the conduct of clinical and behavioral research and the introduction of new technologies.

The costs of these additional missions traditionally have been supported by patient care revenues from public and private payers through a financing system of cross-subsidization. For example, patient service revenues have supported medical education and research, and payments from paying patients have supported charity care patients.

The AAMC believes that the ability of teaching hospitals and teaching physicians to fund their mission-related costs through charges to patients is eroding. In a price-conscious delivery system, private payers of patient care services increasingly limit their payments to only those specific services that their enrollees receive. Teaching hospitals cannot require or receive higher prices for their services. Additionally, some state Medicaid programs, which traditionally have recognized costs associated with the academic missions, are retreating from the inclusion of explicit payments in their financing structures.

At a time when it is most needed, the AAMC regrets that the possibility of establishing all-payer funds for the special missions of teaching hospitals and medical schools appears to have diminished. However, the Association continues to emphasize the fundamental importance of the principle that all payers of patient care services must support the training of the work force as well as providing an environment in which education and clinical research can flourish.

2. The AAMC believes that teaching hospitals and teaching physicians should not bear more than their "fair share" of reductions in the rate of projected Medicare spending. Teaching hospitals rely heavily on the two Medicare payments with an educational label: the direct graduate medical education (DGME) payment and the indirect medical education (IME) adjustment. In the absence of a marketplace where all insurers or sponsors of patient care programs share responsibility for supporting the academic missions, these historical, explicit payments to teaching hospitals take on added importance.

The AAMC recognizes that unrestrained growth in Medicare spending threatens the long-term solvency of the Federal Hospital Insurance (HI) Trust Fund, and supports reforms to align trust fund income and outlays. But any reductions proposed for DGME and IME payments are real cuts for teaching hospitals. These proposed reductions, coupled with private sector losses, reductions in Medicaid spending and other cuts in projected Medicare payments, will force teaching hospitals to bear an unfair burden of Medicare payment reductions, making it more difficult for them to sustain their additional missions.

3. Any changes in Medicare payment policy should be implemented gradually with an annual evaluation of their impact on the financial viability of different groups of hospitals. The AAMC believes that Congressional decisions on Medicare payment policies should be made in the context of their impact on the entire health care system. Nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) account for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges. For many COTH member hospitals, Medicare payments comprise from one-quarter to one-third of all their revenue. Clearly, changes in Medicare payments will have a profound impact on these institutions.

As the Congress turns its attention from the overall level of federal spending, the particulars about which programs and payments to reduce become difficult. These decisions, including those about Medicare support for graduate medical education and for the higher costs incurred by teaching hospitals in fulfillment of their special missions, must be informed and fair, and based on objective analyses of the impact of various options on Medicare beneficiaries and other patients and on the financial viability of health care providers.

I urge the members of this Committee to consider carefully its Medicare payment policy recommendations. Teaching hospitals and teaching physicians play critical roles in our

health care delivery system. They could be damaged severely unless changes are crafted carefully and are based on an extensive understanding of the education and service missions of academic medicine. Massive reductions in Medicare payments for activities related to graduate medical education will negatively affect these institutions' continued excellence and touch every American's life.

Today, I would like to comment specifically on four issues of significance to academic medicine:

1) the role of Medicare payments for DGME costs in support of residency training;

2) the importance of the Medicare IME adjustment to the financial viability of teaching hospitals;

3) the methodology for calculating the adjusted average per capita cost (AAPCC), the rate that the Medicare program pays to risk contractor HMOs; and

4) the importance of clinical practice income as a source of financial support for the nation's medical schools.

While many understand the importance of DGME and IME payments to teaching hospitals, failure to address the way in which they and the disproportionate share (DSH) payment are incorporated in the AAPCC rate poses a threat to the financial viability of teaching hospitals. Finally, it should be understood how changes in the delivery system threaten the ability of the clinical faculty to make their traditional contribution to medical schools in support of the schools' education and research activities.

Direct Graduate Medical Education Payments

In addition to providing health care, hospitals that train health professionals provide the resources for the clinical education of physicians, nurses, and allied health personnel. To provide this formal, experientially-based clinical training, hospitals incur costs beyond those necessary for patient care. These added direct costs include: salaries and fringe benefits for trainees and the faculty who supervise them; classroom space; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

The Purpose and History of the Medicare Direct Graduate Medical Education Payment

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (Senate Report. Number 404. Pt. 1. 89th Congress. 1st Sess. 36 (1965) and House Report, Number 213. 89th Congress. 1st Sess. 32 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals. If there was ever an assumption that the "community" would take responsibility for its share of these costs, it certainly is not occurring in the current competitive environment.

Until the mid 1980s, Medicare paid for its share of DGME costs based on the hospital's historical and reasonable costs as determined by an audit. Reimbursement was open-ended in that a portion of "reasonable and allowable" DGME costs incurred every year was "passed through" to the Medicare program. DGME payments also were open-ended because there was no restriction on the number of years that Medicare reimbursement would financially support a resident's training.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-72), which dramatically altered the DGME payment methodology from one based on annual historical DGME costs to a prospective per resident amount. The Medicare program now pays its proportionate share of a hospital-specific per resident amount based on audited costs from a base year and updated for inflation rather than on the basis of DGME costs actually incurred. Today, a hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital. Other legislative and regulatory changes have been made since COBRA, but the basic methodology for calculating the DGME payment remains the same.

In addition to changing the payment methodology, COBRA placed limits on the number of resident trainee years for which full Medicare payment would apply. In a subsequent change, Congress chose to restrict full support to the direct costs of those residents within the

minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. Payments for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent. The five-year count is suspended, however, for a period of up to two years for training in a geriatric or preventive medicine residency or fellowship program.

The change in DGME payment methodology required by COBRA, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits DGME payments, it still acknowledges the historical scope of direct graduate medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Proposals to Change Medicare Payments for DGME Costs

Nearly ten years after COBRA's passage, policy makers again are examining proposals to reform Medicare DGME payments. Many of these proposals are intended to limit the growth in Medicare expenditures. Several seek to achieve a more appropriately configured physician work force by shifting the balance of generalist and nongeneralist physicians, or placing limits on the total number of physicians-in training. Among the more frequently mentioned proposals that seem to have captured the attention of some policy makers are:

- facilitating the development of non-hospital-based ambulatory training by allowing entities other than hospitals to receive Medicare DGME payments and by encouraging the formation of graduate medical education (GME) consortia;
- limiting payments to the period required for initial board certification;
- limiting payments only to graduates of U.S. medical and osteopathic schools;
- weighting Medicare payments by specialty to encourage training in the generalist specialties; and
- constructing a national average per resident payment methodology to reduce the variation in hospital-specific per resident payments.

Each of these proposals and its potential impact on graduate medical education is discussed below:

Facilitating the development of non-hospital-based ambulatory training sites. The AAMC supports changes in Medicare DGME funding to encourage residency training in non-hospital, ambulatory sites, such as private physicians' offices, freestanding clinics, or nursing homes.

Entities Eligible for Medicare DGME Payments. Training sites chosen by residency program

directors should be selected because they offer appropriate educational experiences, not because they are more easily funded. However, the law regarding Medicare DGME payments explicitly states that DGME payments may be made only to hospitals. On the other hand, the law and implementing regulations allow hospitals to receive DGME payments for the training of residents in non-hospital, ambulatory settings (subject to certain requirements). Although an ambulatory site may not at present receive a Medicare payment directly for any DGME costs it might incur, nothing in the law prevents it from negotiating for a payment from a hospital for the residents that the non-hospital site accepts.

The Association believes that Medicare DGME payments should be made to the entity that incurs the cost. Recipients of payments could be teaching hospitals, medical schools, multi-specialty group practices or organizations, such as GME consortia, that incur training costs. Funding for graduate medical education should support residents and programs in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the residents. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization in which the program functions must determine the institutional commitment to graduate medical education.

Formation of GME Consortia. The AAMC strongly encourages the formation of GME consortia. GME consortia are formal partnerships, involving two or more separate institutions involved in graduate medical education, formed to reorganize or strengthen medical education and characterized by shared and joint decision making. Local or regional educational consortia have been advanced as mechanisms for enhancing the quality of medical education, especially graduate medical education, while at the same time better aligning the physician work force with the needs of the newly emerging health care system.

In 1993, the AAMC and the Maine Medical Center jointly conducted a national survey to determine the number, composition and accomplishments of existing GME consortia. These findings were subsequently published, and led to another research effort. At present, the AAMC, in conjunction with the Center for the Health Professions at the University of California, San Francisco, is conducting an in-depth study of GME consortia.

Given the current interest in GME consortia, and the relative paucity of data, we hope to significantly expand the information available. Specific objectives include: developing a national directory of GME consortia; characterizing consortia on the basis of their dominant theme or purpose; identifying new and innovative relationships between medical schools, teaching hospitals, managed care organizations and communities in reorganizing medical education; identifying controversial issues, delineating potential strategies for their resolution and defining those features that are central to successful implementation; and developing resource materials to guide health care institutions in developing their own consortia.

In March 1995, a questionnaire was mailed to the Chief Executives of all hospitals with ACGME- or AOA-approved residency training programs. From the information obtained, a tentative directory of 103 GME Consortia was developed. In June 1995, the directors of

these putative consortia received a detailed, 29-page survey instrument organized into nine topic areas: Identifying Data; Consortium Membership; Mission; Governance/Authority; Financing; Administration/Management; Medical Education; Consortium Impact; and Miscellaneous. These data are presently being analyzed. We would be happy to share a preliminary report, expected by the end of the summer, with the members and staff of this Committee.

The AAMC urges Congress to consider modifying the statutory requirement that only hospitals may receive Medicare DGME payments and permitting other entities to receive payments if they incur the cost of training. As Clayton Jensen, M.D., interim dean of the University of North Dakota School of Medicine, testified before this Committee in March 1994, removing the barriers for local or regional entities that want to set up GME consortia, like the North Dakota Center for Graduate Medical Education, would be an important step in providing flexibility for developing collaborative relationships for medical education. A payment methodology would have to be developed based on the costs of training at those sites.

To explore the issues inherent in such a change, the AAMC supports the interest of the Health Care Financing Administration (HCFA) in designing a research and demonstration project to encourage the development of new integrated training sites and/or GME consortia. Under such a project, HCFA could experiment and monitor the impact of allowing non-hospital sites to receive DGME payments if they run the training programs and incur the costs.

Limiting Payments to the Period Required for Initial Board Certification. Currently the Medicare program restricts full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. The five year count is suspended, however, for a period of up to two years for training in a geriatric or preventive medicine residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent. The Medicare program then continues to support residents at the 50 percent level indefinitely, as long as they remain in a training program approved by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or in a specialty for which a member organization of the American Board of Medical Specialties (ABMS) issues a certificate.

Several policy makers have proposed imposing additional limits on the length of time for which the Medicare program should provide its support. Some have suggested that Medicare should pay only through the period required for initial board certification in a specialty or pay only for a three-year period, regardless of the specialty.

The AAMC believes that support through initial board eligibility is an essential minimum training period that every patient service payer should help finance. Medicine involves a

number of different specialties, and each specialty area has developed its own residency training period. The initial skills and techniques needed by different specialties require different lengths of training. The AAMC believes that the variable length of training for each specialty area is appropriate and in the national interest, but recognizes that Medicare payment policies must be balanced.

Table A, derived from the AAMC's DGME microsimulation payment model, shows the financial impact of limiting Medicare support to the period required for initial board certification on all teaching hospitals. The financial impact would reduce significantly the viability of many training programs. If this policy were implemented for Federal FY 1996, DGME payments would decrease $342 million, or 19 percent, compared to what Medicare would expect to pay next year under current policy. Those groups experiencing the greatest average losses would be integrated academic medical center hospitals[1], hospitals with intern and resident-to-bed ratios greater than 0.40, and major teaching hospitals that receive DSH payments.

Another often-discussed policy option would limit Medicare support for graduate medical education to three years. The AAMC believes that limits on support should not be arbitrary or inconsistent with adequate minimal residency training. In its March 1993 report to the Congress, the Physician Payment Review Commission (PPRC) also "rejected as unwise the options of paying only for primary care positions or only for the first three years of training" (page 66). The commission concluded that the nation would continue to require well-trained physicians in all specialties, and that such a policy would not be "sufficiently flexible" if changes in the health needs of the population called for physicians in specialties that required more than three years of training.

Limiting Payments Only to Graduates of U.S. Medical and Osteopathic Schools. The Medicare program currently sets no limit on the number of residents it will support. Additionally, Medicare provides support for medical school graduates regardless of whether they are graduates of U.S. or foreign medical schools. International medical graduates (IMGs), or those U.S. citizens or nationals of other countries who have graduated from overseas medical schools must, however, pass Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) and be in an approved training program.

Some policy makers have called for an examination of national policy on IMGs in light of a growing consensus that U.S. medical and osteopathic schools have sufficient capacity to train an adequate number of physicians for the nation. They also have questioned whether it is appropriate to use public funds, including Medicare payments, to support the large number of foreign-trained physicians entering residency programs in the U.S. when many agree that there is an oversupply of physicians. These policy makers point out that the majority of IMGs who participate in graduate medical education ultimately enter practice in the U.S.,

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[1] An integrated academic medical center hospital is either under common ownership with a college of medicine, or has the department chairmen at the school also serving as the chiefs of service at the hospital.

TABLE A

Distributional Impact of Limiting Payments to Residents Within Initial Residency Period, FY96

	Number of Hospitals	Total Medicare DGME Payments		Change	
		Baseline ($Mill.)	Policy Option ($Mill.)	$Mill.	%
DGME Payments	1,138	$1,795	$1,454	($342)	(19)
COTH Membership					
Integrated AMC's	114	666	516	(150)	(23)
Independent AMC's	180	590	479	(111)	(19)
Non-COTH Teaching	844	539	459	(80)	(15)
Intern Resident Bed Ratio					
<0.10	608	213	183	(30)	(14)
0.10 - 0.25	280	497	421	(76)	(15)
0.25 - 0.40	108	314	253	(61)	(20)
>0.40	142	771	598	(174)	(23)
Medicare Share [1/]					
<25 Percent	195	154	124	(30)	(20)
25 - 40 Percent	269	676	531	(144)	(21)
40 - 55 Percent	453	773	631	(141)	(18)
>55 Percent	221	193	167	(26)	(13)
Medicaid Share [1/]					
<10 Percent	435	455	375	(80)	(18)
10 - 25 Percent	458	901	735	(166)	(18)
25 - 35 Percent	114	253	196	(57)	(23)
>35 Percent	131	185	147	(38)	(20)
No. of FTE Residents					
<50 Residents	769	338	290	(47)	(14)
50 - 100 Residents	148	284	240	(44)	(16)
100 - 250 Residents	145	550	442	(108)	(20)
>250 Residents	78	624	482	(142)	(23)
Type of Hospital Ownership					
Voluntary Nonprofit, Church	243	317	264	(53)	(17)
Voluntary Nonprofit, Other	686	1,222	984	(238)	(19)
Proprietary	81	34	28	(6)	(18)
Government	128	222	177	(45)	(20)
DSH Payments by Teaching Status [2/]					
Major Teaching / No DSH	74	195	153	(42)	(21)
Major Teaching / DSH	176	890	697	(193)	(22)
Other Teaching / No DSH	449	291	248	(42)	(15)
Other Teaching / DSH	439	419	355	(64)	(15)
Region of Country					
New England	88	171	134	(38)	(22)
Middle Atlantic	246	639	511	(128)	(20)
South Atlantic	140	220	175	(45)	(21)
East North Central	244	378	309	(69)	(18)
East South Central	52	52	43	(9)	(18)
West North Central	97	116	100	(16)	(14)
West South Central	93	71	60	(12)	(16)
Mountain	42	36	32	(5)	(13)
Pacific	136	110	91	(19)	(18)

1/ Based on inpatient days.
2/ Major teaching hospitals are those with IRB ratio greater than 0.25.
Source: Calculated for AAMC by Health Policy Economics Group, Price Waterhouse Graduate Medical Education Model.

adding to the projected oversupply of physicians and aggregate health care costs.

Data show that in the past few years, the number of physicians-in-training has continued to increase. While the number of graduates of U.S. allopathic medical schools has remained relatively stable for several years, the number of IMGs receiving training in this country has increased substantially. Between 1988 and 1993, the number of IMGs in graduate medical education nearly doubled from approximately 12,000 to nearly 23,000. In 1993-94, nearly 27 percent of all first-year residency training slots in allopathic and osteopathic programs were filled by IMGs.

In response to concerns regarding overall physician supply, on June 22, 1995, the AAMC Executive Council adopted a policy position on the physician work force and the participation of IMGs in graduate medical education:

> That the Association of American Medical Colleges, in recognition of the growing oversupply of physicians in the United States, pursue and undertake initiatives to address the future supply of physicians consonant with legal restrictions and requirements. While the Association should consider all available options for addressing this oversupply, it should--first and foremost--pursue options to diminish the number of international medical graduates pursuing graduate medical education in the United States and remaining in the United States following the completion of their graduate training. Any options supported by the Association that would result in constraints on the number of international medical graduates receiving training must include mechanisms to mitigate the impact on hospitals that currently train IMGs and those hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for IMGs would cause substantial access and service problems for Medicare beneficiaries. One of the issues that policy makers would need to address in enacting such a change would be the implementation of a process and a time table so that patient access to services would not be reduced precipitously. Additionally, mechanisms would be needed to mitigate the impact on hospitals that currently train IMGs and on hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

Table B demonstrates the significant financial impact on teaching hospitals in FY 1996 if Medicare payments were limited only to graduates of U.S. allopathic and osteopathic medical schools. Medicare DGME payments would decrease $374 million, or 21 percent, compared to what the Medicare program would expect to pay in 1996 under current payment rules. The greatest average losses would be for hospitals with 50 to 100 residents; resident-to-bed ratios between .10 and .40; major teaching hospitals with no DSH payments; other teaching hospitals that receive DSH payments; and hospitals in the Middle Atlantic states.

TABLE B

Distributional Impact of Limiting Payments to U.S. Residents, FY96

	Number of Hospitals	Total Medicare DGME Payments		Change	
		Baseline ($Mill.)	Policy Option ($Mill.)	$Mill.	%
DGME Payments 1/	1,138	$1,795	$1,421	($374)	(21)
COTH Membership					
Integrated AMC's	114	666	566	(100)	(15)
Independent AMC's	180	590	452	(138)	(23)
Non-COTH Teaching	844	539	404	(136)	(25)
Intern Resident Bed Ratio					
<0.10	608	213	173	(40)	(19)
0.10 - 0.25	280	497	369	(128)	(26)
0.25 - 0.40	108	314	231	(84)	(27)
>0.40	142	771	649	(123)	(16)
Medicare Share					
<25 Percent	195	154	128	(27)	(17)
25 - 40 Percent	269	676	559	(117)	(17)
40 - 55 Percent	453	773	601	(172)	(22)
>55 Percent	221	193	134	(58)	(30)
Medicaid Share					
<10 Percent	435	455	356	(100)	(22)
10 - 25 Percent	458	901	723	(178)	(20)
25 - 35 Percent	114	253	207	(46)	(18)
>35 Percent	131	185	135	(50)	(27)
No. of FTE Residents					
<50 Residents	769	338	266	(72)	(21)
50 - 100 Residents	146	284	206	(78)	(27)
100 - 250 Residents	145	550	439	(112)	(20)
>250 Residents	78	624	511	(112)	(18)
Type of Hospital Ownership					
Voluntary Nonprofit, Church	243	317	253	(64)	(20)
Voluntary Nonprofit, Other	686	1,222	942	(280)	(23)
Proprietary	81	34	29	(6)	(16)
Government	128	222	197	(25)	(11)
DSH Payments by Teaching Status 2/					
Major Teaching / No DSH	74	195	144	(51)	(26)
Major Teaching / DSH	176	890	735	(155)	(17)
Other Teaching / No DSH	449	291	229	(61)	(21)
Other Teaching / DSH	439	419	312	(106)	(25)
Region of Country					
New England	88	171	143	(28)	(17)
Middle Atlantic	246	639	455	(184)	(29)
South Atlantic	140	220	189	(31)	(14)
East North Central	244	378	300	(78)	(21)
East South Central	52	52	48	(4)	(8)
West North Central	97	116	88	(28)	(24)
West South Central	93	71	64	(7)	(10)
Mountain	42	36	33	(3)	(9)
Pacific	136	110	101	(9)	(8)

1/ Based on inpatient days.
2/ Major teaching hospitals are those with IRB ratio greater than 0.25.
Source: Calculated for AAMC by Health Policy Economics Group, Price Waterhouse Graduate Medical Education Model.

A variation of this proposal offered by some policy makers would limit Medicare DGME payments to a defined number of residents. One option could be to freeze the number of full-time equivalent (FTE) residents that the Medicare program would support at the current number of residents in the training system. A more aggressive option that has been suggested might be to impose an aggregate limit on the total number of positions, e.g., the number of U.S. graduates plus some add-on percentage for IMGs. It should be understood that these proposals could require the establishment of control or regulatory mechanisms.

Weighting Payments by Specialty. For several years, some policy makers have proposed changes in Medicare DGME payments to provide incentives for training generalist physicians and to eliminate the variation in hospital-specific per resident amounts. Additionally, these proposals could reduce the Medicare program's role in GME funding.

Weighting proposals would attempt to accomplish these policy goals by paying relatively favorable amounts for generalist residencies, and substantially less favorable payment amounts for all other residencies. For example, Medicare DGME payments could be based on a per resident amount that would then be weighted based on the specialty area that a resident is pursuing. The Medicare program would make a higher payment for a resident in a generalist specialty than for a non-generalist resident. Thus, a hospital's total DGME payment would be based not on its costs, but on the specialty mix of its trainees.

Current Medicare payment policy includes modest differential payments for residents in generalist specialties. OBRA 1993 (P.L. 103-66) created separate hospital-specific payment rates for generalist and nongeneralist residents. In FY 1994 and 1995, only hospitals' per resident payments for residents in generalist disciplines were updated by the annual inflation factor. Per resident payment levels for all other residents were frozen.

The Association did not oppose the change adopted in OBRA 1993 and strongly supports more individuals entering generalist practice. However, the AAMC does not believe that more intensive weighting of DGME payments by specialty would achieve its intended objective.

The Association recognizes that the present system has not produced the number of generalist physicians that society may need in a reconfigured health care system. An Association policy adopted three years ago calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The AAMC's policy rests on the implementation of voluntary, private sector initiatives. Personal incentives such as loan forgiveness, tax benefits, and other inducements to narrow the income gap between generalist and non-generalist physicians, are more likely to result in

greater numbers of U.S. medical school graduates entering the generalist disciplines. There are already a variety of federally-sponsored student loan repayment programs that could be bolstered. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs.

The nation's medical schools have implemented programs to increase the awareness and attractiveness of generalist medicine. More schools are adding required clerkships in one of the generalist disciplines during the third- and fourth-year of the curriculum. Schools have convened primary care task forces, appointed new Associate Deans for Primary Care, and developed new departments of family medicine and divisions of general internal medicine and general pediatrics.

The AAMC is pleased that medical schools' efforts are bearing fruit as medical students' interest in generalist practice continues to increase. Although data on medical students' career choice from as recently as the graduating class of 1989 showed a declining selection of the generalist specialties, more recent data signal that medical school graduates continue to respond to changes in the health care environment. In 1994, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased again. Of graduating medical students, 22.8 percent indicated an intent to choose a generalist career in 1994 compared to 14.6 percent in 1992 and 19.3 percent in 1993. In addition, results from the National Residency Matching Program (NRMP), released on March 15, 1995, showed that medical students "matched" into family medicine residency programs at the highest rate in the NRMP's 43-year history. Over 2,000 graduating seniors from U.S. medical schools, or 15.4 percent of those seeking first-year residency positions, matched into a family medicine residency. This compares to 14.0 percent of all U.S. seniors in 1994.

Additionally, data on career choices of medical school graduates indicate that medical students' selection of residency training programs is affected not by Medicare payments to hospitals, but by market conditions and personal suitability to a particular specialty. At present, there are more generalist training positions offered than there are interested students to fill them. In March 1993, the PPRC concluded that weighting DGME payments to hospitals is undesirable. The commission indicated that there was already a sufficient number of existing generalist training slots, and weighting would have little influence on hospital management's and residency program directors' decision making.

While proponents of preferential weighting proposals indicate that a higher payment differential would be enacted only for generalist disciplines, it is likely that many clinical specialties would argue that they also deserve a "special weighting factor." It is unclear what criteria would be used to define a "primary care" program. The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal in 1991, and that physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

The AAMC supports strategies to develop the generalist physician work force. Strong residency programs require continuity of effort and stable support, but proposals to weight Medicare DGME payments based on specialty, if enacted, would only contribute to the instability of GME funding.

Constructing a National Average Payment Amount for DGME Costs. Last year, during the debate over comprehensive health care reform, some policy makers recommended the development of a national average per resident payment methodology with payment adjustments for regional differences in wages and/or wage-related costs. In some instances, the proposals excluded certain types of costs, such as direct overhead costs or allocated institutional overhead costs. These changes were suggested in the context of a package of proposals for graduate medical education reform, including an all-payer funding mechanism that was to be separate from payments for patient care services.

The AAMC supports the continuation of the current Medicare hospital-specific per resident payment method because it recognizes structural factors that legitimately affect a hospital's per resident costs. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne variably by the medical school or teaching hospital. The diversity of support for the costs of faculty who supervise residents is probably the most important reason for the variation in Medicare per resident amounts. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Wide variation in per resident amounts exists among hospitals in the availability and amount of support from non-hospital sources, including public subsidies and faculty practice earnings. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While some proposals would adjust the Medicare national average per resident payment for differences in wages and other wage-related costs, these other structural factors would not be reflected in the national average payment methodology, creating inappropriate winners and losers.

Last year, at its January 1994 meeting, the Prospective Payment Assessment Commission (ProPAC) discussed recommendations on graduate medical education financing for its March 1994 report. Reviewing a staff analysis of graduate medical education costs and payments, the Commissioners noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Altman, Ph.D., cautioned those who would prefer a national average payment methodology for DGME costs without incorporating a number of payment adjustments. Citing the commission's eleven-year experience with the prospective payment system (PPS)--the first attempt by the federal government to standardize payments based on national averages--Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's analysis of graduate medical education costs found significant relationships between per resident costs and hospital size; its share of full-time equivalent residents in the outpatient setting; its share of costs related to faculty physicians' salaries; geographic region; location in a metropolitan statistical area; and area wages.

The AAMC also supports the current methodology because it recognizes all types of costs, including salaries and fringe benefits of the faculty who supervise the residents; direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for maintenance and utilities. The AAMC opposes proposals to exclude certain types of DGME costs, such as faculty supervision costs or direct or allocated institutional overhead costs, from the calculation of the Medicare per resident amount. The current method recognizes the diversity in how graduate medical education is organized and financed. Further, ample faculty supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing patterns of practice. Graduate medical education in all specialties is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

The AAMC believes that, within certain policy parameters, the Congress should consider changes that would ensure equitable, economically justified Medicare DGME payments among training sites, including non-hospital and ambulatory settings. The AAMC believes that the payment system should recognize the significant diversity across institutions that participate in graduate medical education. Graduate medical education rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and are based on an extensive understanding of both the nature of the teaching hospitals and other settings in which it is conducted and the nature of graduate medical education itself.

Indirect Medical Education (IME) Adjustment

Since the inception of the Medicare PPS in 1983, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment. The IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals.

The Purpose of the IME Adjustment

While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the Senate Finance and the House Ways and Means Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG

> case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, Number 98-23, March 11, 1983, and House Ways and Means Committee Report, Number 98-25, March 4, 1983).

The IME adjustment is not to be confused with the Medicare payment for DGME costs. Payments for Medicare's share of the direct costs of graduate medical education programs are separate from the PPS and serve a different purpose.

The Importance of IME Payments to Teaching Hospitals

As the Congress contemplates adjustments in the annual growth rate of the Medicare program, payments for hospital services are principal targets and changes in payment policy naturally affect not only the total amount but the distribution of payments. PPS operating costs represent the largest single source of payment for the Medicare program. In FY 1995, Medicare payments for hospital services are expected to total $105.7 billion, with the largest portion of the total, $66.5 billion or 63 percent, attributable to PPS operating payments. PPS operating payments include the basic Diagnosis-Related Group (DRG) payment, and, if warranted, payments for outliers, IME and DSH. IME payments, expected to be about $3.9 billion in 1995, represent 3.7 percent of all Medicare payments to hospitals and 5.9 percent of all PPS operating payments. DSH payments are expected to account for 3.6 percent of all Medicare payments to hospitals, and 5.7 percent of total PPS operating payments, or about $3.8 billion.

Proposals to slow the growth in PPS operating payments have centered on three specific elements: the annual increase in the basic PPS price for all hospitals, called the update factor, and two add-on payments, the IME and DSH adjustments. All hospitals' Medicare payments are affected by changes in the update factor, but only certain types of hospitals experience the effect of changes in IME and DSH payment policy. While teaching hospitals recognize the need to control Medicare expenditures to protect the long-term solvency of the program, these institutions would be affected not only by IME reductions, but also by reductions in the update factor and DSH payments. At the levels being proposed by some policy makers, these would be real cuts in payments that would endanger the ability of teaching hospitals to fulfill their core missions of patient care, education and research.

The Financial Viability of Teaching Hospitals. Since the inception of the PPS, the IME adjustment has been reduced twice from its original level of 11.59 percent. In recent years, however, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has

recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care for all Americans.

Historically, teaching hospitals have had higher PPS inpatient operating margins--the excess or loss of revenue attributable to PPS patients expressed as a percentage--on average than non-teaching hospitals, but teaching hospitals' total margins--the financial margins from all patients--have remained consistently lower than other hospitals' total margins. As analyzed by ProPAC in its June 1995 report and shown in Table C below, data from the tenth-year of PPS (1993-94), the most recent information publicly available, show that average PPS margins for non-teaching hospitals were minus 4.0 percent, but total margins were plus 4.8 percent. Major teaching hospitals, however, posted PPS operating margins of 11.7 percent, but their average total margins were substantially lower at 2.7 percent. The average total margin for all hospitals was 4.3 percent.

Table C
PPS Operating Margins and Total Margins, by Hospital Group, PPS 10

Hospital Group	PPS Margin	Total Margin
Major Teaching	11.7%	2.7%
Other Teaching	0.5	4.6
Non-teaching	-4.0	4.8

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

An analysis of FY 1994 financial data supplied by 91 hospitals belonging to AAMC's COTH shows that a precipitous reduction in the IME adjustment would substantially harm teaching hospitals, destroying the relative equity that has been achieved with the current level of the IME adjustment. If the IME adjustment were reduced from 7.7 to 3.0 percent, as proposed in one of the three Medicare restructuring options by Congressmen Christopher Shays (R-CT), Dave Hobson (R-OH), Dan Miller (R-FL), and Steve Largent (R-OK), the average PPS margin in 1994 would fall from a positive 11.75 to a negative 1.49 percent, a reduction of 13.24 percentage points. The impact on average total margins would be substantial. The average total margin in 1994 would fall from 5.1 percent to 2.8 percent, a decrease of 2.3 percentage points.

PPS Improvements that Would Distribute Payments More Equitably. Now in its twelfth year, the prospective payment system continues to be based on national average rates that do not by themselves recognize important differences in hospital costs. Originally developed to create a "level playing field" for teaching and non-teaching hospitals, the IME adjustment serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;

- non-recognition of the teaching hospital's costs of maintaining a broader and more specialized scope of services, often at the regional level, and the capacity for introducing new technology;

- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;

- unavoidable decreases in productivity stemming from the presence of trainees; and

- additional ancillary services ordered by trainees as they learn how to diagnose and treat patients.

The AAMC supports efforts to improve payment accuracy and the equitable distribution of PPS payments. The Association believes that improvements could be made in the PPS, such as the introduction of better measures of severity of illness, that would distribute payments more equitably across hospitals. The overall payment impact of changes in the DRG patient classification system must be budget neutral. Therefore, more accurate measurement of severity of illness would not increase Medicare expenditures. The primary payment impact would be a different allocation of PPS payments across hospitals, all other things being equal.

The inability of the DRG system to distinguish severity of illness within diagnostic groups, or account for other characteristics that are likely to affect a patient's costs, such as whether the patient was transferred from another facility, has led to research on improved measures of severity. For example, HCFA has developed a new patient classification system that incorporates severity refinements, called the Refined DRGs. This new set of DRGs, if implemented, would result in more accurate patient classification and payment for PPS cases.

The AAMC understands that the use of better severity measures likely would result in a reduction in the empirical level of the IME adjustment. However, teaching hospitals may experience less uncertainty from year to year if severity of illness were captured in the DRGs and were paid through the case mix index. The AAMC believes that a complete analysis of the integration of a new DRG system would be required, including the impact of the new system on outlier policy and the interaction of the IME and DSH adjustments.

Similarly, research efforts also could focus on improvements in the Area Wage Index (AWI), which accounts for variation in hospital wage rates across geographic areas. As with the DRG classification system, the overall payment impact of changes in the AWI must be budget neutral. The current labor market areas used to determine the AWI, which are based on fixed county and state boundaries, fail to account for the higher labor costs faced by hospitals located in central, inner city areas compared to hospitals in suburban areas. To some unknown degree, these central city/suburban ring cost differences are incorporated in the level of the IME adjustment.

Finally, the AAMC supports a more equitable approach to outlier policy that targets outlier payments to the highest cost cases. Adjustments to outlier payment policy should be considered to protect hospitals from the risk of large losses on some cases. Teaching hospitals, because of their special missions, treat groups of patients who are more likely to

become unusually costly cases, resulting in costs that are much greater than the DRG payment. Under current policy, costly cases treated in teaching and/or DSH hospitals are less likely to qualify for cost outlier payments and when these cases do, the outlier payment is smaller than one in a non-teaching, non-DSH hospital.

The AAMC urges the Congress to consider carefully the impact of a reduction in the IME adjustment on all teaching hospitals. Teaching hospitals understand that to protect the solvency of the HI Trust Fund, Congress must moderate the projected growth in Medicare spending. However, teaching hospitals also are concerned that they will be asked to bear a disproportionate burden of the proposed payment reductions. For these institutions, the proposed levels of Medicare spending growth would mean real cuts in their payment levels. Adjustments can be made to the PPS to improve payment equity, but the financial position of teaching hospitals, as measured by total margins, is tenuous. Teaching hospitals are concerned about their ability to fulfill their missions, including the provision of high technology care, costly services for referred patients, and community services such as burn and trauma units.

Adjusted Average Per Capita Cost (AAPCC)

As the delivery system moves toward capitated payments for patients, separating the payment for DGME costs and for patient care costs attributable to the special roles of teaching hospitals (IME and DSH) from patient care revenue becomes necessary. The AAMC believes that the current method of calculating the Medicare AAPCC, the rate that the program pays to a risk contractor, results in a payment system that creates an uneven playing field between teaching and non-teaching hospitals.

The AAPCC calculation incorporates all Medicare expenditures, including the DGME, IME and DSH payments. These payments are intended respectively to compensate hospitals for specific missions (graduate medical education), or for providing services to atypical patients who are severely ill or are of low-income socioeconomic status. Once these payments have been included in the AAPCC and paid to a risk contractor, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with risk plans because the risk contractor receive the same AAPCC amount regardless of with whom the risk plan has a contract.

ProPAC recently noted this problem in its March 1995 report to the Congress:

> Medicare's capitated payment under its managed care risk contracting program does not appropriately distribute payments for the costs of teaching programs or of caring for a disproportionate share of low-income patients. The capitated rate reflects the extra Medicare payments provided to teaching and disproportionate share hospitals in the fee-for-service sector, regardless of whether Medicare enrollees receive care in those hospitals. The relationship between HMOs and the teaching and disproportionate share hospitals in their service area warrants further evaluation (pages 7-8).

On May 24, 1995, Gail R. Wilensky, Ph.D., Chair of the PPRC, noted that changes are needed in how the Medicare program pays risk contractors. In testimony before the Subcommittee on Health of the House Ways and Means Committee, Dr. Wilensky explained that "Medicare's current payment methodology for risk-contracting HMOs has a flaw that results in overpaying many HMOs for expenses related to graduate medical education." As part of its work plan, the PPRC will assess the impact of this policy in the coming months and analyze the implications of moving towards alternative financing approaches.

In recent months, the AAMC has been working to develop a methodology for removing these costs and distributing these payments to the appropriate hospitals for the special costs they incur. The AAMC believes that both near-term actions to address the immediate issue at hand, as well as longer-term actions to resolve issues surrounding the current Medicare payment methodologies (DGME, IME, DSH, and AAPCC) should be pursued. Based on an analysis for the AAMC by Deloitte and Touche and discussions with hospital groups about the results, the AAMC recommends the following near-term and long-term actions:

Near-Term Actions. The AAMC believes that DGME, IME, and DSH payments should be removed prior to the calculation of the AAPCC rates and paid directly as intended by Congress to teaching and non-teaching DSH hospitals that incur the costs of these activities. These "carved-out" mission-related payments should be made to teaching institutions when Medicare risk contract enrollees utilize their services. The AAMC recommends that separate payment methodologies, which mirror the current Medicare regulations and are administratively feasible, be applied to each component of the DGME, IME and DSH payments. This approach could be accomplished through direct payments to the providers by continuing to use the current Medicare payment methodologies and settlement process with some relatively minor changes:

- Direct Graduate Medical Education. Using the current methodology for DGME, identify the number of inpatient days that are incurred by Medicare risk plan enrollees. Allow the teaching institution to count these days as part of the formula for calculating Medicare's share of DGME costs.

- Indirect Medical Education. Because care for Medicare risk plan patients is paid for at a rate negotiated between the hospital and the risk contractor, there is no longer a DRG payment against which to apply the IME adjustment. However, when a teaching hospital cares for Medicare risk plan enrollees, it would compute what the DRG payments would have been for these patients. This amount would then be combined with the actual DRG payments for remaining Medicare fee-for-service patients, and the IME formula would be applied.

- Disproportionate Share. The DSH formula would be used in the same "shadow bill" manner. In the cases of risk contract Medicare inpatients, the teaching hospital would calculate what the DRG payments would have been under the prospective payment system. This amount would then be added to the actual DRG payments of the fee-for-service patients, and the DSH formula would be applied.

Long-Term Actions. Initiatives should be undertaken to identify and study potential alternative contracting mechanisms to the AAPCC methodology, and to reform payments for the education-related missions and the care of low-income patients.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk-based plans grows. Additionally, the same issues will arise under proposals to give vouchers to beneficiaries so that they may purchase other types of insurance. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding risk-based contracts among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Medical School Financing in an Emerging Price Competitive Environment

Thus far, this testimony has addressed the impact of potential changes in Medicare on teaching hospital payments. Finally, I would like to make members of the Committee aware of how the emerging competitive delivery system threatens the fragile nature of medical school financing and the importance of clinical income to the financial viability of the nation's medical schools. The competitive environment is beginning to unravel medical schools' entire financing system at a time when medical schools and teaching physicians are being called on to transform the medical education system from one that focuses on specialist training in hospital inpatient settings to a more expensive system of small group education and generalist curricula carried out in ambulatory sites.

Like teaching hospitals, medical schools finance education and research activities through a complex system of cross-subsidization. Education, research and patient care exist as joint products. Undergraduate medical education in the clinical setting, directed by the medical school, is not recognized explicitly by any payment system. Like other academic costs, it has been financed indirectly through patient care dollars. Even at public schools, undergraduate medical education derives minimal support from tuition, fees and state appropriations. Tuition accounted for 4.1 percent and state appropriations for 11.5 percent of total medical school revenues in 1991-92.

Education and research programs rely in large part on revenues from the delivery of medical services by the faculty of the school. Clinical faculty practice plans represented 32.4 percent of total medical school revenue in 1991-92; by contrast, in 1980-81, medical service revenue contributed only 15.7 percent of the total.

Hospitals also support medical schools for activities conducted in the hospital. Payments from hospitals have increased from 6.2 percent in 1980-81 to 11.4 percent of total medical school revenue in 1991-1992. Research is supported partly by federal and local grants and

contracts. Grants and contracts represented about one-third of total medical school revenue in 1991-92. Philanthropic support supplements these sources, but by themselves these funds remain insufficient. Education also benefits from an elaborate system of nonpaid voluntary faculty drawn from the community.

For several reasons, medical schools are having difficulty sustaining this complex financial system undergirding the education and research missions. Federal support for research is increasingly constrained, with medical schools expected to accept a greater share of the costs. Pressures brought to bear on medical service costs will likely lead to declining income from the faculty clinical practice, and less money available to support educational and research efforts. To preserve the patient base critical for medical education and research, faculty physicians are being drawn into developing networks with affiliated teaching hospitals and are being asked to accept capitated or discounted payments from private payers. As community physicians are forced to align with various health plans in integrated networks, their willingness to "contribute" teaching services may even be threatened. The shift to a more explicit financing system threatens the ability of medical schools and teaching hospitals to fund education and research.

Conclusion

The AAMC regrets that the possibility of establishing all-payer funds for the special missions of teaching hospitals and medical schools apparently has diminished. This "shared responsibility" approach to financing the special missions of academic medicine is an issue that deserves the Committee's attention. All evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals and teaching physicians so that their fundamental missions can be preserved. Reductions in Medicare payments to teaching hospitals and teaching physicians will undermine the ability of these institutions to fulfill their multiple responsibilities at the same time they are struggling to adapt to a new delivery environment. Academic medicine supports those changes that assure the provision of high quality health care in a cost effective delivery system, a vibrant research capability and the capacity to educate outstanding practitioners. Academic institutions need the understanding and support of society to fulfill their obligations. The AAMC looks forward to working with the members of the Committee and their staff to meet these common goals.

21st Century Medicare
Summary of New Medicare Proposal

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The worst thing that can happen to a forecaster is to be held accountable by a powerful Senate Committee for a prior *ad lib* forecast. I lucked out. My forecast to this Committee in March 1994 of a sharp decline in the rate of health care cost increases has held up. The rate of increase in the medical care CPI is converging on the "All Items CPI" (Chart #1). Given the way the medical care CPI is derived (by leaving out employer health insurance expenditures), the actual rate of growth in private sector health spending is probably deflating. Even Medicare, which continues to do business as usual, appears to be benefitting from changed provider behavior in highly competitive HMO markets.

What we're learning from the new U.S. health system is that aggressive buying by large purchasers combined with intense competition produces the same improvements in efficiency that characterize much of the rest of the economy, especially that segment of the economy that is technology-driven.

What Works On Medical Inflation?

The smartest health care purchasers encourage Health Plan competition by offering consumers multiple choices. They motivate employees to be wise shoppers by paying a fixed contribution to be used for purchasing a Health Plan. They enhance their choices by offering uniform benefits and comparative information on quality from each Health Plan. Medicare should emulate their tested and successful methods (Chart #2).

Why Do Regional Medicare Costs Vary?

Where market forces are exploited in a program like FEHP, the range of premiums from one area to another is narrow. Where incentives are weak or perverse (such as in the traditional Medicare program which actually penalizes efficiency), the regional differences in program costs are profound (Chart #3). New York's Medicare per capita costs are 25% above the national average, but New York's FEHB competitive HMO prices are only 2% above the national average. For Miami, the discrepancy is even greater: Medicare costs are 35% above the national mean, but FEHB premiums are 5% below the national average. In Portland, the discrepancy is much narrower because the FEHP HMO prices and Medicare costs are both below average.

The reasons for the discrepancy in two government health insurance programs are apparent. As Medicare attempts to micromanage doctor fees and hospital reimbursement, the providers in high cost areas beat the government by running up the volume of services. Note the contrast in volume of services purchased by Medicare in high cost Florida vs. low cost Oregon (Chart #4).

Is Success Sustainable?

How long will medical inflation remain quiescent? Critics of the new medical market often charge that we're dealing with a short-term one-time set of savings. Data from numerous regional markets like Minnesota suggest they are wrong. For more than ten years, Minnesota has experienced continuous shifts from costly inpatient surgical stays to one-day outpatient surgical procedures, but the volume of surgery has not yet declined. That's next, especially if New Medicare takes over (Chart #5).

The Jackson Hole Group's proposed New Medicare structure is based on two principles:

- The new Medicare program should be patterned on the private business sector's successful experience in making the transition from traditional indemnity insurance (analogous to traditional Medicare) to cost-conscious consumer choices between Health Plans that compete on price, quality, and customer satisfaction.

- Real cost savings can be achieved while increasing seniors' health care benefits, quality and satisfaction. Reducing Medicare's 9-10% exponential rate of cost growth would occur gradually at first, but would become significant following a program-wide shift to New Medicare per capita reimbursement rates in the year 2000.

We propose using the first four years of the new program to put in place the necessary Health Plan choices and quality assurance system, to get Health Plans competing with each other, and to help seniors make the transition from traditional Medicare to a New Medicare system based on cost-conscious choices between competing Plans. Depending upon when it's enacted, this New Medicare approach can produce potential savings of $272 billion in 7 years and $671 billion in 10 years.

The New Medicare Approach. From past experience in Medicare and the private sector, we know that further raising of deductibles and coinsurance can be tried to decrease program costs, but the effectiveness of this approach in reducing demand will be negated by Medigap insurance and employer supplements. However, it could lead to some acceleration in New Medicare enrollment in Health Plans. Giving the HCFA director more discretion in managing care by modifying payments and incentives to physicians and hospitals may lead to some modest, though unpredictable, reduction in the cost of traditional Medicare.

This proposal focuses on moving away from traditional Medicare as expeditiously as possible without threatening seniors' sense of security, health or scope of coverage. It assumes that, like employers, the Congress and the Department of Health and Human Services will expand Health Plan options and will encourage seniors to choose more economical and comprehensive sources of care.

Step 1: Separate Health Plan Payments from Rate of Increase in Traditional Medicare Program Costs. Medicare Health Plan premiums are currently linked to traditional Medicare indemnity costs, so savings accrue only to the extent that cost growth in the traditional program is reduced. Chart 6 shows the CBO baseline, estimated to increase at nine percent per year in the absence of program reforms, as a reference.

Medicare should transition to a new risk-adjusted defined sum payment for Health Plans and traditional Medicare. During the transition, government payments to Health Plans would be disconnected from traditional Medicare fee-for-service payment levels. Risk-adjusted Medicare payments to Health Plans would be permitted to grow in the aggregate at five percent per year, beginning in the first year with a payment level at 95 percent of what the government pays traditional Medicare. However, actual Health Plan premiums charged beneficiaries would be based on competitive market rates, so beneficiaries choosing a Plan costing more than the government contribution would have to pay any additional amount, while beneficiaries choosing a less costly Plan would be refunded the difference. Traditional Medicare will only gradually deviate from the CBO baseline, unless HCFA management can do better.

As a policy, we recommend reducing the growth rate of per capita reimbursement for traditional Medicare by 1% per year below the CBO baseline. The growth rate would be targeted at 8% during 1996, 7% during 1997, 6% during 1998 and 5% during 1999. After that, traditional Medicare risk-adjusted per capita payments should be the same as the Health Plan per capita contributions under New Medicare. New beneficiaries would not undergo a transition and would immediately be reimbursed at New Medicare Health Plan rates.

While managed care growth has been remarkably strong in some communities (like Minneapolis and Portland) where Medicare capitation rates are below average (Chart 7), the current system for Medicare reimbursement has created a pattern of payments that is inherently unfair to the most economical health care markets and rural areas. These inequities should be corrected during the course of overall reform. A possible formula for effecting this correction over a few years would be to offer lower rates of New Medicare per capita payment growth in above-average regions and higher rates in below-average regions while holding to a 5% aggregate rate of payment growth for the country. The following formula coincides with the FEHB experience with premium differences in a competitive environment without resorting to elaborate calculations of differences in cost-of-living and factor costs by region.

Medicare Regional per Capita Costs	Risk Adjusted Rate of Payment Increase
> 110%	3%
110% - 105%	4%
105% - 95%	5%
95% - 90%	6%
< 90%	7%

The New Medicare Baseline curve in Chart 6 shows the combined effect of this transitional policy. We did not assume any deviation from CBO's baseline for traditional Medicare, as experience has shown that there is little long-term savings from making the changes typical of past years. For this analysis, this testimony contains no recommendations on how to deal with such important topics as medical education and clinical research, which will be major topics for consideration at the Jackson Hole Group's August discussions.

Step 2: Encourage Medicare Health Plan Enrollment. In order to encourage Medicare beneficiaries to join a Health Plan, Plans should offer a more comprehensive benefits package. The benefits would be similar to the HMO benefit package, including prescription drugs and reduced deductibles and coinsurance, which should eliminate the need for additional Medigap coverage and the confusion over who should pay doctor and hospital bills. Among the Health Plan offerings, POS and P.P.O. options should be allowed.

Step 3: Ensure Competition on Quality of Care as Well as Price. Open enrollment periods should be established to ensure that each individual beneficiary has a choice among all participating Plans, including traditional Medicare. Seniors should be given information on Health Plan quality performance to facilitate informed decision making. Initial information should include beneficiary satisfaction data and ultimately the impact of various Health Plans on treatment results, function and well-being. The private sector is increasingly focused on quality and outcomes of care issues, so the same quality assurance systems that are employed by the private sector can be used by government (Chart 8). Very good progress was made in integrating public and private demands for Health Plan quality accountability at a recent meeting sponsored by the Jackson Hole Group for purchasers and consumers.

Step 4: Invest in Beneficiary Education. Any restructuring of the Medicare program will fail unless the public, and especially seniors, are convinced of the benefits of a more rational, efficient, high quality health care system structured around competitive Health Plan choice. The federal government therefore needs to educate and promote the New Medicare choices available to seniors through the years.

For the past 25 years, I have observed in HCFA and among some traditional indemnity

insurors a reluctance to shift beneficiaries to the managed care side of the house. This is an especially serious problem for HCFA when no powerful outside purchaser is pushing for Health Plan choices. The reluctance of HCFA managers to undermine traditional Medicare – their own insurance company – is sufficiently persistent that Congress should consider administratively separating the old "health care selling administration" from the New Medicare "health care buying administration."

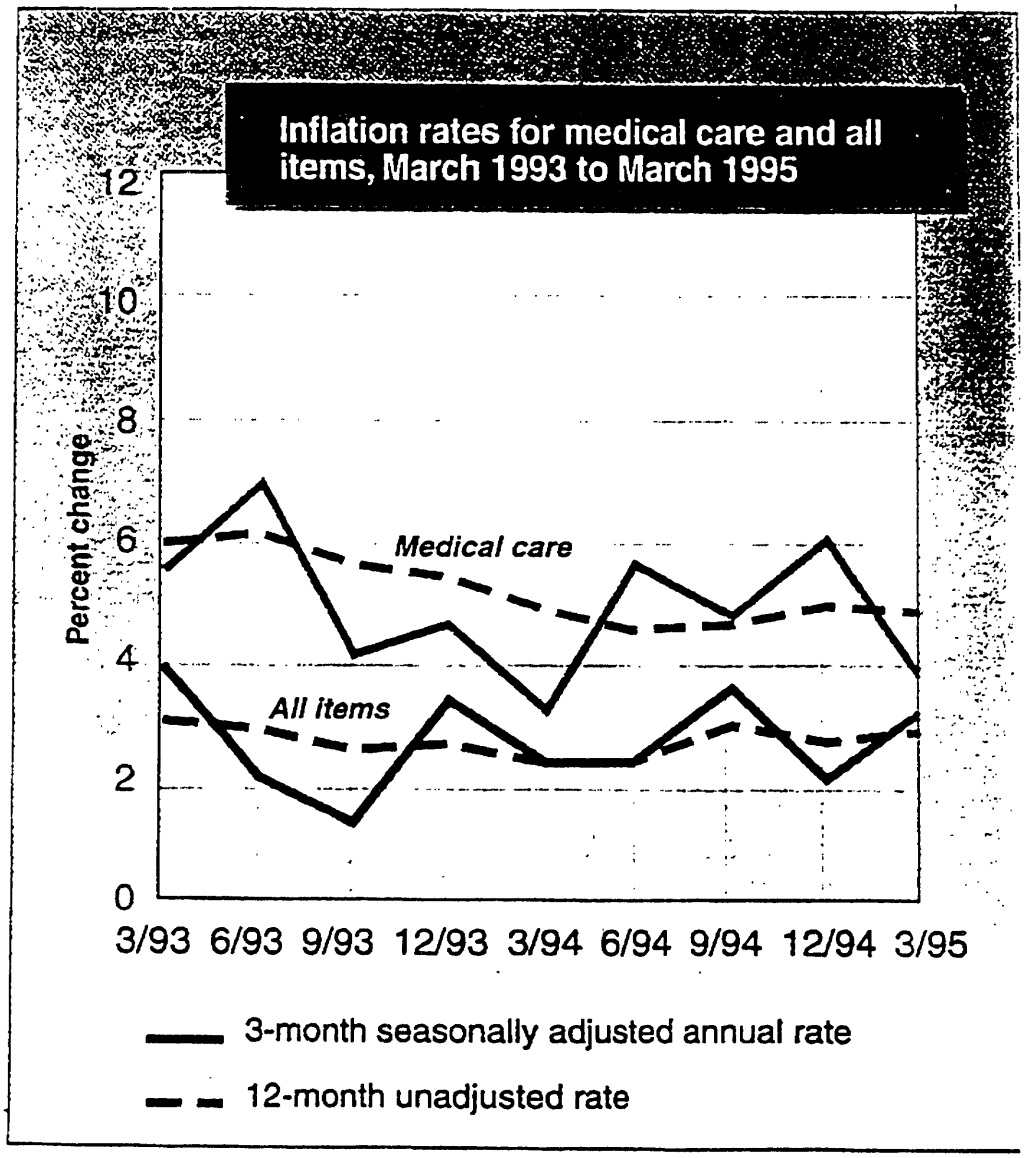
Private sector groups, especially organizations that have traditionally served seniors, should be allowed to function as benefits managers to strengthen the leverage of Medicare recipients, to provide comparative information on Health Plan choices, and to conduct beneficiary education.

Step 5: Move to Specified Annual Per Capita Government Contributions Based on Competitive Market Rates. We estimate that Medicare Health Plan per capita costs in 1999 would be, on average, $1290 less than the cost per traditional Medicare beneficiary (see page 1 of the Spreadsheet) if old Medicare follows the CBO baseline. Since Health Plan market penetration should then be sufficiently high that Plans will be familiar to and acceptable to most seniors, traditional Medicare payments from the year 2000 should be based on the New Medicare Health Plan rates. Sometime after the year 2000, the government's contribution per beneficiary could be based on market rates through a bidding process, rather than through government limits. This decision can be deferred until we are assured costs are contained by competition and become more skillful in scoring the elasticity of demand. The hypothetical effect of this change to government reimbursement based on competitive bidding is shown in Chart # 6. If desired, a market-based government contribution could be adopted earlier in those high cost Medicare areas where managed care penetration is likely to be highest.

Even after the year 2000, when defined contribution rates apply to all, seniors would continue to have the option of traditional Medicare, but would be responsible for paying any amount in excess of the government's contribution. Similarly, if some private Plans found it necessary to charge more to deliver the more generous HMO benefits package, they would be free to do so, but the beneficiary would again pay any difference in premium cost. Conversely, any Health Plan able to provide the covered benefits for less than the government payment could rebate the difference to the beneficiary unless the government chooses to base its premium contribution on the lower-priced plans.

Our analysis shows that, by increasing choice of private Health Plan options, initially controlling the rate of Medicare Health Plan payment growth, but ultimately moving the whole program – traditional Medicare and New Medicare – to a government contribution in 2000 based on Health Plan premiums, Medicare can save approximately $272 billion by 2002 and $671 billion by 2005, without going through the political trauma of trying to change drastically, and perhaps ineffectually, the course of traditional Medicare. The annual savings under New Medicare over time will exceed those of a program designed to lower the rate of total Medicare cost growth from nine percent to six percent immediately, as shown in the 6% Program Cap reference curve in Chart # 6. With the adoption of market-determined premium contributions in the year 2000, we estimate potential savings as great as $285 billion by 2002 and $748 billion by 2005.

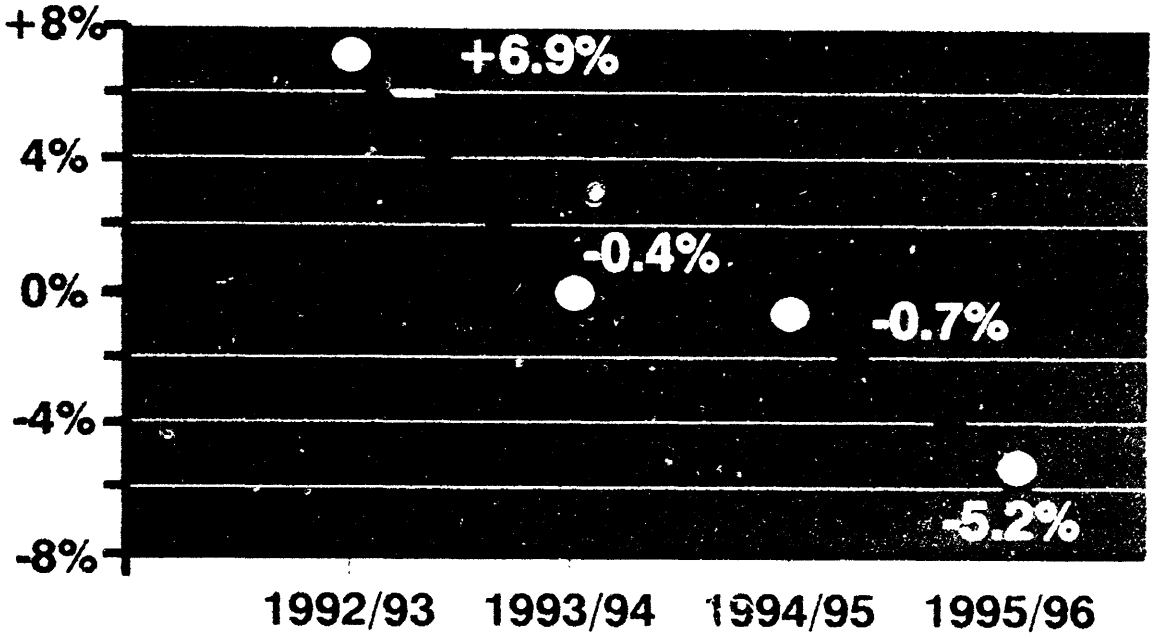
CHART 1



Source: Bureau of Labor Statistics, 1995

CalPERS HMO PREMIUM RATE INCREASES/DECREASES

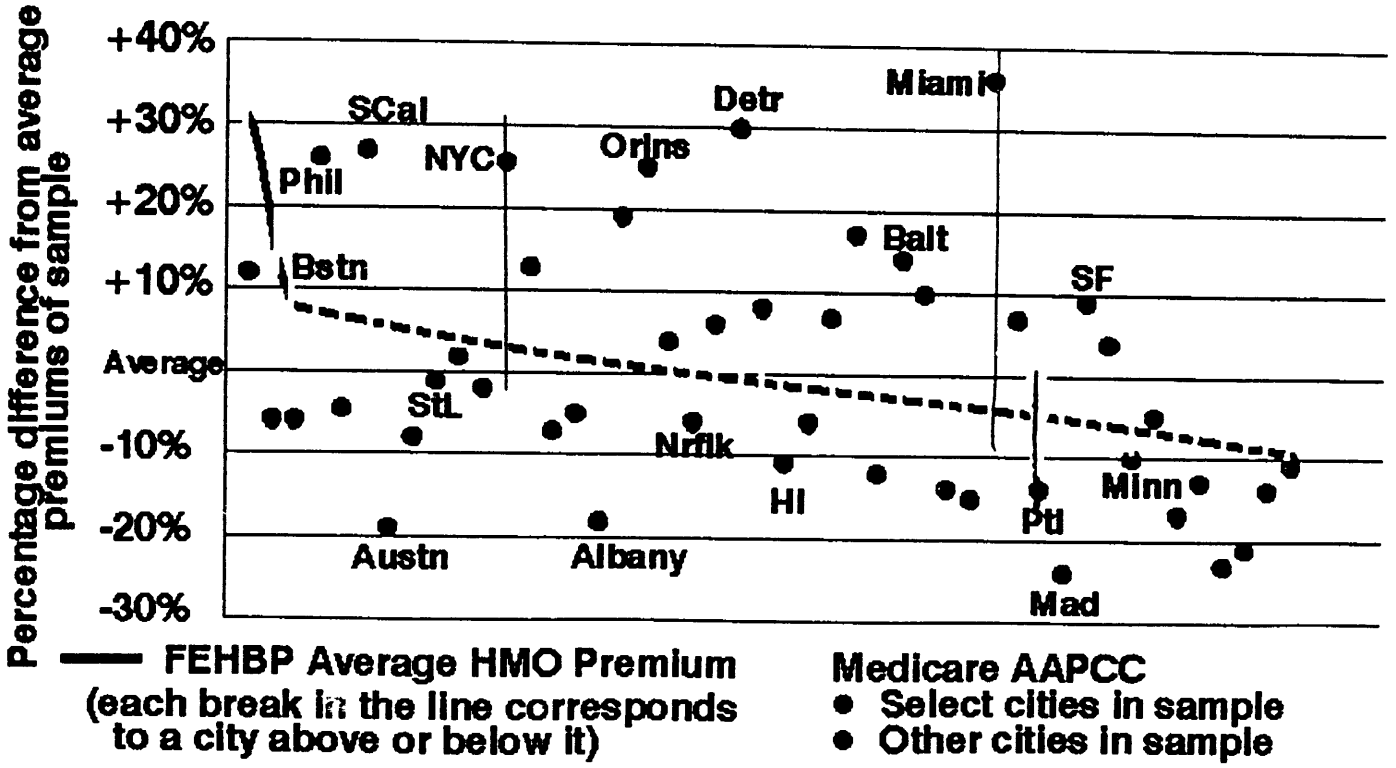
Basic Plans



JACKSON HOLE GROUP 1995

CHART 2

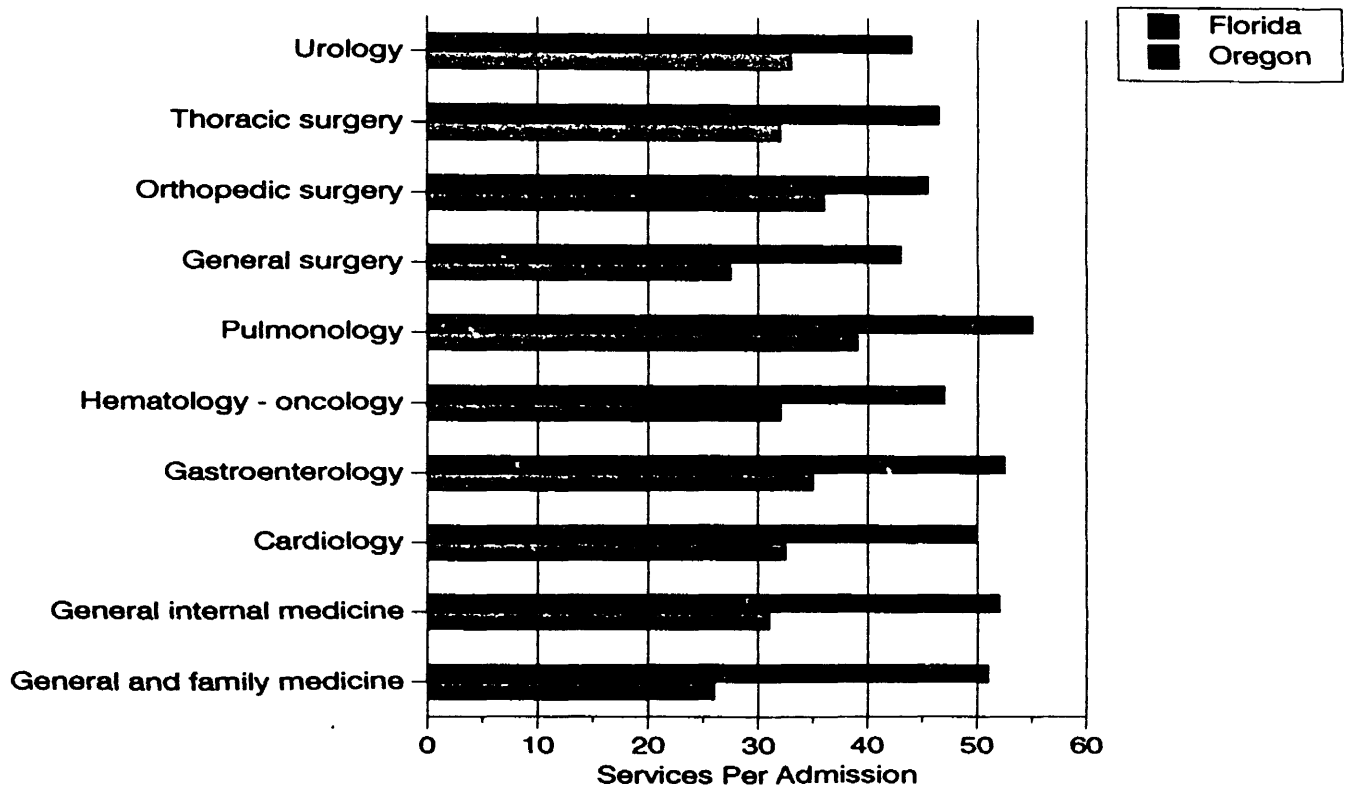
Comparative Geographic Variation In AAPCC And FEHBP HMO Premiums, Forty-Six-City Sample In Decending Order Of Average HMO Premium



Source: Modified from Stuart G. Schmid, *Health Affairs*, Spring 1995

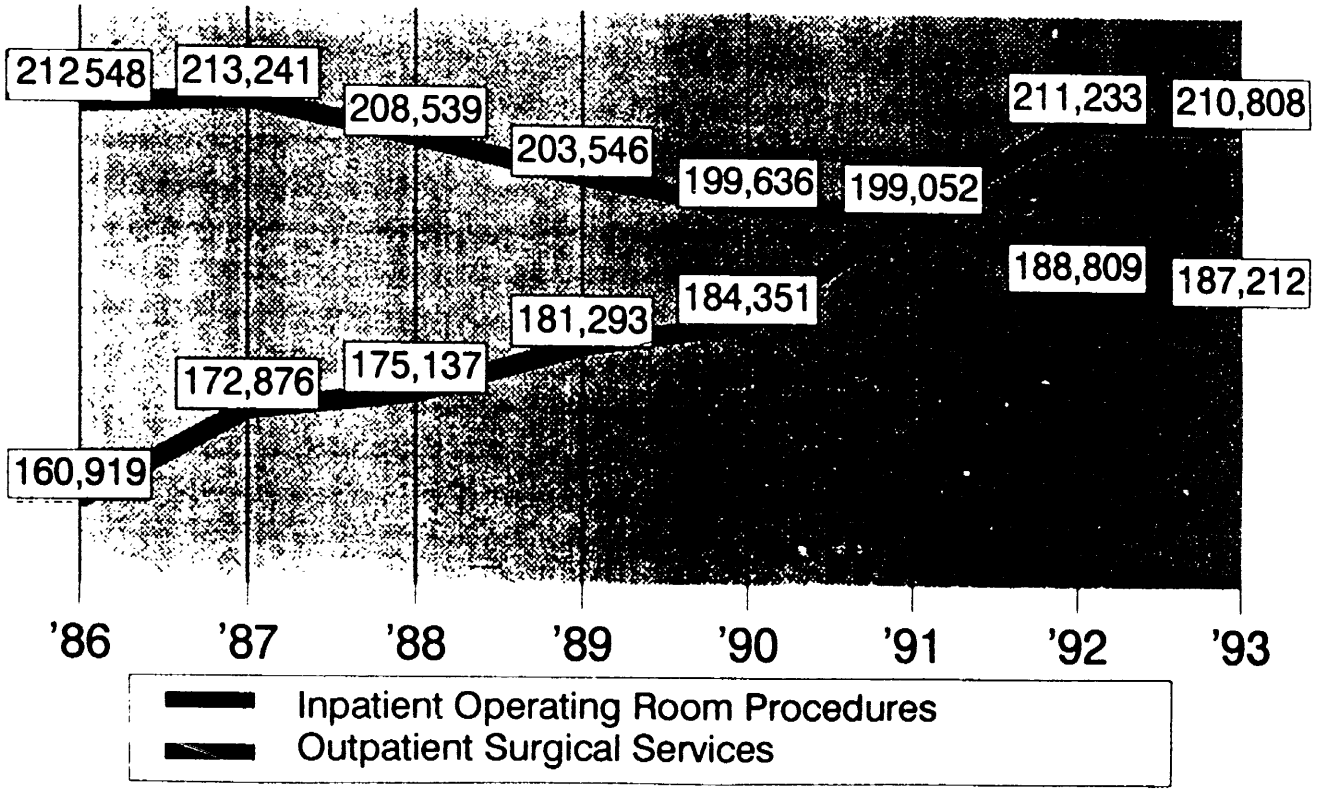
CHART 3

Case-Mix-Adjusted Number of Services per Admission, According to Medical Specialty



Source: New England Journal of Medicine

Surge in Minnesota Outpatient Surgery



Source: Minnesota Department of Health

CHART 5

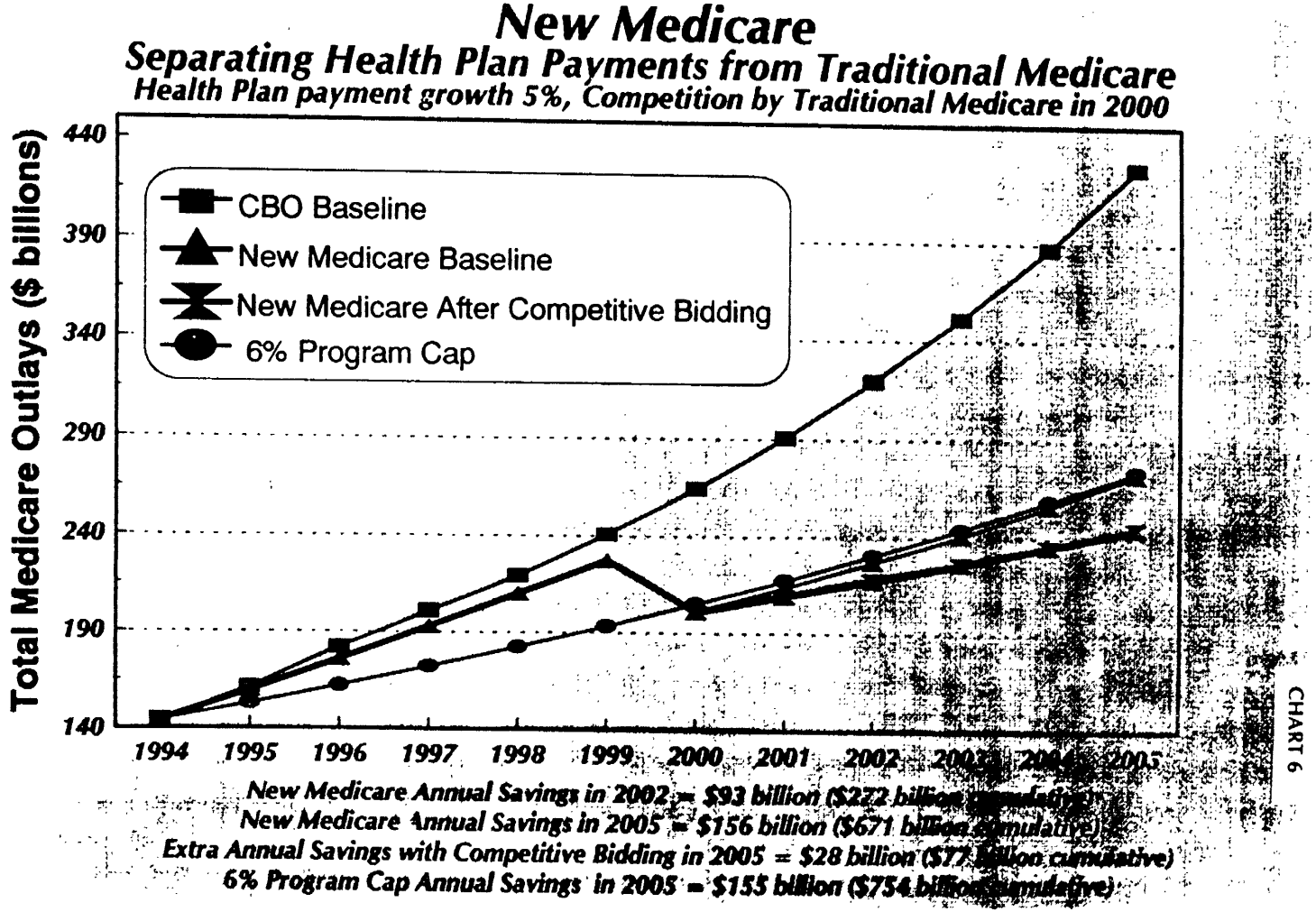

New Medicare
Separating Health Plan Payments from Traditional Medicare
Health Plan payment growth 5%, Competition by Traditional Medicare in 2000
Total Medicare Outlays ($ billions)
440
390
340
290
240
190
140
CBO Baseline
New Medicare Baseline
New Medicare After Competitive Bidding
6% Program Cap
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
New Medicare Annual Savings in 2002 = $93 billion ($272 billion cumulative)
New Medicare Annual Savings in 2005 = $156 billion ($671 billion cumulative)
Extra Annual Savings with Competitive Bidding in 2005 = $28 billion ($77 billion cumulative)
6% Program Cap Annual Savings in 2005 = $155 billion ($754 billion cumulative)

CHART 6

Higher AAPCCs Do Not Mean Increased Market Penetration

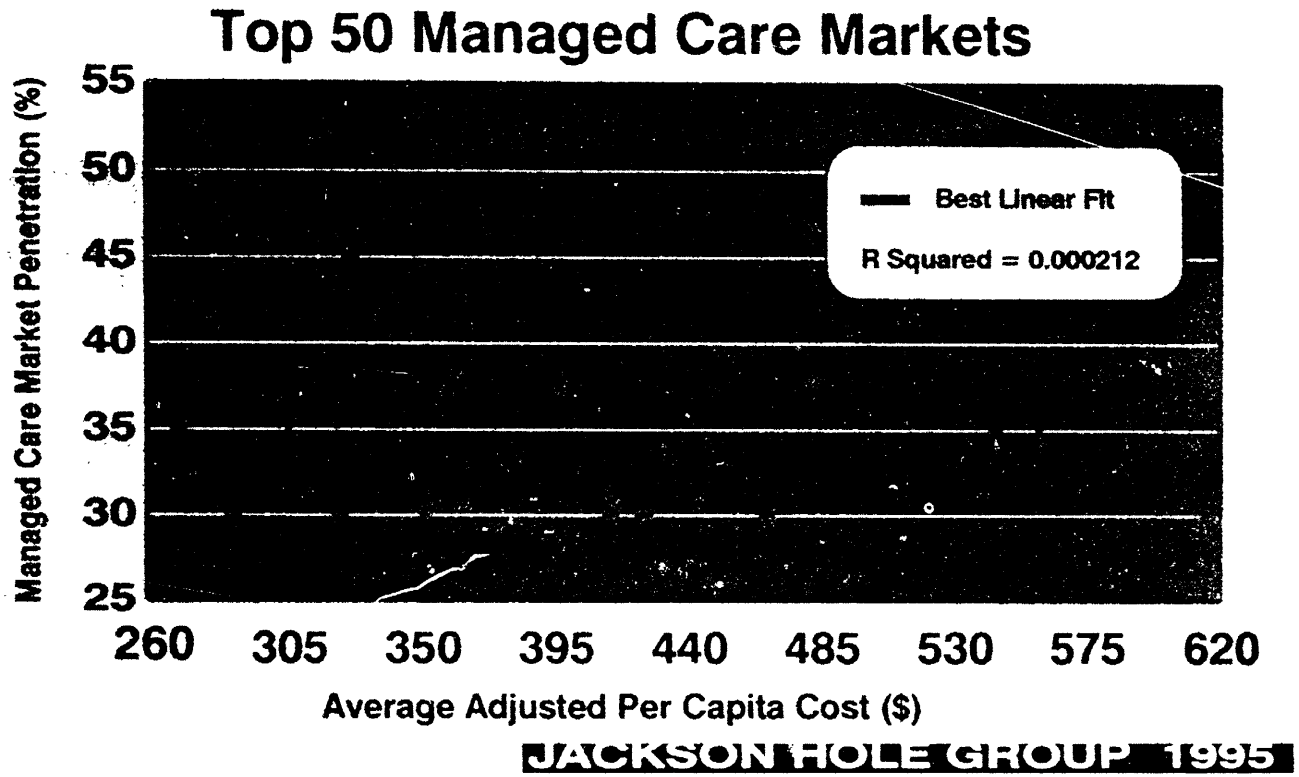


CHART 7

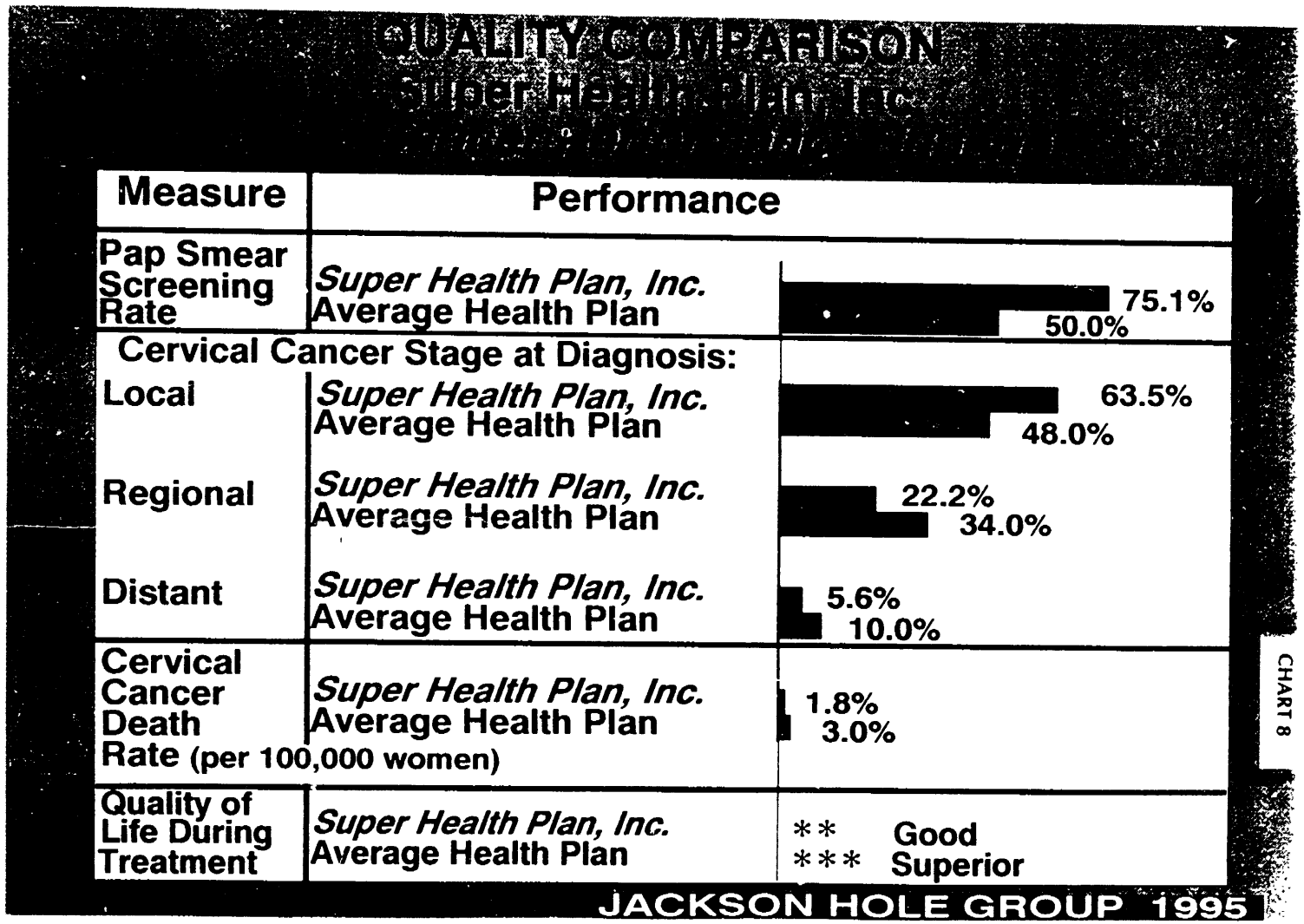

QUALITY COMPARISON
Super Health Plan, Inc.
Measure
Performance
Pap Smear Screening Rate
Super Health Plan, Inc.
Average Health Plan
75.1%
50.0%
Cervical Cancer Stage at Diagnosis:
Local
Super Health Plan, Inc.
Average Health Plan
63.5%
48.0%
Regional
Super Health Plan, Inc.
Average Health Plan
22.2%
34.0%
Distant
Super Health Plan, Inc.
Average Health Plan
5.6%
10.0%
Cervical Cancer Death Rate (per 100,000 women)
Super Health Plan, Inc.
Average Health Plan
1.8%
3.0%
Quality of Life During Treatment
Super Health Plan, Inc.
Average Health Plan
** Good
*** Superior
JACKSON HOLE GROUP 1995

CHART 8

Assumptions Made in Calculating Medicare Spending Projections

- HMO payment growth 5% per annum from 1995.
- Fee for Service per capita costs increase 9% annually until 2000, then same as HMO payment from 2000.
- Annual HMO enrollment growth assumed 34% annually till 1999 then tapers off.
- Competitive bidding commences in 2000 and achieves 4% annual growth from 2000 but this effect is shown separately.
- The effect of increased beneficiaries are shown in all calculations except 6% Medicare program growth cap line.

Assumptions Made in Calculating Deficit Reduction Graph

- All savings from Medicare and Medicaid are used to reduce the deficit.
- Medicaid total Federal Outlays are capped to 5% annual growth.
- The interest rate for government debt is 5.6% which is a six year (1995-2000) average interest rate based on the ratio of net interest projected by the Entitlement Commission to public debt projected by the CBO.

Sources

CBO Baseline: CBO, March 1995 (includes discretionary outlays and premium receipts).

Total Medicare Beneficiaries: Office of the Actuary, HCFA, March 1995.

1994 HMO Beneficiaries: GAO , February 1995.

GDP Projections: Extracted from: 1994 Social Security Trustee's Annual Report by Senate Budget Committee Staff.

Public Debt: The Economic and Budget Outlook: Fiscal Years 1996-2000. CBO, January 1995.

% GDP for Medicaid, Social Security, Discretionary Spending and Interest: Bipartisan Commission on Entitlement and Tax Reform.

Separating HMO Payment Rates from Fee for Service in Medicare

Year	CBO Baseline ($ Billions)	Total Beneficiaries (millions)	HMO Beneficiaries (millions)*	Traditional Medicare Beneficiaries	HMO Beneficiaries per capita cost ($K)**	Traditional Medicare per capita cost ($K)***	Total HMO Outlays ($ Billions)
1994	144.5	36.89	2.34	34.55	3.73	3.93	8.73
1995	161.1	37.53	3.14	34.39	3.92	4.28	12.28
1996	181.9	38.13	4.20	33.93	4.11	4.67	17.28
1997	200.7	38.73	5.63	33.10	4.32	5.09	24.31
1998	219.4	39.26	7.54	31.72	4.53	5.55	34.21
1999	241.0	39.74	10.11	29.63	4.76	6.05	48.13
2000	264.6	40.23	13.14	27.09	5.00	5.00	65.69
2001	290.6	40.71	16.43	24.28	5.25	5.25	86.22
2002	319.4	41.16	19.71	21.45	5.51	5.51	108.64
2003	351.7	41.64	22.67	18.97	5.79	5.79	131.19
2004	387.9	42.16	24.94	17.22	6.08	6.08	151.52
2005	428.8	42.69	27.43	15.26	6.38	6.38	175.00

Assumptions:

* Enrollment growth assumed 34% through year 1999, then 30%, 25%, 20%, 15% each succeeding year to a constant of 10% growth per year in 2004 and beyond.
** 5% annual increase
*** 9% annual increase, then fixed to managed care costs from 2000

Traditional Medicare per capita costs become linked to New Medicare Health Plan costs in 2000.
Competitive bidding commences in 2000 and achieves 4% annual increase in per capita costs.

Sources:

CBO Baseline–CBO, March 1995 (includes discretionary outlays and premium receipts)
Total Medicare beneficiaries–Office of the Actuary, HCFA, March 1995
1994 HMO beneficiares–GAO, February 1995

Year	Traditional Medicare Outlays ($ Billions)	Total Program Outlays ($ Billions)	Annual Savings CBO vs. New Payment Method ($ Billions)	Cumulative Savings CBO vs. New Payment Method ($ Billions)	6% Program Cap Outlays ($ Billions)
1994	135.78	144.51	0.00	0.00	144.5
1995	147.34	159.62	1.48	1.48	153.17
1996	158.42	175.70	6.20	7.69	162.36
1997	168.46	192.77	7.93	15.62	172.10
1998	175.94	210.15	9.25	24.87	182.43
1999	179.17	227.30	13.70	38.57	193.37
2000	135.40	201.09	63.51	102.08	204.98
2001	127.44	213.67	76.93	179.01	217.27
2002	118.19	226.83	92.57	271.58	230.31
2003	109.76	240.95	110.75	382.34	244.13
2004	104.64	256.15	131.75	514.08	258.78
2005	97.34	272.34	156.46	670.54	274.30

Year	Annual Savings CBO vs. 6% Program Cap ($ Billions)	Cumulative Savings CBO vs. 6% Program Cap ($ Billions)	Total Outlays with Competitive Bidding? ($ Billions)	Extra Annual Savings with Competitive Bidding? ($ Billions)
1994	0.00	0.00		
1995	7.93	7.93		
1996	19.54	27.47		
1997	28.60	56.07		
1998	36.97	93.04		
1999	47.63	140.67		
2000	59.62	200.29	201.09	0.00
2001	73.33	273.62	209.14	4.53
2002	89.09	362.70	217.50	9.33
2003	107.57	470.28	226.20	14.75
2004	129.12	599.40	235.25	20.91
2005	154.50	753.89	244.66	27.68

Statement of Lynn Etheredge
for the
Senate Finance Committee
July 25, 1995

Mr. Chairman,

Thank you for the invitation to testify this morning. My name is Lynn Etheredge. I am a health policy consultant now working primarily with foundation-sponsored programs on health insurance reforms, state health policy, and tracking health system changes. I am appearing today as an independent witness. My experience related to the Medicare program includes having served as the director of the OMB health staff under both the Carter and Reagan administrations and, previously, as OMB's lead analyst for the Medicare and Medicaid programs. I have, since then, been involved in a number of policy studies related to the Medicare program, as well as private health insurance, and serve on the Physician Payment Review Commission (PPRC) advisory panel on access to care.

Mr. Chairman, most of the recent policy debate about the Medicare program's future has centered on making available new managed care options for Medicare's enrollees. Proposals include developing "managed competition" arrangements, similar to the Federal Employees Health Benefits (FEHB) program, which will allow Medicare's elderly and disabled enrollees to make an informed choice among a number of privately-managed health plans. I am supportive of these efforts. But my testimony today will focus on another aspect of needed Medicare reform: What can be done to improve the basic Medicare program?

There are several reasons why this Committee might desire to consider options for better management of the basic Medicare program. Most importantly, more than 90% of Medicare's enrollees and expenditures are still in the basic Medicare program. This is where the vast amount of the federal government's expenditures, and the expenditure growth, will occur during the 1995-2002 period. Dealing with the basic Medicare program is thus essential for dealing with the Medicare program's fiscal crisis; it is also through better management of the basic Medicare program that Congress can have the most impact on improving the quality of care and services for Medicare's 37 million elderly and disabled enrollees

Secondly, given the seriousness of the budget situation, it would be a high-stakes risk for Congress to place most of the government's fiscal bets for Medicare savings on persuading Medicare enrollees to leave the basic Medicare program, which is very popular, to join private sector HMO and managed care plans. To date, most voluntary Medicare HMO enrollment has been concentrated in only a handful of states, such as California (42% of Medicare HMO enrollees) and Florida (17% of Medicare HMO enrollees). As of January 1, 1995, 32 states (with 64 Senators) had 1% or fewer of their Medicare populations enrolled in HMOs.

Thirdly, the Medicare program is now far behind the state-of-the-art in health benefits management. When it was enacted 30 years ago, Medicare was patterned on the health insurance models widely used by private employers, in which the primary function of insurance administrators was to pay bills. Today, Medicare remains essentially a bill-paying insurance program, with the addition of national formulas for hospital and physician payment rates.

In nearly every aspect of Medicare's program management -- such as a 3-year long rule-making processes, the volume increases in specific services and geographic areas that are the program's "cost-drivers", quality assurance issues, fraud and abuse, and rapidly rising budget costs (about $175 billion this year alone) -- it is clear that the Medicare program does not now have the tools it needs to deal with the complexity and pace of change in today's health system. Given the constraints under which it now must operate, however, Medicare is about as good a program as it can be.

In contrast, the private sector has moved beyond the traditional bill-paying model. Private-sector payers are no longer simply paying bills but are using a variety of purchasing techniques, in a competitive marketplace, to restrain costs and improve quality and service. Among these purchasing strategies are many forms of selective, competitive contracting; capitation and risk-sharing arrangements; provider performance standards, with incentives, penalties and continuous quality improvement goals; management of high-cost cases; centers of excellence for transplants, heart surgery, cancer care and other treatment; prevention and chronic disease management initiatives; and specialized contracting for pharmaceutical benefits,

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substance abuse, mental health, and other services; and specialized claims-auditing firms to deal with fraud. Employers also increasingly try to hold health plans (and providers) accountable for performance through "report card" initiatives, e.g. the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS).

What I am suggesting, Mr. Chairman, is that the Congress, as part of its consideration of restructuring the Medicare program, also include new national policies and statutory authorities so the Medicare program can incorporate the "best practices" from the private sector into its benefits management.

What would be involved in making available these new statutory authorities, so that Medicare would be more of a state-of-the-art health plan?

• First, Medicare needs a mission philosophy -- established by the Congress, on behalf of Medicare's beneficiaries and taxpayers -- that emphasizes Medicare as a health program. Medicare needs to be accountable not just for accurate bill-payment, but for improving the health of enrollees, by providing preventive health measures and quality medical care.

•Second, Medicare should develop report cards that assess its performance -- and the performance of its health care providers and its contractors -- on a national, state, and areawide basis so that there are objective performance measures of how well they are doing on a wide range of quantifiable quality of care and outcomes, preventive care, consumer satisfaction, and other measures. These report cards should be available to enrollees, as well as to Congress.

The case for initiatives to improve Medicare performance on clinical measures of care has been highlighted by a recent study, by PPRC and RAND, that developed 50-some measures of clinical performance, a number of which are similar to NCQA's HEDIS measures for employer-based plans. The study noted that, in some areas, Medicare performs well, i.e. an "A" grade of 95% or better of professionally developed standards, while other areas, often in preventive or chronic care, the program should receive a "D" or "F", e.g. only 39% of women enrollees received a mammogram during the two-year 1992-1993 period. Medicare falls short of

having already become a "gold standard" of care. Its performance needs to be measured so appropriate corrective actions can be taken by providers, beneficiaries, program administrators, and Congress. A number of thoughtful proposals for a new quality mission for the Medicare program -- based on the private sector's successful experience with continuous quality improvement techniques, as well as outcomes measures -- are discussed in the Institute of Medicine's Medicare: A Strategy for Quality Assurance (1990), a report requested by the Congress.

• Third, Medicare should have new authorities to purchase heath care on the basis of explicit quality and other criteria and competitive performance. Today, the heart of a well-managed health plan's ability to improve quality and assure accountability is its capacity, using report card information and other criteria, to decline to do business with poor performers and to move business toward better performers. In contrast, to be certified as a Medicare provider usually requires little more than state licensure or accreditation by certifying organizations that are provider-dominated. Competitive procurement is a standard business method for assuring good quality, cost, and service, which has also proved useful in health benefits administration; Congress should update the Medicare statute to also make it a available, as needed, for Medicare administrators.

How should Medicare use such new authorities? Given the scale and complexity of the Medicare program, and its many problems, much work will be required to develop an overall management plan for use of such new authorities that will have wide professional and political support. The accompanying paper (*Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser),* discusses a number of specific areas where, in my view, statutory change would be useful to give Medicare new business-like purchasing discretion, such as competitive purchasing for standardized products and services (e.g. durable medical equipment), dealing with fraud, abuse and sub-standard providers, fostering centers of excellence and specialized disease management networks, high-cost case management, and other areas. The paper also identifies a number of research studies that would be useful to Congress, as well as to Medicare administrators, in identifying "best practices" from private sector health benefits management and applying them to the Medicare program.

I do not want this Committee to be misled into thinking that these suggestions are an easy and simple strategy. The scale of the Medicare program is enormous. Medicare's spending last year was $160 billion, financing health services for 37 million elderly and disabled persons. For comparison, General Motors (the largest U.S. corporation) had revenues of $154 billion. In 1994, only 11 U.S. corporations had revenues of $50 billion or more. Similarly, Medicare, while it can appear to be an easy-to-reform program, is not at all uniform in service use or spending, nor is it uniform and gradual in rates of increase by geographic area or type of service. To cite just a few examples: (1) Medicare enrollees' use of hospital care varied by a ratio of 2:1, from 1,735 days/1,000 enrollees in the western states to 3,455 days/1,000 enrollees in the northeastern states in 1992; (2) Over the 1986-1992 period, increases in Medicare part B annual expenditures varied more than 3:1 among states -- from 4-5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada and North Carolina; (3) Rates of nursing home use vary by 6:1 across states; home health use by more than 17:1; (4) While hospital discharges rose by 8.3% for Medicare enrollees from 1988-1992, Medicare reports that discharges for 17 DRGs increased by 20% to 40%, 9 rose by 40% to 60%, and 5 increased by more than 60%. The assumptions of an earlier era, that medical care is science-driven enough that it will not vary much area-to-area; that clinical care patterns change gradually, primarily as a result of the steady advance of scientific knowledge, and that nearly all health care use is "medically necessary" are now all questionable. Earlier this year, GAO officials testified that the Medicare program is now "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers".

Although Medicare management needs to go beyond the limits of price-setting and rule-making, the implementation process can be incremental. Medicare could use these new tools selectively, over the next several years, to deal with major cost and quality issues. I would also see Medicare typically using new purchasing authorities to enter into "preferred provider" arrangements, so that beneficiaries will still have complete freedom of provider choice (although they may face a higher copayment rate if they choose a provider that does not have a preferred arrangement with the Medicare program). Congress should also consider providing an oversight and advisory commission, similar to ProPAC and PPRC, for an initial period of market-

oriented Medicare reforms, including both the FEHB-type choice arrangements and these management initiatives.

In the several weeks since the accompanying paper was released, I have had conversations that suggest that this strategy for reforming the basic Medicare program may be a welcome initiative by groups with varying interests and perspectives. In the context of the current budget situation and the traditional Medicare insurance paradigm, Congress must usually enact across-the-board savings measures that reduce all DRG, RBRVS and AAPCC payment rates, or enact across-the-board savings measures that affect all 37 million beneficiaries, such as higher premiums or copayments. All providers and/or beneficiaries pay a penalty if Medicare does not have the tools to deal effectively and selectively with its specific problems. It seems fairer for Medicare, with new tools, to target unwarranted spending, overuse, fraud and abuse, and high cost areas than to penalize everyone for the behavior of a relatively few providers, explosive growth in some services, or the problems of a few areas.

Medicare beneficiaries could also find appeal in a Congressional commitment to make Medicare a better program, not just to slow its spending growth, and to provide the needed authorities to improve all areas of performance. The suggested reforms include "report cards" for all beneficiaries that assess Medicare's performance on quality of care, health status, consumer satisfaction and other measures - and thus provide a basis for effective initiatives to better serve its enrollees. Coupled with FEHB-type reforms, such report cards can also help inform a beneficiary's choice between staying in the basic Medicare program or choosing a competing plan.

Many Medicare providers - especially those with exemplary quality -- also have concerns that can be addressed through these reforms. Today, Medicare budget-cutting offers providers only across-the-board DRG and RBRVS restraints and the prospect, with only FEHB-model reforms, that providers will increasingly be working for insurance companies. In addition to loss of autonomy to insurer managers, providers also confront the fact that Medicare HMOs frequently take 15% to 20% of premium dollars "off the top" to pay for their administrative expenses, marketing efforts, and profits. (Medicare's administrative expenses are about 2%). As

an illustration, if applied in full to today's $175 billion in Medicare spending, these margins would represent $25-$35 billion annually in management fees to insurers -- and subtractions from provider revenues. To deal with such "middleman" issues, large purchasers (e.g. the Minnesota business health care action group, Minnesota state employees and the state's Medicaid program) and self-managing health care providers are starting to consider "direct contracting" arrangements. As it evolves, a direct contracting model may also prove economical for the Medicare program, as well as attractive to many providers.

Finally, lower-expenditure states -- which are often rural states -- can also be protected against arbitrary DRG, RBRVS, and AAPCC cutbacks to pay for excesses in other areas. State governments may also find it useful to pursue new "joint contracting" of the Medicare and Medicaid programs for dual eligible populations, which would be possible with Medicare purchasing flexibility. (States could become the "purchasing agents" in such a relationship.) Such arrangements may be particularly useful in helping to build well-functioning systems of care for disabled populations and for integrating the separate Medicare/Medicaid long term care spending streams into a long-term care system for the elderly.

In summary, Mr. Chairman, my suggestion is that the Committee consider a "two track" Medicare reform strategy this year -- combining: (1) new statutory authorities for the basic Medicare program, such as those described above, with (2) an FEHB-type arrangement for selection of private plans. If this approach were adopted, Medicare-eligible individuals would be able to enroll either in a modernized Medicare program that is working hard to provide the best economy, quality, and services or in competing private-sector health plans. One might expect that both taxpayers and Medicare-eligible persons would benefit by such competition.

Research Agenda Brief

June 1995

Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser

Prepared by

Lynn Etheredge
Consultant

Prepared for the Health Insurance Reform Project, George Washington University, with funding from the Robert Wood Johnson Foundation

Reengineering... is the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical contemporary measures of performance, such as cost, quality, [and] service.

—Michael Hammer and James Champy,
Reengineering the Corporation

At the time of its enactment 30 years ago, Medicare was patterned on the health insurance models widely used by private employers and insurers for the under-65 population. In this model, the primary administrative function of insurance companies and of the Medicare program was simply to pay bills. Today, Medicare remains essentially a bill-paying insurance program, with the addition of national formulas for hospital and physician payment rates.

In recent years, the private sector has moved beyond this traditional insurance model. Private-sector payers are no longer simply paying bills but are using a variety of evolving *purchasing* techniques, in a competitive marketplace, to restrain costs and improve quality and service. Among these purchasing strategies are many forms of selective, competitive contracting; capitation and risk-sharing arrangements; provider performance standards, with incentives, penalties, and continuous quality improvement goals; management of high-cost cases; centers of excellence for transplants, heart surgery, cancer care, and other treatment; prevention and chronic disease management initiatives; consumer information and incentives; specialized contracting for pharmaceutical benefits, substance abuse, mental health, and other services; and specialized claims-auditing firms to deal with fraud. Individuals with benefits offered by large employers—including, through the Federal Employees Health Benefits Program (FEHBP), the nation's political leaders and federal workers—are usually able to make choices among a number of health plans on the basis of provider networks, cost, quality, service performance, and other features.

In this new purchasing environment, private-sector employers and consumers are increasingly able to make informed choices—to hold providers (and the plans that contract with them) *accountable*—through the use of tools such as the National Committee on Quality Assurance's (NCQA's) "report cards," which are based on the Health Plan Employer Data and Information Set (HEDIS), and other quality measures, such as health outcomes. The HEDIS data set includes more than 60 quality, service access, patient satisfaction, outcomes, and other performance measures, including preventive care (such as immunizations, mammography screening, and eye exams for diabetics) and signal indicators for poor quality (such as inpatient admissions for asthma and treatment following heart attacks).

In the current political climate, there is great interest in the federal government's making available to the Medicare population a broader choice of competing private health plans that use such purchasing technologies. Today, health maintenance organizations (HMOs) and other private plans enroll only about 10% of the Medicare population. Among the many measures that could open up more plan options are an FEHBP-type "managed competition" approach that would allow Medicare beneficiaries to make informed choices among a wide range of HMO, preferred provider organization (PPO), Medicare Select, medigap, and other plans during an annual open season. Other options being discussed involve workers staying with employer/association plans after turning age 65 or some use of medical IRA accounts and catastrophic coverage. Much of the attention in Congress now centers on the policy questions involved in structuring new options for Medicare enrollees.

As a complete reform strategy, such options would fall short. They do not reform the basic Medicare program. Over 90% of Medicare's spending is through the fee-for-service model. As of January 1, 1995, 19 states had no Medicare HMO enrollees and 32 states had 1% or fewer of their Medicare-eligible populations

enrolled in HMOs. A handful of states—including California (42% of Medicare HMO enrollees) and Florida (17% of Medicare HMO enrollees)—accounted for most of the Medicare HMO membership.[1] Even with an FEHBP-type arrangement and optimistic growth assumptions about private plan enrollments, many factors make it likely that most Medicare eligibles in most states will still be in the program for the rest of the decade and beyond.[2] In its traditional bill-paying mode, the Medicare program has very few tools for dealing with the volume, intensity, and quality issues that are its major cost-drivers. Thus, devising a strategy for fundamental reform of the basic Medicare program—"reengineering" Medicare—is essential not only to deal with budget issues but also to achieve improvements for the 37 million people who depend on the program.

What should be done about the basic Medicare program? What would be in the best interest of its 37 million elderly and disabled enrollees?

This paper considers the question of whether Congress should give Medicare the same types of authorities that are available to its private-sector competitors—particularly authorities to use new purchasing techniques—and require performance accountabilities for their use through HEDIS-like quality and health outcomes measures. Should not the nation's elderly and disabled, as well as taxpayers, ask for and expect a state-of-the-art Medicare program? If this approach were adopted, Medicare-eligible individuals would be able to enroll either in a Medicare program that is working hard to provide the best economy, quality, and services or in competing private-sector health plans that are paid equivalent (risk-adjusted) capitation amounts. One might expect that, over the long term, both taxpayers and Medicare-eligible persons would benefit by such competition.

At the most general level, reforming the Medicare program in this way would start with three fundamental changes:

- *A revised mission philosophy that emphasizes Medicare as a* health *plan.* Most importantly, Medicare would need to become accountable, not just for insurance to pay bills and protect financial assets, but for improving the health of its enrollees, by providing preventive health measures and quality medical care.[3]
- *The adoption of "report cards" that assess Medicare's performance on the basis of cost, quality, outcomes, and service so that it can be held* accountable *by enrollees and policymakers.* These measures need to reflect a wide range of criteria, including preventive care, quality of care, consumer satisfaction, and health outcomes, and should also apply to competing private health plans. Report cards should show national, state-level, and market-area performance.

The measures that could be used by a reformulated Medicare can be illustrated by comparing current official data reports with new health-related data that could be a basis for the above-described report cards. The most extensive public accounting for Medicare's operations is the *Medicare and Medicaid Statistical Supplement* published in February 1995.[4] Its more than 370 pages are filled with statistics that emphasize financial, workload, and claims-paid data, such as hospital days of care and expenditures, that are appropriate to a traditional health insurance program. Nowhere are there measures of quality of care and improved health status or reports on enrollee satisfaction.

Two recent studies highlight the kinds of health-related measures that might be used to assess Medicare's future performance as an accountable health plan. The Physician Payment Review Commission (PPRC) and the RAND Corporation have recently developed a set of approximately 50 quality measures that can be implemented, using claims data, for the current Medicare program. Several measures, which have been run against Medicare's national claims data, are shown below in Table 1. A number of them are similar to the

NCQA's HEDIS measures used for private-sector health plans. In the view of the physician consensus panels developing the measures, these are "necessary care" indicators; that is, professionally acceptable practice should be near 100% compliance.

TABLE 1

Clinically Based Indicators of Quality of Care for the Elderly
Medicare Claims Data, 1992 and 1993

Breast Cancer	
For patients with breast cancer, interval from biopsy to surgery less than 3 months	64%
Mammography every year for patients with a history of breast cancer	61%
Mammography every 2 years in female patients	39%
Diabetes	
Eye exam every year for patients with diabetes	38%
Heart Problems	
Visit within 4 weeks following discharge for patients hospitalized with MI	84%
EKG during ER visit for unstable angina	81%
Mental Diagnosis	
Visit within 2 weeks following discharge of patients hospitalized for depression	95%

The PPRC-RAND study shows several quality indicators on which the care received by Medicare elderly patients merits an "A" (95%+) on a nationwide basis. But it also highlights a number of prevention indicators, such as mammography and eye exams for diabetics, for which there should be failing grades, "D" or "F," as well as many indicators in the 60% to 85% range where care falls well below professional standards. The study also highlights particular problems for minority populations and for rural and underserved areas.[5]

Another recent study, by Lewin-VHI for the National Institute for Health Care Management, analyzed Medicare hospitalization rates for three diagnoses that are sensitive to good ambulatory care and preventive measures. For 1992, the study reported Medicare hospitalization rates for asthma to vary by more than 3:1 among states, hospitalization rates for diabetes by more than 5:1, and hospitalization rates for hypertension by more than 8:1. Even after statistical adjustments for demographic characteristics, several-fold variations still remained.[6]

Given such statistics, any presumption that Medicare has already become the "gold standard" of quality care and that it is up to its competitors to prove their superiority should be put aside. Medicare's performance needs to be measured and accountable on the same basis as its competitor plans, so its enrollees can make informed choices.

The third fundamental change that would need to occur for Medicare to become more like a state-of-the-art accountable health plan is the following:

- *Medicare should have new authorities to purchase health care on the basis of explicit quality and other criteria and competitive performance.* Within the many statutory constraints Medicare has to operate under as a government program, it has generally been run effectively, efficiently, and with continuing improvement and innovation. Given its constraints, Medicare is now about as good a program as it can be. But, in nearly every area—such as three-year-long rule-making processes, volume increases and quality assurance issues, fraud and abuse, and rapidly rising budget costs—it is clear that Medicare cannot deal as effectively as it

needs to with the complexity and pace of change in today's health system, nor can it hold physicians, hospitals, and other providers accountable for improving their performance. To improve Medicare's performance, Congress needs to provide authority to move beyond the limits of regulatory rulemaking and price-setting so that Medicare can adopt the same types of successful purchasing techniques pioneered by private-sector payers. Such evolution could build incrementally through many Health Care Financing Administration (HCFA) initiatives, but, if fully reengineered, the Medicare program would be quite different a decade hence. Such changes will require a new bipartisan political consensus.

The next section elaborates on management challenges for the Medicare program's future if it is to be an effective health care purchaser. Following that is a discussion of specific legislative changes needed to allow Medicare to be an effective purchaser and competitive health plan. A third section sketches a research agenda for developing a Medicare management strategy to use these new statutory authorities. A final section discusses issues related to competition between a reengineered Medicare program and competing private-sector health plans.

THE CHALLENGE OF MEDICARE MANAGEMENT

For the federal government, serious efforts to manage Medicare as an accountable health plan would be among the most enormous and complex tasks it has ever undertaken. To put the task on the scale of private-sector enterprises, the Medicare program, with $160 billion of spending in 1994, has passed General Motors—with $154 billion in revenues, the nation's largest private company—to become the nation's largest business-type operation.[7] In 1994, only three privately managed U.S. corporations (General Motors, Ford, and Exxon) had more than $100 billion in revenues, 11 had $50 billion or more in revenues, and 110 had $10 billion or more in revenues. Today, 37 million persons depend on the Medicare program. Within 30 years, as the baby boom generation retires, Medicare will be purchasing health care for about 70 million persons, and its annual spending will be many times greater than it is today.

An understanding of the challenges of charting Medicare's future begins with an understanding of the scale involved. Nevertheless, there is a widespread misperception about the Medicare program that must be dealt with to understand just how difficult it will be to manage the program. That is the myth of uniformity, predictability, and gradual change.

Medicare can seem to be a deceptively simple and easy-to-reform program. Its enrollments, financing, and benefits are defined in statute. It has a centralized administrative structure (DHHS/HCFA); a uniform set of regulations; payment rates for hospitals, physicians, and other services that are specified by national formulas; and a national quality assurance/peer review structure, the Professional Review Organization (PRO) system. Individuals who are not health services researchers also tend to presume that health care is enough of a science that area-to-area rates of service use will be roughly uniform and that clinical practices change gradually, primarily as a result of the steady accumulation of scientific data. A misperception that the health care system is evolving in gradual, uniform ways is also reinforced by national health expenditure and Medicare actuarial data that aggregate a vast number of complex changes and variations into single categories such as "intensity."

The following selection of data illustrates how far assumptions of uniformity and steady change are from the Medicare program's reality.

- *Hospital use.* Even on a regional basis, Medicare enrollees' use of hospital care varies by a ratio of 2:1—from 1,735 days/1,000 enrollees in the western states to 3,455 days/1,000 enrollees in the northeastern states in 1992. As they have for years, hospital

lengths of stay continue to average about 50% longer in the northeastern states (10.4 days) than for the western states (6.7 days).[8]

- *Rates of change in hospital use by diagnosis-related groupings (DRGs).* In the 1988-1992 period, hospital discharges for Medicare enrollees rose by 8.3%. Of the 65 leading DRGs, however, only 12 had increases between 0% and 20%. Seventeen DRGs had increases of 20% to 40%, 9 rose by 40% to 60%, and 5 increased by more than 60% in the four-year period. The most rapid increases were reported for DRG 88 (chronic obstructive pulmonary disease), 219%; DRG 462 (rehabilitation), 103%; and DRG 214 (back and neck procedures with complications and/or comorbidities), 75%. Discharges declined for 22 DRGs. Eleven DRGs had declines of between 0% and 20%; 8 declines were in the 20% to 40% range; 3 declined by over 40%. The DRGs that decreased most were DRG 90 (simple pneumonia and pleurisy) and DRG 96 (bronchitis and asthma with complications and/or comorbidities), which had declines of 52% and 58%, respectively.[9]
- *Nursing home use.* Rates of nursing home use varied by 6:1 across states. Minnesota residents used 1,364 days/1,000 enrollees, Connecticut residents 1,235 days/1,000 enrollees, and Indiana residents 1,067 days/1,000 enrollees in 1992. Among the low-use states were Maine (248 days/1,000 enrollees), Oklahoma (326 days/1,000 enrollees), and New Hampshire (327 days/1,000 enrollees).[10]
- *Home health use.* The rate of home health visits per 1,000 enrollees varied by more than 17:1 among states in 1992. The high-use states included Mississippi, with 11,786 visits/1,000 enrollees and Tennessee, with 11,717 visits/1,000 enrollees. At the other end of the range were Hawaii, with 668 visits/1,000 enrollees, and South Dakota, with 969 visits/1,000 enrollees.[11]
- *Growth rate in part B spending.* Over the 1986-1992 period, Medicare part B annual expenditures rose at a national average of 8.8%. Here again, substantial national diversity, rather than uniformity, is the dominant pattern. The rate of increase varied more than 3:1 among states—from 4% to 5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada, and North Carolina.[12]
- *Growth in physician procedures.* Over the 1991-1994 period, the growth rate of Part B services averaged 3.5% annually. Behind these averages, however, were quite different and rapidly changing patterns for different services. Echocardiograms increased at a 19.3% annual rate, angioplasty at 17.1% annually, MRIs at an 11.9% rate, arthroscopy at 9.1%, coronary artery bypass grafts at 8.8%, and joint prostheses at 7.3% per year. Among the declining procedures were transurethral prostate surgery, falling 9.9% annually, and cataract lens replacements, falling 2.3% annually.[13]

A common-sense view might be that high-use areas would probably also be areas of high overuse. This assumption was rigorously tested by RAND researchers using 1981 data for three procedures: carotid endarterectomy, coronary angiography, and upper gastrointestinal tract endoscopy. The rates per 10,000 elderly varied among three sites by 3.8 times for carotid endarterectomy, 2.3 times for angioplasty, and 1.5 times for upper gastrointestinal tract endoscopy. Their findings were that rates of inappropriate use were not much different between low-use and high-use areas. However, rates of inappropriate use for all three procedures were significant, ranging from 17% to 32%.[14]

One might be skeptical about some of the Medicare-reported trends. (Were there really major epidemics of chronic obstructive pulmonary disease and complicated back and neck problems requiring hospitalization of the elderly that escaped the national media attention in 1988-92?) But Medicare has spent a

great deal of effort and money to improve its data systems. To the extent that Medicare's payments do not accurately reflect the services being provided to its beneficiaries, then far more is wrong about provider billings (and Medicare administration) than data errors.

REENGINEERING MEDICARE MANAGEMENT

The only way we're going to deliver on the full promise of reengineering is to start reengineering management.

—James Champy

If Medicare were to be operated in a more business-like way, what important changes should Congress consider making in the Medicare program's authorities? Many government-sponsored activities do have flexibility similar to that found in private-sector businesses; these activities include the Tennessee Valley Authority and other power marketing authorities, the Government National Mortgage Association, and the Federal Reserve Board. But granting Medicare, with $175 billion in purchasing power and 37 million enrollees, a freer rein will need to be done carefully and watched vigilantly.

In general terms, *Medicare needs the authority to select providers based on quantifiable measures of quality, outcomes, and service and to use competitive purchasing.* The heart of a private-sector plan's ability to improve quality and assure accountability is its capacity to decline to do business with poor performers and to move business toward better performers. In contrast, Medicare is the prime remaining example of the traditional insurance "any willing provider" philosophy. To be certified as a Medicare provider usually requires little more than state licensure or accreditation by certifying organizations that are provider-dominated. Congress has created a virtual entitlement for health care providers to participate in Medicare. Competitive procurement is a standard business method for assuring good quality, cost, and service, and it should also be available for Medicare administrators.

Among the areas for possible use of such authorities are:

- *Competitive purchasing of standardized services and supplies,* including durable medical equipment, laboratory testing, radiology, and outpatient surgery
- *Establishment of explicit quality and service performance standards and refusal to do business with providers that do not measure up.* For the welfare of its beneficiaries, Medicare needs to move beyond the minimal participation requirements that are now set in legislation. New standards for providers should include the HEDIS-type "report card" and health outcomes measures for which the Medicare program will be accountable (for example, physicians who fell below certain standards in providing mammography screening for their patients would be dropped from the program).
- *Development and use of centers of excellence and specialized services contracting.* Medicare now uses such concepts in its coverage for transplant services; private-sector plans use selective contracting even more widely for many forms of surgery, cancer care, mental health, and so forth. Major expansions may be possible to develop disease management and preventive services for patients with chronic or high-expense illnesses and for disabled enrollees. Intelligent purchasing by Medicare could call forth better quality, cost, and service competition among providers, to the benefit of Medicare beneficiaries and taxpayers. To preserve Medicare's role in assuring a broad choice of providers, Medicare enrollees might still be able to go to non-preferred providers, but with higher co-payment rates.
- *Use of case management for high-cost patients.* Most private-sector health plans have the flexibility to work with high-cost patients to develop service packages, such as home

care, that can better meet their needs. The Medicare statute does not permit such flexibility, even when it would be in the best interests of the patient and the program. With so many frail elderly and disabled patients, Medicare might be able to make good use of such authorities.

- *Elimination of notice of proposed rule-making process for purchasing.* Like Gulliver tethered by many bonds, the Medicare program's effective use of its purchasing power is held back by numerous technical constraints, some of which are appropriate to a rule-making administrative style but not to a business-type operation. Most important of these is the Notice of Proposed Rule Making requirements that now involve at least a three-year process for major Medicare policy initiatives or changes. Such rule-making is frequently, in essence, simply a statement of contractual terms, that is, what Medicare will and will not pay for, under what terms, and in what circumstances. A private business that had to go through a three-year process any time it wanted to write or revise a contract with its suppliers would probably be in the same financial predicament as the Medicare program.
- *Authorization for Medicare simply to drop providers in the best interests of the program to deal with fraud and abuse.* In recent testimony, a Government Accounting Office (GAO) official noted that the Medicare program is "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers."[15] Among Medicare's many problems are the difficulties of kicking providers out of the program and the limited resources made available by the Department of Justice. A recent GAO study based on studies of claims denial rates for 74 services across 6 carriers noted that one-half of denied claims were submitted by between 2% and 11% of providers.[16] Acting as a business-type purchaser, Medicare would have authority to simply stop doing business with any supplier, at its discretion. In areas of widespread fraud, Medicare might also be allowed to engage private-sector law firms to recover on behalf of the government.
- *Authorization for Medicare to organize and contract for quality assurance at its discretion.* Since 1965, the major initiative to improve Medicare quality has been enactment of the PRO system. It is an expensive program (costing some $325 million in 1994), deals almost exclusively with inpatient hospital care, and has been of questioned effectiveness. The 53 PROs are provider-dominated organizations. Most are physician-sponsored, for example, by local medical societies, and typically have a board of directors composed primarily of physicians and other provider representatives. Medicare Part B services are largely subject to quality review by the claims-paying carriers. As noted in an Institute of Medicine report on Medicare quality improvement, the implementation of a new health-oriented mission for the Medicare program will require far-reaching administrative, contractual, and other changes that include reconsideration of PRO, carrier, and HCFA roles.[17] Would a private-sector purchaser, intent on improving quality of care, want to be constrained to contracting with a medical society or provider-dominated organization?
- *Publicity about data on quality and service.* With the advent of HEDIS and buyers insisting on accountability, provider secrecy about quality problems is being replaced by publicized reporting in the private sector. Statutory change should also allow this approach to be adopted by the Medicare program. Such publicity about where physicians and hospitals stand compared to professional benchmarks and guidelines can be important acts in themselves to encourage better patterns of care and service.
- *Improvement of customer service.* The Medicare program has never had a strong customer orientation. As an adjunct to the Social Security Administration (SSA), it started with representatives in SSA's district offices, but

it lost these community-level staff when HCFA was established. Customer service is an area in which Medicare is at a competitive disadvantage vis-à-vis competing private health plans.

- *Enactment of special authorities for Medicare in the hiring, promotion, and compensation of employees.* There is no activity which is of larger budgetary consequence or greater management challenge for the federal government over the next half century than the Medicare program. Today, Medicare is bound by government-wide civil service procedures, promotion, firing, compensation levels, and personnel ceilings. In business-type operations, such as the Federal Reserve Board, Congress has been willing to make exceptions so that federal activities can be carried out with the required professional expertise. In particular, the Medicare program may need such flexibility if it is to compete with private-sector plans.

Certainly some health care providers—and competing health plans—will question the wisdom of such new Medicare authorities. But why would beneficiaries and taxpayers want to keep Medicare from being as good a program as it can be? If Medicare is expected to compete with private plans for enrollees, why should it not have comparable purchasing flexibility?

A STRATEGIC PLAN FOR MEDICARE MANAGEMENT

If the Medicare program, as an accountable health care purchaser, is to begin to use these authorities to deal with quality, service, and cost issues, where should it start and what should it do? Given the program's scale and complexity, a great deal of work will need to be done to devise an intelligent purchasing strategy before that question can be answered in a way that has wide professional and political support. As a matter of law, Medicare cannot deal with such problems in an arbitrary or capricious manner. Beneficiaries have rights to due process and to judicial review for claims denials. Much of the needed research will be useful for competing private-sector health plans, since these plans will face the same issues and few yet have much special expertise in managing care for the Medicare populations.

Research might help Congress, the executive branch, and other interested parties in the following five basic areas:

- *A national strategy for clinical effectiveness and outcomes studies for the Medicare populations.* This strategy could be built by analyzing the Medicare data to identify procedures with wide variations that seem likely to reflect overuse and underuse or excessive rates of increase and by prioritizing a research agenda by potential payoffs in enrollee health and program costs. It also needs to include recommendations concerning funding for the effort, the appropriate methodologies to assure usefulness, and an ongoing system to automatically evaluate new technologies and clinical practices. The serious shortcomings of much of the published literature on medical treatment, well-known to clinical effectiveness researchers, was highlighted in a recent *New York Times* story of a Canadian assessment of treatment for whiplash injury that found only 62 of 10,382 studies met the evaluators' criteria for solid scientific evidence.[18]
- *Development of HEDIS-type "report card" measures* for quality/health outcomes, consumer satisfaction, and service. These data need to be collected at the state and market-area level, so that HCFA can manage its carrier/PRO contractors accountably and so that enrollees have comparable data to private-sector plans for making their enrollment decisions. These report card measures need to be selected for their validity and reliability and should include information that is important to consumers for making choices among health plans.
- *Studies of "best practices" in all major areas of costs, quality, and service.* Medicare is a vast program that has not been very amenable to

centralized, command-and-control management. Political decision-makers and the Medicare program have rightfully been extremely wary about trying to use government coercion to change medical practices. Perhaps the best way to foster desirable change in a competitive-choice market system is to make sure that patients, providers, and competing health plans are well-informed about the best practices and performance benchmark standards that they should look for in making purchasing decisions or should offer to be successful in the marketplace. The private sector's new purchasing techniques, and their applicability to Medicare's populations, need to be carefully assessed.

- *Effective communication strategies.* The development of a national research effort for effectiveness and outcomes studies, report card data, and identification of best practices need to be matched by strategies to be sure the information is effectively communicated and that it takes into account the range of sociological and other factors that need to be addressed for effective change. Good clinical research data on outcomes and effective communication seem to have been an effective strategy in the recent declines in prostrate operations and cataract surgery, two procedures that had been increasing rapidly until better information was made available to clinicians and patients.
- *Assessment of where both Medicare and competing private health plans do and do not work well, and why.* One of the important open issues for health policy is to identify market conditions where health plan competition can improve health care and where such competition does not work well. In today's market, for example, while the Twin Cities area has one of the highest national rates of HMO enrollment for the under-65 population, only 9% of Medicare eligibles are enrolled. A possible reason is that HMOs cannot make much money or provide many additional benefits for 95% of the Medicare expenditures in this area. Some analysts have also argued that managed competition will not work well in rural areas. If Medicare competition is opened up to a wide variety of options more attractive than HMOs—for example, PPOs, point-of-service (POS) plans, Medicare Select options, and other arrangements—market research on their comparative success can yield insights about how the Medicare program may need to be changed to better meet the needs and preferences of its enrollees.

In addition to these areas, there are a number of special study topics that could prove useful for devising a strategy for Medicare to operate as an accountable health plan.

- *Special studies of needs and service for Medicare's disabled populations.* Medicare's 4 million disabled enrollees have been badly neglected by health policy analysts and in Medicare policy discussions. Medicare publishes very little data on their characteristics, needs, and service use. Nevertheless, this is an important group for analysis, as its rate of growth (4.0% annually in the period 1982-1992) is more than twice that of the elderly population (a 1.9% annual increase during the same period); the under-45 disability group has been growing even faster, almost 11% annually over this period. With a benefit package focused on acute medical care, the Medicare program is not well-designed for totally and permanently disabled persons. Since this group is unlikely to be attractive to private health insurance plans, it is particularly important that the Medicare program, as an accountable health plan, make special efforts to be sure that they are being well served. Separate HEDIS-type measures may be needed for disabled subpopulations.
- *Special studies of high-use elderly populations.* As is the case with the under-65 population, Medicare's spending for the aged is highly skewed, with about 5% of enrollees accounting for about 50% of expenditures on care, 10% for about 70% of expenditures on care, and about 20% accounting for about 80% of

expenditures on care. Among the high-expense populations are important subpopulations with chronic illness. Trying to identify these groups and analyze potential improvements in their care will be of particular importance for dealing with Medicare spending issues. To the extent that such high-use groups remain with the Medicare program, it will be even more important for Medicare to have a scientifically strong clinical basis for assessing their needs and care.

- *Special studies of disease management and prevention initiatives.* It may seem unusual to think about prevention and long-term disease management for Medicare enrollees, but its elderly enrollees are in the program, on average, for over a decade, with some enrolled for up to 40 years; its disabled enrollees receive benefits for even longer. Among prevention initiatives reported by HMOs for the over-65 are activities to reduce falls, a leading cause of hospitalization in the elderly, and to identify inappropriate prescribing and potential drug-drug interactions. As an increasing number of pharmacy benefit management and other firms develop disease management expertise, it will be important to assess the potential of these developments for the Medicare population, particularly in light of the many studies that show misprescribing for the elderly.
- *Policy development for post-acute hospital care.* A particularly rapid part of Medicare's recent growth has been in post-acute hospital care. Between 1992 and 1993, Medicare spending for home health and skilled nursing care each grew by about 40%, to a total of nearly $17 billion. Rehabilitation therapy claims are growing about 30% a year.[19] This entire policy area needs careful review, in conjunction with the Medicaid program, which is the nation's largest financer of long-term care, to rationalize the service efforts. Standards of appropriateness of care are more difficult to come by in this area than for clinical effectiveness and outcomes studies of acute care.
- *Better risk-adjustment mechanisms and procedures.* It is predictable that the basic Medicare program will continue to have a less healthy population than competing private health plans, at least for the foreseeable future. This will be an ongoing area of research and policy analysis. Perhaps an independent or quasi-independent organization should manage the annual "open season" competition between Medicare and private health plans to help assure fair, well-informed choice by eligible individuals.

This is an outline for a very broad and multi-year research agenda. But such an effort is needed, by both public and private sectors. Over the past 10 years the primary focus of Medicare policy has been to design, implement, and refine its price controls—using DRGs and a resource-based relative value scale (RBRVS). Today, there is very little that is "on the shelf" that can be implemented in the short run.

CAN MEDICARE COMPETE SUCCESSFULLY?

Given new accountabilities, new management authority to purchase health care, and a strategic plan for its future, can Medicare compete successfully with private health plans for the benefit of the elderly and disabled? Why not just leave Medicare alone as a traditional bill-payer and hope that it will whither away as beneficiaries choose better-managed private health plans? There will be those who believe that privately managed health care plans will out-perform any new-model, government-run Medicare program in head-to-head competition and that trying to manage Medicare as a competitive health program is hopeless or unwise.

Nevertheless, the Medicare program is still the choice of over 90% of its eligible population (and, in a majority of states, of 99% or more of eligibles), and it seems premature to predict Medicare's demise or to make an unchallengeable case about private health plans' interest and ability to compete, on a nationwide basis, for the Medicare population,

particularly its high-expense frail elderly, chronically ill, and disabled populations. Given the current situation, it would be a high-stakes risk to ignore upgrading Medicare and place all of the nation's Medicare budgetary bets on presumptions about the success of private-sector plans that may prove to be wishful thinking. In addition, the federal government has a number of strengths to build on in trying to make Medicare a better program. Among these strengths are:

- *Good track record.* It is fashionable to disparage government competence, but, compared to much of the private insurance industry, the Medicare program has an excellent track record for innovation and efficiency, within its statutory constraints. Through the use of DRGs and RBRVS, Medicare has led private payers in reducing payments for overpriced procedures and using purchasing power to restrain inflation and rationalize payment rates. Medicare has also led in investing in medical efficacy studies and protocol development to improve clinical practices reflecting outcomes research (through the Agency for Health Care Policy and Research [AHCPR]); publicizing information on comparative provider quality, for example, hospital mortality rates and nursing home reviews; setting up standardized data systems; establishing electronic submission of claims; and overall administrative efficiency. In all of these areas, Medicare still betters the private insurance norms. Among recent innovative steps are beneficiary surveys, a consumer information strategy (immunizations, mammography), a coronary artery bypass surgery demonstration with bundled payment rates, Medicare Select demonstrations, and performance contracts with PROs. With a new statutory mandate and authorities, Medicare may also excel in new competition vis-à-vis private health insurance plans.
- *Flexible administrative structure.* Medicare is normally thought of as a government-run program, but, in fact, no federal employees actually pay claims. Federal employees oversee a system of some 74 private contractors (called intermediaries and carriers—mostly Blue Cross/Blue Shield plans or commercial insurers) that actually run the program on a day-to-day basis. These private-sector insurers—themselves now involved in developing and managing private health plans—bring administrative flexibility, staffing and subcontracting capabilities, and expertise in local markets. When Medicare was first established, its contractor system offered administrative capabilities the government did not possess and could not develop on the scale and in the time frame that was needed. A well-managed Medicare program might be able to take advantage of this flexibility, in new relations with its contractors. As discussed in a recent companion piece,[20] the Blue Cross Blue Shield Federal Employees Plan managed pharmacy benefits program offers a model for how state-of-the-art managed care programs can be developed and offered in a government-financed framework for public beneficiaries. Medicare might be able to cross-fertilize between HCFA's rule-making and bill-paying culture and the private payers' purchasing culture to produce hybrid plans through joint efforts with its primary contractors.
- *Public trust and freedom of choice.* While government, in general, may be viewed with distrust and suspicion by many voters, the Medicare and Social Security programs retain strong senior citizen support. Medicare remains the program of choice of the elderly. In the Medicare program, enrollees have much broader freedom to choose a provider than in private managed care plans. They also have legal rights and due processes that help to guarantee their benefits—and an ability to appeal to their members of Congress for assistance.
- *Enormous purchasing power.* Medicare is the nation's largest health care purchaser, with an estimated $175 billion of spending in

1995. In 1993, it accounted for 19% of personal health care expenditures, including 28% of hospital care expenditures, 20% of physician care expenditures, and 39% of home health expenditures. The price discounts Medicare has been able to achieve through DRGs and RBRVS alone—although now undercut by HMOs in some markets—and its high assignment rate (over 96%) suggest a reasonable amount of optimism should be in order about the success of future purchasing strategies. If managed purposively, Medicare should be able to strike economic terms that are at least as favorable as its competing health insurance plans, as well as use its purchasing discretion for upgrading quality and service standards.

- *Data and research capacity.* Finally, Medicare has an unsurpassed data system, including claims records on medical services use by some 37 million enrollees and a potential for service-profiling and quality-auditing most of the nation's health care providers. This is a unique resource for developing national management strategies and for rapid learning about the effectiveness of these providers. Medicare and AHCPR also have a strong tradition of health services research and can work with many professional groups in developing clinical quality indicators and improvement strategies.

How best to manage competition between competitive Medicare and private-sector plans, all trying their best to enroll Medicare eligibles with the most attractive benefits, costs, quality, and service, is a complicated topic in its own right. If reengineering Medicare, as described in this paper, is a primary challenge, another ongoing challenge of daunting complexity will be to assure that competition among Medicare and competing health plans works well. Congress is now in the midst of debating many major policy questions, including enrollee financial incentives and the potential for budget savings, and there are numerous questions which will require long-term learning agendas.

Thirty years after Medicare's enactment, a much-needed debate about Medicare's future is taking place; its focus is whether (and how) the Medicare program should be rethought in light of the private sector's transition from bill-paying insurance to accountable health care purchasing. Whether one favors Medicare reforms alone, more private plan options alone, or a "two-track" strategy that includes both approaches (the possibility raised in this paper), there are good reasons to proceed with caution in use of either Medicare's new business-type authorities or new competitive arrangements. The welfare of 37 million elderly and disabled individuals is at stake. While it is attractive to envision improving the Medicare program, it is also important to realize that discretionary authority can also be misused, and competitive forces can go awry. The Medicare program could be made worse if it is subjected to unrealistic budget pressures and its new authorities are used to ration services, or if competing plans "skim" the Medicare enrollment. As well, the American tradition of public management —based on the view that government officials should not be allowed to act in ways that are arbitrary, capricious, and unfair—has usually insisted on "a government of laws and not of men." But protection of Medicare enrollees in private plans from poor HMO practices should be no less an issue.[11] With broader administrative discretion for political appointees also comes increased possibility for the application of political pressures, from Congress and other sources, and the pursuance of personal agendas. Perhaps the Medicare program is unmanageable or will prove to be so; perhaps private plan enthusiasm about the profit potential of Medicare enrollees will abate. For many such reasons, there will need to be a great deal of oversight and vigilance about Medicare and its competitors. Just as Congress established the Prospective Payment Assessment Commission and PPRC to advise on development of Medicare price regulation, it may also wish to establish a similar advisory commission for an implementation period of market-oriented Medicare reforms.

ENDNOTES

1. *Medicare: Opportunities Are Available to Apply Managed Care Strategies*, statement of Janet Shikles, GAO/T-HEH-95-81, February 10, 1995 (Appendix I).

2. About 77% of Medicare eligibles already have medigap, Medicaid, or other supplemental coverage, so switching enrollment to an HMO may provide them few additional benefits. Individuals may also be deterred from enrolling in an HMO because they would have less freedom of choice of physicians and other providers and would not be able to re-enroll in their current plans if the HMO were not satisfactory. Insurers' ability to compete with Medicare is also lessened because Medicare pays providers well below average private market rates.

3. An Institute of Medicine committee has also recommended that Congress make quality assurance, including improved patient health outcomes, a fundamental program goal. See Kathleen Lohr (ed.), *Medicare: A Strategy for Quality Assurance*, National Academy Press, 1990. The study, chaired by Steven Schroeder, M.D., was requested by Congress in OBRA 1986.

4. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, HCFA Pub. No. 03348, February 1995.

5. Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, Report No. 95-1 (forthcoming); S. Asch, et al., *Access to Care for the Elderly Project*, Final Report, RAND Corporation, April 13, 1995 (photocopy).

6. National Institute for Health Care Management, *Health Care Problems: Variation across States*, December 1994, pp. 34-36 (exhibits 4.4, 4.5, 4.6).

7. "The Fortune 500 Largest U.S. Corporations," *Fortune*, May 15, 1995, p. F-1.

8. *Medicare and Medicaid Statistical Supplement*, p. 199 (table 25).

9. Ibid., pp. 208 (table 28).

10. Ibid., p. 232 (table 37).

11. Ibid., p. 252 (table 46).

12. Physician Payment Review Commission, *Expenditure Limits*, July 1993 (staff paper), p. 62.

13. Physician Payment Review Commission, *Annual Report to Congress: 1995*, p. 20 (table 1-1).

14. M. Chassin, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *J.A.M.A.*, November 13, 1987. Jack Wennberg has been among the pioneers in Medicare area variation studies.

15. Statement of Sarah Jagger, March 22, 1995 (cited in *BNA Health Care Policy Report*, March 27, 1995, p. 479).

16. *Medicare Part B Factors That Contribute to Variations in Denial Rates for Medical Necessity across Six Carriers*, GAO/T-PEMD-95-11.

17. Lohr, *Medicare: A Strategy for Quality Assurance*.

18. "Study Finds Most Treatments for Whiplash Are Ineffective," *New York Times*, May 2, 1995.

19. *Medicare: High Spending Growth Calls for Aggressive Action*, Statement of William Scanlon, February 6, 1995, GAO/T-HEHS-95-75.

20. Lynn Etheredge, *Pharmacy Benefit Management: The Right Rx?* Research Agenda Brief, Health Insurance Reform Project, George Washington University, April 1995.

21. Complaint rates vary by more than 25:1, from 1.8/10,000 enrollees for Group Health of Puget Sound to 45.8/10,000 enrollees at Humana (Florida).

Medical Savings Accounts for Medicare

John C. Goodman, Ph.D.
President, National Center for Policy Analysis

Federal budget experts across the political spectrum agree that the Medicare program is having a financial crisis. This one program already accounts for 11 percent of the entire federal budget, and is exploding at the unsustainable pace of 10 percent per year.

Without fundamental change, the future looks bleak. As Figure I shows, Medicare will go bankrupt by 2002. In 2005 — just 10 years from now — Medicare alone will be adding about $100 billion a year to the federal deficit in constant 1995 dollars. By 2010, Medicare will be increasing the deficit by almost $200 billion a year in today's dollars, almost as much as the entire federal deficit today.

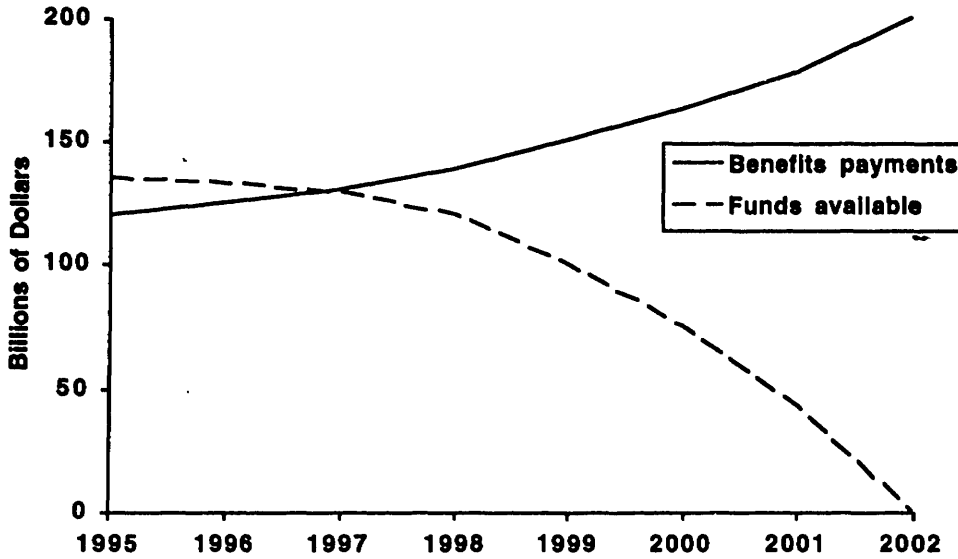
The budget resolution passed by Congress promises to balance the budget by the year 2002. That means cutting the projected growth of Medicare by $270 billion over the next seven years.

Yet Medicare already is beset by problems that many attribute to *too little* spending. Because Medicare underpays doctors, many refuse to take new Medicare patients. Because Medicare underpays hospitals, some prematurely discharge patients and deny Medicare beneficiaries access to technologies available to other patients.

Is there a way to simultaneously cut the spending and solve the problems of the Medicare program? Many health policy analysts believe the answer is Medical Savings Accounts (MSAs).

FIGURE I

The Path of Medicare



Source: The 1995 Annual Report of the Board of Trustees of the Federal Health Insurance Trust Fund.

Problem: Rising Costs. Medicare is probably the only large health insurance plan in the country that has not undergone fundamental change over the past decade. Many employers have increased deductibles and copayments — requiring employees to manage more of their own health care dollars. More frequently, employers have begun directing their employees to lower-cost doctors and actively managing health care costs.

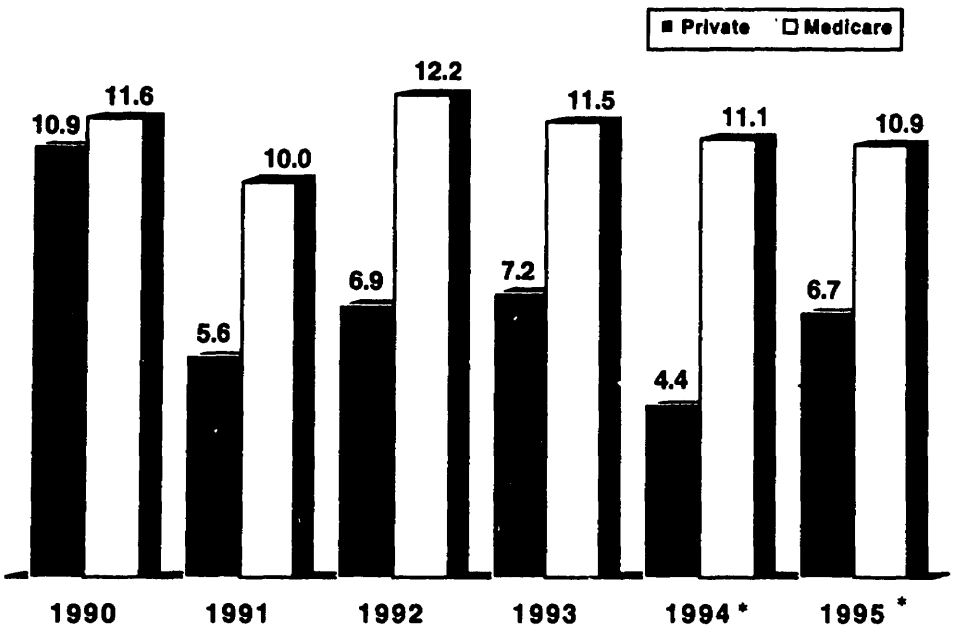
Medicare has moved in the opposite direction. In recent years the deductible for Part A (hospital insurance) has not changed in real terms, and the deductible for Part B (other medical expenses) has actually decreased in real terms. While there have been some managed care demonstration projects with the Medicare population, in most places Medicare is still a wide-open, fee-for-service plan in which patients can see almost any doctor for any service.

These features may explain why Medicare has done such a poor job of controlling costs. As Figure II shows, in recent years private sector health care costs have grown much more slowly than those of Medicare.

FIGURE II

Health Care Spending

(Average annual percent change)



* Projected

Source: Health Care Financing Administration, Office of the Actuary.

Problem: Price Fixing. In its effort to contain spiraling Medicare costs, the federal government has resorted to price fixing — dictating how much doctors and hospitals get paid for delivering services to Medicare patients. According to the Congressional Budget Office, Medicare pays doctors and hospitals, on the average, about 70 percent of the costs of the services they provide the elderly. Where they can, providers shift costs by overcharging private patients. However, in an increasingly competitive

market, this is becoming more difficult. Thus, Medicare's underpayment is resulting in reduced access and lower-quality care for some elderly patients.

Problem: Rationing and Lower-Quality Care. Other Medicare practices exacerbate the impact of underpaying for services. For example, Medicare pays the same fee, regardless of the quality of care provided. This encourages lower-quality, less-expensive care. The system also allows hospitals to make more net income by discharging patients earlier, regardless of health condition, and evidence suggests that premature discharges have harmed some patients. Medicare is also slow to approve new medical technologies, leaving the elderly without access to the latest and best treatments.

For example, cochlear implants are far superior to previous technology for treating some types of hearing loss. But most elderly patients are stuck with hearing aids because Medicare doesn't pay for the more costly implants.

Solution: Private Health Insurance. Current law already allows some Medicare beneficiaries to withdraw from Medicare and join a health maintenance organization (HMO) instead. While no one should be forced to leave Medicare, we should build on this precedent and allow each Medicare beneficiary to withdraw from Medicare Parts A and B and choose an alternative private plan, including a Medical Savings Account, an HMO or an employer's health plan. Each retiree would be free to remain in Medicare and not choose any private coverage. Therefore, this proposal creates new options without eliminating existing ones.

The private health plan should cover services now covered by Medicare and receive 95 percent of the actuarial value of Medicare spending. People could add the funds they currently use to pay supplemental Medicare (medigap) premiums and out-of-pocket medical expenses. The additional premiums plus cost savings could finance such extra benefits as long-term home health care, complete catastrophic coverage and prescription drugs.

Solution: Risk-rated premiums. The premium payment made by Medicare to the private plan for each beneficiary should be risk-adjusted to reflect the beneficiary's age, sex, geographic and health status. Consequently, Medicare would pay a higher premium for those who are older and sicker. It would pay a lower premium for those who are younger and healthier. This would prevent adverse selection raising Medicare costs, since retirees who leave would only take the share of funds that actuarially reflect their own risks.

Private health plans also could negotiate with Medicare for a fee to provide coverage for Medicare patients with special health problems. For example, Medicare might agree to pay a certain fee to a private plan for coverage for each elderly heart patient or cancer patient in a certain area (similar to the centers of excellence program already under way).

Solution: Rules for Private Plans. To participate, the private health plans would have to cover the same services as Medicare, though they could offer additional benefits and charge additional premiums. For example, they could offer coverage for prescription drugs, dental care and even long-term care.

The private insurers also would have to accept anyone from Medicare who applied, regardless of health status, along with their risk-adjusted premium. Yet, private health plans would not be required to accept patients switching from other private plans, since that would create perverse incentives for plans to dump their sickest patients on their competitors.

Solution: Medical Savings Accounts. One private option would be a catastrophic policy coupled with a Medical Savings Account. For example, private insurance might cover all health expenses over a $3,000 deductible, and place any premium savings in an MSA. MSA funds would then be used to pay for expenses below $3,000. In case a gap remained between the MSA deposit and the catastrophic deductible, retirees could top up their MSA by contributing amounts they otherwise would have used to purchase private, medigap insurance or pay out-of-pocket expenses.

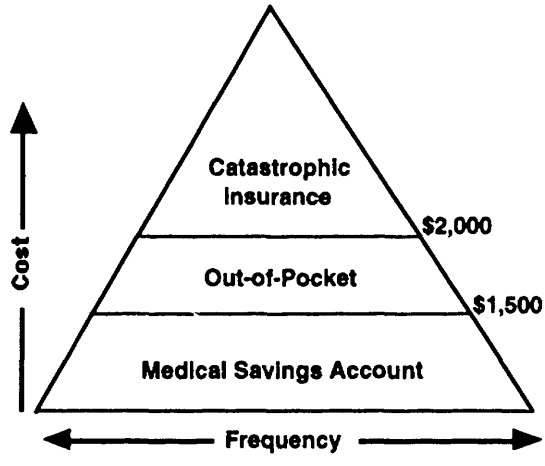
There would be no tax deductions for funds contributed to the MSA. But returns on MSA investments, as well as all withdrawals for any purpose, would be tax free. During a 12-month insurance period, MSA funds could only be used for medical expenses, since the purpose of the MSA is to back up a high deductible. However, retirees could withdraw any remaining MSA funds at the end of each year.

Medical Savings Accounts at Work. In 1994 the employees of the National Center for Policy Analysis had a conventional fee-for-service health plan with a $500 deductible and a 20 percent copayment. Under this policy, an employee was at risk for up to $1,500 out of pocket. If three members of the same family all became seriously ill, the family was at risk for $4,500 in medical bills.

This year the NCPA adopted an MSA plan that limits the exposure of the employees and at the same time gives them more control over their health care dollars. *At no extra cost to the employer*, the plan creates a $1,500 deductible and deposits $1,125 to an MSA for individual employees. For family coverage, the deductible is $2,000 and the MSA deposit is $1,500. [See Figure III.] The total out-of-pocket exposure is $375 per individual and $500 per family. [See Table I.]

FIGURE III

Medical Savings Accounts for NCPA Employees



NCPA employees may use their MSA funds to see any doctor, enter any hospital or pay any medical bill. However, spending counts toward satisfying the deductible only if the service or procedure is covered under the health plan. For example, employees can pay for dental care or eye glasses with their MSAs, but those expenses do not apply toward the deductible. Furthermore, the plan encourages participants to see doctors within a network, paying only 75 percent of "usual and customary" fees above the deductible if they go outside the network.

In the future, the buildup of MSA funds will give NCPA employees important options with respect to expensive medical procedures. For example, the health plan will pay the full costs above the deductible only if the procedure is done by a network doctor in a network hospital. But employees will be able to use their MSA funds outside the network to pay that portion of the bill not covered by the insurance.

TABLE I

Options for NCPA Employees

	Family	
	Conventional Policy[1]	Medical Savings Account Policy
Deductible	$500	$2,000
Maximum copayment	$1,000[2]	- 0 -
MSA deposit	- 0 -	$1,500
Total out-of-pocket exposure	$1,500	$500

[1] The figures in this column are per family member up to a maximum of three people.

[2] 20 percent of the first $5,000 of expenses above the deductible.

Benefits of MSAs. As in the case of employer-sponsored plans, Medical Savings Accounts for Medicare beneficiaries would create the following benefits.

- The elderly would have first-dollar coverage to use for primary or preventive care, using their MSA funds; this would be particularly beneficial for lower-income enrollees who may be tempted to avoid basic care.
- MSAs would restore the doctor/patient relationship, making doctors agents of patients, rather than agents of third-party payers bureaucracies.
- MSAs would allow patients rather than third-party payers to make the sometimes though choices between health care and other uses of money.

- Paperwork and administrative costs would be greatly reduced; since patients would be paying most bills directly out of their MSA, primary care physicians would rarely be burdened by Medicare paperwork.

- MSAs would put the consumer, rather than an insurance company or the government, in charge of the health care system.

Answering the Critics of MSAs. The existence of plans like the NCPA's refutes most of the major criticisms against MSAs. It is ridiculous to argue, as some have, that MSAs are not actuarially feasible since the very existence of the NCPA employee benefit plan and 1,000 similar private plans prove the opposite. The argument that MSAs benefit the healthy, but not the sick is also easily refuted. A person with high expected health care costs benefits by choosing the new NCPA plan because his total financial exposure is $375, rather than $1,500 under the NCPA's old plan. For families, the exposure is $500 rather that $1,500.

Medicare enrollees who have a serious illness would benefit even more from Medical Savings Accounts. The reason is that Medicare currently pays too many small bills which the elderly could pay themselves and leaves them exposed for catastrophic medical expenses that could devastate them financially. Take the Hospital Insurance program, for example:

- After a first-day deductible of $716, Medicare Part A pays inpatient hospital bills through the 60th day.

- Beginning on the 61st day, however, coinsurance payments are one-fourth of the deductible, or $170 per day.

- After the 90th day, coinsurance payments are one-half of the deductible, or $358 per day, provided the beneficiary still has "lifetime reserve" days upon which to draw.

- When the lifetime reserve is exhausted, Medicare inpatient hospital coverage during an individual's benefit period ends after the 90th day.

The Supplementary Medical Insurance program has a similar defect:

- Medicare Part B generally pays 80 percent of approved costs for doctor and other outpatient services after a $100 annual deductible.

- But while providing a good deal of first-dollar coverage for some services, it provides no coverage for others, such as prescription drugs.

As a result, some Medicare enrollees face large out-of-pocket costs. Of the 27.9 million participants who experienced some Medicare cost-sharing in 1992, 8.5 percent had to pay at least $2,000 themselves. [See Table II.] For the 1.5 percent with cost-sharing of at least $5,000, the average patient liability was $8,657. [See Figure IV.]

TABLE II

Patient's Share of Medicare Bills, 1992

Amount of Patient Cost-sharing	Percent Incurring Liability[1]	Percent of Total Medicare Cost-sharing Liability[2]
$1 to $499	62.8%	17.3%
$500 - $999	13.4%	12.8%
$1,000 - $1,999	15.3%	27.3%
$2,000 - $4,999	7.0%	25.4%
$5,000 or more	1.5%	17.2%

[1] An estimated 27.9 million out of 35.6 million Medicare beneficiaries used covered services and incurred cost-sharing liability in 1992.

[2] Deductibles, coinsurance and balance billings paid by people paying this amount.

Source: Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, Baltimore, MD: HCFA Pub. No. 03348, February 1995, Figure 17, p. 45.

Finally, the criticism that MSAs are incompatible with managed care is clearly untrue, since the NCPA's MSA plan has a managed care component. Although MSAs probably are inconsistent with the traditional philosophy of HMOs, efforts to make medicine cost-effective are natural allies of Medical Savings Accounts.

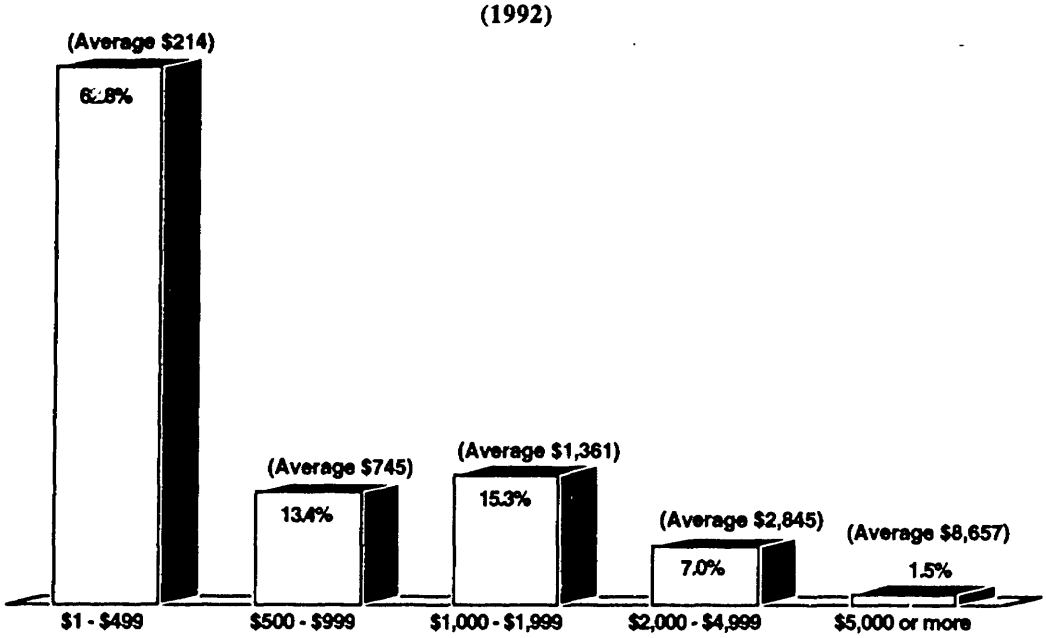
Under the NCPA plan, for example, the insurance company has established a preferred provider network (PPO) and has negotiated discounted rates with hospitals and other providers. But the employee is free to use that MSA money for the purchase of any

type of medical care. Patients who go outside the network can pay for the full cost of the service from their MSAs.

FIGURE IV

Cost-Sharing by Medicare Participants

(1992)



Simulations for Medicare. Three private sector simulations have been performed to estimate potential savings to the federal government from using Medical Savings Accounts to solve the financial crisis in Medicare. All three assume a catastrophic deductible of $4,000 and a Medical Savings Account deposit of $2,000.

- In one study, Mark Litow (Milliman & Robertson) calculated that if MSAs were incorporated into Medicare for all beneficiaries (elderly only) the seven-year savings (through 2002) would be more than $200 billion.

- Using the National Center for Policy Analysis/Fiscal Associates Health Care Model, Gary and Aldona Robbins estimated that if MSAs were created for all beneficiaries (including the disabled, but excluding the 5.2 percent of enrollees

who are high risk) seven-year savings (including dynamic feedback effects on the economy as a whole) would total $232 billion.

- In a third calculation Litow assumed MSAs can be combined with private sector managed care for costs above the deductible and estimated seven-years savings to the federal government as high as $300 billion.

These simulations are very encouraging since they show that the budget goals Congress has set for Medicare are reachable with reasonable reforms.

Conclusion: Health Care in the Information Age. The traditional philosophy of HMOs was summed up by an HMO manager several years ago: "Patients do what their doctor tell them to do; therefore, if you can tell doctors how to practice medicine, you can cut costs." This approach assumes that patients are compliant because they do not know what services they are not receiving.

A model based on patient ignorance, however, is unlikely to survive in the new Information Age. Increasingly, patients (yes, even elderly patients) will use the Internet and other computer services to tap into various medical libraries and databases, discuss ailments with other network users and follow diagnosis decision trees. Thus, the best model for the future is one that assumes that patients will know as much as their doctors — not about how to practice medicine but about what medical practice offers.

One such model is Medical Savings Accounts. Using their accounts, patients will seek doctors who are financial advisors as well as health advisors. Physicians will be aided by sophisticated computer programs. No large bureaucracy will be required. When patients have ready access to information, doctors acting as their agents will probably outperform most bureaucracies.

In order to take full advantage of the information age, however, Congress needs to give elderly patients, health care providers and private insurers the freedom to experiment with the most efficient and cost effective ways of providing quality health care.

PREPARED STATEMENT OF KAREN IGNAGNI

Mr. Chairman and members of the Committee, I am Karen Ignagni, President and CEO of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs). Our 385 member HMOs serve 80 percent of the 50 million Americans receiving health care through HMOs today.

We are pleased to be asked to testify as the Committee explores the future of the Medicare program, and look forward to working with the Congress and the President in a bipartisan fashion on Medicare. GHAA believes that Medicare must be modernized to reflect the dramatic developments that have occurred in the private sector since Medicare was enacted 30 years ago. Medicare can best be strengthened by offering beneficiaries the same kinds of choices that are already available to millions of working Americans both in the private sector and in the federal government. Today, I would like to:

- o review the environment for change in the health care marketplace, and in Medicare;
- o review the current status and experience of the Medicare HMO contracting program;
- o review GHAA's guiding principles for discussion of Medicare reform; and
- o present GHAA's recommendations for "where to begin" -- initial steps in a transition to broader reform of the Medicare program.

The Changing Environment

When Medicare was enacted in 1965, the health care environment for which this vitally important public program was designed was substantially different than it is today:

- o the overwhelming majority of insured Americans received their health care under

the then-predominant fee-for-service approach;

- o health care services were more focused on inpatient hospital care;
- o health care was less complex and bewildering than today, so coordination of care was not as essential;
- o the advantages of coordinated care -- including preventive care, quality measurement, management of chronic conditions, and the ability to provide comprehensive care within a budget -- were not yet fully apparent;
- o treatment costs were a fraction of what they are today, so cost containment was not as urgent a national concern; and
- o health maintenance organizations and other organized systems of care were not yet available to most Americans.

Medicare was in many ways a "market-based" health system in the environment that prevailed in 1965. And measured in terms of the security that it has brought to the elderly, the disabled, and their families, Medicare has been a success. However, in 1995, thirty years later, the environment in which Medicare operates has changed dramatically:

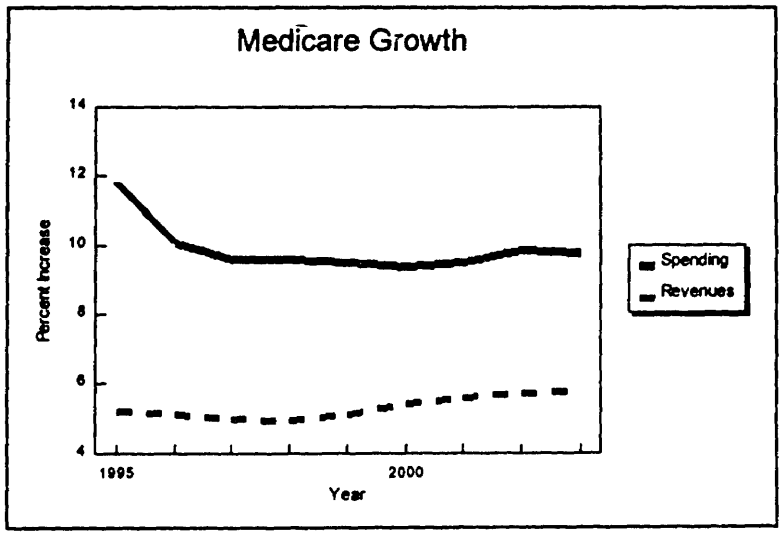
- o fee-for service coverage is no longer the predominant approach to coverage in the market;
- o more consumers are choosing coordinated care through organized systems of care because of the disadvantages of the fee-for-service approach in an increasingly complex medical system;
- o Americans by the millions have joined HMOs and are overwhelmingly satisfied with the care they and their families receive;
  - -- more than 60 percent of all working Americans with private health coverage now receive their care through HMOs or other organized systems of care;
  - -- about 35 percent of federal employees have chosen HMOs from among the wide array of choices that are offered;

Medicare too is changing, but slowly -- only about 10 percent of today's Medicare

beneficiaries are in HMOs. The result is that Medicare has fallen behind the evolving market environment -- Medicare beneficiaries no longer have coverage that is typical of that available to the working population, and do not derive the benefits of the choices available to other Americans.

Without reform, Medicare faces insolvency in a few years.

Figure 1



But modernization of Medicare is feasible and within reach. The key is to provide Medicare beneficiaries with the choices that are already available to Members of Congress and other working Americans.

Guiding principles for discussion

Given the changing environment, Medicare must be updated to reflect the dramatic

changes that have occurred in the private sector during the three decades since the program began. GHAA believes that Medicare can best be strengthened by giving beneficiaries the same kinds choices that are already available to millions of working Americans both in the private sector and in the federal government. Medicare -- and the Health Care Financing Administration (HCFA) -- should be reoriented toward a model in which Medicare beneficiaries have the opportunity to choose from among a broad array of options that compete on the basis of quality, service, and cost, and are held to comparable accountability standards. When beneficiaries can choose the option that best meets their needs, Medicare will benefit from the progress that has been made in the private sector.

- **Beneficiary choices**: Medicare reform should be consistent with the promise of providing access to basic Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population.

- **Medicare standards**: Our experience also tells us that standards are vitally important. All organized systems of care, as well as providers under the fee-for-service Medicare program should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency. Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.

- **Medicare payments**: Medicare payments should permit widespread availability of organized systems of care, as well as the traditional fee-for-service option, for Medicare beneficiaries nationwide. The Medicare program should act in a fashion similar to private sector purchasers. This can be done by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis, with an equitable allocation of resources between organized delivery system options and the fee-for-service program. Total expenditures should be trended forward on an appropriate basis to meet program goals.

The current status of Medicare HMO coverage

In developing proposals for modernization of Medicare, it is useful to review briefly the current status of Medicare contracting with HMOs and competitive medical plans (CMPs)[1] because that program can provide a platform for future changes in Medicare.

The Medicare HMO risk contracting program was enacted in 1982 as part of Tax Equity and Fiscal Responsibility Act (TEFRA), after a number of years of successful demonstrations of this contracting approach. The TEFRA program provided for Medicare contracting with HMOs and CMPs, and authorized payment to those plans of 95 percent of the estimated cost of fee-for-service Medicare in the geographic area (the county) -- the adjusted average per capita cost, or AAPCC.

While the specifics of the AAPCC calculation are complex, the methodology incorporates four basic steps:

- o calculation of the national per capita cost for care under Medicare (this is the United States Per Capita Cost, or USPCC);
- o estimating the county per capita cost of fee-for-service care by:
  - -- applying a county adjuster to the USPCC (the county adjuster is a moving five-year average of the ratio of county per capita costs to national per capita costs);
  - -- adjusting for county HMO expenditures; and
  - -- adjusting for the demographic mix of the county's beneficiaries;
- o multiplying the county per capita cost by 95 percent; and
- o applying the actuarial risk adjustments developed by HCFA to account for age,

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[1]Competitive medical plans (CMPs) are HMOs that have not chosen to become federally qualified but meet similar federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMOs and CMPs.

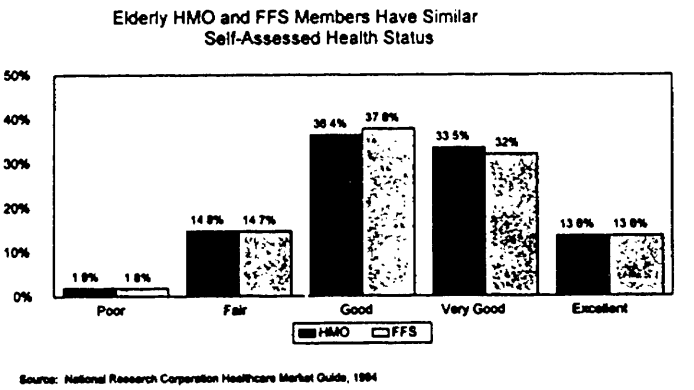
sex, Medicaid status, institutional status, and employer-based coverage of the beneficiary.

As of this year, roughly 3.1 million Medicare beneficiaries have chosen to be served through one of the HMO contracting options offered by the Medicare program. Since 1990, enrollment in Medicare risk plans has doubled while combined enrollment in all HMO options has grown by 70 percent.

The Medicare HMO contracting program has proven successful in a number of ways -- it has achieved a broad enrollment base, member satisfaction, documented quality, and savings.

Broad enrollment base: The National Research Corporation found that seniors enrolled in HMOs and in fee-for-service Medicare are very similar in terms of overall self-reported health status and incidence of chronic medical conditions. As shown in Figure 1, 47.1 percent of HMO members reported that they were in "excellent" or "very good" health, compared with 45.6 percent of fee-for-service enrollees. The percentage in both populations reporting "poor" health was the same, slightly less than 2 percent.

Figure 2



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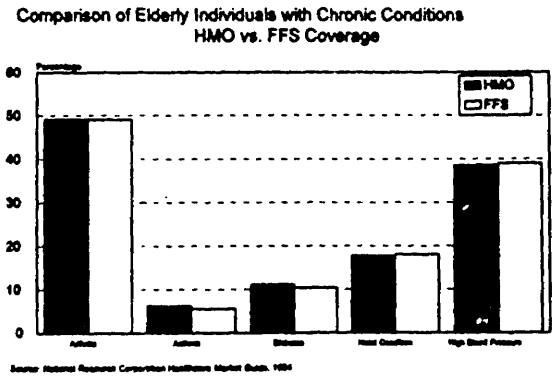
Further, the percentage of Medicare HMO enrollees with selected chronic conditions is generally similar to the fee-for-service sector, as shown in Figure 3. For example, 49.2 percent of seniors enrolled in HMOs reported suffering from arthritis, compared to 49.1 percent in FFS Medicare.

Figure 3

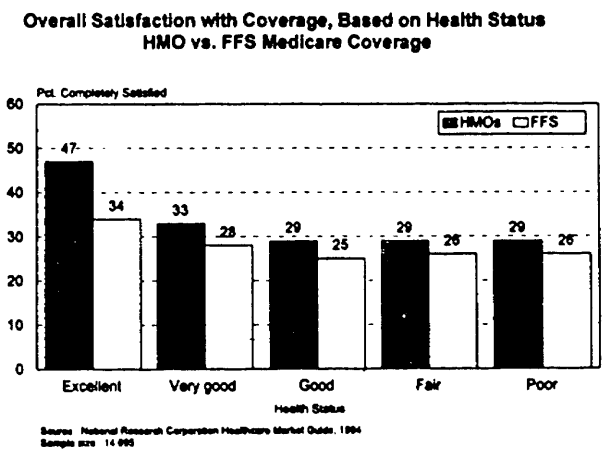


These data are inconsistent with the often-cited Mathematica Policy Research study on favorable selection in the Medicare HMO program -- a study that was based on beneficiaries who enrolled in 1987 or 1988 (seven to eight years ago). Since 1987 -- when the risk contracting program was just two years old -- enrollment in Medicare risk HMOs has more than doubled, and as that enrollment has grown, the characteristics of the HMO population have become increasingly similar to those in the fee-for-service population.

Satisfaction: Medicare HMOs attract a broad mix of enrollees, and those enrollees are satisfied with their care. During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied overall with

their health plan than fee-for-service subscribers. A National Research Corporation survey of over 19,000 elderly Americans found that, for all levels of self-designated health status, the elderly enrolled in HMOs are more satisfied with their coverage than the elderly receiving services under the traditional Medicare fee-for-service program. Figure 3 highlights these data -- indicating that HMOs achieve higher subscriber satisfaction not just among the healthy, but also among the sick.

Figure 4

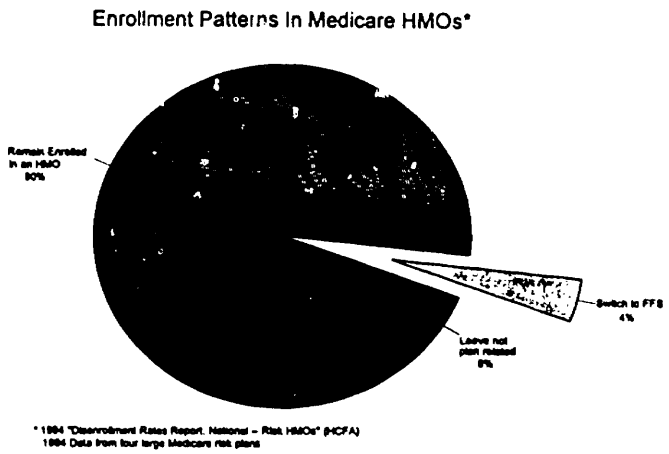


This level of satisfaction is highlighted further by the fact that Medicare beneficiaries who choose HMOs stick with them. A recent study of Medicare HMO enrollees in 1994 showed that:

- o 84 percent remained with their HMO;
- o 6 percent switched to another HMO in their area;

- o 6 percent left for reasons unrelated to the plan (e.g., they move out of the area);
- o 4 percent returned to local fee-for-service care.

Figure 5

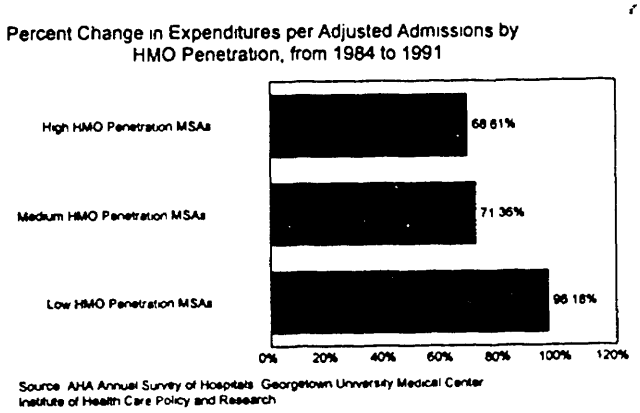


Quality: Medicare HMOs offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service sector. This is due to coverage of and improved access to preventive care under comprehensive HMO coverage, which is also highlighted in a study by the Centers for Disease Control (CDC) and the National Center for Health Statistics that showed that women in HMOs are more likely to obtain mammograms, pap smears, and clinical breast exams than those in the fee-for-service sector. Another study, comparing care for patients age 65 and older with acute myocardial infarction (heart attack), concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.

Savings: Finally, HMOs lower the rate of increase in spending on health care in two ways -- by holding down costs in their plans, and by producing savings in the marketplace as a whole (the so-called "spillover" effect).

By promoting competition in an area, HMOs lead to reductions in fee-for-service costs. W.P. Welch of the Urban Institute estimated that for metropolitan statistical areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Studies by Glenn Melnick and James Robinson found that hospital costs increase less rapidly in areas of California where HMOs had a larger market share. Jack Hadley and Darrel Gaston of Georgetown University report that hospital costs per admission increased 69 percent in high HMO penetration markets from 1984 to 1993, compared with 96 percent for low HMO penetration markets, as shown in figure 6 below.

Figure 6



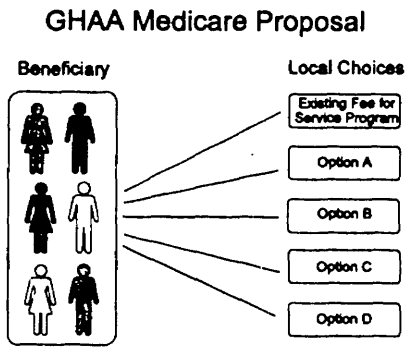
The current program is a promising start, and demonstrates that HMOs can successfully serve the Medicare population. But despite recent enrollment growth, Medicare still lags

considerably behind the private sector in the HMOs and other organized systems of care it offers to beneficiaries.

Where to begin

Looking at the current Medicare program and using the GHAA principles as a guide, the question, of course, is how to begin to take the steps necessary to modernize Medicare. Based on the practical and proven experience of our member plans in serving tens of millions of Americans, including three million Medicare beneficiaries, we are recommending a series of changes to transition from the current approach to a model based on beneficiary choices.

Figure 7



The changes are designed to foster expansion in existing Medicare markets, encourage new Medicare markets to emerge, permit the development of increased capacity for Medicare beneficiaries to enroll in organized options offered by HMOs and other entities, and provide the experience necessary to permit informed decision-making by the Congress on the future design

of the Medicare program. We recommend changes in the following five areas:

- o improve beneficiary information, awareness, and enrollment process;
- o expand the infrastructure of health plan choices available to beneficiaries;
- o maintain strong standards for health plans participating in Medicare;
- o begin to transition HCFA from the current regulatory approach to the beneficiary choice model; and
- o transition to improved Medicare payment methodologies.

Improve beneficiary information, awareness, and enrollment process: Mr. Chairman, we should start with the basics. We cannot expect beneficiaries to make informed choices if we do not inform them about their choices, and make it easy for them to enroll.

- o Information/awareness: The Health Care Financing Administration (HCFA) should work with entities that participate in the Medicare program, including HMOs and in the future, other arrangements, to develop information that HCFA could disseminate to beneficiaries about the enrollment options available to them, including educational information about the basic characteristics of those choices. This information should be sent to all prospective beneficiaries in the six-month period prior to their becoming eligible for Medicare, and periodically thereafter.
- o Enrollment: HCFA should develop a mechanism that would allow newly-eligible beneficiaries to elect HMO enrollment that is effective the first month that they become entitled to Medicare, rather than requiring them to wait (and be uncovered for supplemental benefits) until the second month.

Expand the infrastructure of options available to beneficiaries: Second, the choice model requires that we increase the array of options offered by the Medicare program.

- o Expanded array of choices: A broader spectrum of offerings should be phased-in for Medicare beneficiaries by encouraging participation of an expanded array of benefit options by HMOs and other entities under rules that permit all to participate on an equal footing.
- o Self-referral option: HCFA should continue its work to develop guidelines that

would permit HMOs to offer a point-of-service (POS) product through what HCFA is referring to as a "self-referral option" (SRO) for Medicare beneficiaries. Plans would then be allowed to offer beneficiaries a product that enables them to go outside the HMO network to receive covered services.

Maintain strong standards for options participating in Medicare: As we expand the infrastructure of offerings, it is vitally important to maintain strong and comparable standards for all options.

- o Comparable standards for all options: All organized options, such as those offered by HMOs, PPOs, PHOs, as well as providers under the Medicare fee-for-service program, should meet comparable standards designed to address quality of care, access, grievance procedures, and solvency. Standards should include:
  - -- Quality: all offerings and providers should have the capacity to develop reports on performance that permit comparisons among options and providers.
  - -- Access: all offerings and providers should accept all beneficiaries who wish to enroll or who select those providers up to the limits of the capacity of such offerings/providers and without regard to health status.
  - -- Grievance procedures: all offerings and providers should make available to beneficiaries procedures for hearing and resolving grievances under the Medicare program.
  - -- Solvency: all offerings should be fiscally sound and meet standards for an initial deposit, initial net worth and ongoing solvency.
- o 50/50 rule: Statutory criteria in connection with waiving the 50/50 enrollment requirement for HMOs and other organizations offering organized options should be developed.
- o Anti-managed care: Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.
- o Deemed status: To enhance and streamline Medicare's quality assurance program, organized offerings that meet accreditation standards of private sector

organizations designated by the Secretary should be deemed to comply with applicable Medicare quality standards.

- Ensure level playing field among array of choices: As the Medicare program is expanded to provide beneficiaries with an array of choices, new entities undoubtedly will emerge to participate. To ensure that consumers are provided with a wide range of viable coverage options competing on the basis of quality and cost, it is crucial that the government treat all forms of coverage in an equitable manner.

  One option that has been raised is a medical savings account linked with catastrophic coverage. Under designs that are currently being discussed, this option would receive preferential tax treatment (i.e. a tax preferred cash payment from the Medicare program that would be available for both health care related and non-health care related expenditures). The potential result will be that beneficiaries will select the MSA option primarily for its savings potential rather than its health benefits coverage and that selection bias against comprehensive coverage options may reduce their general availability. If an MSA option is created for Medicare beneficiaries it should be designed to contribute to broadening the array of choices available and avoiding these potential problems.

Begin to transition HCFA to implement new model: Changes in HCFA's focus on individual claims payment and basic improvements in administrative mechanisms can help enhance the modernization of the choices available to beneficiaries.

- Transition to new model: HCFA needs to begin the process of reorienting its approach from management of the transactions in a fee-for-service system to implementation of a beneficiary choice model.

- Administrative procedures and processing of applications: In the short-term, HCFA should take immediate steps to improve administrative procedures and processing time:

  -- reduce the time it takes to process and approve two types of applications from HMOs: initial applications to serve Medicare beneficiaries, and applications from approved plans to expand their service area and be able to serve additional Medicare beneficiaries;

  -- simplify administrative procedures for submission and processing of applications (i.e., permit information associated with the application to be submitted on computer disk); and

-- streamline oversight of multi-state organizations, for example by eliminating duplicative filing requirements and facilitating communications among regions.

o Policy guidance/ regional variations: HCFA should take steps to identify and narrow the variation in interpretation of policy by regional offices and promote consistency in decision making in such areas as review and approval of contracts, products, and marketing materials; this should include the development and issuance of guidelines for regional offices.

Transition to improved Medicare payment methodologies: Finally, the program needs to begin the transition to improved Medicare payment methodologies. We present this as the final component of our plan, because it requires attention to a number of issues. We include implementation of a transitional payment approach designed to meet current program and budget objectives, and steps to set the stage for future decision making about payment policies.

Transition to Medicare payment mechanism: Medicare should implement a method of payment that would provide greater incentives for beneficiaries to choose options that deliver high quality, cost-effective care. The payment mechanism should permit these options to establish premiums for the benefits they offer and should establish a government contribution based upon the per capita cost to the Medicare program of providing Medicare-covered benefits to all eligible beneficiaries.

In general, the starting point should be the payment methodology under the current Medicare program.

o The total Medicare budget should be established and a per capita amount should be calculated based on the total number of beneficiaries. The per capita amount should be trended forward on a basis appropriate to meet program goals.

o The allocation for the fee-for-service program should be established by aggregating the per capita amounts associated with the beneficiaries who select the current program. Medicare would continue to pay claims for covered services

provided to these beneficiaries. A periodic determination should be made about whether expenditures are within the desired range, and a framework should be established, perhaps in the annual budget process, for making adjustments to the program in light of this determination.

- o The payment for all other options should be based on the same per capita costs.

- o Changes from the current methodology for determining per capita payments should be phased-in over a period of years. Such changes would be designed to address the problem of low payment rates in under funded areas and promote new markets for private sector offerings for Medicare beneficiaries. This process should ensure that health care for beneficiaries who have already elected HMO membership is not disrupted and preserve the vitality of markets in which significant numbers of Medicare beneficiaries have already joined HMOs.

- o Under this system, health plans would have the flexibility to offer benefit packages that include at least the standard Medicare benefits, and perhaps greater coverage, for the premiums they have developed.

Demonstrations on alternative payment methods: To set the stage for future decisions about Medicare payment approaches, HCFA should continue to explore the feasibility of alternative payment systems, such as other market-based approaches and mechanisms that will support participation by entities offering organized options in rural and other less populous areas. The projects should continue to encourage voluntary participation and should identify issues related to the design and implementation of alternative systems.

Risk adjusters: One of the most misunderstood features of the Medicare HMO contracting program relates to risk selection and risk adjustment in payments. First, as noted earlier, the fact of the matter is that Medicare HMOs today attract a cross-section of beneficiaries -- sick and well -- comparable to those in the fee-for-service sector. The often-cited Mathematica report on risk selection is simply out-of-date. Second, Medicare already makes a number of actuarial adjustments in its payments to HMOs based on enrollee age, sex, Medicaid status, institutional

status, and employer-coverage. These are efforts to assure that payments are as accurate as possible in reflecting the relative risk of the enrollees.

GHAA has consistently expressed support for improvements to the AAPCC that will enhance its accuracy. However, adjustments should be tested to determine if they will serve this goal in a cost-effective way. We believe that the Health Care Financing Administration should undertake demonstrations designed to identify the administrative issues and costs involved for HMOs and for HCFA in implementing risk adjusters that appear promising. Progress on these issues will permit the agency to work with participating entities to move to the next step of implementing appropriate risk adjusters beyond those currently in place.

Maintain comprehensive, capitated approach: As the private health care market imposes more competitive pressures on the health system, and Medicare is modernized as well, the committee will be confronted by pressures to fragment Medicare's capitated payment in a variety of ways. We understand, for example, that proposals have been made to split out Medicare medical education payments from the AAPCC, and to make those payments separately and directly to providers on a fee-for-service or other basis.

The growth of HMOs and other organized delivery systems requires reform of medical education programs and funding designed to increase the supply of primary care physicians and to improve and expand training opportunities that will prepare physicians to practice effectively in HMOs and other network-based settings. At this point, rather than re-fragmenting the payment stream, we believe that the comprehensive, integrated approach offered by HMOs -- and the enhanced competitive pressure that is being generated -- is exactly what is needed in our health system. The reality is that HMOs must contract with academic health centers for

compelling health care and competitive purposes -- beneficiaries want access to the prominent institutions in their community, and HMOs, to be successful in meeting beneficiary needs, contract with them.

For example, the Health Insurance Plan of Greater New York (HIP) in New York City has affiliations with a total of a total of thirteen teaching hospitals and academic medical centers. Because HIP's medical groups provide care in HIP-owned medical centers and provide complete primary and most specialty care in-house, referrals to these institutions are for diagnoses and treatment that require highly specialized expertise. However, HIP's admissions to such hospitals and centers are not limited to these referrals. About sixty percent of HIP admissions occur in teaching hospitals, and academic medical centers account for about eleven percent of admissions. If emergency admissions and highly specialized admissions to nonaffiliated hospitals are included, more than seventy percent of admissions are to teaching hospitals.

Other HMOs contract with a variety of academic and teaching institutions in their areas. For plans that do not operate their own medical centers, it is common for these contracts to encompass both primary and tertiary care. It is also common practice for each contract negotiation between an HMO and such an institution to result in an agreement that reflects both the HMO's need for health care services for its members, and the institution's unique character and costs. A variety of payment mechanisms are reflected in these agreements, but all involve consideration of the costs the institutions must incur in providing care.

Creating a stable and equitable payment environment: We need to secure for Medicare and seniors the benefits of the choices and changes that have reshaped the private marketplace. We recognize the budgetary pressures confronting the Congress, but would stress that without

adequate and predictable payments none of the long-term reforms will be possible. Creating a stable and adequate payment environment whose predictability supports expanded participation by HMOs and other organized systems will make real the promise of choices for Medicare beneficiaries like those available in the private market. For the long-term, such a strategy will allow you to bring Medicare spending growth in line with private sector health spending.

Conclusion

GHAA appreciates this opportunity to present our views about modernizing the Medicare program. We look forward to working with the Committee on this issue, and I would be pleased to answer any questions that you may have. Thank you.

STATEMENT
on
NEW DIRECTIONS IN MEDICARE
before the
SENATE COMMITTEE ON FINANCE
by
Dennis Kasselman
for the
AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS
July 26, 1995

Good morning, Mr. Chairman and members of the Committee. I am Dennis Kasselman, a member of the Board of Directors of the American Association of Preferred Provider Organizations (AAPPO), and President of its Mid-America region. I am also a senior vice president with Mid-America Health Network, Inc., a PPO in Kansas City that does business throughout the states of Kansas and Missouri. On behalf of AAPPO, I am very pleased to take part in this important hearing, and to share with you our ideas for strengthening and improving the Medicare program.

AAPPO is the national trade association representing a large segment of the PPO industry and its partners in managed care, such as employers, insurers, and providers. Since its founding in 1983, the rapid growth of the association's membership has paralleled the dramatic expansion of network-based managed care. Our members include comprehensive medical/surgical networks as well as specialty networks offering benefits for mental health, dental and ophthalmic services, workers' compensation, and the like. Through its members, AAPPO represents a significant portion of both the delivery systems and recipients of health care in the United States. Data just in from AAPPO's about-to-be published 1995 *Directory of Operational PPOs* documents 802 active PPO networks in the United States, extending coverage to approximately 79 million eligible employees.

AAPPO believes strongly that Medicare needs to come into step with the private sector in delivering and paying for health care services. The public program's need to contain cost while maintaining accessibility and quality is the very same need that motivated the employers

who are the primary private-sector purchasers to develop new health care strategies. Among the successes has been developing a means of managing fee-for-service medicine: the PPO.

The private health care market today is immensely competitive. It is no coincidence that runaway cost trends -- the annual double-digit increases that marked the last decade -- have moderated. This is the way the marketplace is supposed to work. Robust competition encourages product improvement and brings down costs, benefiting investors and consumers alike. In this case, both the federal government and Medicare beneficiaries have much to gain.

We agree with many members of Congress that Medicare beneficiaries should have the same choices available to their privately-insured fellow citizens. The success that PPOs have achieved in delivering choice and quality while substantially reducing costs offers a model that Congress can turn to in meeting the twin challenges of reducing the growth in Medicare expenditure while expanding choice to older Americans.

The PPO: Another Managed Care Option

A PPO is an entity through which employer health benefits plans and health insurance carriers (collectively, payers) contract to purchase health care services for covered beneficiaries from a selected group of "preferred" participating providers, including hospitals, physicians, and diagnostic facilities. Benefit plans offer a PPO network to eligible participants as an effective means of furnishing access to an array of qualified providers. The PPO is a separate, identifiable legal entity that can have various types of owners, including entrepreneurs, insurers, and providers. PPOs contract directly with their payer customers -- as we would envision them contracting directly with HCFA in the Medicare context.

A PPO's preferred providers generally are selected on the basis of their cost efficiency, community reputation, and scope of services. Payers offer financial incentives to the covered beneficiaries to encourage them to obtain needed health care services from the preferred providers. In return, the participating providers agree to conform to certain utilization

management and quality management requirements established by the PPO and to accept contractually set reimbursement levels for their services.

Unlike HMOs, PPOs do not require their members to use only PPO providers. Individuals with PPO coverage are permitted to use non-PPO providers if they are willing to pay higher levels of coinsurance or deductibles. As a result, the PPO offers more consumer choice of provider.

In 1994, PPOs were offered by 40 percent of employers with 10 or more employees, according to a survey of employer-sponsored health plans by the firm Foster Higgins. The average per-employee cost for PPO coverage for large employers actually dropped from 1993 to 1994, and four-fifths of plan sponsors characterized their PPO as effective in controlling costs.

Benefits of a Medicare PPO Option

Since the early 1980s, the federal government has sought ways to reduce spending for Medicare-covered health services. Notwithstanding efforts focused on price-setting, costs have continued to rise because of utilization increases. It has become abundantly clear that cost containment cannot be achieved merely by cutting back on payment rates without addressing utilization as well. For more than 90% of current beneficiaries, Medicare remains an unmanaged fee-for-service entitlement program. By contrast, the private sector has controlled its fee-for-service expenditure through reliance on PPOs to manage both rates and utilization.

Even where the government has attempted to address utilization through a capitated payment, it has met with limited success in controlling Medicare expenditures. The Department of Health and Human Services moved into managed care in the 1980s, contracting on a risk basis with HMOs for the provision of comprehensive health services to Medicare beneficiaries. However, enrollment in HMOs by Medicare beneficiaries has been quite limited over the years, and HMOs have not achieved significant penetration of the Medicare

market.

The private insurance market in the early 1980s also had just two options -- indemnity plans based on fee-for-service and the HMO with its lock-in requirement of enrollment. The market demanded more, and PPOs were the response. As described above, payers with a PPO option use financial incentives to encourage the consumer's use of the managed care features of the PPO. I have found in my own PPO management experience -- and my AAPPO colleagues will bear me out -- that 60-70% of health care services obtained by PPO-eligible persons are provided by network providers. Because of the flexibility inherent in a PPO, these arrangements are popular with consumers and providers alike.

PPOs are successful in reducing unnecessary utilization while allowing consumers to choose their own health care providers from a select panel of high-quality, low-cost providers. By adding a PPO option to Medicare, increased savings and controlled utilization can be achieved while offering an attractive managed care alternative to beneficiaries. Indeed, those who have been reluctant to venture into managed care because of the "lock-in" nature of provider panels should find PPOs particularly appealing.

PPOs have contractual agreements that physicians, hospitals, and other providers accept voluntarily, under which providers pledge to help develop and to participate in utilization review and quality assurance programs. A collaborative, non-adversarial relationship is fostered between the PPO and its physicians, based on a mutual commitment to cost-effective, high-quality health care and reinforced by the dramatic success their partnerships have enjoyed.

As PPOs have proliferated across the nation, they have developed tremendous aggregate capacity for the enrollment of new beneficiaries. More so than other managed care models, PPOs tend to be characterized by a broad array of providers, both physicians and hospitals.

PPOs offer Medicare savings in several areas:

- **Utilization review**: Prospective and concurrent reviews reduce unnecessary admissions and surgeries.
- **Part A:** PPOs may negotiate hospital rates at levels lower than DRG payments. DRGs were based on length-of-stay assumptions that have since been reduced in practice. Medicare has not participated in the savings generated by this reduction. Most PPOs pay a per diem rate and manage length-of-stay with their physicians. A cost-per-admission based on a PPO per diem may easily be less than the corresponding DRG level.
- **Part B**: PPOs make extensive use of freestanding facilities with lower overhead costs than hospitals for outpatient diagnostic and treatment services. Payment typically is at negotiated fixed rates, less than the cost-based discount rates currently payable under Medicare.

PPOs and Risk

Most PPOs are not licensed as insurers and do not bear insurance risk. They typically are compensated on the basis of a per-member-per-month administrative fee. Capitated arrangements, characteristic of HMOs, are not common among PPOs. While some PPOs are exploring the process of becoming legally qualified as risk-bearing entities, and some indeed have done so, others are not prepared to recast themselves, in effect, as insurance carriers or HMOs.

AAPPO proposes that both standard and risk-bearing PPOs be recognized by Medicare. In the standard arrangement, a PPO would qualify as an eligible Medicare contractor through meeting federal standards related to the functions it performs (e.g., provider credentialing and contracting, utilization and quality management, review and complaint procedures). A qualified PPO would receive a per-beneficiary-per-month fee in return for making available its network, its negotiated rates, and its utilization and quality management services. HCFA would thus stand in the same relation to the PPO as self-insured employers do now. Such employers enjoy a cost/benefit trade-off in the neighborhood of 10 to one, savings achieved through PPO management compared to the monthly administrative fee paid.

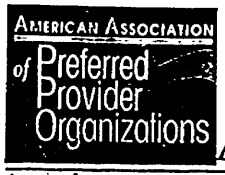
In a variation on the standard arrangement, the PPO's administrative fees could be augmented or reduced based upon its success or failure to meet performance targets negotiated between the PPO and HCFA.

Finally, as noted, some PPOs are interested in pursuing risk contracts with HCFA. AAPPO's proposed risk option would establish by law a means whereby PPOs could become federally qualified, irrespective of their status under state licensure, by demonstrating compliance with federal standards similar to those now established for HMOs.

Conclusion

AAPPO appreciates the Committee's willingness to look at a PPO option for Medicare. PPOs have been effective in the private sector, and will prove effective for Medicare as well. AAPPO understands that PPO participation would be in the context of a menu of choices for Medicare beneficiaries -- a prospect that we applaud, having every confidence that PPOs can hold their own in healthy competition. We ask you, though, to keep in mind the importance of real as opposed to apparent variety. There always exists a temptation to minimize complication by putting everyone through the same regulatory slicer. PPOs want to compete as PPOs. We believe that existing law and regulations should be changed to recognize the character of PPO networks, rather than refashioning the PPO to suit the statute.

I thank you for this opportunity to represent AAPPO before you today, and look forward to working with you as the budget reconciliation bill takes shape. AAPPO will be happy at any time to discuss our option proposal with you in greater detail.



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THE PPO: PREFERRED MANAGED CARE

The Preferred Provider Organization (PPO) is the fastest-growing form of managed care organization, offering more choice than any other managed care model. A PPO promotes appropriate high-quality health care services and controls the growth of health care costs. Benefit plans offer a PPO network to eligible participants as an effective means of providing access to an array of qualified providers. The PPO integrates the financing and delivery of health care and adds value to all key parties through services such as:

To **patients:**	carefully selected credentialed providers, lower out-of-pocket costs, grievance procedures
To **payers:**	cost control, quality review, broad geographic service areas
To **providers:**	source of new patients

In order to fulfill these commitments, a PPO has the following functional characteristics:

A PPO tracks the numbers and geographic locations of its patients and providers in order to monitor **adequate patient access to a full range of contracted and fully credentialed providers** as required by the product (e.g., general medical/surgical, specialty services, workers' compensation, etc.) being offered. A stable network is maintained through management of provider turnover and a formal program to discourage inappropriate out-of-network referrals. The PPO encourages its eligible patient population, through education and benefit plan design (i.e., cost-sharing incentives), to use network providers, and facilitates the provider's ability to identify eligible patients.

A PPO has a **formal written program for credentialing and recredentialing providers** that includes specific criteria, an application process, primary source verification of key credentials, and a decision process with physician input. The program applies, with appropriate tailoring, to all provider types represented in the network. Recredentialing includes evaluation of quality and utilization data, patient satisfaction measures, and grievances.

Reasonable payment methodologies allow a PPO to achieve measurable savings for its patients and its payer partners. A PPO offers competitive and equitable compensation to provider members, controls payment-level adjustments by contract and formal monitoring, and uses the reimbursement mechanism to create incentives for efficient provider practices.

Where permitted by law, PPOs may assume financial risk and enter into risk-sharing arrangements with providers.

Formal programs for **utilization management** and **quality assessment** are essential to an effective PPO. Both programs share the aim of optimal utilization of health care services to avoid both over- and under-utilization. A utilization management program manages care prospectively, concurrently, and retrospectively. The needs of individual patients are addressed on a a case-by-case basis. The quality assessment program examines opportunities for improvement in all care settings and by all provider types. It uses mechanisms such as practice guidelines, preventive health measures, outcomes studies, access measurement, and patient satisfaction assessment. Under both the utilization and quality programs, providers have access to performance-specific feedback and a formal written appeals process.

A PPO is **financially viable**. This entails diversified revenue sources, such as payer fees for network access, utilization review/quality assessment, and other services (e.g.,bill audits, retrospective review). Such fees are paid on an administrative-fee and/or percentage-of-savings basis. A PPO also may receive revenues from services to providers. Risk arrangements with payers involve a variety of payment methodologies. A PPO observes standard business and financial practices, e.g., budgeting, accounting, auditing, and insurance.

A PPO **establishes contractual relationships** with the payers and providers of health care and the appropriate intermediaries, binding these parties to the respective duties and responsibilities necessary to satisfy the PPO purpose, role, and functions described in this definition.

The legal definition of PPOs varies based on state law. Most PPOs are not licensed as insurers.

ppodef/706

An estimate of savings to be generated by PPOs in the Medicare program depends on a number of variables, not least of which is the statutory framework that Congress constructs to permit their participation. If PPOs are required to become risk-bearing, state-licensed entities engaged in the business of insurance, the number who qualify will be comparatively small and savings correspondingly modest. If, as AAPPO has proposed, PPOs are able to become contractors under the same arrangements that they currently make with self-insured employers -- i.e., PPOs are paid on an administrative-fee basis and do not necessarily bear insurance risk, though compensation may be tied to performance targets -- then we would expect the pattern of successful saving mirrored as well. As a rule of thumb, PPOs are able to generate savings on a 10-to-1 ratio to administrative fees.

Kasselman, 7/26/95, p. 42

SAVING MEDICARE AND BUDGET RECONCILIATION ISSUES

"FAIRNESS IS ESSENTIAL TO MEDICARE REFORM"

Statement of John P. Lee, Regional Vice President
for Oregon and California
Sisters of Providence Health System

on behalf of the Medicare Fairness Coalition

Before The Finance Committee
U.S. Senate
Washington, D.C.

July 26, 1995

Mr. Chairman and members of the Finance Committee, my name is John Lee. I am Regional Vice President for Oregon and California for the Sisters of Providence Health System, and the Chairperson of the Board of Directors of Providence Good Health Plan in Oregon. The Sisters of Providence Health System is composed of hospitals, medical groups, long-term care facilities and managed care health plans. Our health maintenance organization (HMO), called Providence Good Health Plan, serves 213,000 members in Oregon and Washington, including 33,000 Medicare beneficiaries in TEFRA risk contracts. Providence Good Health Plan has been contracting with HCFA to serve Medicare beneficiaries for ten years.

I appreciate this opportunity to appear before you today to share some of the experiences of our health system and other HMOs who make up the organization we call the Medicare Fairness Coalition.

Who Are We?

The Medicare Fairness Coalition is a multi-state group of managed care organizations who support modernization of the Medicare program. We recognize the imperative need to control spending in Medicare and to increase the choices for Medicare beneficiaries.

We include health plans offering services in Washington, Minnesota, Oregon, Alaska and Idaho. We are a fledgling organization, but we have attracted the interest of hospital systems, rural health organizations, state hospital organizations, and other health plans across the country who share our concern. At present, our health plans serve approximately a quarter of a million Medicare enrollees.

Why We Have Formed The Medicare Fairness Coalition?

Our message to members of Congress can be simply summarized:

- Capitated managed care plans/HMOs have a proven record of significantly reducing the costs and maintaining -- or increasing -- the quality of health care. Any reform of the Medicare payment system should incorporate strong incentives to enroll in managed care plans.

- At this time, enormous inequities exist in the Medicare capitated payments to HMOs depending upon the county in the U.S. in which they reside:

  In 1995, the Medicare payment rates to HMOs varied geographically from a low of $176 per month in the lowest county to a high of $647 per month in the highest -- a difference of 367%.

  This results in little or no HMO availability in parts of the country that receive low Medicare capitated payments.

- Medicare beneficiaries in different parts of the country are not being treated fairly: Those Medicare HMO plans that operate in counties receiving low Medicare capitated payments are not able to provide the same level of benefits for their Medicare beneficiaries as HMOs in more highly paid counties. As a result, Medicare HMO members in high-payment areas get more benefits, more choices, and pay less out-of-pocket than similarly situated beneficiaries who happen to live in low payment areas. In nearly half of all counties in America where Medicare managed care is offered, health plans rarely offer a comprehensive benefit package because the payment rate is too low to break even.

- The success of Medicare reform in reducing costs and increasing choice of health plans for Medicare beneficiaries will require that the U.S. Congress address the dramatic regional variation in Medicare capitation payments.

The good news is that if we do work toward eliminating unfair disparities, we can achieve the savings goals in the Budget Agreement and open up markets all over the nation to a wider variety of health plans. The result will be greater equity for all Medicare beneficiaries regardless of where they live.

Background of Medicare Managed Care

In 1965, Congress guaranteed health insurance coverage for retirees and the disabled. Medicare was modeled on the prevailing fee-for-service insurance programs, reflecting the way health care was delivered at the time. Medicare paid hospitals and providers for each service -- hospitals under Part A and physicians under Part B.

In the mid-1970s, HMOs began to thrive in some communities as an alternative to fee-for-service. HMOs offer a comprehensive set of benefits through an organized network of providers, for a single prepaid premium. In 1982, Congress gave seniors the opportunity to choose either traditional fee-for-service Medicare or a new HMO package. Under the HMO option, called TEFRA risk contracts, Medicare HMO members could receive comprehensive, integrated health coverage with little paperwork, more benefits, no deductible and low copayments.

A payment formula was developed that was tied to the fee-for-service spending. Starting with historical fee-for-service costs, HCFA calculates annually an average rate called the USPCC (United States Per Capita Cost), and then calculates separate rates for each county in the nation.

Through a series of subsequent steps, HCFA derives what is known as the AAPCC (Average Adjusted Per Capita Cost). The AAPCC reflects various demographic adjusters, and includes Part A, which reflects hospital spending, and Part B, which reflects physician and outpatient services in the fee-for-service side. Part A and Part B dollars are combined and the health plans are paid 95% of that rate.

The Impact of Capitated Managed Care on Health Care Costs

What no one anticipated was the dramatic change in how medicine was practiced in a growing number of markets. Recently, HMO growth has flourished in the private sector. There was a 10-12% growth in 1994, with a total of more than 50 million members nationwide.

An important effect of HMO growth in some markets has been a slowing of medical cost increases in these markets. To compete, fee-for-service plans try to

emulate the efficiencies in the managed care sector; wasteful practice patterns and unnecessary capacity decline. This reduces overall medical costs, which are reflected in the AAPCCs.

Let me describe the situation in our state: Oregon leads the nation in HMO enrollment. 43% of our overall population, and 49% of our Medicare beneficiaries are enrolled in HMO plans. Medicare HMO enrollment in Portland is nearly 60%. Such high capitated managed care activity is yielding positive results. The recent ProPAC report shows that Oregon is the lowest cost state in the U.S. for Medicare resource costs per enrollee and has the 4th highest health status. Although the reasons for Oregon's success in these areas are many, we believe that capitated managed care -- with its focus on responsible resource utilization and improving health outcomes -- is making a very positive contribution.

In particular, we are seeing the following results through managed competition between HMO plans:

- **Hospital inpatient days declined 22%** in Portland from 811,000 in 1985 to 633,000 in 1994 due to declining admission rates and lengths of stay. As a result, four general acute care hospitals have closed (or are soon to close) in the Portland area since 1985, and significant consolidation of services is occurring between the hospitals that remain.

- **Medicare premiums among the leading Medicare HMOs have seen flat or very modest increases** over the last 6 years. (Providence Good Health Plan has had no premium increase in 6 years.)

- **HMO commercial premiums have seen flat to CPI (4%) increases** in the last 2 years.

- **The first quality reports on Portland-area HMOs were published** this year according to standards developed by the National Committee on Quality Assurance. (We are proud to report that Medicare member satisfaction in Providence Good Health Plan in Oregon -- using member satisfaction as defined by NCQA -- is 98%.)

The influence of capitated managed care in reducing resource utilization is being felt in the overall delivery of health care in Oregon -- including in the fee-for-service sector. According to national surveys, costs for Oregon employers are significantly below the national average, and their employees enjoy more comprehensive coverage.

Across the country, we have seen counties where, as their markets become more efficient, growth in the AAPCC has declined. At the same time, we have seen in other counties in the U.S. -- because of overcapacity, patient demand, and lack of concern about costs in fee-for-service environments -- that AAPCCs have climbed more rapidly each year, often in the double digits.

The Special Case in Rural Areas

Another aspect of the variation is played out in rural areas. Because of low numbers of physicians, less Medigap coverage, and fewer high specialty facilities, per capita spending in rural areas lags behind most urban areas. While the per capita spending in high volume markets has grown, rural areas have been left way behind.

Medicare HMOs must guarantee easy access to a wide range of comprehensive services. At the payment rates now available, it is economically impossible to offer choices to beneficiaries in many rural areas. In the 1980s, many Minnesota HMOs enthusiastically offered HMO choices in rural Minnesota. However, the low payment rate soon discouraged them all and now there is no Medicare managed care available in rural Minnesota.

State by State Comparisons

The Fairness Coalition has developed charts to illustrate graphically the unfair nature of the current payment methodology. A selection of maps showing state variation in rates is attached. The Fairness Coalition will be pleased to provide additional maps to the committee on request.

Note that rural states suffer the lowest AAPCC payment rates, essentially foreclosing any alternatives to fee-for-service in those areas. States like Oregon, Washington, Nebraska, South Dakota, North Dakota, and New Mexico illustrate this point. All counties in these states receive less than the average AAPCC, and for many counties the payment is well below 30% of the average. Our research indicates that Nebraska appears to have the largest percentage of counties falling in the lowest range.

Efficient markets that have reduced overutilization, closed empty hospital beds, and aim for the highest quality at the lowest price are also penalized. Efficient urban areas, such as Seattle, Portland, Rochester N.Y., Minneapolis, and Honolulu are all well below the national average. As fee-for-service utilization decreases, the AAPCCs fall, and plans struggle to continue to offer the extra benefits that are offered in the high payment areas.

Here are some examples of urban area variations in the AAPCC:

Clackamas County (Portland)	$350 (per beneficiary per month)
King County (Seattle)	$377
Monroe County (Rochester NY)	$399
Los Angeles County (Los Angeles)	$558
Dade County (Miami)	$615
Philadelphia County (Philadelphia)	$625
Kings County (NYC)	$646

Cost of Living Differences Do Not Justify the Existing Variations

This variation cannot be explained on the basis of cost of living differences. In order to determine what are real differences in costs from region to region, and what differences can only be explained by utilization of services, our actuary looked to the DRG (diagnostic related groups) program as a model. Medicare pays hospitals on the basis of DRGs for bundles of services performed. HCFA allows the DRG rate to vary from region to region, based on a hospital price index that computes legitimate differences in measurable labor and price inputs. Currently, the variation based on cost of living is plus or minus 7%.

The AAPCC variation far exceeds the 14% DRG range by orders of magnitude! We believe that moving toward a similar variation for capitated payments is imperative for the success of Medicare reform.

AAPCCs are Irrational and Unpredictable

According to ProPAC, between 1994 and 1995 in the top 50 counties in terms of risk contract enrollment, the increase in the AAPCC ranged from 2.1 percent to 9.5 percent. For the most part, growth rates are higher in the inefficient markets and lower in highly competitive ones.

Left unaddressed, the variation will get worse. Using documented growth trends, the variations will increase over the next 7 years. Graph I illustrates how the disparity will expand if growth continues as predicted on such a widely variable base.

The inequity is exacerbated by irrational variations across neighboring counties.

For example, Senators D'Amato and Moynihan represent New York state. The 1995 AAPCC for Putnam County was $518, well above the average, and the Ulster County payment was $383, a full $135 difference per enrollee per month. Do

beneficiaries in Ulster County deserve less than their neighbors in Putnam County?

Similar irrationalities exist in northern Louisiana which Senator Breaux represents. Ouachita County receives $418 per member per month while neighboring Union receives only $318. Are medical costs that much different across rural county lines?

Unstable rates are a particular problem in rural areas. Because of small Medicare populations in some rural counties, variations in use of services can occur from year to year quite randomly. Thus, it is not uncommon to see major fluctuations on rates of increase from year to year.

Variation occurs in urban areas as well. The 1995 monthly capitated rate in the Washington D.C. area varied from $361 in Fairfax County to $543 in Prince George's County. It is difficult for health plans to care for individuals in a region when the government payment varies so much. It costs the same to deliver the care in a Washington hospital whether or not the patient resides in Fairfax County or Prince George's County.

The instability and unpredictability of AAPCCs are additional factors that discourage health plans from entering and staying in markets subject to these swings.

Beneficiaries Pay the Highest Price

The geographic disparity has the greatest negative impact on the Medicare beneficiaries, although this problem is not widely known or understood.

Let's take the case of two Medicare beneficiaries who choose a managed care plan in their respective communities. Ms. X lives in Portland. Ms. Y lives in Los Angeles.

Recall that both have paid in the same amount in Medicare taxes (2.9% of payroll) throughout their working lives. Despite the similarity in their contributions, they will receive vastly different benefits in their HMO options due to the "accident" of where they live.

Ms. Y's HMO in Los Angeles County is paid an AAPCC of $558 per member per month. Ms. X's HMO in Clackamas County receives $350 per month. Since rebates are not allowed, the Los Angeles health plan can load on additional benefits, such as prescription drugs, eye glasses and dental coverage. It may

charge no member premium, can reduce copays and deductibles and still make a nice profit.

The Portland HMO generally cannot afford to add additional benefits and must charge a monthly member premium to cover costs. Those premiums vary from $24 to $81 per month.

The inequitable payment rate means that a Portland senior may pay between $288 and $972 more per year to choose managed care, while the Los Angeles senior receives all the Medicare benefits plus lots of extras, free of charge. In other words, in areas with high payments from Medicare, beneficiaries get more and pay less out of pocket than those in low payment areas.

Health plans who have done business in efficient markets have struggled with this problem for years. We have had to reduce our benefits and raise our premiums while trying to compete. Recent GAO testimony before the Commerce Committee, Subcommittee on Health and the Environment, reported that the number of risk contracts with zero premium is increasing. Zero premium plans are only growing in the high pay markets. It is not the case in efficient markets. There are NO zero premium options in the Portland market, for example. Plans simply can't afford to offer them and survive.

One last example from Portland: for many years, Medicare members of Providence Good Health Plan have told us that their greatest unmet health care need was prescription drug coverage. In 1995, we were finally able to craft a modest benefit whereby Providence Good Health Plan pays 50% of the prescription drug cost up to a monthly maximum of $100. However, we are unfortunately experiencing significant losses on this benefit and are having to consider scaling the drug benefit back or dropping it altogether. Yet we know that even more comprehensive drug benefits are offered in other areas in the country that receive high Medicare AAPCC payments.

Chart 1 summarizes the impact of the differences in two markets -- Portland and Miami.

Managed Care Growth is Discouraged, Particularly in Rural Areas

Managed care has the potential to save dollars for beneficiaries and for the federal budget. However, the current inequitable payment means that growth in Medicare managed care is taking place primarily in the high payment areas.

The counties in the top 10% of payment rates have approximately 30 percent of the Medicare population. These areas account for 50% of all the Medicare

managed care. By contrast, the counties in the bottom 50% of AAPCCs, also have 30 percent of Medicare enrollees, but only 15% of the Medicare managed care.

Let me use an experience in Minnesota to illustrate this point. In the mid-1980s, more than 50% of Medicare eligibles in the Twin Cities of Minneapolis-St. Paul enrolled in the new risk contracts -- a full two-thirds of whom had not previously been enrolled in HMOs. Now, a little over 10 years later, only 9% of Minnesota's Medicare beneficiaries are in risk contracts and this percent has not increased since 1990. This is in a market in which managed care for the employed population has been booming.

Why? The AAPCC increases have been minimal and in several years they experienced actual cuts in payment. Plans have had to reduce the extra benefits that attracted many to the programs in the first place, and also increase premiums, copays etc. Although they are anxious to serve this portion of the population, it is becoming economically more challenging every year.

The three remaining risk contractors in Minnesota (all of whom are members of this coalition), offer plans only in the Twin Cities metro area. Beneficiaries in rural areas have virtually no managed care options. This is true for all of the coalition member states and many states across the country.

Across-the-Board Growth Limits in AAPCCs Will Make this Problem Worse

It has been suggested that, in order to make savings targets, Congress should allow Medicare to grow at an average rate of 5% per year until 2002. This would permit the average annual per capita expenditure to increase from $4,800 to $6,300 (the number in the original House proposal) or $6,700 (the number in the Budget Agreement.)

Clearly, it is necessary to control the growth in expenditures in the program. However, if the rate of growth in the federal payment is imposed across the board the inequities will increase, inefficient markets will continue to be rewarded, and fewer and fewer areas will offer the choices that are anticipated in a reformed program.

Some health plans already receive sums in excess of what would be the average in 2002. Plans in Dade County, for example, already receive $7,380 per year in 1995! Plans in Oregon receive $4,476 in 1995. Allowing similar growth with this disparity as a base is patently unfair to the seniors in those markets and to the health plans seeking to provide quality care to them.

The attached graphs illustrate how much growth would be permissible based on assumptions underlying the Congressional reform goals. Whether the goal is an average of $6,300 or $6,500, or $6,700, it is clear that holding the 10 percent of the counties in the top AAPCCs to smaller growth rates will allow rural areas and efficient markets, which account for the vast majority of counties in the nation, to reach some level of equity by 2002.

A transition to equity is often referred to as "normalization" of rates. Normalization was achieved in the DRG transition and is also part of the RBRVs (resource based relative value scale) for physician fee. The government will have to determine what level of contribution it will make to beneficiaries, whether it be in the form of a voucher, defined contribution, or other arrangement. We believe that fairness requires that the federal payment be equitably distributed, taking into account the legitimate and measurable variation in input prices from market area to market area.

The Opportunity

Congress has an opportunity to modernize the Medicare program. It can accomplish its budgetary goals in the process of offering more choices in a competitive environment.

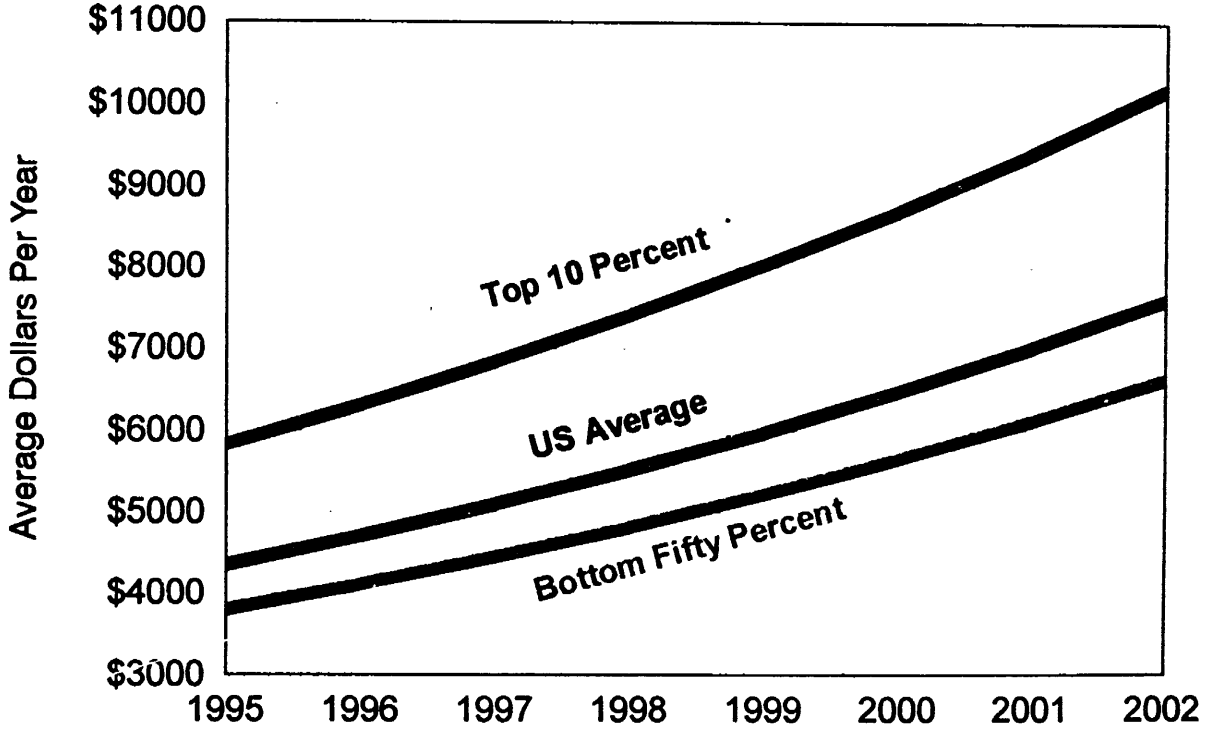
Provider groups have insisted that simplistic cuts to provider payments will not be adequate to solve the long-term challenge and could cripple the health care infrastructure, particularly in rural areas. We hope we have convinced you that across-the-board cuts in fee-for-service payments to providers or capitation payments to risk contracting health plans would ignore the wide variation that presently exists in Medicare spending and would penalize efficient markets and many rural communities.

There are a growing number of thoughtful proposals on the table that will introduce competitive market forces to modernize the program, by changing both provider and consumer behavior to reward wiser choices. We applaud the work of the Physician Payment Review Commission, the Prospective Payment Review Commission, the Group Health Association of America, the American Hospital Association and others who have called for solutions rooted in the marketplace to improve the Medicare program in the long run.

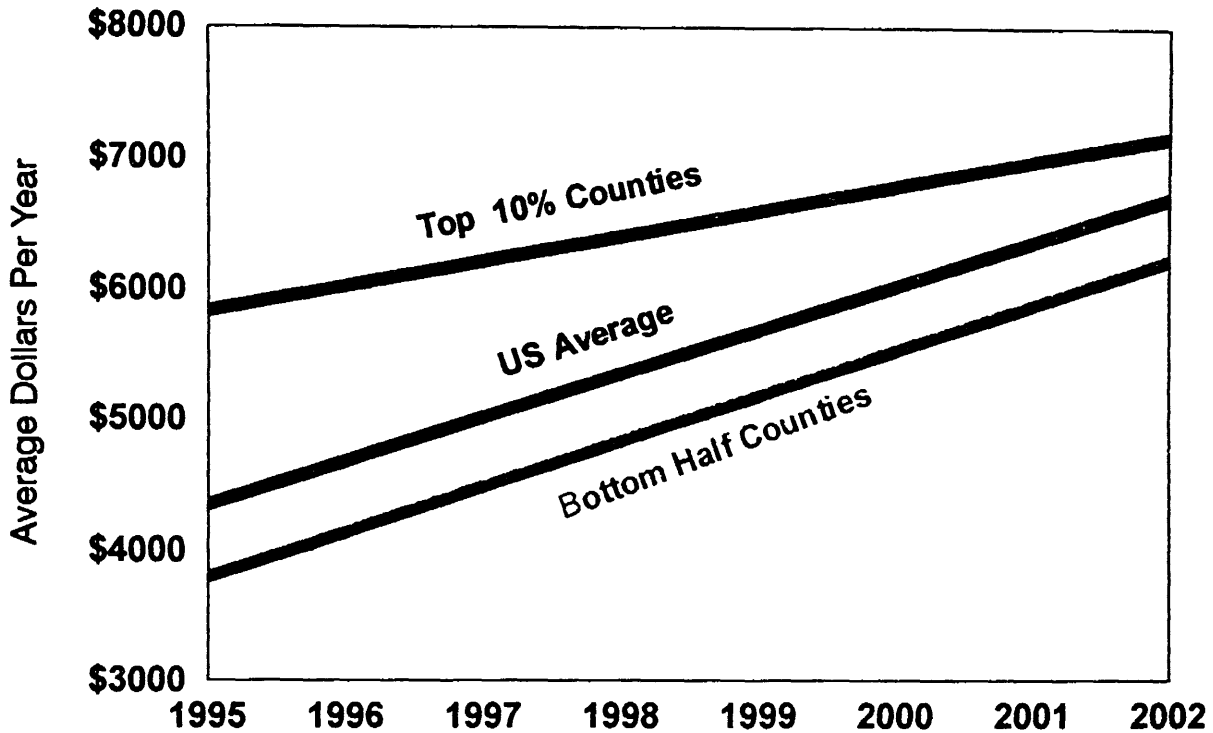
We are pleased to provide the committee with copies of our Fairness Coalition Concept Paper which describes in greater detail our principles for Medicare reform. (Appendix 1)

Today, however, our contribution is to illustrate the magnitude and the negative impact of the geographic disparity in payment on the present Medicare system. We hope you can see that failure to address the disparity problem will prevent the Congress from achieving its essential goals – savings to the federal budget to preserve the program and expansion of choices for Medicare beneficiaries in all communities across the nation.

Graph 1: If Nothing Is Done, The Disparity Between TheTop Ten Percent Of AAPCC Counties And The Bottom Half Of AAPCC Counties Will Increase



Graph 2: Eliminate The Disparity Between The Top And Bottom Half Of AAPCC Counties To A US Average Of $6700 in 2002 And Save $270 Billion*

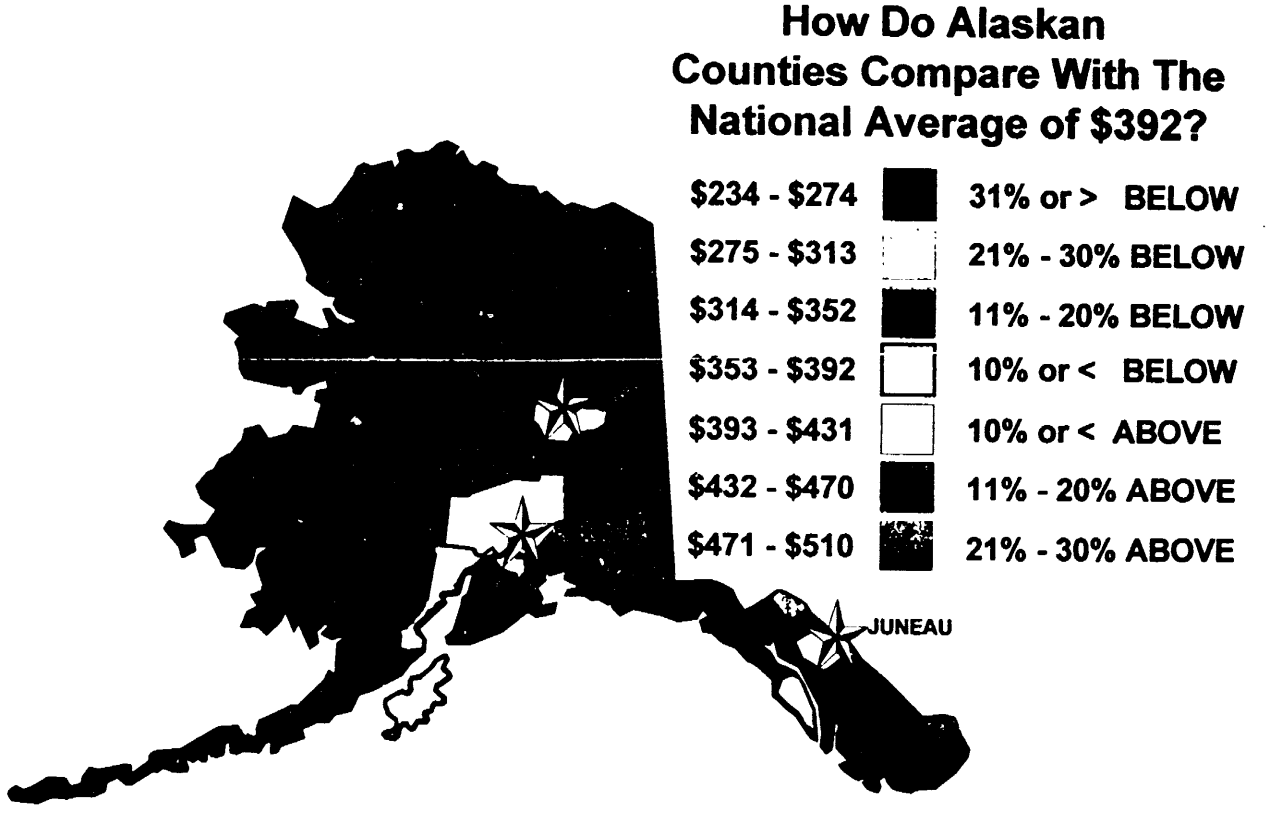


*Note: Assumes that by 2002, the Medicare Care Package this proposal is in has encouraged 50% of beneficiaries into managed care plans.

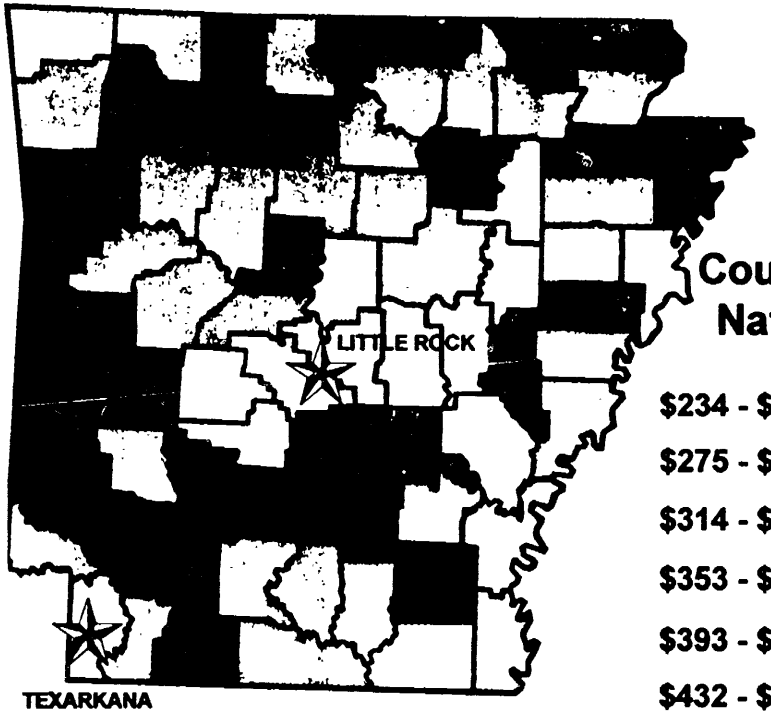
Medicare Payment Formula Unfair to Taxpaying Seniors

Medicare Beneficiary Identical Earned Income and Paid Medicare Taxes	HCFA Payment to HMO for Medicare Services	HMO Monthly Senior Premium for Non-Medicare Covered Services	Benefit Variances
Minnesota (Hennepin)	$362	$58	- no prescription drug coverage - $10 office visit copayment
Florida (Dade)	$615	$0	- prescription drug coverage - no office visit copayment
Oregon (Clackamas)	$350	$30	- no prescription drug coverage - $9 office visit copayment

Eighty-Eight Percent Of Alaskan Counties Receive Less Than The National AAPCC Average



Ninety-Five Percent Of Arkansas Counties Receive Less Than The National AAPCC Average



How Do Arkansas Counties Compare With The National Average of $392?

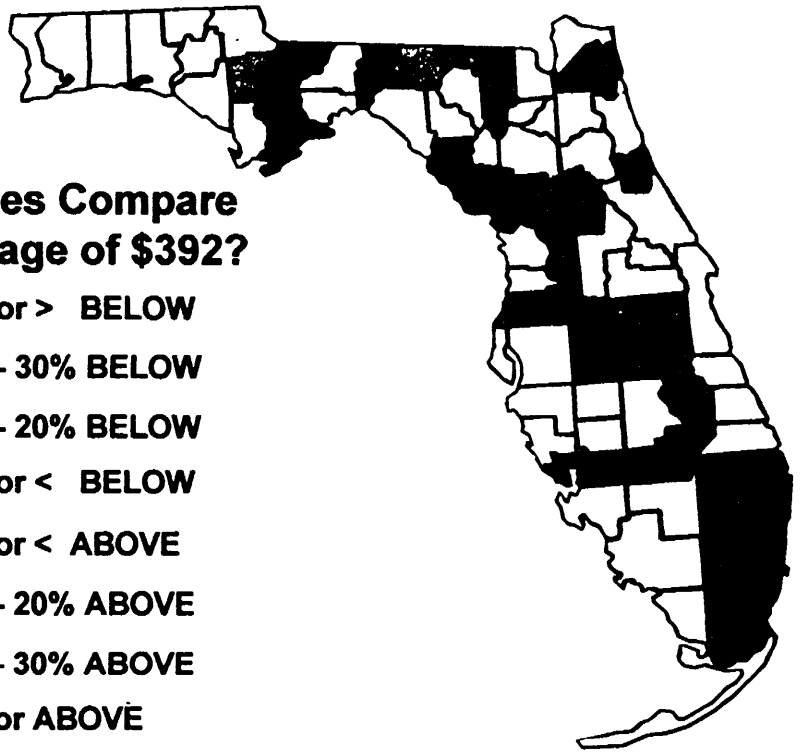
$234 - $274		31% or > BELOW
$275 - $313		21% - 30% BELOW
$314 - $352		11% - 20% BELOW
$353 - $392		10% or < BELOW
$393 - $431		10% or < ABOVE
$432 - $470		11% - 20% ABOVE
$471 - $510		21% - 30% ABOVE

Two-Thirds Of Delaware Counties Receive Less Than The National AAPCC Average

How Do Delaware Counties Compare With The National Average of $392?

$234 - $274		31% or > BELOW
$275 - $313		21% - 30% BELOW
$314 - $352		11% - 20% BELOW
$353 - $392		10% or < BELOW
$393 - $431		10% or < ABOVE
$432 - $470		11% - 20% ABOVE
$471 - $510		21% - 30% ABOVE

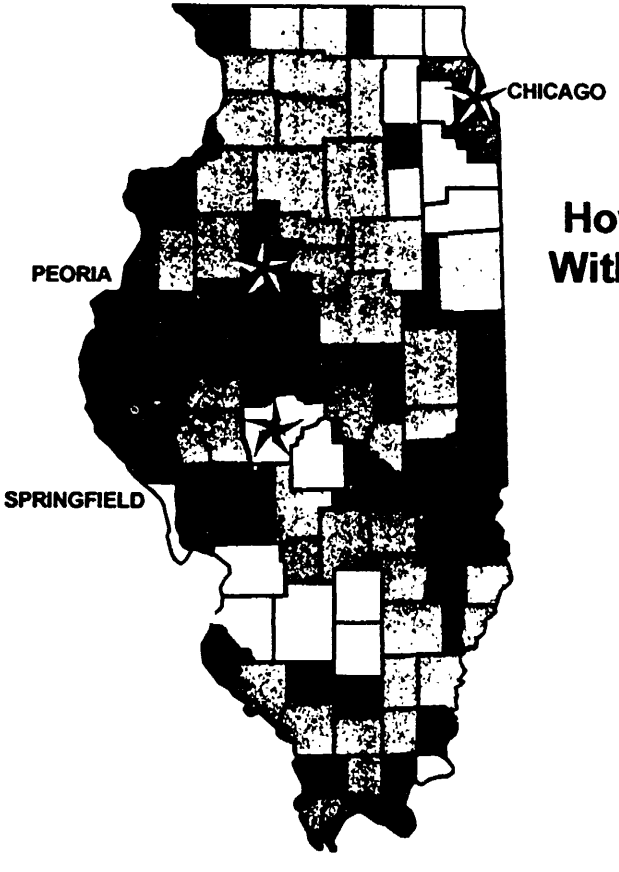
Almost One-Half Of Florida Counties Receive More Than The National AAPCC Average



How Do Florida Counties Compare With The National Average of $392?

$234 - $274	■	31% or > BELOW
$275 - $313	▒	21% - 30% BELOW
$314 - $352	■	11% - 20% BELOW
$353 - $392	□	10% or < BELOW
$393 - $431		10% or < ABOVE
$432 - $470	■	11% - 20% ABOVE
$471 - $510	▒	21% - 30% ABOVE
$511 PLUS	■	31% or ABOVE

Ninety Percent Of Illinois Counties Receive Less Than The National AAPCC Average



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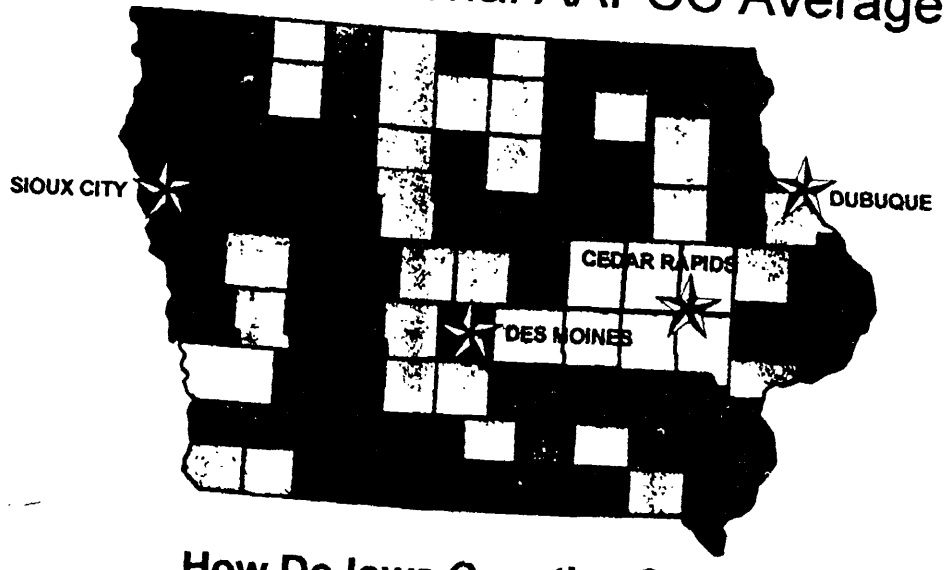
$393 - $431		10% or < ABOVE
$432 - $470		11% - 20% ABOVE
$471 - $510		21% - 30% ABOVE

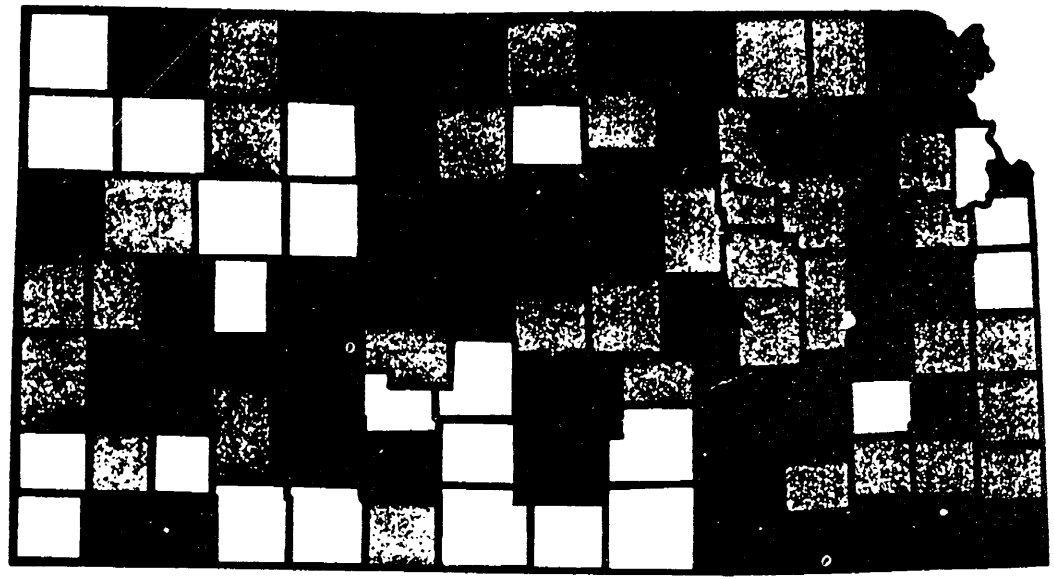
All Iowa Counties Receive Less Than The National AAPCC Average



How Do Iowa Counties Compare With The National Average of $392?

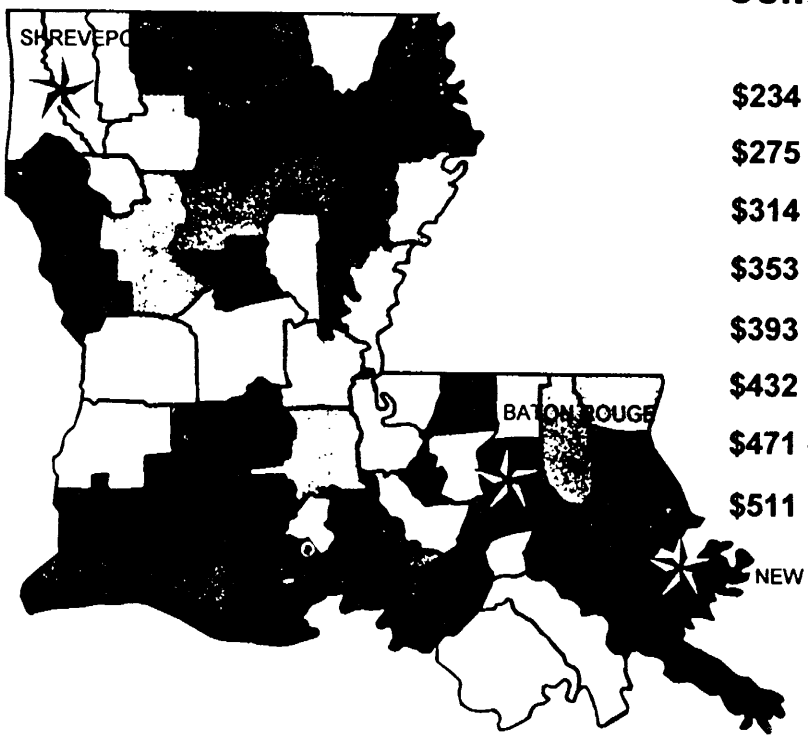
$234 - $274	■	31% or > BELOW
$275 - $313		21% - 30% BELOW
$314 - $352	▪	11% - 20% BELOW
$353 - $392	□	10% or < BELOW

Three Out Of Every Four Kansas Counties Receive Less Than The National AAPCC Average



$234 - $274		31% or > BELOW	$353 - $392		10% or < BELOW
$275 - $313		21% - 30% BELOW	$393 - $431		10% or < ABOVE
$314 - $352		11% - 20% BELOW	$432 - $470		20% or < ABOVE

Fifty-Two Percent Of Louisiana Counties Receive Less Than The National AAPCC Average



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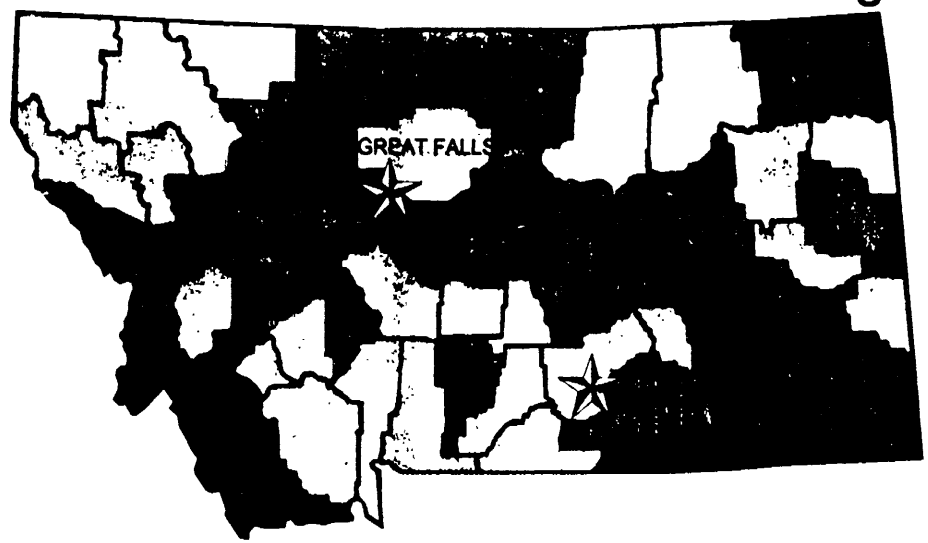
$432 - $470		11% - 20% ABOVE
$471 - $510		21% - 30% ABOVE
$511 PLUS		31% or ABOVE

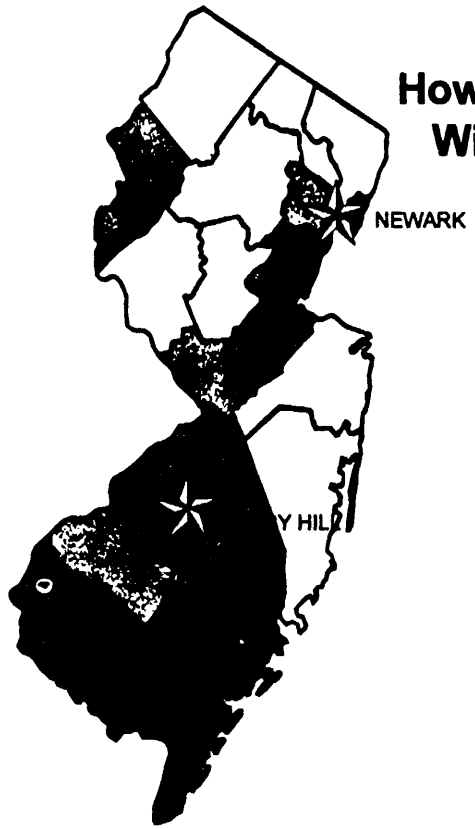
All Montana Counties Receive Less Than The National AAPCC Average



How Do Montana Counties Compare With The National Average of $392?

$234 - $274	■	31% or > BELOW
$275 - $313		21% - 30% BELOW
$314 - $352	▒	11% - 20% BELOW
$353 - $392	□	10% or < BELOW

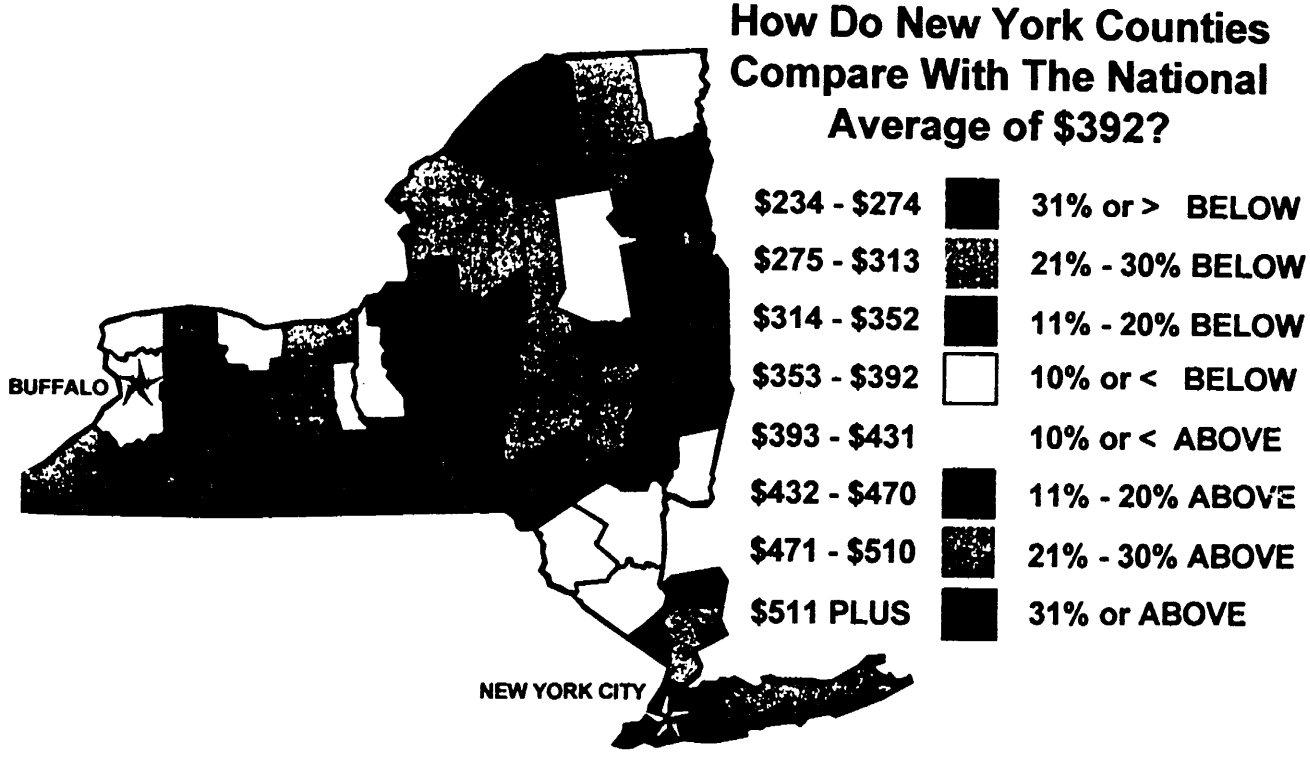
All But One New Jersey County Receives More Than The National AAPCC Average



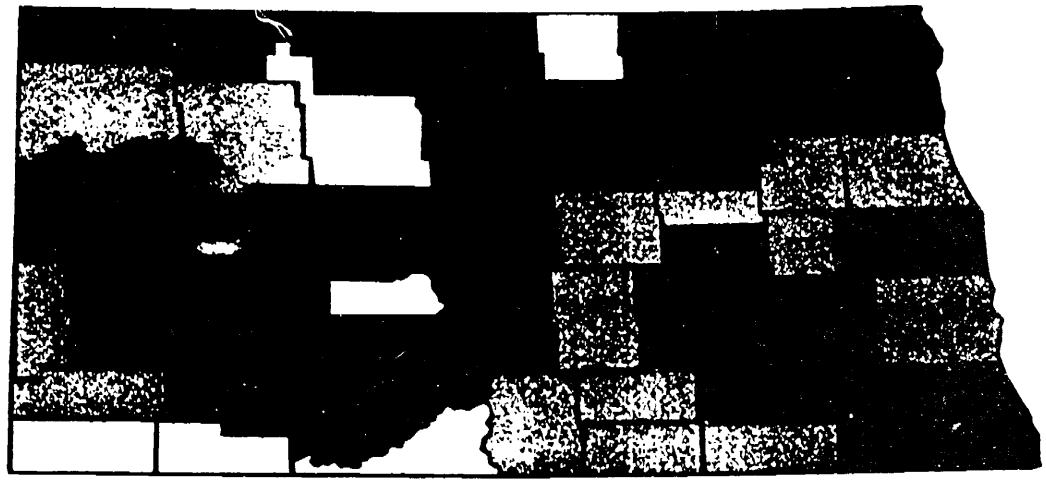
How Do New Jersey Counties Compare With The National Average of $392?

$234 - $274		31% or > BELOW
$275 - $313		21% - 30% BELOW
$314 - $352		11% - 20% BELOW
$353 - $392		10% or < BELOW
$393 - $431		10% or < ABOVE
$432 - $470		11% - 20% ABOVE
$471 - $510		21% - 30% ABOVE

Eighty Percent Of New York Counties Receive Less Than The National AAPCC Average



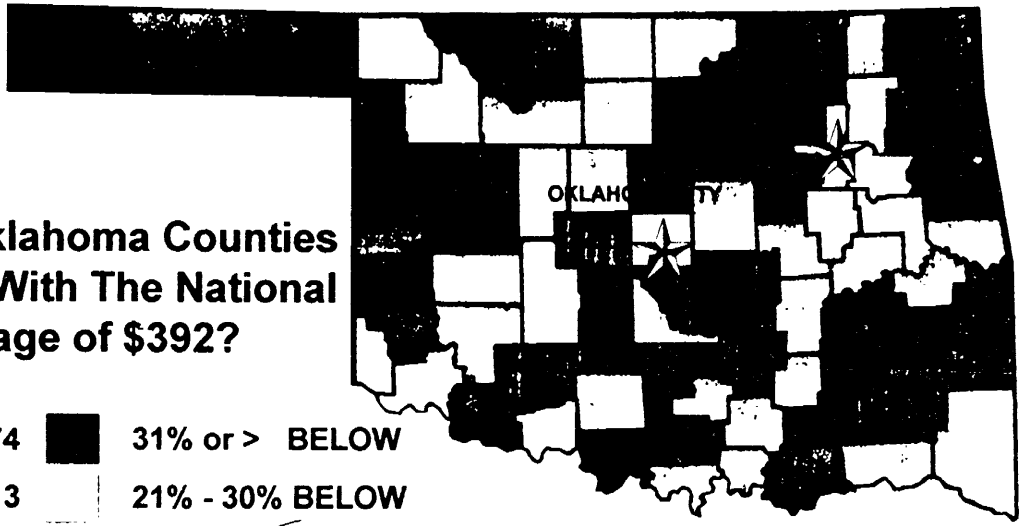
All North Dakota Counties Receive Less Than The National AAPCC Average



How Far Below are North Dakota Counties Compared To The National Average of $392?

$234 - $274	■	31% or > BELOW
$275 - $313		21% - 30% BELOW
$314 - $352	■	11% - 20% BELOW
$353 - $392	□	10% or < BELOW

All Oklahoma Counties Receive Less Than The National AAPCC Average



How Do Oklahoma Counties Compare With The National Average of $392?

$234 - $274		31% or > BELOW
$275 - $313		21% - 30% BELOW
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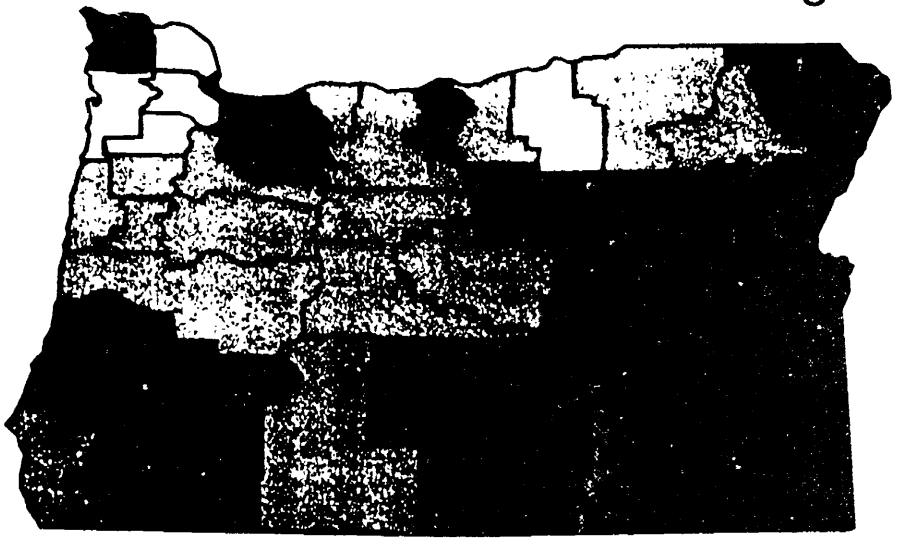
$432 - $470		11% - 20% ABOVE
$471 - $510		21% - 30% ABOVE

All Oregon Counties Receive Less Than The National AAPCC Average



How Far Below are Oregon Counties Compared To The National Average of $392?

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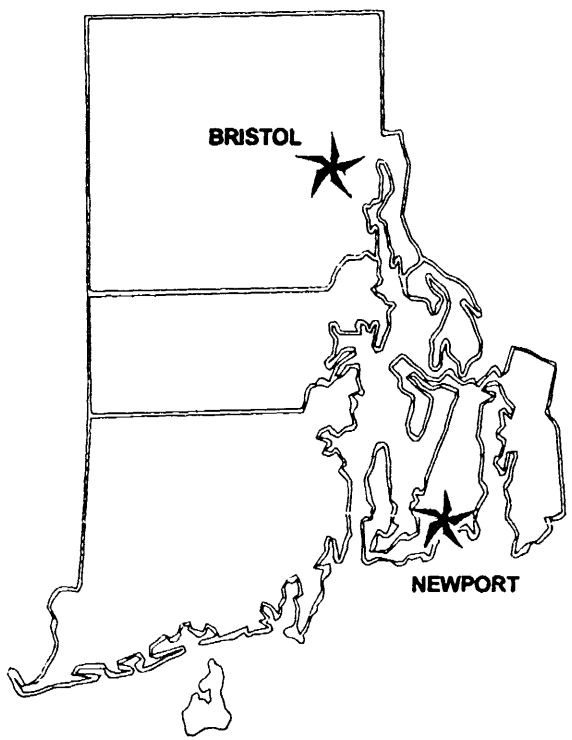
Sixty Percent Of Rhode Island Counties Receive Less Than The National AAPCC Average



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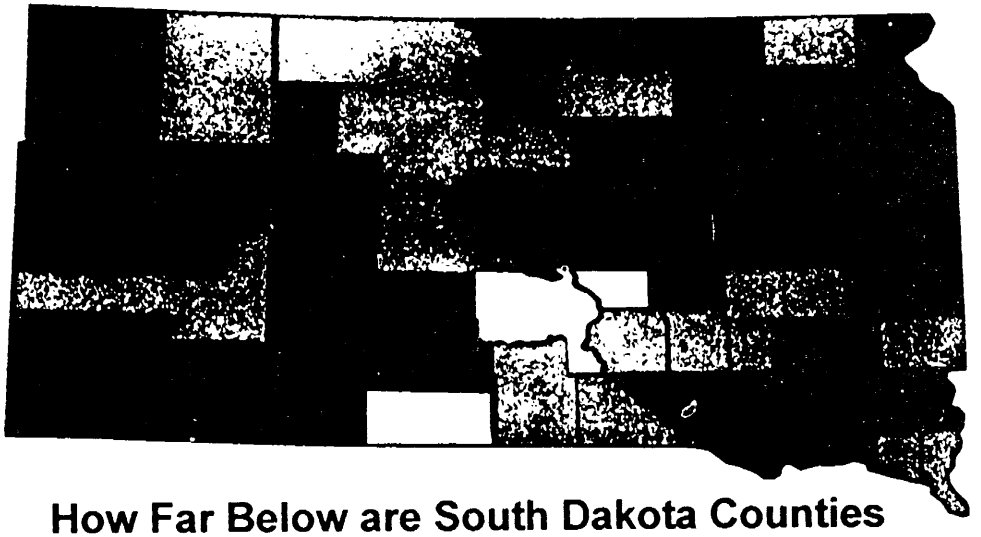
All South Dakota Counties Receive Less Than The National AAPCC Average



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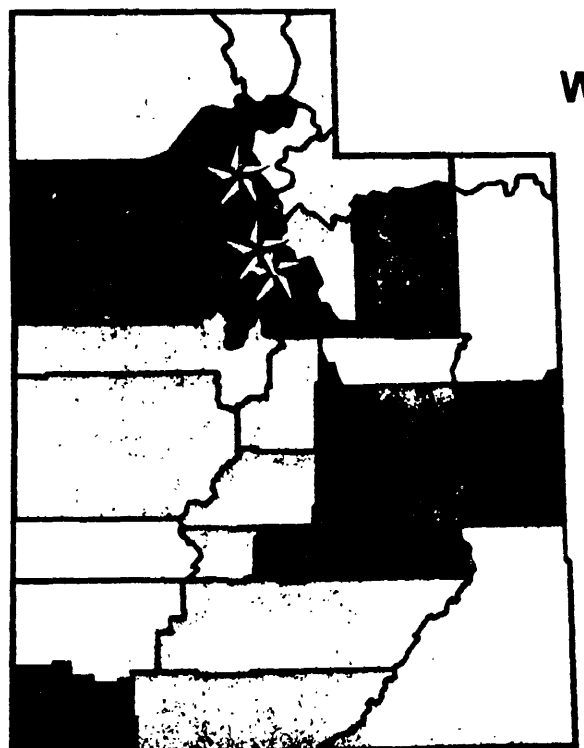
All Utah Counties Receive Less Than The National AAPCC Average



How Do Utah Counties Compare With The National Average of $392?

$234 - $274		31% or > BELOW
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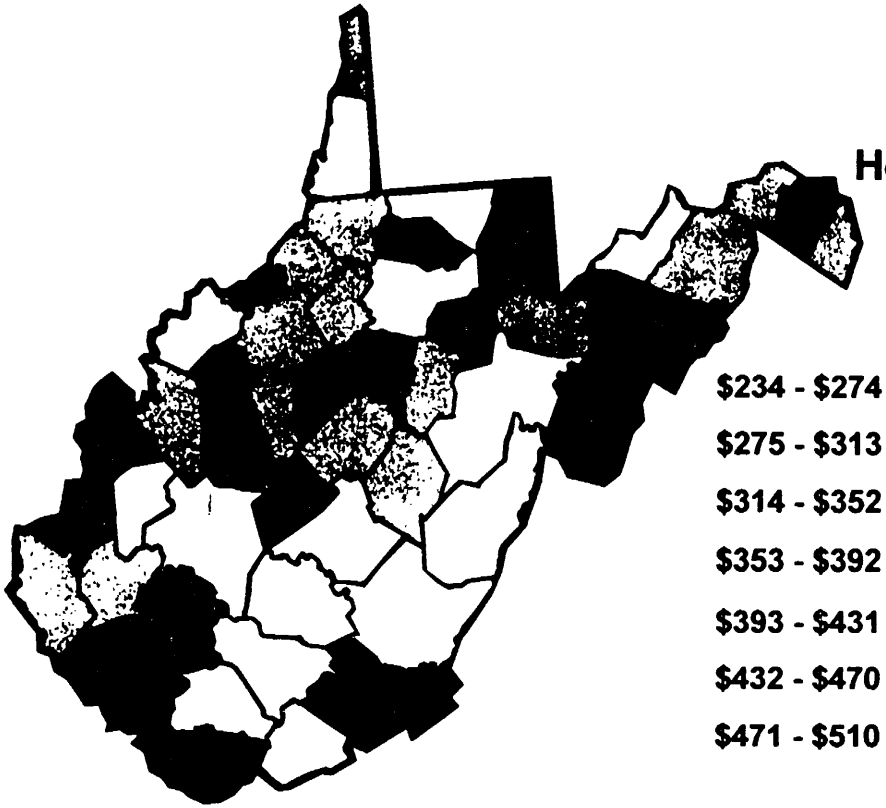
Eighty-Five Percent Of West Virginia Counties Receive Less Than The National AAPCC Average



How Do West Virginia Counties Compare With The National Average of $392?

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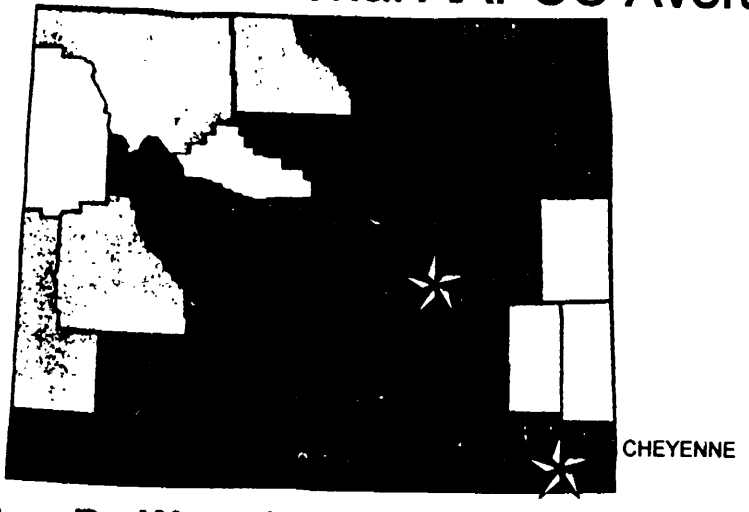
All But One Wyoming County Receives Less Than The National AAPCC Average



How Do Wyoming Counties Compare With The National Average of $392?

$234 - $274	■	31% or > BELOW
$275 - $313	▨	21% - 30% BELOW
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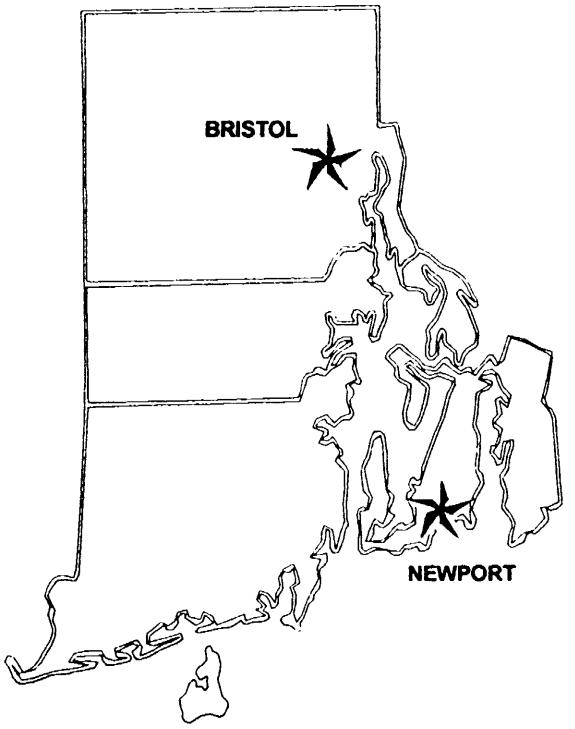
Sixty Percent Of Rhode Island Counties Receive Less Than The National AAPCC Average



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All South Dakota Counties Receive Less Than The National AAPCC Average

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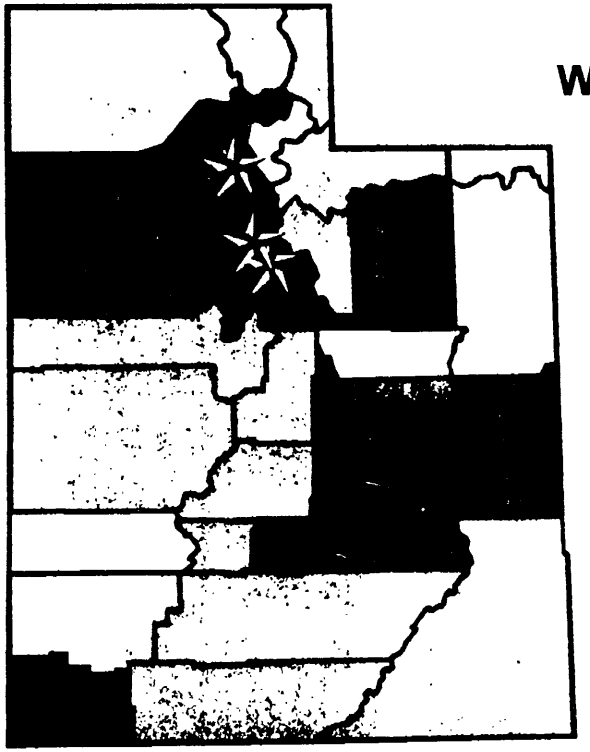
All Utah Counties Receive Less Than The National AAPCC Average



How Do Utah Counties Compare With The National Average of $392?

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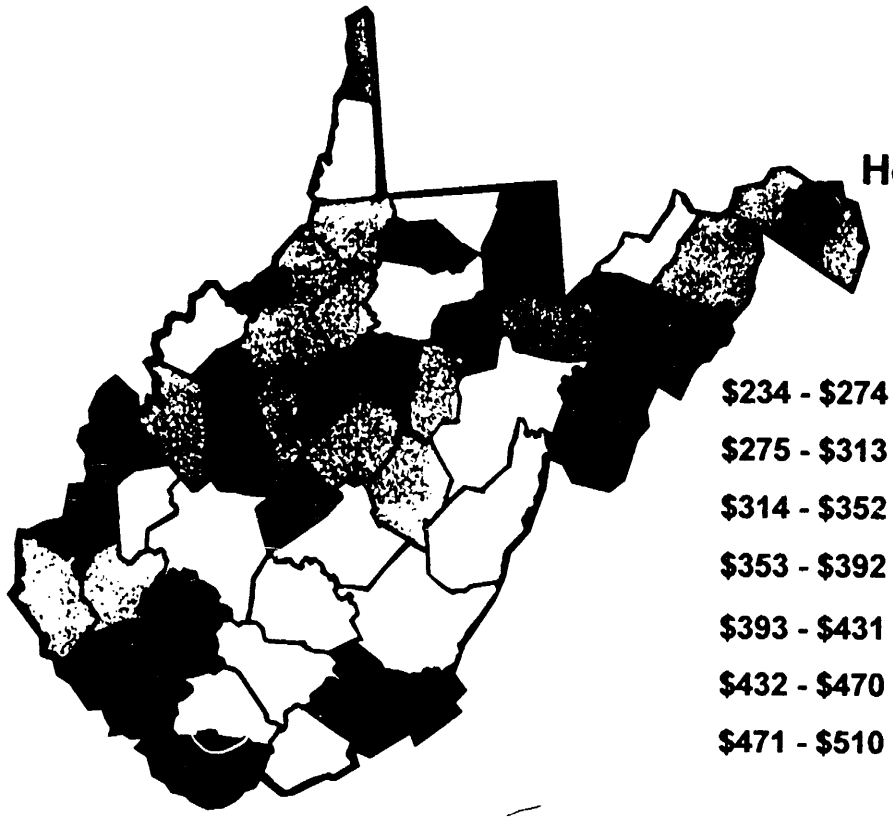
Eighty-Five Percent Of West Virginia Counties Receive Less Than The National AAPCC Average



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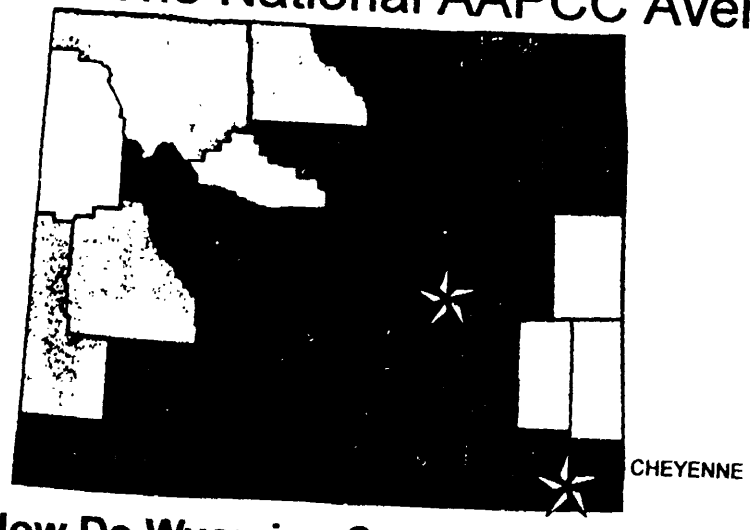
All But One Wyoming County Receives Less Than The National AAPCC Average



How Do Wyoming Counties Compare With The National Average of $392?

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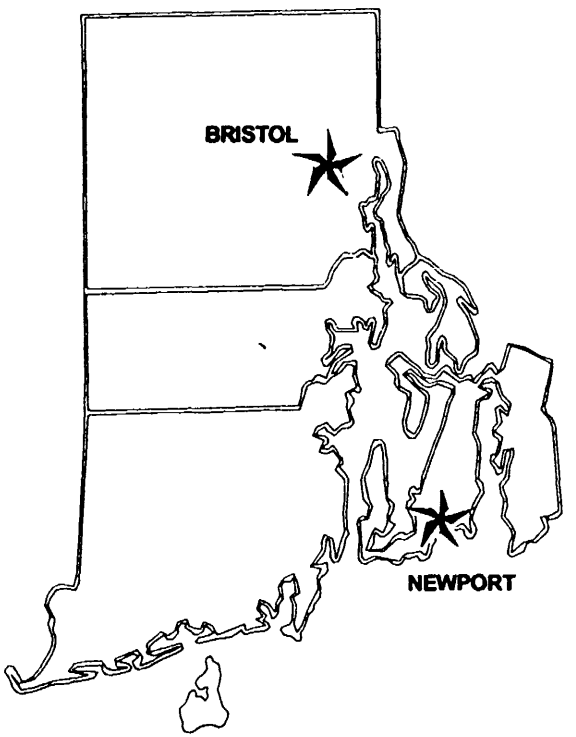

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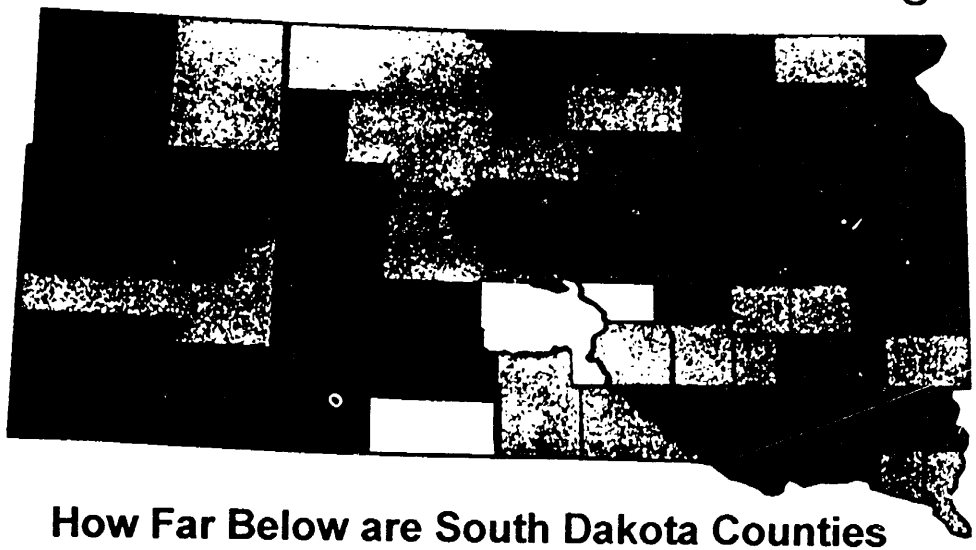
All South Dakota Counties Receive Less Than The National AAPCC Average



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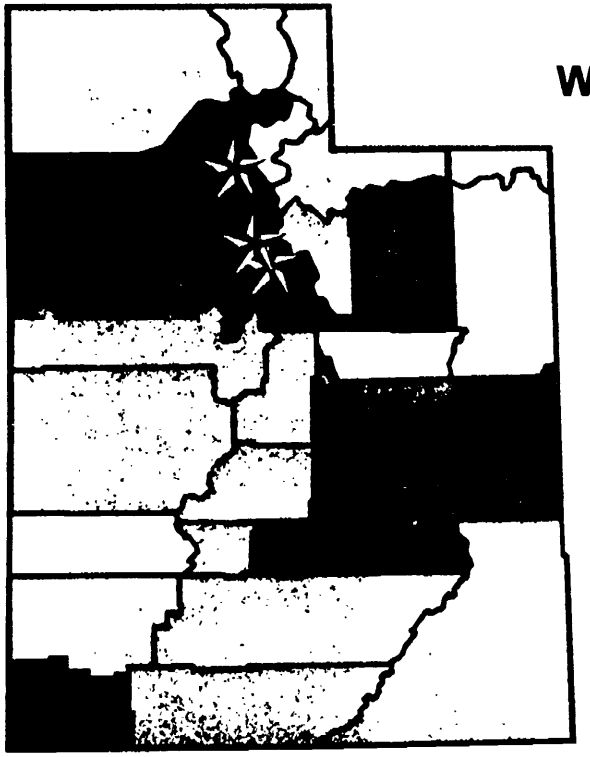

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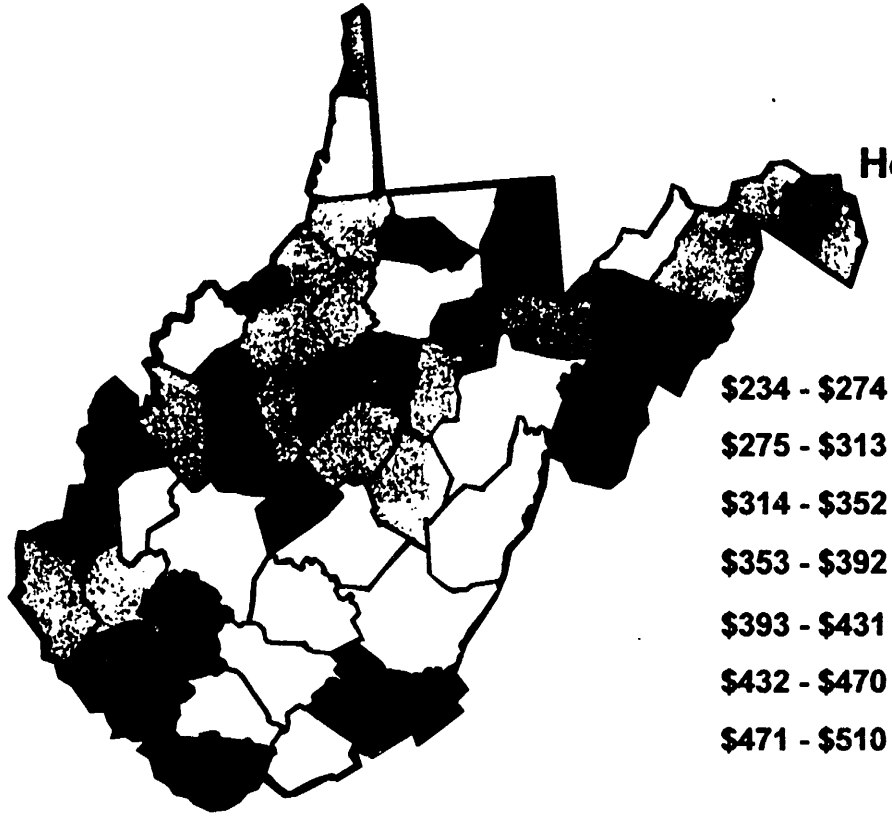

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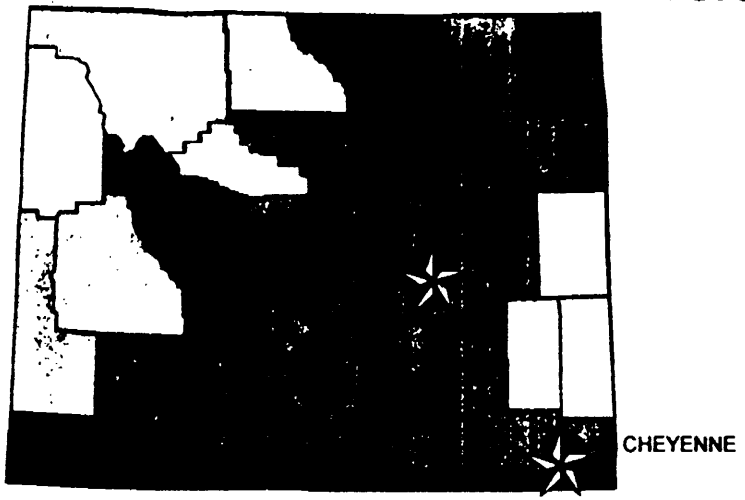

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MEDICARE FAIRNESS COALITION

CONCEPT PAPER

WE SUPPORT MEDICARE REFORM

Medicare is an important and highly valued entitlement program. But, we recognize the 30 year old program has problems. We have an unprecedented opportunity to modernize and improve the Medicare program, while keeping it solvent and offering more choices for all Medicare beneficiaries.

There is a recognition that simplistic cuts to provider payments will not solve the long-term challenge and could crippled the health care infrastructure in many parts of the country. Across-the-board cuts in fee-for-service payments to providers or capitation payment to risk contracting health plans would ignore the large variation that presently exists in Medicare spending and would especially penalize efficient markets like Seattle, Portland and Minneapolis and most rural communities.

There are a growing number of thoughtful proposals on the table to use competitive market forces to revitalize Medicare. Competition would alter provider and consumer incentives and reward cost-conscious behavior. The Physician Payment Review Commission, the Prospective Payment Assessment Commission, the Group Health Association of America, the American Hospital Association and others have all called for a restructured program based on market solutions to improve the Medicare program in the long run.

The Fairness Coalition supports expansion of choices for beneficiaries through competitive market forces. The Coalition recognizes the need to control the growth in Medicare spending to preserve the solvency of the program for the future.

We add to the discussion the fundamental premise that these goals cannot be accomplished without addressing the large variation in Medicare spending that now exists from community to community. If we focus on eliminating the wide variation in per capita spending from county to county, the Coalition believes we can create functioning markets for Medicare nationwide.

PRINCIPLES FOR REFORM

The Fairness Coalition believes that choices for Medicare beneficiaries can be expanded and the savings to the program can be achieved if markets are fairly structured. We seek equity within and across markets to drive the needed changes. Without equity, budgetary savings cannot be realized without significant adverse

consequences for seniors, employers and taxpayers across the nation. Moreover, seniors in efficient markets and in rural areas will NOT have expanded choices of health plans because cuts will preclude competitors from entering these markets. Fairness within markets means that the expanded range of choices among competing health plans should be treated equally with respect to federal payments. Essentially, Medicare would continue to entitle beneficiaries to a core benefit package, but federal contributions could be made to a wider variety of private plans that offer the core benefit package. (Details described herein). The fee-for-service option should be maintained. Capitation should be an option in all markets, but it need not be the only mechanism for cost control.

Properly designed market forces are the key. If government pays no more for fee-for-service plans than for capitated ones, there is no need for artificial price controls on what consumers may be willing to pay for the option they desire. If properly designed, a capitation payment system can re-orient provider and health plan incentives toward efficiency and prevention, and should be part of the competitive mix in every community. Flaws in the current method by which HCFA pays capitated plans make this impossible today. Any reform plan which relies on market forces must correct these flaws.

Fairness across markets means that government can realize savings by eliminating subsidies for wasteful spending in some markets. In this model, the government's defined contribution would be made equitable across regions over time. The current variation from county to county is as high as 367%. The contribution (phased in similar to the DRG and RBRVs transition models) should vary based only on legitimate differences in "illness burden" of Medicare population and "input costs" of medical practice (labor, cost of living, etc). Variation is acceptable when based on actual, measurable differences. Payments that reward inefficient and excessive spending and penalize cost-efficient markets and wise choices are not acceptable.

Budgetary savings can be assured by establishing in advance the per capita federal contribution to the Medicare program in each market under the defined contribution approach.

FAIRER FEDERAL CONTRIBUTIONS

Many proposals include a "voucher" concept where beneficiaries have a set amount of money to choose qualified plans. In many proposals, the voucher amount is set on the basis of some competitive bidding system. The Fairness Coalition's proposal is entirely compatible with an eventual competitive bidding design, but we strongly

caution that without adjusting for greater regional equity in the government's share of total spending first, the resulting inequity of a competitive bid system in the range of consumer choices and out-of-pocket costs would be extreme.

Furthermore, employers who operate in markets disadvantaged by the current federal payment approach bear a disproportionate burden for their retiree costs as well as a general cost-shift within the community. (Other concerns are identified below.)

The essential elements in The Fairness Coalition's proposed approach are:

- The federal contribution (or voucher) would be based on a new "Market Area Budgeted Benchmark" (MABB). It would replace the current AAPCC system which is retrospective calculation based on a 5-year rolling average of actual spending in each county.

- By contrast, the MABB would be a ceiling on federal contributions based on a formula set in advance, thereby protecting (capping) the federal budget and creating incentives for competitors to deliver services within the budget. Consumers (individual beneficiaries or employers on behalf of consumers) could spend private dollars above the MABB.

- In year one of the transition, the MABB would be based on actual current fee-for-service costs in the market area. Over time, the MABB become "normalized" to achieve geographic equity (detail below).

- Qualified capitated health plans would submit "premium proposal" – the price for which they would offer the standard Medicare coverage package.

- If the proposal any given plan makes is above the MABB, the beneficiary pays the difference between the federal contribution and the proposal.

- If the premium proposal is lower than the MABB, the capitated plan would offer additional benefits and/or the government get a rebate.

- Capitated plans bid in relation to the benchmark and bear all the risks if their spending exceeds the allowable rate. Thus, capitated plans that bid competitively will never exceed the MABB.

- FFS Medicare is a competitor, but doesn't bid prospectively like a capitated plan and its budget enforcement mechanism is applied retrospectively. Cuts

using a volume/performance standard or VPS (applicable to the aggregate of Part A and Part B) will be applied if FFS Medicare expenditures exceed the MABB.

- The VPS can be tailored to address the particular cost drivers in each market area.

NORMALIZATION OF MABB TO ACHIEVE FAIRNESS

- Market-Area Budgeted Benchmark will be subject to "normalization" over a 5-10 year period, net of input price and illness burden differentials. Normalization simply means that over time we move to a fairer federal payment in all markets.

- Every fall HCFA will calculate the MABB for each market area, based on the normalizing formula. This formula will be calculated on a blend of the national average of FFS Medicare expenditures and the actual expenditures in that market area. The blend will change over time using a DRG-like transition to achieve normalization. As the rates are normalized, we can expect that the benchmark in high cost areas will show little growth and, in the highest cost areas, may experience no growth. On the other hand, benchmark rates in low cost areas may experience greater growth rates as they gravitate upward to the national norm. This redistribution is essential if Medicare savings and regional fairness are to be achieved.

- Such normalization is essential to create functional markets in places where low AAPCCs now mean no choices exist for beneficiaries, and to reward the most efficient and competitive provider and health plan markets over time.

ADDITIONAL STEPS TO IMPROVE MARKETS

A number of other ideas should be incorporated into any restructuring proposal. Most of these are common to many of the proposals already offered by the Congressional advisory commissions and leading health industry groups. They include the following:

- Redefine market areas in which health plans bid. Move from county-specific rates to rates for cohesive market areas using concepts like PPRC's "shrinkage estimator," or adjust for "core" and "ring" counties within them.

- Develop health status adjusters so that government does not overpay for low-cost cases and provide incentives for organized systems to deal with complex high-cost cases.

- Develop better ways to directly calculate FFS costs. Current technical problems in HCFA calculations have led to inaccurate AAPCCs.

- Remove medical education costs from HCFA's calculation of fee-for-service patient care costs. A new method is needed for funding medical education and research.

- Develop special adjusters to encourage coordinated care networks in rural areas and to support the existing rural provider infrastructure.

CONCERNS ABOUT COMPETITIVE BIDDING ABSENT FAIRNESS REFORMS

Moving prematurely to a competitive bid system would have the infirmities noted above. Other issues to be considered include:

- Unless there is a cap on the federal contribution, the federal budget remains at risk. The lowest bid could be a high one, especially in high-cost areas. No savings could be assured where markets are resistant to change.

- Reliance on a market-based federal contribution may not produce savings fast enough to meet balanced budget goals or to preserve the Trust Fund from bankruptcy.

- What about FFS Medicare? We recognize that preserving the FFS Medicare choice is important. Any competitive bidding proposal that ignores FFS costs does so at its peril. Our plan preserves the option, subjects only those FFS markets that exceed the benchmark to volume/performance standards and treats all participants fairly.

For further information about The Fairness Coalition, please contact:

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Dorsey & Whitney
(202) 452-6935/(202) 338-5350

or

Patricia Riley
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APPENDIX 1

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September 1, 1995

Editorial Section
US Senate Committee on Finance
Room SD-219
Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Hearing - New Directions in Medicare, Part II
Wednesday, July 26, 1995, US Senate, Comm. on Finance

Following is my response to Senator Larry Pressler's handwritten question which has been submitted for record in the above matter:

QUESTION FROM SEN PRESSLER:

ACCORDING TO YOUR TESTIMONY, HMOS HAVE VERY LITTLE INCENTIVE TO PARTICIPATE IN MEDICARE BECAUSE PAYMENTS ARE OFTEN TOO LOW. IN SOUTH DAKOTA YOU SHOW PAMENTS FOR HMOS UNDER MEDICARE ARE BY FAR BELOW THE NATIONAL AVERAGE. HOW WOULD PAYMENTS HAVE TO CHANGE TO INCREASE INCENTIVES FOR HMOS TO OFFER COVERAGE IN SOUTH DAKOTA??

ANSWER TO SEN. PRESSLER'S QUESTION:

Thank you, Sen. Pressler, for allowing me to respond to your question.

I believe that because HMO payments are relatively low in South Dakota, there is no incentive for HMOs to develop and accept full risk in South Dakota. As you are aware, one of the precepts of risk contract HMOs is that they receive 95 percent of the AAPCC in a particular county, and yet they are required to provide the same benefits as counties where they are paid significantly more. An HMO looking for an opportunity to develop services would target counties with high AAPCCs. This is precisely why over 50 percent of the enrolled HMO risk product Medicare recipients are in the top 10 percent of the highest paid AAPCC counties. By narrowing the variance from 367 percent to something more reasonable, you will find that the amount of money available to HMOs will increase in South Dakota and you will find an influx of the HMO options in South Dakota.

Testimony of Joseph J. Martingale, Towers Perrin
Before the Senate Finance Committee
July 25, 1995

Good morning Mr. Chairman and members of the Committee, I'm Joe Martingale, a principal in the New York office of Towers Perrin, an international management consulting firm. Towers Perrin has been consulting with employers about their health care benefit programs for many years. In the last ten years, we have helped numerous employers control their health care costs by converting indemnity insurance plans into programs that coordinate health care through organized delivery systems (i.e., managed care). I'm pleased to be here to tell you about some of the lessons our clients in the business community have learned and what we are now doing through a unique National Medicare HMO Initiative we're spearheading on behalf of 60 of this country's leading employers.

Congress will soon be considering a wide array of approaches to control the growth of Medicare costs. I know the magnitude of the challenges you face and the inherent difficulty when the health and security of this nation's senior citizens are at issue. It is my hope to convey private employers' experience with trying to manage their health care costs generally — and retiree medical costs in particular — and the important role that managed care arrangements such as HMOs have played in this effort. Perhaps some of the lessons we in the private sector have learned will be of use to you in finding a solution to rising Medicare costs.

Background

Towers Perrin's experience with retiree medical programs and managed care is based on more than 50 years of helping large organizations manage their health care, retirement and other employee benefit programs. We assist employers with the design, financing and administration of employee benefit plans. In a broad sense, we help them manage their investments in people to ensure that human resource programs support the organization's business strategy.

As employer health care costs surged in the 1980s, our clients began looking at utilization controls and alternative health care delivery systems, such as HMOs and other forms of managed care, to help bring the cost growth under control. Over the past decade, we've helped hundreds of employers navigate the issues and introduce managed care arrangements — HMOs, PPOs, point of service (POS) networks, etc. — to their employees.

Like many of you, we and our clients were initially concerned about the effect managed care would have on employees and their families. We worried about how limiting the choice of providers and employing utilization controls would affect people's use of health care services and their ability to get appropriate treatment when they needed it. And we worried about how provider reimbursement arrangements and other built-in incentives to control costs would affect the quality of health care people receive.

As a result, we counseled our clients introducing managed care to carefully monitor quality and employee satisfaction with these programs. Through employee surveys, focus groups and by closely tracking employee enrollment and utilization patterns, we learned a lot to

reassure us and our clients. In short, we found that while managed care takes a little "getting used to," employees who have been in these programs six months or more like them as well — if not better — than traditional indemnity (fee for service) plans. Employees like the cost savings and convenience (for example, no claim forms), and they generally report that the quality of care is as good as they received under their previous programs. On average, 6 months to 1 year after implementation we find that:

- 76% feel the network care they receive is the same or better than the care they received before the plan was implemented

- 78% report being satisfied with the quality of medical care and services received in the network

- 81% would recommend their primary care physician to a friend or relative.

In focus groups with retirees of companies that had implemented managed care plans, we found that while potentially severing current physician relationships is a major psychological hurdle for this group, physician allegiance is typically transferred to the new network physician. In contrast, retirees of companies that had implemented managed care plans for only the active workforce were disappointed that the managed care option was not available to Medicare beneficiaries. Moreover, they were upset that as an active employee they could select an HMO, yet when they retired they were forced back into an indemnity plan.

We have also worked closely with our clients and health care organizations to increase accountability in the system and develop reasonable performance standards for all aspects of health care delivery including the quality of care. Effective methodologies for measuring health care quality have proven difficult to develop, as you well know. The NCQA and other organizations have made important contributions in this respect. Towers Perrin has also participated in this effort by serving on the committee that launched the HEDIS project and by developing our own health plan performance measurement tool.

We have found in our study of best practices that while not all managed care organizations are alike, good managed care organizations reduce inappropriate utilization, contain provider fees, emphasize prevention and coordinate the delivery of health care to members. Although much more work remains to be done in this area, we've now had enough experience with managed care to be confident that when carefully selected, the quality of care provided under these arrangements is comparable — and in some cases superior — to that provided in the fee-for-service arena.

Impact on Costs

Where managed care has clearly been shown to be effective is in the area of controlling the growth of costs. After growing at double-digit rates during the late-1980s and early 1990s, employer health care cost increases slowed to about 6% on average in 1994 and about 2% this year — the first time in the history of Towers Perrin's annual health care cost survey that employer health care costs have lagged behind the overall inflation rate. Notably, our 1995 survey found that average employer costs for employees enrolled in HMOs actually declined

this year — by about 2%. While some of this slowdown is due to economic conditions and cyclical forces, the growth of managed care has clearly played an important role in bringing health care cost inflation under control.

What's more, there is no indication that this progress on the cost front has come at the expense of the quality of care employees receive or merely by shifting costs to other payers. Not only do managed care organizations negotiate provider discounts, but it has been definitively shown that effective plans reduce inappropriate utilization of certain high-cost inpatient and specialty services, deliver care in the most appropriate settings, and increase the use of preventive health care services. In other words, health care professionals in managed care plans don't appear to be "rationing" care to keep costs low. The savings are real — the result of appropriate utilization controls and more efficient delivery of services.

Until quite recently, managed care has not been viewed as a viable option for employers' retiree medical programs — even though employers have been making a concerted effort to reduce the growth of these costs. Of course, a primary impetus for these efforts is FAS 106, the recent rule that forces employers to take current accounting charges for their future retiree welfare benefit obligations. Also fueling employer concern is the fact that the cost of retiree medical benefits has grown far faster than the cost of health benefits for active employees in recent years.

Coordination of benefits with Medicare has been the biggest impediment to bringing retirees into managed care in the employer community. Most large employers have traditionally offered their retirees age 65 and older health coverage designed to supplement Medicare. Like

individual "Medigap" policies, the typical employer supplemental plan covers a portion of the Medicare deductibles, copayment charges and other out-of-pocket costs on a fee-for-service basis. But as more companies have moved their active populations into managed care, coordination between the employer-sponsored plan and Medicare has proven to be particularly problematic.

Within the past few years, however, the growing popularity of Medicare risk HMOs has begun to alter the retiree medical landscape. Under Medicare risk contracts, as you know, HMOs contract with HCFA to provide a comprehensive array of health care services to Medicare beneficiaries for fixed premiums based on a percentage of Medicare's average per capita health costs in the region. These arrangements can save money for retirees, employers and for Medicare. Retirees win because Medicare risk HMOs typically offer richer benefits that under traditional Medicare and employer-sponsored supplemental coverage, fewer out-of-pocket costs, freedom from claim forms and no worries about physician fees exceeding Medicare's "reasonable and customary" limit. While more popular in certain parts of the country, Medicare risk HMOs have become more conspicuous in the past couple years as HMOs seeking to expand market share have shown growing interest in the largely untapped retiree market.

The National Medicare HMO Coalition

A little over a year ago, a few of our clients approached us for help with exploring the possibility of offering Medicare risk HMOs to their Medicare-eligible retirees in Florida. Managed care had helped these organizations reduce the growth of their active employee

health costs and they were looking for similar savings in their retiree medical programs. And as managed care had become increasingly popular with their employees, they wanted to be able to offer continuing managed care coverage to their people in retirement.

A number of issues were holding them back. Among them was the geographic dispersal and mobility of their retirees, many of whom move to warmer climates or spend at least part of the year in the sunbelt. Employers have traditionally dealt with a limited number of HMOs — in areas where the bulk of their employees work and live. Concern about the quality of care their retirees would receive was also a factor. How could an employer based in New York assess the quality of an HMO in Miami?

The upshot of these employers' interest was the Florida HMO Initiative we launched last year. In essence, a group of large employers in the Northeast joined forces to select a group of HMOs they would offer to their retirees in Florida. Towers Perrin coordinated the HMO selection process and helped the participating employers in evaluating and negotiating with the HMOs. By working together, the group was able to gain enhanced HMO coverage for their retirees and the HMOs' commitment to meet specific quality and member service goals. The group's combined purchasing clout also helped them address the "snowbird" issue by working out a plan to develop reciprocal arrangements between HMOs in Florida and in the north to provide coverage for retirees who spend only part of the year in Florida.

The Florida Initiative generated so much interest among our clients that we've now expanded the effort nationwide. In a sense, a key goal of the National Medicare HMO Initiative is to create the kind of managed competition that you will have probably heard about from other

witnesses here today. Specifically, the Initiative will attempt to foster managed competition among Medicare risk HMOs by standardizing plan design (and price for a given level of coverage), enrollee satisfaction measurement and ongoing quality monitoring — with a focus on how well participating HMOs are meeting the unique health care needs of the age-65-and-over market.

What makes this possible is the combined purchasing power of the participating employers. At present, the Initiative includes 60 large employers nationwide and is still growing. Together, they represent more than 1.5 million retirees and are negotiating with more than 100 managed care organizations in 65 metropolitan areas from coast to coast. With such numbers behind it, the Initiative is well-positioned to accelerate the growth and transformation of the Medicare HMO market by:

- negotiating lower-cost Medicare risk plans for retirees and their former employers
- encouraging HMOs to enhance their products by offering benefits of special importance to Medicare beneficiaries, such as prescription drug coverage
- developing strategies to maximize retiree enrollment in Medicare risk plans since for the vast majority of employers, the Medicare HMO option will be completely voluntary for retirees.

Other objectives include, driving the development of reciprocal HMO arrangements for snowbirds, coverage for non-Medicare eligible dependents of retirees, and creating specialized retiree communications and marketing strategies.

The Bottom Line

Since the National Initiative is just getting under way, it's too early to say how successful we'll be in expanding HMO enrollment among the Medicare population and controlling costs while maintaining quality and patient satisfaction. We're just now completing the HMO assessment, selection, and negotiations. Most of the participating employers have yet to present the HMO alternative to their retirees. In short, we've got a lot of work ahead of us. However, Towers Perrin and the 60 organizations that have joined the Initiative are firmly convinced that efforts such as this one hold great promise for managing retiree medical costs over the long term, while enhancing the level and quality of care Medicare beneficiaries receive.

Perhaps there are valuable lessons to be learned. If, as we expect, a significant number of retirees enroll in HMOs; and if, as we expect, research demonstrates that they, like their younger counterparts, feel that the care they receive is as good as or better than the care they received before; and if, as we expect, statistics on the care delivered to the senior population provide the basis for measuring continued improvement in the quality of that care, then we will be able to say that managed care networks like HMOs, carefully selected and monitored, can be as effective for and accepted by the senior population as they have been for the younger population.

I would hope that you would invite me back here to testify a year or so from now to tell you definitively that employers' experience with managed care and active employees carries over to retirees as well: They tried it. They like it. And it can save everyone an awful lot of money.

COMMUNICATIONS

Testimony of

The American Dietetic Association

on Medicare and Budget Reconciliation Issues

submitted to the

Senate Committee on Finance

The American Dietetic Association (ADA) is the world's largest organization of food and nutrition professionals with 66,500 members who serve the public through the promotion of optimal nutrition, health and well-being. Over 80 percent of all registered dietitians work in health care delivery, including hospitals and HMOs, long-term care facilities, and clinics and physicians' offices. ADA appreciates the opportunity to share its views with the Subcommittee on ways to reform the Medicare program to achieve cost savings that enable Congress to meet budget resolution targets.

Dietetics professionals appreciate the monumental task that Congress faces in reforming the Medicare program. Finding creative ways to cut costs while providing good health care is a daunting challenge. Dietitians believe that attention to services that reduce long-term medical costs is essential in meeting this challenge. One such service is medical nutrition therapy, which, according to ADA's internal analysis of case studies, has been shown to save an average of over $8,000 per case. When medical nutrition therapy is applied to the disease or condition, it saves money by reducing the length of hospital stay, decreasing complications, decreasing the need for costly medication, and lessening the need for high technology treatment.

Medical nutrition therapy is defined as the assessment of patient nutritional status followed by appropriate therapy, ranging from diet modification to administration of specialized therapies such as intravenous or tube feedings. It is a medically necessary and cost-effective way of treating and controlling many diseases and medical conditions, including AIDS, cancer, kidney disease, diabetes, severe burns, pediatric failure to thrive and surgical wounds. Medical nutrition therapy addresses an individual's nutrient status, which is key to the body's healing process. For example, someone who has suffered extreme tissue damage as a result of severe burns requires extremely large quantities of calories and nutrients to heal.

Findings both from randomized controlled clinical trials and from case studies show that medical nutrition therapy can save health care dollars and improve outcomes when provided to patients with

diseases or injuries that place them at high risk of malnutrition -- being inadequately nourished. Almost 17 million patients each year are treated for illnesses or injuries that stem from or place them at risk of malnutrition. Whether in hospitals, long-term care institutions, or scattered throughout the community, medical professionals recognize that medical nutrition therapy is a key factor in improving outcomes and speeding recovery for at least 40 percent of hospital patients in the U.S. who are malnourished based on clinical nutrition evaluations (Roubenoff, Roubenoff, Preto & Balke, "Malnutrition among hospitalized patients: A problem of physician awareness," *Archives of Internal Medicine*, 1987).

Based on clinical research and experience, medical professionals (physicians, dietitians and nurses) identify a range of specific medical nutrition therapies necessary to treat illness and injury that involve:

- Assessment of the nutritional status of patients with a condition, illness or injury that appropriately requires medical nutrition therapy as part of the treatment. The assessment includes review and analysis of medical and diet history, blood chemistry lab values, and anthropometric measurements to determine nutritional status and identify treatment modalities.
- Therapy ranges from diet modification to administration of specialized nutrition therapies such as intravenous medical nutritional products as determined necessary to manage a condition or treat illness or injury.

An internal analysis of nearly 2,400 case studies submitted by ADA members shows that on average more than $8,000 per patient can be saved with the intervention of medical nutrition therapy. Case studies show that, for diseases and conditions in which medical nutrition therapy is appropriate, the average annual or one-time savings per case include:

- For **cancer**, $10,535 savings per case because specialized nutrition therapy enhances effectiveness of chemotherapy and radiation therapy;
- for **heart disease**, $9,134 savings per case because medical nutrition therapy reduces the need for drugs and other artery-clearing procedures and/or surgery;
- for **type I diabetes** (insulin-dependent), $9,049 savings per case because diabetic complications that result in hospitalization are reduced;
- for **type II diabetes** (non insulin-dependent), $1,994 savings per case because medical nutrition therapy reduces or eliminates the need for insulin or oral agents;
- for **kidney disease**, $18,467 savings per case by postponing the need for dialysis;
- for **high cholesterol**, $2,709 savings per case by reducing the need for drugs;
- for **hypertension**, $4,075 savings per case by reducing drug use and preventing complications such as stroke; and
- for a variety of other conditions -- such as **burns and surgery** -- requiring tube or intravenous feedings, $7,051 saving per case by transitioning the patient to less invasive and less expensive nutrient sources.

A survey of 2,337 patient records at 19 hospitals indicates that early nutritional interventions and regular clinical nutrition services reduce hospital stays for malnourished and at-risk patients. The reduced hospital days translate into $8,200 per bed per year average cost savings according to *Cutting Hospital Costs with Clinical Nutrition Services*, a new report by the Nutritional Care Management Institute (NCMI) of Tucker, Georgia.

A report in the July 1995 issue of *The American Journal of Medicine* highlights a study which found that the use of a diabetes team, led by an endocrinologist working with a nurse diabetes educator and dietitian, resulted in a 56 percent reduction in length of hospital stays among patients hospitalized with a primary diagnosis of diabetes compared with patients treated by an internist alone. Currently, hospital care of diabetic patients costs an estimated $65 billion a year. The potential 5-day reduction in hospitalization found by this study translates into billions of dollars per year in potential health care savings.

The evidence is clear. Medical nutrition therapy is an appropriate means for cutting costs. Yet, the Medicare program is inconsistent in utilizing this important service. Currently, no policy or approach exists for covering the costs of medical nutrition therapy.

In inpatient settings, dietitians' services must be covered by DRG payments. Yet, when DRGs were implemented in 1983, medical nutrition therapy was only a small piece of treatment and was hidden within general and administrative or overhead costs. As a consequence, hospitals, for the most part, today view medical nutrition therapy as uncovered by DRGs because there has never been an explicit accounting for the cost of medical nutrition therapy. However, as data more clearly show savings and as dietitians approach hospital administrators with this data, medical nutrition therapy becomes more essential to efficient Medicare inpatient care.

In outpatient settings, Medicare coverage for nutrition services is practically non-existent. Medicare technically covers outpatient diabetes education -- which is primarily medical nutrition therapy for those with diabetes. However, recent collection of claims data by ADA in this area reveals problems with obtaining reimbursement, primarily because no clear-cut coverage policy and code for billing exist. Yet, a study last year by the International Diabetes Center in Minneapolis, MN, showed that persons with type II diabetes can better control their blood sugar levels, weight and cholesterol with medical nutrition therapy.

Even if Congress takes an incremental approach such as the one proposed by Senator Breaux in S. 491 -- providing for Medicare coverage of self-management training (which includes medical nutrition therapy) for diabetes patients -- dietitians believe this is a vital step in the process of reforming the Medicare program.

Dietitians are one of the most highly trained allied health professionals. Other allied health professionals -- such as occupational or physical therapists -- receive consistent medical reimbursement under the Medicare program. Dietitians should be named in the list of those allied health professionals who receive reimbursement. Yet, to date, that has not occurred.

Dietitians are extensively trained and educated in the science of nutrition and its application to disease prevention and treatment. In practice, the dietitian integrates and applies the principles derived from the sciences of nutrition, biochemistry, physiology, food management and behavior to achieve and maintain health. The dietitian has become a fundamental team member in effective health care delivery with the rapid advance of the science of nutrition and its correlation with disease prevention and treatment.

As part of an interdisciplinary treatment team (physicians, nurses, dietitians, and other health professionals), dietitians educate treatment team members in the science of nutrition; assess the patient's blood chemistry, anthropometric measurements, medical history, and diet history to determine nutrition status; and, with the interdisciplinary treatment team, develop, administer and evaluate the patient's response to nutrition therapies.

The growing evidence of the vital importance of medical nutrition therapy in treating many diseases and conditions is being recognized throughout the health care community. While coverage by private health insurance plans varies from plan to plan, managed care programs such as Cigna, Harvard Community Health Plan, Health Insurance Plan of Greater New York, and US Healthcare are contracting with dietitians to provide both medical nutrition therapy and preventive services for their subscribers. Medical nutrition therapy may also be covered in some states under some policies -- especially managed care products -- offered by insurers such as Aetna, Blue Cross/Blue Shield, Humana, John Hancock, MetraHealth, Mutual of Omaha, Provident, Principal Mutual, and Prudential. And, even more significantly, the annual call letter for the Federal Employee Health Benefit Program includes "cost effective, medically necessary services (such as medical foods and nutrition therapy)" as a specifically encouraged service under Fee for Service Plans. As others have said, shouldn't our seniors have the same services through Medicare that are available to federal workers?

The American Dietetic Association with its 66,500 members stands ready to work with the Senate Finance Committee in the development of Medicare reform proposals. We appreciate the support and interest of the Committee on this issue.

Thank you.

Testimony of the AmHS Institute

James L. Scott
President

Mr. Chairman and members of the Committee, the AmHS Institute is pleased to submit this statement for the record of the Committee's hearing on the future of the Medicare Program. The AmHS Institute is the public policy center for American Healthcare Systems. AmHS is a national alliance of forty of our nation's premier integrated multi-hospital systems. AmHS and its subsidiaries operate insurance, purchasing, quality assurance and marketing programs that strengthen its shareholders' ability to provide intergrated health care services more effectively and efficiently. These systems own, lease, or manage nearly 400 hospitals and have affiliation agreements with over 600 other hospitals. AmHS shareholders employ over 280,000 people and generate $36 billion in annual revenues.

In our testimony, we will:

- review the environment for reform in both the public and private sectors;
- present an overview of our recommended approach to Medicare reform; and
- describe long-term objectives and specific short-term action steps in five key areas of reform.

Environment for reform

The federal fiscal environment for the Medicare program is simple to describe: the program is in serious trouble. The financial statistics are all-too-familiar to the committee.

- This year, Medicare will spend $178 billion -- 11 percent of total federal spending.
- Under current law, the program is expected to grow by 9.9 percent annually from 1995 - 2002, nearly double the 5.5 percent annual growth rate in the total federal budget.
- Under this scenario, Medicare will grow to 15 percent of total federal spending by the year 2002 -- with no end in growth in sight in the future.

The status of the Medicare Hospital Insurance (HI) Trust Fund presents an equally bleak picture. The most recent report of the Board of Trustees of the Hospital Insurance Trust Fund projects that the Medicare Trust Fund will begin spending more than it receives as revenue starting next year, which begins the process of exhausting the Trust Fund reserves. The Trust Fund could be depleted in just 7 years -- by 2002.

The Congress has responded with a budget target that proposes to lower Medicare growth rates from the baseline growth of 9.9 percent annually to growth of about 6.4 percent per year over the next seven years -- for total Medicare savings of $270 billion below baseline spending projections.

We are opposed to this level of reduction in the rate of growth. The amount of savings needed to keep the Medicare Hospital Insurance Trust Fund solvent for the forseable future is much lower. Spending reductions in the Medicare program should not be used to fund tax cuts. In addition, this level of proposed spending reduction is both politically unrealistic and programatically unattainable.

Having noted our strongly held belief that the budget savings targets for the program are excessive, we will focus our testimony on the need for Medicare program reform and our specific recommendations for achieving that reform.

It is clear that Medicare is an important budget issue, especially at a time when the Congress is seeking to move toward a balanced budget. However, we have reached the practical, political, and policy limits of the traditional approaches to "cutting" Medicare: provider payment reductions, increased beneficiary cost sharing and premiums, and increases and extensions of the coverage of the HI tax.

That approach has been tested repeatedly: such short-term, budget driven "savings" approaches have been tried in budget reconciliation bill after budget reconciliation bill in the past 15 years. And the approach has failed. Despite all the annual short-term "savings" and political pain over this time period, we continue to be confronted by the current budget and trust fund problems.

It is time to step back from this never-ending treadmill of "cuts" and call for Medicare reforms. And to do that, we need to go back to the basics. We believe that the objective should be to restore one of the original concepts of Medicare: Medicare was to offer financial protection to seniors through a health insurance program that mirrored the coverage available in the private sector.

And the Congress succeeded in fulfilling this objective -- in 1965 -- by building Medicare on the then-predominant fee-for-service approach. In today's terminology, Medicare was a variant of a "market-based" plan in 1965.

But it it is now 1995. The private health system has changed dramatically, and Medicare has not kept up to date.

- Managed care arrangements now cover about 63 percent of privately insured employed individuals -- growing nearly 20 percent in just the last year.

- That managed care penetration level among employers is about six times Medicare's managed care enrollment of 10 percent (about 9 percent in Medicare HMOs and managed care plans, and about 1 percent in Medicare Select - a Medigap PPO being demonstrated successfully in 15 states).

If Medicare's design continues to remain stagnant in the midst of a rapidly changing health care market, the program will fall farther and farther behind the plans available to the working population. This increases the risk to the program -- financially, politically, and programmatically -- because Medicare beneficiaries no longer have coverage like that available in the private sector.

If we are to address fundamental reforms, we must shift our thinking from short-term to long-term. The irony is that the more we focus on "guaranteeing" short-term "savings," the less we are able to achieve structural reform and real long-term savings.

In order to meet the nation's commitments to the elderly and disabled in a manner that is financially and politically sustainable, Medicare must be updated to provide beneficiaries the choice of managed care and other arrangements that now are the dominant form of benefits in the private sector. For Medicare, voluntary -- not mandatory -- enrollment is crucial. This requires that we remove current barriers and provide incentives for beneficiaries to enroll in alternative health plans.

We believe that this approach will serve government, beneficiary, and provider interests in a balanced manner:

- The government can achieve real long-term, structural savings in Medicare if it can avoid the more simplistic short-term targets that lock-in short-term "solutions."

- Beneficiaries will benefit from a program that is once again similar to private sector health coverage, as well as from enhanced choices and the stability available from a Medicare program with long-term financial viability.

- Providers will benefit by being able to provide services within a framework that allows them to focus on what they do best -- provide high quality care at an affordable cost.

Recent CBO data highlight the long-term potential for restructuring and managed care in Medicare (CBO, February, 1995).

- For the total population, HMOs reduce overall utilization by an average of 8 percent -- and the most tightly integrated models, the group/staff HMOs, reduce use by nearly 20 percent.

- For the Medicare population, the utilization reduction by group/staff HMOs is potentially greater -- nearly 22 percent.

- The potential Medicare savings depend on assumptions about how much of the population might be in effective HMOs -- the savings range from 2 percent to 20 percent.

AmHS Institute Medicare Reform Proposal

Overall approach

The AmHS Institute believes that Medicare should be restructured so that the program is able to take advantage of the competitive revolution taking place in the private health care market. A reformed Medicare program should provide beneficiaries a choice of health plans, including provided based delivery networks and managed care arrangements, along with incentives to join the plans that are best able to deliver quality benefits at a competitive price.

We would stress, however, the need to proceed in a practical, staged manner. The reality is that this reform will require a transition period. One of the lessons of previous health reform debates is that policy makers should establish a sense of direction of where they are going, but proceed incrementally, testing new ideas, monitoring implementation and results, and making changes and revisions in the future. As a result, the Institute is recommending long-term views about the direction for reform, as well as focusing on specific short-term actions that could be taken this year to begin the process.

Policy makers must also recognize and deal with the interrelationships among many of the health care changes taking place: Medicare restructuring, the rapid movement to a more competitive private market, and Medicaid reforms all call for a reexamination of some current health care arrangements.

- As we move to a more competitive health care system, we must also adapt our mechanisms of public support for "public goods" such as health professions education, and mechanisms for helping providers finance care for the uninsured.

- In addition, for the millions of dual Medicare/Medicaid eligibles, Medicare and Medicaid changes must be linked.

The following reviews the AmHS institute's long-term objectives and short-term action steps in five areas: delivery system and health plan participation options, retiree health plan approaches, payment policies and methodologies, making the market more competitive, and information/enrollment/consumer protection measures.

Options for delivery systems and health plans available to serve beneficiaries

One critical element of Medicare reform is to expand the options under which health plans and delivery systems could participate in Medicare.

Long-term: Medicare should make payments to a wide range of health care plans under a competitive market model. The existing Medicare system should remain as an option, but it too should be revised to move beyond a pure Fee-for-Service (FFS) approach and pay providers under a variety of arrangements -- FFS, partial capitation, competitively determined prices, and other models.

Short-term: Medicare should begin to expand the options for delivery system and health plan participation in two ways. First, the program should begin to expand the definition of health plans qualified to participate on a capitated, full risk-basis for all Medicare benefits. The program should move beyond the traditional health maintenance organizations (HMOs) and competitive medical plans (CMPs) that today are available to beneficiaries. Additional entities could include (subject to meeting appropriate financial and quality standards designed to assure consumer protection):

- o Managed care plans such as well defined "point of service" (POS) and "preferred provider organization" (PPO) products; and

- o Provider based integrated delivery networks that include physician, hospital, and other services required to serve beneficiaries.

Second, Medicare should begin to reflect the reality that there is not a strict dichotomy in the market between a FFS plan and a fully capitated health plan: instead, there are numerous delivery arrangements between the two, and the program and its beneficiaries should take advantage of them. Medicare should establish alternative payment options within the "traditional" plan for an array of delivery system options on the spectrum between FFS and full risk, full capitation models. These would include:

- o traditional FFS Medicare (PPS for hospitals; RBRVS for physicians).

- o potentially broader bundles of payments such as those that would combine the hospital and physician payment per admission. This would be a way to encourage hospitals and their admitting physicians to begin to work under the same incentives, without having to leap immediately to fully capitated managed care.

- o partial capitation models of various types: Medicare should explore partial capitation arrangements under which Medicare makes capitated payments for a subset of Medicare services.

- o risk sharing arrangements that move beyond pure capitation: Medicare could, for example, define risk corridors, sharing in gains and losses. These arrangements could be applied to partial capitation models as well as full capitation models.

As the Congress pursues these strategies, it is vitally important that they be linked with changes in the regulatory standards for health plans, including capitalization and solvency standards. There appears to be a substantial level of effort in the health plan community to try to apply insurance standards to the new provider based integrated delivery networks that are evolving in the market. That is a very short-sighted approach, because it relys on the old standards for FFS insurance -- a model that is at the heart of the failure of the health system -- to meet financial and coverage needs of the American people. We need to adapt our regulatory structures to keep pace with the changes in the market -- not use an old regulatory structure to stifle a potentially innovative market.

While some level of financial standards should apply to all health plans contracting with Medicare, the measurement and definition of the assets that count toward meeting the standards should take into account differences in types of plan. Insurers require cash assets to purchase services from others, while delivery systems have existing human and physical assets -- hospitals and health professionals that can actually provide the contracted care.

Employer/retiree health plans

Long-term: retired workers should have the option to remain in their employer's retiree health plan so long as that plan meets standards set by Medicare, with Medicare making its defined contribution to the employer much as it would if the individual enrolled in a traditional qualified health plan.

Short-term: Medicare, working with the employer and health plan communities, should develop standards for such arrangements and methodologies for making payments to such plans. Further, the federal government should use the Federal Employees Health Benefit Program (FEHBP) as a model program for this effort, with Medicare making payments to the retiree health plan of federal retirees who are also eligible for Medicare.

Medicare and beneficiary payments

If Medicare is to take advantage of the changes taking place in the market, it needs to revise its current approach for making payments to health plans.

Long-term: Medicare should establish its payments for coverage of the Medicare benefit package based on premium competition in local markets. For example, health plans would establish their premiums for Medicare's defined package of benefits. Medicare would establish its payment at some percentile of those premiums; all of the plans could then compete to attract beneficiaries with additional benefits or lower out-of-pocket costs, but with Medicare's established payment level for that local market. Beneficiaries would then choose among health plans.

Alternatively, Medicare might select those plans with the best bids to serve the Medicare population -- the high cost or low quality losing bidders would not be allowed to serve the Medicare population. This approach could have the greatest potential savings.

Beneficiaries would always have the statutory Medicare benefit package available to them without extra costs (beyond the Part B premium). And beneficiaries could always opt for a richer benefit package by joining a health plan that can provide the additional benefits within the Medicare payment amount or by paying additional amounts for such richer benefits, as is the case today.

Short-term: Medicare should begin to take the steps necessary to develop the capacity to move to this new system, as well as make short-term changes in the existing system.

First, Medicare needs to begin to fund demonstrations on how to develop and move to a market-based model, and test the various approaches that might be envisioned. While the market-based model is much discussed by the experts, policy makers need to examine real-world experience with this system before nationwide implementation.

Second, it is well-known that Medicare's current mechanism for paying health plans, which is based on the "adjusted average per capita cost" (AAPCC), is inherently flawed. However, since it has to be retained pending development of the longer-term, market-based model, temporary changes should be enacted to improve it as much as possible. For example, three changes should be considered:

- o the AAPCC should be based on a direct calculation of fee-for-service costs;
- o AAPCC rates should be set for Metropolitan Statistical Areas (MSAs) rather than counties; and
- o Medicare should establish some type of "payment band" -- a ceiling and floor on AAPCC payment rates -- to bring payments in rural counties up to levels that would allow those communities to begin to develop the health plan infrastructure to serve beneficiaries.

In addition, if the Congress is serious about Medicare restructuring and a move to organized delivery systems and managed care, an investment strategy is called for. Congress should set aside a portion of the savings from other Medicare cuts and allocate them as targeted investments to enhance payment rates and encourage the development and participation of health plans and beneficiaries in areas where Medicare managed care penetration is currently low.

Finally, HCFA should accelerate its work on risk adjusters, and begin to conduct demonstrations of alternative models of risk adjusters.

Market competition

If Medicare beneficiaries are to make choices in a competitive market, Medicare must take the steps to make sure that the various options operate on a "level playing field."

Long-term: the supplemental market -- whether Medicare supplemental policies (traditional Medigap plans), or comprehensive plans that provide Medicare as well as supplemental benefits -- should be made more competitive, with these products competing for beneficiary enrollment on a more level playing field.

Short term: The Congress has already taken one important step to expand competition and managed care options to beneficiaries through the supplemental market, by extending and evaluating the Medicare Select demonstration nationwide for a period of three years (Medicare Select is a Medigap PPO being demonstrated successfully in 15 states).

In addition, we should begin tests and demonstrations of how best to standardize the rules for participation among the various types of options that are available to beneficiaries. For example, policy makers can begin to examine standardization of underwriting policies, rating rules, and benefit offerings, to make this market more understandable for beneficiaries making choices among health plans. The following should be tested:

- o standardization of medical underwriting policies in local markets. Currently, Medigap products can deny coverage to Medicare beneficiaries after an initial enrollment opportunity; while HMOs that participate in Medicare on a risk basis cannot.

- o standardization of rating rules in local markets. Currently, Medigap products can use "attained age" rating (i.e., charge higher rates as a person ages); while HMOs that participate in Medicare on a risk basis charge all enrollees the same (although HCFA's payment to the health plan varies by age).

- o standardization of benefits supplemental to the basic Medicare benefit package. Currently, Medigap products must fall within one of 10 product categories; while HMOs that participate in Medicare on a risk basis can offer any combination of benefit additions.

Information/enrollment/consumer protection

Finally, if beneficiaries are to make choices in a market, they need information and fair enrollment options.

Long term: a Medicare program in which beneficiaries have a choice of health plans is predicated on timely, accurate information and performance measures that beneficiaries can use to make comparisons among benefits, delivery systems, quality, service, and price. Moreover, health plans must be available to beneficiaries at specified times so that beneficiaries have the option to change their enrollment -- otherwise, the "choice" model cannot work.

Short-term: HCFA should be required to provide beneficiaries with information on the options available prior to the time of initial Medicare eligibility (which is when the beneficiary makes initial decisions about enrollment in Medicare health plans or Medigap plans). In addition, HCFA should test approaches and models for enhancing enrollment, including the following:

- o models for providing comparative information on performance measures to beneficiaries for all products available to them, including Medigap plans and health plans participating in Medicare. These models could include requiring health plans to provide some type of information on a comparative basis.
- o approaches to coordinated open enrollment in different markets, including options such as coordinated annual periods, as well as various models of "rolling" open enrollment.
- o approaches that would require active marketing in targeted areas, such as inner cities, as a condition of health plan participation in Medicare.

Conclusion

The AmHS Institute recognizes that the challenges confronting the Congress are enormous. But the importance of Medicare for current and future beneficiaries calls for action. We urge that you proceed by adopting specific steps this year to begin the process of restoring Medicare to a program which will continue to provide health benefits like those available to Americans under the age of 65 into the 21st century. We would be pleased to work with the Committee in that effort.

Statement of The College of American Pathologists for The Record of The Senate Fincance Committee Hearing Regarding "New Directions in Medicare" Part 2 July 26, 1995

The College of American Pathologists (CAP) appreciates the opportunity to present its views to the Senate Finance Committee regarding the need to transform the Medicare program into a system that serves the elderly and disabled in a more efficient manner. The College is a national medical society representing nearly 15,000 physicians who are board certified in clinical and/or anatomic pathology. College members practice their specialty in community hospitals, independent clinical laboratories, academic medical centers, and federal and state health facilities.

The College is grateful to Mr. Packwood, chair of the Senate Finance Committee, for his leadership and foresight in holding hearings to solicit the views of health care professionals on transforming the Medicare program. Ideally, Medicare should be a model of efficient interaction between the public and private sectors in serving patients. Instead, the program is failing from a budgetary standpoint due to its financial structure and unrealistic expectations. Rather than deal with these underlying structural problems, Congress and the Executive Branch have historically attempted to deal with the program's financial problems by cutting provider payments and making numerous operational changes that have increased the administrative burden and confusion for everyone involved with the program.

The College believes that the necessity of preserving the solvency of the Medicare trust funds and introducing marketplace efficiency into the program offers unique opportunities for Congress to correct these problems. However, the College is concerned that the desire to reduce the rate of growth in the Medicare program could once again force Congress to resort to short-sighted budget cuts to meet deficit reduction targets rather than taking a careful, comprehensive look at how the Medicare program could be financed more equitably. The College believes that restructuring of the fundamental financing of the Medicare program is a viable way to address these concerns with the program.

RESTRUCTURING THE MEDICARE PROGRAM

Although the Medicare program is clearly a success story in improving the access to health care of the nation's elderly and disabled, the thirtieth birthday of the program is an appropriate time to assess whether it is financially feasible to continue its current financial structure. Increases in the number of beneficiaries, improvements in diagnostic and therapeutic technology, and inefficiencies in the current administration of the program, call for reconsideration of the manner in which program benefits are offered and provided to beneficiaries and financed by the federal government.

The markets for and modes of provision of health care services have changed dramatically in the last thirty years. Proposals that restructure both the beneficiaries' and the governments' responsibilities in administration of the Medicare program may offer the best methods to

enhance its long-run fiscal integrity, improve its efficiency, and control costs, while continuing to provide access to needed services. Several such proposals have surfaced in the last few months that would involve Medicare beneficiaries in decision-making about how their health care benefits are provided and financed, similar to the decisions that many others make in the private sector when they choose among health plans, and that would attempt to put the program on a more sound financial footing.

The College supports the following changes to financing and coverage under the Medicare program:

- **Restructure of the government funding of Medicare premiums to give beneficiaries choices in selecting among the traditional government-administered fee-for-service option, enrollment in private-sector administered insurance plans, and establishment of alternative health care financing funds such as Medical Savings Accounts to be used to purchase health care coverage as needed.** While the government would continue to financially subsidize each of these options, beneficiary choice could, over time, place more of the day-to-day administration of the Medicare program in the private sector and reduce program costs, while allowing the beneficiaries much more choice of health care plans than they have today. As those now in the workplace, who enjoy and expect those choices, reach Medicare age it is appropriate that they continue to have choice and responsibility in determining how their health care dollars are spent.

- **Elimination of the coinsurance for Medicare covered services.** Restructured and adequate funding of health insurance for Medicare beneficiaries should also include elimination of the requirement for payment of coinsurance and purchase of supplemental insurance such as Medigap policies. Currently about three-fourths of beneficiaries purchase Medigap policies to cover the coinsurance and deductibles that the program imposes--in effect, most beneficiaries pay no coinsurance or deductible at time of service provision. Appropriate restructuring of government financing to eliminate the need for a Medigap policy would make the Medicare program more financially sound and simplify its administration both for the government and for the beneficiary.

- **Reduction in the premium subsidy for higher income beneficiaries.** A sliding scale for determining beneficiary premium contribution, with higher income beneficiaries paying more, would reduce the government subsidy of Medicare coverage without reducing access to services.

- **Increase in the Medicare eligibility age.** As the nation's elderly live longer and more productive lives, and continue to have available and to be able to purchase private health insurance, it is appropriate to adjust the age at which Medicare coverage is provided.

- **Elimination of the Medicare balance billing restrictions on covered services.** Integral to proposals to restructure the Medicare program and give choices to beneficiaries is increased responsibility among beneficiaries and the private sector and decreased government tinkering with health care provision. Elimination of current restrictions on physician's charges to Medicare beneficiaries and institution of a system where physicians set their prices, the government sets its payment amounts, and the purchaser chooses, will enhance competition and alleviate much of the confusion about what charges are, what Medicare pays, and what the beneficiary can expect in cost sharing, issues that have plagued the program since its inception. Physicians have long demonstrated their willingness to forego balance billing when the patient's financial situation warrants. In an era of enhanced competition and beneficiary choice and responsibility overly intrusive restrictions on charging patterns are not appropriate.

BENEFICIARY SAFEGUARDS UNDER MANAGED CARE PLANS

The College believes managed care plans should be required to meet a minimum set of standards designed to assure that beneficiaries have continued access to quality care. The College supports legislation establishing standards of operation for managed care plans, requiring full disclosure of those standards to patients and providers, and providing effective options to resolve problems when enrolled in or contracting with managed care plans.

Congress should require that beneficiaries receive easily understood information about plan costs, covered and excluded procedures, and requirements for prior authorization. In order to ensure fairness and that needed medical services are provided, managed care plans should be required to afford due process procedures for physicians seeking participation in plans and timely notice and appeals procedures for physicians who are denied participation. Physician involvement in utilization review and other medical policy development activities should be required.

The College believes that Medicare beneficiaries who opt for a managed care plan alternative should maintain their right to choose their provider. Managed care plans should be required to provide access to out-of-network providers chosen by the patient or by the patient's attending physician. Reimbursement disincentives for patient use of out-of-network providers such as increased cost sharing must be limited to a reasonable amount and beneficiaries must be able to appeal denials of coverage of out-of-network services.

THE MEDICARE RBRVS

The College continues to be concerned about the inappropriate structure of conversion factors and volume performance standards under the Medicare physician services resource-based relative value scale. There are three distinct conversion factors and Medicare Volume Performance Standards (MVPSs) under the RBRVS, one each for surgery services, primary

care services, and all other nonsurgery services. Increases in volume and expenditures for surgery, office and other primary care visits, and pathology, radiology and other nonsurgery nonprimary care services are tracked under each respective MVPS and the update to each conversion factor is determined accordingly. Many physicians provide services in each category and the volume of many services in the all other category is determined by physicians who are not directly affected by payment changes for those services because the services are provided by other physicians. Examples of this last phenomenon are pathology, radiology and other diagnostic services ordered by attending physicians but provided by physicians in other specialties. The existence of multiple MVPSs and conversion factors (with different annual conversion factor updates) is divisive among physicians, inaccurate in determination of the source of increases or decreases in volume and expenditures, and inequitable in implementation of updates based on performance.

The College urges Congress to establish a single MVPS and a single conversion factor that is applicable to all physician services paid under the RBRVS.

Ideally, this would be accomplished with a statutory change eliminating the separate standards and conversion factors for 1996. At a minimum, we urge Congress to establish the 1996 updates to the existing three conversion factors in a manner that is consistent with movement toward a single MVPS and conversion factor. A single, equal conversion factor update of 1.1 percent as suggested by the Physician Payment Review Commission and the Administration will not move toward a single MVPS and conversion factor but will continue current distortions. Differential updates to each of the three existing conversion factors that are designed to reduce the differences in those factors are much more appropriate.

COMPETITIVE BIDDING FOR MEDICARE CLINICAL LABORATORY SERVICES

Proposals for competitive bidding of certain Medicare services, such as clinical diagnostic laboratory services, continue to resurface although they have been considered many times by the Congress and rejected for sound reasons. Most recent proposals would require that the competitive bidding process achieve at least a ten percent savings, thus focusing the competition on the lowest price not the best price for quality and access.

The College opposes Medicare competitive bidding for clinical laboratory services.

While competitive bidding is a well established mechanism for purchasing goods and services where quality is readily discerned by visual inspection of the item, it is wholly inappropriate for the purchase of medical services that are tailored to dynamic and highly individual needs. Competitive bidding for medical services, such as clinical diagnostic laboratory services, may result in a reduction in the quality of and access to the services sought, a problem that would not be apparent until harm had been done. Competitive bidding will not promote competition if it drives qualified laboratories out of business and thus decreases competition in an area.

This would be especially probable if a single "winning bidder" is chosen to provide services to Medicare beneficiaries in a given area. The winning bidder may not be immediately accessible to the patient or patient's physician, delays in service provision and patient diagnosis may occur, and overall quality of services may fall. Forced reduction in bidding prices may achieve immediate budget goals, but such savings are short-sighted and carry a high potential for negative health care outcomes. Eliminating freedom of choice of clinical laboratory services provider through a competitive bidding process would remove a major quality determinant in health care: the ability to seek care from the complete range of health care providers.

The College urges the Congress to again reject competitive bidding for Medicare clinical diagnostic laboratory services and to work with the physician and laboratory community to achieve savings through other means.

COINSURANCE FOR MEDICARE CLINICAL DIAGNOSTIC LABORATORY SERVICES

The College opposes reinstitution of a 20 percent coinsurance for services in the clinical laboratory fee schedule (CLFS).

Since eliminating the coinsurance requirement for clinical diagnostic laboratory services in 1984 Congress has repeatedly rejected proposals to restore it, with good reason. Reimposing coinsurance would place a significant administrative burden on laboratories and a new cost on beneficiaries while doing little to affect utilization of laboratory services. In many instances the cost of billing for coinsurance will exceed the amount collected from the beneficiary.

If coinsurance were reimposed, laboratories would have to produce two claims — one to the Medicare program and one to the patient. On average, laboratories estimate it would cost about five dollars just to produce the additional invoice billing the coinsurance to the patient. In many instances, this cost would be a substantial percentage of the amount collected from the patient and could easily exceed collected amounts. The table below illustrates the approximate coinsurance amount this year for several commonly ordered tests. Once the Omnibus Budget Reconciliation Act of 1993 payment reductions already passed are fully phased in the coinsurance amounts will be even less. For these common tests, the collection costs exceed the coinsurance payments:

	1995 CLFS Amount	Coinsurance
Common Chemistry Panel	$15.65	$3.13
CBC	$11.00	$2.20
Urinalysis	$4.47	$0.89

Past experience with coinsurance suggests that many laboratories will have to write off from 20 to 50 percent of the billed amounts as uncollectible. These collection problems are the very reason that coinsurance was eliminated by Congress as part of Deficit Reduction Act of 1984, with the support of the Health Care Financing Administration and the laboratory industry. In exchange for eliminating the copayment, Congress mandated the current fee schedule methodology which set the fee schedules at 60 percent of then-prevailing charges.

Imposition of coinsurance would shift the costs of the Medicare program to beneficiaries and force them to incur an additional $7 billion in out-of-pocket expenses, a burden that Congress specifically relieved them of in 1984. However, it is unlikely that coinsurance would have any impact on the volume of clinical laboratory services performed. Patients do not decide when to order testing nor do they select the testing laboratory. These decisions are made by the physician. As the Congressional Budget Office noted in a 1990 Report, "Cost-sharing probably would not affect enrollees' use of laboratory services substantially...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing."

The College urges the Congress to again reject reimposition of coinsurance for services in the Medicare clinical laboratory fee schedule.

DIRECT BILLING FOR CLINICAL LABORATORY SERVICES

The College supports legislation which would require that payment for all pathology services, including both anatomic and clinical pathology, be made only to the person or entity which performed or supervised the service--a direct billing requirement--with an exception for referrals between laboratories that are independent of a physician's office.

In order to provide clinical laboratory services as efficiently and cost effectively as possible, the College urges Congress to require that laboratories seek payment directly from the patient or a financially responsible third party, such as the patient's insurer. Medicare already requires laboratories to bill the program directly for clinical diagnostic laboratory testing provided to its beneficiaries. In addition, California, New York and Rhode Island legislatures have each enacted some form of direct billing. Payors in other states, such as Michigan, Connecticut and Pennsylvania, require direct billing as a matter of payment policy.

The Center for Health Policy Studies (CHPS) recently completed an analysis that found that the number of services per person is *28 percent greater in non-direct billing states* than in states where direct billing is required and that *total lab charges per person are 41 percent higher* in non-direct billing states. The Center concluded that if a direct billing requirement were adopted nationwide, *the annual private sector cost savings* attributable to this change would fall in the range of *$2.4 to $3.2 billion*, or *between $12 billion and $16 billion over five years.*

In addition, CHPS found that Medicare utilization also declined in states that require direct billing for other payers, suggesting that Medicare expenditures could also be reduced by enactment of a national direct billing requirement.

The College urges enactment of an all-payer direct billing requirement this year.

PAYMENT FOR MEDICARE PAP SMEARS

All Part B payment for Medicare Pap smears should be in the physician services fee schedule rather than split between two separate fee schedules. To accomplish this, payment for the Medicare screening (technical component) Pap smear should be moved from the clinical laboratory fee schedule to the RBRVS fee schedule.

Medicare covers a Pap smear, in the absence of signs or symptoms of disease, every three years. More frequent coverage is available if certain signs, symptoms or history are present. In either event, payment for the screening portion of the Pap smear (the technical portion) is made through the clinical laboratory fee schedule. Payment for physician interpretation of the Pap smear is made through a separate fee schedule, the RBRVS. Each fee schedule bases payment on a different method and is subject to different payment rules and restrictions. This dichotomy causes considerable confusion among beneficiaries, physicians, laboratories, and even Medicare carriers. Currently there are six billing codes (CPT or HCFA codes) to choose among to report the service, three for the screening service on the clinical laboratory fee schedule and an additional three for the physician interpretation on the RBRVS.

The College believes that payment for the screening (technical) portion of the Pap smear should be moved to the RBRVS as a technical component to the physician service. This would be consistent with the fee schedule convention for other diagnostic services such as mammograms, x-rays and EKGs. In addition, the three technical billing codes now on the clinical laboratory fee schedule could be eliminated and the technical portion reported using a technical component modifier to the RBRVS service, consistent with the method for reporting other diagnostic services. This would simplify administration of the Pap smear benefit for all concerned.

The College requests that payment for the screening (technical component) Pap smear be moved from the clinical laboratory fee schedule to the RBRVS fee schedule.

CONCLUSION

As fundamental changes in the structure and financing of the Medicare program are considered it is important to realize that measures designed to achieve short-term savings, such as arbitrary cost sharing or experimental competitive bidding projects, will not result in

cost-control and may eventually separate the Medicare system and its beneficiaries from the mainstream of American medical care. Instead of stop-gap measures, sound changes in the way the government finances health care for Medicare beneficiaries should be implemented, consistent with the goal of continuing to provide access, choice and quality.

The recommendations discussed above for achievement of those goals would also move the federal government toward cost-containment without overreaching and negatively affecting the health care of Medicare beneficiaries. The College welcomes the opportunity to discuss these proposals further and thanks the Committee for the opportunity of submitting this statement.

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TESTIMONY OF W. BRUCE LUNSFORD
PRESIDENT AND CHIEF EXECUTIVE OFFICER
VENCOR, INC.

BEFORE THE SENATE COMMITTEE ON FINANCE
JULY 19, 1995

Mr. Chairman, thank you for the opportunity to offer written comments to the Committee as it prepares to draft Medicare program reforms. I hope you will give them consideration and feel free to ask for additional detail. I am a co-founder of Vencor, Inc. and have been its Chief Executive Officer since its beginning in 1985.

Vencor owns and operates 35 hospitals which are certified by Medicare as "long-term care hospitals" and thus are exempt from the Prospective Payment System (PPS). The company was founded in 1985 and will provide 500,000 days of care to catastrophically ill, medically complex patients during 1995. Vencor's 3,200 hospital beds, located in 17 states, represent a portion of the approximately 18,000 beds in the nation's 160 certified long-term hospitals.

Vencor's patients, however, represent a much more acutely ill patient than the typical patient treated in a majority of the long-term care hospitals. Most Vencor patients are referred from the intensive care units of acute care, PPS hospitals. The majority are dependent upon life-support systems and are being treated for multiple system failure. More than 75% of Vencor's patients are on ventilators during some portion of their hospitalization.

In every market where Vencor's mature hospitals operate, our acuity adjusted costs are the first, second or third lowest of all other hospitals. Vencor's long term hospitals cost Medicare less per discharge than the DRG and outlier payments combined at a short term hospital. Our patient outcomes are equivalent or better.

Vencor's successes have not attracted wide notice because long-term hospitals represent a very small niche within the Medicare payment system. PPS exempt hospitals account for less than 3% of Medicare Part A expenditures and fewer than 2% of Medicare discharges. Long-term hospitals account for approximately 15% of PPS-exempt program expenditures and less than 10% of the facilities.

Various proposals are under consideration by Congress that would penalize providers, such as Vencor, which successfully treat the most acutely ill patients and ultimately save the Medicare program money. We think that it is in the taxpayers' interest to maintain current incentives to reduce costs and not penalize the efficient provider by rebasing older long term hospitals that do not treat the same kind of patient admitted to a Vencor hospital. We also think that the unrestrained growth of the "hospital within a hospital" units is driving up Medicare costs and has created a loophole in the TEFRA payment system.

Vencor proposes that Congress take the following steps to achieve intermediate term budgetary savings in the long-term hospital segment of the Medicare program until a comprehensive new payment system is developed.

1) Establish 1997 as a target date for the Health Care Financing Administration (HCFA) to establish a new payment system for long-term hospitals.

2) Freeze target update factors for all long-term hospitals and avoid rebasing until a new payment system is developed by HCFA and approved by Congress.

3) Do not certify anymore "hospital within a hospital" units until a new payment system for long-term hospitals is adopted.

I appreciate the opportunity to bring these ideas to your committee and am available to discuss these proposals in detail at your convenience.

KPMG Peat Marwick

TRENDS IN HEALTH INSURANCE

HMOs Experience Lower Rates
of Increase than Other Plans

II. Premium Increases

True value in health care coverage requires a combination of affordable premiums, comprehensive benefits and low out-of-pocket expenses. This section presents data over a five-year period on the average annual rates of increase in health plan premiums. As the data clearly show, rates of increase in HMO premiums are consistently lower than either FFS or PPO premiums.

However, the rates of increase in the plan premiums tell only part of the story. The benefits offered under the plans and the level of out-of-pocket costs faced by consumers not only affect the plan premiums over time, but also largely determine the market shares of the different types of health plans. It is important, then, when considering temporal changes in the total costs of health plans, to also pay attention to these other factors. Section III on plan benefits and Section IV on out-of-pocket costs present more data that are important for determining the overall value of the health benefits of most Americans today.

Summary

HMO premiums increased at a slower rate than either FFS or PPO premiums from 1988 to 1993.

Exhibit 1

Total Premium Costs and Annualized Rates of Increase
1988 to 1993 (Calculated from average premiums, 1988 and 1993)

	Total Premium Cost 1988	Total Premium Cost 1993	Total Percent Change	Annualized Percent Change
Individual HMO	$97	$157	61.9%	10.1%
Individual FFS	86	175	103.5	15.3
Individual PPO	92	176	91.3	13.9
Family HMO	225	415	84.9	13.1
Family FFS	186	439	136.0	18.7
Family PPO	207	436	110.6	16.1

Source: KPMG Peat Marwick 1993 Survey of Employer Sponsored Health Benefits; HIAA 1988 Health Benefits Survey.

Exhibit 2

Trend in Total Monthly Premium Costs from 1988 to 1993 by Plan Type
Smoothed Curve Projection

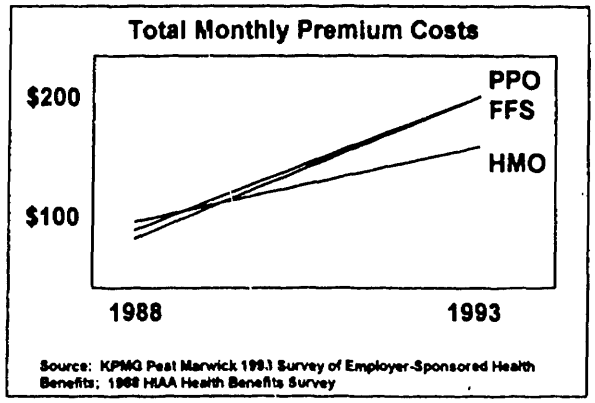

Exhibit 3

Annual Increases of FFS, HMO and PPO Premiums 1988 to 1993 (Based on reported annual rates of increase)

	HMO	FFS	PPO
1988	8.0%	11.0%	17.0%
1989	16.0	20.0	18.0
1990	16.0	17.0	15.0
1991	12.0	12.0	10.5
1992	9.8	11.0	11.1
1993	7.7	9.1	7.2
Average	11.6%	13.4%	13.1%

Source: KPMG Peat Marwick 1993, 1992, and 1991 Surveys of Employer Sponsored Health Benefits; HIAA 1990, 1989, and 1988 Health Benefits Surveys

Discussion

The annualized rates of increase of HMO, FFS and PPO premiums can be calculated using either the growth in the total dollar cost of the premium or by averaging the stated annual percent increases each year.[8] The two methods show that HMO premiums increased at an annual rate 2 to 5 percentage points lower than either FFS or PPO premiums.

Over time these annual percent changes turn into substantial multi-year percent differences in premium costs. Even if you assume that you can buy one year of health coverage under any of the types of plans for exactly $2,000 in 1993. Using the annual rates of increase for each of the plan types from Exhibit 1 and Exhibit 3, and extrapolating that rate over the next decade, means that in just ten years the cost of FFS coverage would be 17% to 59% higher than HMO coverage.

Exhibit 1 above indicates that both individual and family HMO premiums increased at an annualized rate of more than 5 percentage points less than fee-for-service premiums. Where HMO premiums for individual coverage increased an average of just over 10% per annum since 1988, the cost of indemnity coverage for an individual increased at over 15% per year over the same period. Premiums for family coverage have been increasing even faster for all types of coverage. The cost of family indemnity coverage increased at a rate of almost 19% per year since 1988, compared to just over 13% per year for family HMO coverage.

Exhibit 2 graphs the overall change in the cost of individual coverage under all three types of plans. Despite the fact that HMO premiums were slightly higher than FFS or PPO premiums in 1988, the slower rate of increase from 1988 to 1993 made HMO premiums the *least* expensive in 1993.

Exhibit 3 tracks the average stated rates of increase of the three plan types from 1988 to 1993. Averaging these rates of increase over the period of study shows that the rate of HMO premium increase was almost 2 percentage points lower each year compared to FFS premiums.

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8 The two methods of determining the annual rates of increase in health plan premiums are derived from two separate questions on the employer surveys. The first method produces slightly higher rates of increase. We ask "What is the monthly cost for COBRA single coverage?" This gives us a total monthly premium cost which can be tracked over time. The second method relies on the respondent to calculate, or estimate, the rate of increase in the health plan premiums from the year prior to the survey to the current survey year. This method produces lower annual rates of increase in premiums. We ask a series of two questions to determine this rate. First, "How do the total costs for family coverage compare with what they were one year ago? Are they more, less, or the same as last year?" and second, "What percentage did costs increase or decrease since last year?" These two variables can then be combined to produce a rate of increase for each firm, from which averages are determined.

STATEMENT OF AMY BERNSTEIN, Sc.D., ET AL.*

1994 HMO Performance Report

Table 2. Point-of-Service or Open-Ended Membership by Region, October 1, 1994

Region	1993 Membership	Mean Growth Rate 12/31/93 - 10/01/94	Projected 1994 Membership (10/01/94)
Northeast	543,137	37.7	747,900
South	476,278	47.2	701,082
Midwest	1,317,089	19.7	1,576,555
West	297,793	69.5	429,249
Total:	2,634,297	31.1	3,454,786

Source: GHAA HMO Performance Survey, 1994

Changes in Premiums

For the first time since the inception of the GHAA surveys in 1988, the average HMO member will pay lower premiums in 1995 than he or she did during 1994 (see Figure 4). Premiums for single coverage will decrease an average of 0.9 percent, while the cost of family coverage will decline 1.7 percent. Average monthly premiums will be $145 for single coverage, and $392 for family coverage.

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*Christopher Bergsten, M.H.A., Heidi Whitmore, M.P.P., Thomas Dial, Ph.D., and Jon Gabel, M.A.

Figure 4. Average HMO Premium Changes, by Type of HMO, 1994-1995

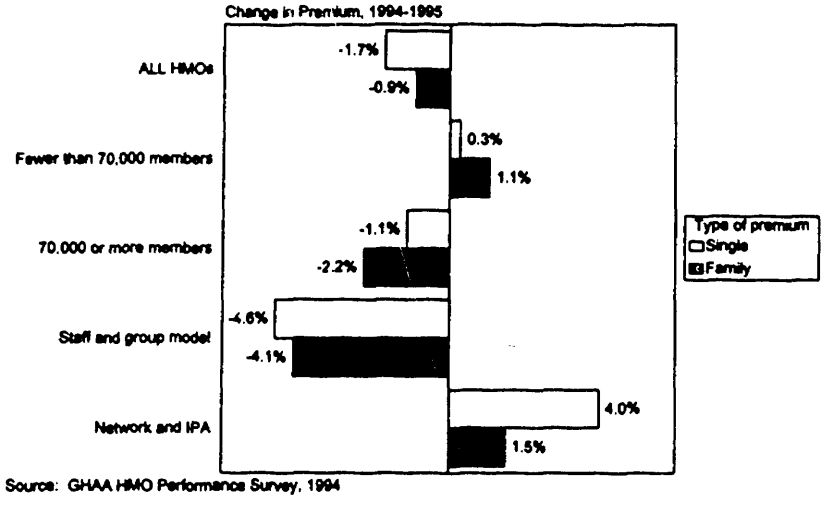

Figure 4 also shows that the decrease in premiums was greatest in the larger HMOs, and in staff and group model HMOs. In HMOs with at least 70,000 members, for example, the average member experienced a 2.2 percent decrease in family premiums, while those in HMOs with fewer than 70,000 members experienced an average increase of 1.1 percent for family coverage. Staff and group model HMOs reduced their family premiums 4.6 percent, compared to an increase of 4.0 percent in network and IPA plans.

This decrease in premiums is a continuation of a downward trend (see Figure 5). The 1993-94 decrease is by far the largest one-year drop in premium growth measured to date. On average, HMOs will reduce their premiums by 1.2 percent. These findings are consistent with data obtained from the California Public Employees' Retirement System (CalPERS), and from the Federal Employees Health Benefit Plan (FEHBP). Health plan premiums declined in 1994 for both of these very large employers.[3]

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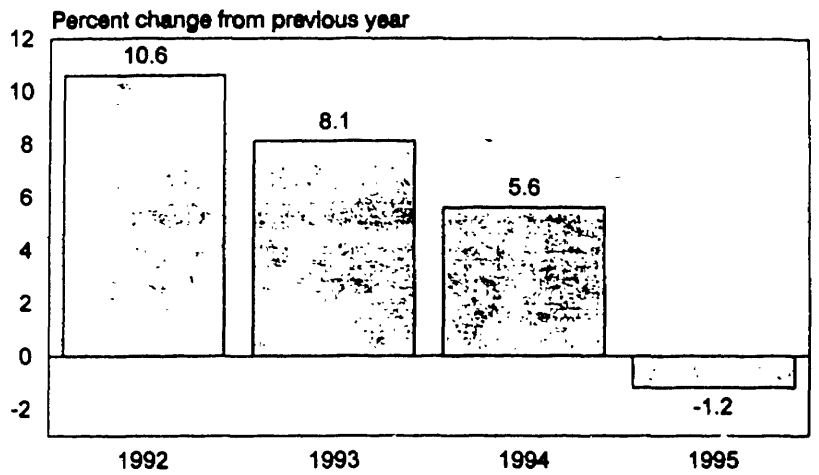
3. Causey, Mike, "Premium Ups and Downs," *Washington Post* (November 7, 1994) ; Sardinha, Carol, "Employers Win Even Steeper Cuts in HMO Premium Rates," *Managed Care Outlook* 7 (July 1, 1994): 1-3; Kertsz, Louise, "Business Group Wins Decreased HMO Premiums," *Modern Healthcare* 24 (June 27, 1994): 17.

Figure 5. Trend in Premium Change per HMO Member, 1992-1995



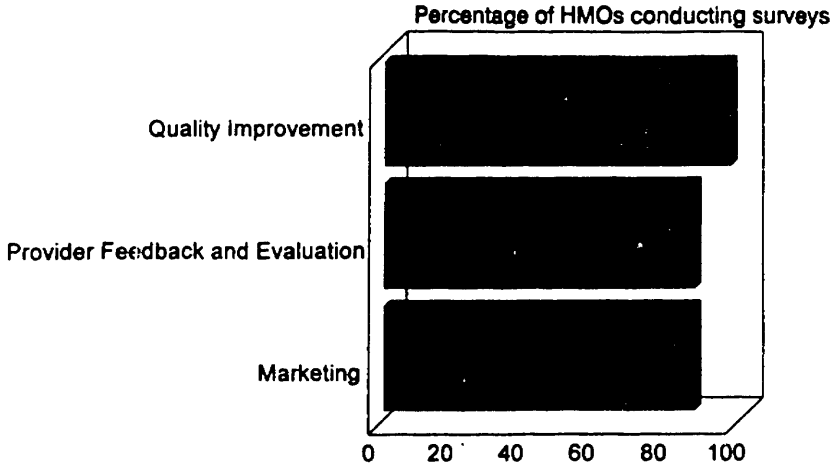
Source: GHAA HMO Performance Survey, 1994

Eighty-five percent of the surveyed HMOs predicted they would break even financially or have surpluses in calendar year 1994. Seven percent predicted that they would fail to break even, and 8.5 percent did not yet have sufficient data to estimate 1994 results. The majority of HMOs predicted they would have surpluses in 1995. Seventy percent predicted that their financial performance would be better in 1994 than in 1993, while 18 percent predicted it would not be as good. Eleven percent were unwilling to forecast how their results for 1994 would compare to those for 1993.

Quality and Consumer Satisfaction

The survey asked HMOs about member satisfaction and quality of care activities. Ninety-seven percent of HMOs conduct consumer satisfaction surveys of their members as part of their efforts to improve the quality of the services they provide. Among HMOs that conduct these surveys, 97 percent use results for quality improvement, 87 percent use them for provider feedback and evaluation, and 87 percent use the results for marketing (see Figure 6).

Figure 6. How HMOs Use Consumer Satisfaction Surveys



GHAA HMO Performance Survey, 1994

Eighty-two percent of surveyed HMOs encourage providers to follow specific clinical practice guidelines to help ensure that members receive state-of-the-art health care. Of those that do, 85 percent have staff formally assigned to developing and implementing guidelines. Fifty-six percent of all responding HMOs reported that they had developed guidelines internally. Of those promoting guidelines, 40.8 percent adapted guidelines from those published by the Agency for Health Care Policy and Research (AHCPR), and 81.6 percent use modified versions of other externally developed guidelines, such as those developed by professional societies and specialty associations (see Figure 7).

FULL TESTIMONY
NATIONAL ALLIANCE FOR INFUSION THERAPY

The National Alliance for Infusion Therapy (NAIT) submits this testimony to the Senate Finance Committee for the record of the hearing held by the Committee on July 26 regarding ways to improve the Medicare program and ensure its financial stability.

NAIT is a national association of providers and manufacturers who serve patients in need of home infusion therapy and other home care services. Home infusion therapy is life-sustaining treatment for people suffering from a variety of diseases and conditions, including cancer, AIDS, infections, severe pain, gastrointestinal disorders, and many others. Appropriately administered, it is far less expensive than comparable care in an inpatient setting.

We are pleased to discuss Medicare savings and reform proposals as they pertain to home infusion therapy. We believe that the Medicare system must be reformed to reflect more accurately the way health care is delivered today. We further believe that Medicare's management of home infusion therapy is an ideal example of how Medicare has fallen far behind the private sector, to the detriment of its beneficiaries.

There are few areas that are more illogical and self-defeating than Medicare's policies toward infusion therapy. Medicare defines home infusion therapy wrongly, and as a result, cannot cover it in a sensible manner or ensure that its beneficiaries are receiving quality care. We would be thankful if, as a result of this legislative process, Medicare is reformed so that home infusion therapy is defined properly. If that occurs, the program can ensure wise expenditures for home infusion therapy and quality care for its beneficiaries.

To better understand why Medicare's coverage and payment policies for infusion therapy do not work, it would be helpful to explain briefly what infusion therapy is and how it can be dramatically cost effective when properly provided.

Drugs are administered by infusion when other routes of administration are not possible, effective, or desirable, or when a sufficiently rapid therapeutic response is not likely to be achieved. In the case of parenteral and enteral nutrition, nutrient solutions are administered by infusion when the patient cannot ingest enough nutrients orally to maintain adequate weight and strength.

Infusion therapy has been provided in acute inpatient settings for several decades. The first infusion therapies introduced into the home setting during the 1970s were nutritional therapies -- parenteral and enteral nutrition. In the mid-1980s, antibiotic therapy, chemotherapy, pain management, and other therapies were added to the spectrum of infusion therapies that are commonly provided to patients in their homes. Currently, there are over 20 different therapies being offered in the home and other outpatient settings, and Attachment A provides a summary of the most common therapies and the clinical indications for their use. Medicare provides limited coverage of infusion therapy, and the portion of Medicare costs attributable to home infusion therapy is actually small in relation to total home care expenditures and extremely small in relation to the total program, but we still believe that it is an area that warrants serious change.

The use of home infusion therapy grew rapidly in the mid-1980s with the trend to release patients from the hospital at earlier stages of recovery to complete treatment in the home or other outpatient settings. In response to this trend, a new type of home care provider evolved, one that specialized in home infusion therapy and other high-tech home care services. These providers utilized technological developments and advancements in home nursing and pharmacy practice to create a "hospital without walls" concept of home care. Compared to inpatient care, home infusion therapy saves hundreds of dollars per day in hospital "room and board" costs, where patients are properly selected for home treatment. For home infusion therapy to be successful, however, nurses and pharmacists must collaborate with the patient's physician to

carry out a patient-specific plan of care. The activities of these professionals are described in Attachment B.

In many respects, home infusion therapy is a genuine success story, combining the application of clear incentives by the government with the technological advances of the private sector to offer high-tech care to persons in their homes. Medicare, however, does not see it that way. As far as Medicare is concerned, home infusion therapy does not really exist, at least not as the entire clinical community understands it. Rather, Medicare persists in looking at infusion not as the provision of therapy but as the delivery of products and equipment, without the accompaniment of medically necessary professional services. The Health Care Financing Administration (HCFA) has strenuously avoided all efforts to regulate home infusion therapy in a manner that would reflect accurately how it is provided. As a result, we believe that HCFA has missed opportunities to reasonably control expenditures for this benefit without reducing the quality of the care provided to Medicare beneficiaries.

Instead, HCFA has sought to control infusion therapy by grouping it with the delivery of products with which it has little in common. Parenteral and enteral nutrition (PEN) therapies are covered under the prosthetic device benefit of Medicare Part B, while other infusion therapies are covered at carrier discretion under the durable medical equipment benefit, also under Part B. Neither benefit explicitly recognizes the professional services described earlier. HCFA interprets both benefits as only covering drugs or nutrients, supplies, and equipment used in the provision of therapy. Although it is commonly understood, even within HCFA, that it is the nursing and pharmaceutical services that enable patients to receive care in the home at all, Medicare's coverage criteria still do not acknowledge that those services have any role in home infusion therapy.

A natural question arises at this point: What does HCFA gain by defining home infusion therapy simply as the delivery of products? The answer is simple -- short-sighted, short-term cost savings. If HCFA can cling to a product-only definition, then it can advocate for product-only reimbursement, even when it is clear that the products are only one component of therapy. HCFA can then trim the current payment so that not one dollar of reimbursement is applied to the provision of services. At best, this position is simply disingenuous, and at worst, it is dangerous for patients and constitutes a poor basis for the creation of new policies to guide the future.

This has resulted, year after year, in a tug of war between HCFA and home infusion therapy providers over HCFA's proposed cuts in reimbursement. HCFA's proposed cuts have varied over the years, but they would all accomplish the same thing, which is to halt any payment that may possibly reflect the provision of professional services. Each time, we have suggested alternative cuts that we believe make more sense and do not threaten patients, and Congress has generally responded well to our suggestions.

This year, HCFA is again suggesting harmful cuts in the form of competitive bidding. HCFA has been testifying before Congress that it wants the authority to competitively bid for certain services covered under Part B of the Medicare program, including parenteral and enteral nutrition. This is a seriously flawed proposal, and we believe Congress should reject it.

It is clear that HCFA and other advocates of Medicare competitive bidding are trying to convince Congress of its merits by touting the "competitive" nature of the proposal. Unfortunately, the Medicare competitive bidding proposal is nothing like the competitive bidding that occurs in the private sector every day. This is a very important point -- we do not oppose competitive bidding, as it is a way of life outside of the Medicare program. What is being proposed for Medicare, however, will do little more than drive many providers out of business and leave the market to the providers that do not provide good quality services along with the products they deliver. That, we hope you would agree, is not a good result for anyone, including HCFA.

In the private sector, health plans that use the competitive bidding approach to select providers rely on one or more of the following:

- quality standards developed by the health plan, or as an alternative, a requirement that all eligible providers be accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
- a clear and accurate definition of the therapy(ies) in question, so that the providers will know precisely what is expected of them; and
- some means of measuring outcomes, so that the health plan can track the clinical effectiveness of the participating providers.

None of these mechanisms would be in place for the Medicare competitive bidding system. There are no program or quality standards for infusion therapy, because these are Part B therapies, and providers are not subject to Medicare conditions of participation. As noted above, HCFA persists in wrongly defining the very therapies it seeks competitive bids on, so that the winning bid will be limited to the items HCFA recognizes as covered under PEN therapy, and would exclude the professional services that make these therapies available in the home. Finally, there is no outcomes measurement mechanism at all in place for Medicare, so there is no way for the program to ascertain how its beneficiaries are faring under this new, untried system.

This all adds up, in our view, to a recipe for disaster for patients and providers alike. One can only imagine how poorly competitive bidding would work in other areas if the government purposely misdefines what is being bid on. For example, if the Department of Defense put out a bid for a new fighter jet, and explicitly excluded the cost of the engine from the bids it was seeking so as to appear to be "saving" money (at least on paper), the Congress and the public would be rightly indignant about the behavior of the Defense Department. HCFA's competitive bidding proposal warrants the same reaction, for the same reasons. We urge Congress to reject this ill-considered policy.

Recommendations

We understand the need to reform Medicare and find needed cost savings to ensure the solvency of the program. We believe there is a sensible way to achieve this for home infusion therapy without undermining quality and competition, as HCFA's competitive bidding proposal would do.

In short, our proposal is to redefine home infusion therapy under Medicare to include professional services. We are not seeking any reimbursement increase to reflect the more accurate definition. In fact, our proposal will allow HCFA to pay for professional services only when the patient needs them and thus save money. We have described the activities of nurses, pharmacists, and other professionals in caring for patients. However, this level of activity is not the same for every patient. Some patients actually may not need services from their home infusion therapy provider, either because they have access to services through another provider (nursing home, nursing agency) or because they have been on therapy for a long time and have grown proficient in self-administering their treatment. However, Medicare payment for home infusion therapy currently does not vary according to whether the patient is receiving services or not.

This is one of the main differences between Medicare and the private sector as far as coverage and reimbursement for home infusion therapy is concerned. Private insurers directly cover services, and pay for them according to the needs of the patient. Medicare pays the same for every patient, regardless of what the patient needs.

There are several ways to remedy this situation. We submit three options for your consideration:

I. One option is within the context of the broad Medicare reform measures under discussion, where beneficiaries would be given a choice among several alternatives for health care coverage, ranging from the current Medicare fee-for-service system to private sector options such as the use of vouchers and managed care. We would simply request that for all beneficiary options, there should be a standard definition of home infusion therapy that includes clinical services, drugs or nutrients, equipment, and supplies. We support the idea of moving Medicare beneficiaries out of the fee-for-service system into managed care. Even if that happens, however, some will choose to stay with the current system. For them, the definition of home infusion therapy should be the same as for those who choose a managed care option. This will ensure equity for beneficiaries who stay in the fee-for-service segment and will give Medicare the same ability as private-sector insurers to control reimbursement and utilization of home infusion therapy services.

II. If there is no broad-based reform of Medicare, there are still ways to improve the current fee-for-service system. A second option is to make a definitional change within the existing coverage of home infusion therapy. As stated earlier, home infusion therapy is covered under the prosthetic device and durable medical equipment benefits of Medicare Part B. Congress could leave infusion therapy within those coverage niches but expand the definition of the therapies to accurately reflect the clinical services in addition to drugs, nutrients, equipment, and supplies. This would allow the program to develop payment rates that reflect varying levels of service intensity.

III. A third option would be to remove coverage of home infusion therapy from the prosthetic device and durable medical equipment benefits and create a new coverage "niche" for infusion therapy that includes clinical services. Only those infusion therapies that are currently covered by Medicare would be covered, and, as in the second option, payment could be structured so that Medicare only pays for services when patients need them.

Any one of the three options described above, if properly implemented, would decrease total Medicare expenditures for home infusion therapy and bring Medicare in line with private-sector reimbursement of home infusion therapy. By simply acknowledging that the services are integral parts of infusion therapy, HCFA can determine when to pay for them and when not to pay for them and thus control cost in an intelligent manner.

In conclusion, we ask that Congress reject ill-conceived and anti-competitive proposals such as HCFA's competitive bidding system in favor of more progressive reforms. For home infusion therapy, this means recognizing the therapy for what it is: a service-driven, patient-specific approach to home care. In so doing, the Medicare program can realize savings without putting beneficiaries at risk and doing irreparable harm to the market. We appreciate the opportunity to submit testimony to the Committee, and we hope to work with Congress as it undertakes the task of reforming the Medicare program. If members of the Committee or their staff have any questions regarding this testimony, please contact Alan Parver or Jana Sansbury at (202) 347-0066.

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ATTACHMENT A
TYPES OF HOME INFUSION THERAPY

Introduction

Drugs are administered by infusion when other routes of administration are not possible, effective or desirable or when a sufficiently rapid therapeutic response is not likely to be achieved. In the case of parenteral or enteral nutrition, nutrient solutions are administered by infusion when the patient cannot ingest enough nutrients orally to maintain adequate weight and strength.

Clinically speaking, drug administration by infusion has advantages and disadvantages. When administered by infusion, the therapeutic agent is completely and reliably delivered to the bloodstream and is therefore immediately available to the body's tissues. In addition, large doses can be administered continuously, thus avoiding tissue damage from potentially irritating drugs. On the other hand, such administration carries with it the risk of systemic infection and venous irritation. Further, certain parenteral drugs can cause a negative reaction if they are incompatible with the patient or if they are administered too rapidly. In such cases, the consequences may be serious and even life-threatening. For these reasons, patients must be carefully screened for their suitability for home infusion therapy.

Typically, most home infusion therapy is administered intravenously (into a vein) but many other routes of administration are feasible, depending on the therapy and other clinical factors. Whatever route is chosen, any infusion requires two basic types of equipment: (1) a vascular access device (usually a catheter) through which the drug or solution enters the bloodstream and (2) an infusion device (usually a pump or a gravity drip system) to move the solution from its container into the delivery system and then into the patient. Technological advances in equipment over the last two decades have played a major role in making infusion therapy possible in the home, and future advances should continue to expand the range of treatment options in the home setting.

Clinical Indications for Home Infusion Therapy

Home infusion therapy is used to treat a variety of medical conditions. A few of the most common are listed below:

- **Infections** of many kinds, including osteomyelitis, cellulitis, endocarditis, respiratory infections, urinary tract infections, gynecologic infections, post-operative infection, cytomegalovirus infection, cystic fibrosis, chorioretinitis, pneumonia and Lyme disease. Such infections can be treated with IV administration of antibiotics.

- **Cancer**, including bronchial/lung, breast, prostate, colon, recto-sigmoid, kidney, ovarian and multiple myeloma. Cancer-related pain is often treated with home infusion therapy as well. Infusion therapy allows precise dosages of chemotherapeutic agents, which can be quite toxic if administered too rapidly.

- **Nutrition-related problems**, such as Crohn's Disease and enteritis, hypoglycemia/malnutrition following GI surgery, intestinal obstruction, short-bowel syndrome, smooth muscle disorders, esophageal cancer, infantile cerebral palsy, and stroke-related conditions such as dysphagia. These patients require IV administration or tube feeding of nutrient formulas.

- **AIDS-related conditions.** AIDS patients suffer from a variety of opportunistic infections and conditions associated with immune deficiency that can be treated with home infusion therapy. Cytomegalovirus infection, chorioretinitis,

pneumonia, anemia, malnutrition and severe pain are the most common. Thus, AIDS patients may receive several infusion therapies, including nutritional therapy.

- **High-risk pregnancy.** Home infusion therapy for these patients usually involves administration of tocolytic drugs such as terbutaline to prevent premature labor.

- **Congestive heart failure.** These patients benefit from IV administration of drugs such as dobutamine to help strengthen cardiac function.

- **Hemophilia.** Hemophiliacs need administration of agents that promote blood clotting (Factor VIII, Anti-Inhibitor Coagulant, Factor IX Complex).

- **Thalassemia.** This condition is caused by an excess of iron in the system and is treated through infusion of drugs such as deferoxamine.

- **Pituitary dwarfism and other growth disorders.** These patients require infusion of human growth hormone to assist in their growth and development.

Types of Home Infusion Therapy

Although a variety of infusion therapies are currently rendered in the home, the most common are antibiotic therapy, chemotherapy, pain management, parenteral nutrition and enteral nutrition. During an episode of illness, most home infusion therapy patients require periodic administration of a single drug or nutrient solution. However, some patients require multiple drugs or therapies concurrently. For example, cancer patients suffering from severe pain and malnutrition may need both pain management and parenteral nutrition; a patient with a serious infection from multiple organisms may need intravenous infusion of multiple antibiotics. Following is a description of the five major home infusion therapies.

Antibiotic Therapy. Administration of antibiotics to treat infections is the infusion therapy most commonly administered in the home. Some of the conditions treated with home antibiotic therapy are listed above. Treatment may last from as little as a few days to several months. Patients who are HIV positive and who have developed serious opportunistic infections often require treatment for significantly longer periods of time.

Chemotherapy. The parenteral administration of anti-neoplastic or anti-cancer drugs is intended to destroy or alter the growth pattern of malignant cancer cells. The type of drug, the frequency of administration and the duration of therapy depend on the type of cancer, the extent to which it has spread and the drug's action and toxicity. Some patients receive chemotherapy once a week for up to six weeks. Others receive it five to ten consecutive days each month. Still others are treated more frequently or for longer time periods. Because the potential dangers of intravenous chemotherapy include life-threatening toxicity, physicians, nurses and pharmacists must monitor chemotherapy patients closely.

Pain Management. Effective pain management using narcotics can alleviate severe pain, thereby decreasing anxiety and enhancing the quality of the patient's life. Chronic and severe pain may be caused by cancer, neurologic, orthopedic or certain AIDS-related conditions. Home pain management enables patients to leave the hospital and receive therapy in the comfort of their homes. It also enables terminally ill patients to spend the last weeks of their life in relative comfort in familiar surroundings with family and loved ones.

The frequency of administration and dosage depend on the medication and the patient's response to the medication. Because the severity of pain typically fluctuates over the course of a day, pumps that allow for continuous infusion of pain medication, as well as bolus "rescue" doses that the patient can self-administer up to a maximum dosage, are often used.

Parenteral Nutrition. Also referred to as intravenous hyperalimentation or total parenteral nutrition, parenteral nutrition enables patients to meet their daily needs for carbohydrates, proteins, vitamins, minerals, trace elements, fats and other nutrients through a surgically inserted venous catheter or other vascular access device. Parenteral nutrition is often recommended for patients with malnutrition resulting from Crohn's disease, short-bowel

syndrome, bowel obstruction, severe burns, malabsorption syndrome, pancreatitis, cancer, ulcerative colitis, and AIDS-related malnutrition. The common element of these indications is that the patient's digestive system does not permit the patient to absorb nutrients sufficient to maintain adequate weight and strength.

Parenteral nutrition formulas are designed to meet a patient's specific nutrient needs; the formulas specified in the physician's prescription are compounded by a pharmacist in a special environment designed to assure sterility. Clinical and laboratory tests are performed to monitor the patient's response to therapy. Parenteral nutrition may be administered continuously throughout the day or cycled over a prescribed number of hours each day (usually overnight). Since an accurate infusion rate is essential, an infusion pump equipped with alarms is used for administration.

Enteral Nutrition. Enteral nutrition involves tube feeding directly into the patient's stomach or intestine. Enteral nutrition therapy is appropriate for patients whose lower gastrointestinal tract functions normally but who are unable or unwilling to swallow, who have a gastric obstruction or who cannot otherwise ingest adequate amounts of food and fluids by mouth. Likely causes include surgery of the gastrointestinal tract, mechanical obstruction or malfunction caused by a malignant or non-malignant disease, a comatose state or Alzheimer's disease.

Most enteral nutrition patients are fed through a nasogastric or smaller feeding tube. The tube is inserted through the nasal passage with the proximal end placed into the patient's stomach or duodenum by a physician or nurse trained in such insertions. Often, enteral nutrition patients needing long-term therapy are fed through gastrostomy or jejunostomy tubes, which are inserted through a surgical incision in the abdominal wall, with the proximal end placed directly into the stomach or jejunum.

Enteral nutrition therapy formulas or solutions ordinarily are premixed by the manufacturer. They may consist of standard dietary ingredients or may be tailored to a patient's specific nutritional requirements. A relatively simple pump is often used to ensure accurate delivery of the formula.

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ATTACHMENT B
DESCRIPTION OF PROFESSIONAL SERVICES

The process of admitting a patient to home infusion therapy begins with a telephone call from a physician, hospital discharge planner, home health agency, case manager, or payer. While office personnel or clinical staff can take referral information related to demographic data and insurance information, only a licensed pharmacist or registered nurse can receive orders for treatments and prescriptions.

A physician's treatment plan for the patient is developed; ideally, this should be a collaborative effort between the prescribing physician and the provider's pharmacist and nurse. The treatment plan is patient-specific, and sets forth the physician's therapeutic goals and desired regimen of care for the particular patient. The infusion therapy provider develops a plan of care to carry out the physician's treatment plan. Where patients require multiple therapies, the provider's plan of care can be quite complex and time-consuming to develop.

A clinical nurse specialist conducts an initial patient assessment to determine the patient's suitability for home infusion therapy. Normally, the nurse interviews the patient in person prior to discharge from the hospital, and visits the patient's home as well. The assessment includes an analysis of the home environment for safety and appropriateness for care delivery, a physical and psychosocial assessment, review of the patient's medical condition and current medication, vascular access assessment, and a summary of the patient's treatment prior to the home care admission.

The home infusion staff verifies insurance benefits, and contacts case managers if necessary to discuss service needs and payment. Often, a nurse and/or a pharmacist become involved in these discussions. Obviously, the absence of adequate insurance may cause the patient to decline home infusion therapy; likewise, a provider will be reluctant to accept an uninsured patient who requires costly treatment. However, inadequate or nonexistent insurance does not necessarily preclude a patient from eligibility for home infusion therapy.

Much of the savings from home infusion therapy are attributable to the fact that the patient or his/her caregiver are trained to administer the therapy. Nurses provide most of the patient training and education, although sometimes pharmacists participate. Training is often initiated while the patient is hospitalized, although it can be started after discharge. With some therapies, patients can learn the necessary procedures in one or two training sessions, totalling about 2-4 hours. On the other hand, a parenteral nutrition patient may require several sessions totalling up to 10-12 hours of training. Certain patients may have functional limitations, which diminish their ability to self-administer the therapy and to change equipment and drug delivery systems. The training regimen depends on the patient's response and ability to learn what is required.

Once the patient is trained and admitted into home treatment, the provider attempts to establish a schedule of deliveries, monitoring, and treatment. The preparation of drugs and solutions is performed by a pharmacist (or a trained technician working under the supervision of a pharmacist, if permitted under state law). Sterile admixture is performed under a laminar flow hood or in a Class 100 clean room. The pharmacist verifies the order received from the physician, and the pharmacist is responsible for checking the medical record for pertinent information before dispensing the prescribed medication. Information such as previous allergic reactions, laboratory tests, appropriateness of the treatment for the disease state, and potential drug interactions are evaluated prior to filling the prescription.

The patient is provided with the equipment required to administer the therapy, and a one-week allocation of supplies, including intravenous catheter supplies. Supplies and equipment vary depending on the therapy being provided.

The nurse initiates the prescribed therapy during the initial visit to the patient's home. The patient and/or caregiver subsequently begin to administer the therapy, and perform self-monitoring activities, at prescribed intervals. In the first week of therapy, a nurse may visit the patient daily to ensure that the therapy is being administered properly and to evaluate the patient's therapeutic response to treatment. In addition, the pharmacist and nurse are available 24 hours a day, 7 days a week to all home infusion patients to respond to problems or questions as they arise.

During visits, nurses perform on-going assessments and technical procedures as outlined in the plan of care. They assess the patient's condition, the vascular access device, the drug delivery system, the patient's compliance and response to therapy, their psycho-social adaptation to home care and their satisfaction with the services they have received. Additionally, they perform various procedures related to maintenance of the access device, conduct blood sampling, insert I.V. catheters, and provide further training to the patient and/or caregiver.

Even after the number of actual patient visits may decrease, a nurse and/or pharmacist communicates regularly with the patient regarding progress and problems. During visits and through other communications with the patient, information about the patient's clinical status, treatments provided and the patient's responses to treatment are recorded and communicated to other practitioners, providers, and the primary physician. This information, along with the results of laboratory tests, is reviewed with the physician during periodic reviews of the plan of care to determine if the goals of care are being met and whether the treatment regimen continues to be appropriate. Typically, it is during communications with the physician that changes in medication and treatment orders are received by the provider.

This routine continues until the treatment goals are met and the patient is discharged from service. Often, long-term patients become quite independent and adept at administering the therapy, thus lessening the need for a nurse to visit on a regular basis. These patients still communicate frequently, however, with the nurse and pharmacist by telephone.

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Testimony
of
the
National Association for Medical Equipment Services
on
New Directions in Medicare

Hearing
of
Tuesday, July 25, 1995

Before
the
Senate
Committee on Finance

The National Association for Medical Equipment Services (NAMES), the only national association representing the home medical equipment (HME) services industry exclusively, is pleased to submit testimony to this Committee regarding New Directions in Medicare.

This is the first step in addressing one of the most pressing issues faced by Congress: how to set the direction for the Medicare program while trying to reduce the federal deficit. This will include a delicate balance of maintaining quality of care and expanding its access, while reducing costs. Toward that goal, this testimony addresses the role of HME services and rehab/assistive technology in ensuring quality, affordable health care for all Americans, as well as Medicare expenditures. This testimony will outline significant policies which will help to eliminate fraudulent health care providers from the Medicare program and will potentially save the federal government millions of dollars. Evidence will be presented to show that competitive bidding is not the way to achieve savings in the Medicare program.

The Role of Quality HME Services

NAMES members comprise approximately 1,800 HME companies which provide quality, cost-effective HME services and rehabilitation/assistive technology to patients in their homes. According to physician prescription, HME providers furnish an extremely wide array of HME and related services to patients in their home, ranging from more "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, intravenous antibiotic therapies, apnea monitors and ventilators, and specialized rehabilitation equipment customized for the unique needs of people with disabilities. Many of these consumers are Medicare beneficiaries.

HME can make the difference by avoiding more costly care, providing for a speedier hospital discharge, and ensuring that the individual continues to live as independently as possible. HME providers furnish a continuum of care. Responsibilities do not end when equipment and supplies are delivered to the home and consumers are trained in their use, but merely begin. Due to the increasing sophistication of equipment that is available in the home today, the HME services industry is routinely "on call" seven days each week, 24 hours per day to provide the support services needed.

The current HME marketplace reflects the growing number of patients as well as their needs and expectations for quality services. Home care using HME services and rehabilitation/assistive technology can ensure the continued provision of high quality health care in a setting preferred by the vast majority of consumers and their families. This kind of care can save our nation's health financing system millions of dollars.

HME Expenditures

NAMES has testified before other Congressional committees this year regarding the growth in Medicare expenditures. In previous testimony, NAMES agreed that Medicare expenditures for home care services have grown. However, this is not the problem, but rather a solution in itself. In an era of increasing cost consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve and foster the very benefit that provides home care services in the most cost-effective and yet compassionate fashion.

HME reimbursement has been essentially level for the past ten years. In April of 1995, NAMES conducted a survey of our long-standing members to obtain information on Medicare fees paid on selected items over the preceding ten years. HME services providers across the country were asked to provide actual Medicare payment information on the following HME items: oxygen concentrators, portable oxygen add-ons, commodes, standard wheelchairs, total electric beds, and semi-electric beds. In addition to the Medicare payment amount, HME services providers were to provide a copy of an actual Medicare Payment Remittance Advice Notice sent to the provider by the Medicare carrier making the payment, as confirmation of the Medicare payment amount reported as received. The results show that **Medicare payment amounts for the selected HME items have remained relatively unchanged during the previous ten years.** For example, in 1985, oxygen concentrators were reimbursed by Medicare at the average rate of $302.50. Currently in 1995 oxygen concentrators are reimbursed by Medicare at the average rate of $303.54. Standard wheelchairs were reimbursed by Medicare at the average rate of $32.45. In 1995 Medicare reimburses on average only $47.11. We have attached a copy of the entire survey to our testimony (Appendix A).

The HME services industry has received 18 cuts in the last nine years (Appendix B). We must remember that HME outlays represent approximately only 2% of the total outlay for Medicare expenditures. We submit to you that any growth in Medicare expenditures for home medical equipment services is not due to rising prices for HME services but utilization rates that reflect why HME is the solution and not the problem. And, that care in the home can save our nation's health financing system millions of dollars.

We understand this Committee's key role in seeking ways to restructure the Medicare program. NAMES would support a radical restructuring of the entire system. This could include a consolidation of Medicare Part A and Part B, in order to provide incentives for patients to choose the best quality, most cost-effective level of care.

Fraud and Abuse

NAMES takes seriously its mission to promote access to quality HME services and rehab/assistive technology and has devoted significant resources for several years to combat fraud and abuse. The industry has worked assiduously with the Administration and Congress to help eliminate the few unethical providers who damage the reputation of an otherwise upstanding industry.

One of NAMES' efforts consisted of working during the 102nd Congress with Rep. Ben Cardin (D-MD), who introduced H.R. 2534, the "Ethics and Treatment of Home Medical Equipment Act of 1991." This legislation, which was co-sponsored by 112 Members of Congress, remains the most far-reaching of all subsequent HME bills introduced in Congress to date. Many provisions and concepts in H.R. 2534 were incorporated into legislation that passed the 102nd Congress in 1992, but were vetoed by President Bush. In the 103rd Congress, NAMES helped Congress enact into law, the Social Security Act Amendments of 1994 (H.R. 5252 & S. 1668), which incorporated many of the ethics provisions contained in H.R. 2534.

Recently, NAMES took a serious look at the specific problems with the provision of HME services and rehab/assistive technology in the Medicare program. The following reflects our solutions to those problems which we believe will potentially save the Medicare program millions of dollars.

- **Accountability Measures — The Need for Standards.** NAMES has advocated for years that there must be stronger accreditation, certification and licensure requirements, including on-site inspections. Despite the work of NAMES and HME providers to create a higher level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding type or frequency of services that should be rendered, record-keeping practices, emergency care, patient education, home safety assessments or infection control practices.

- **Consistent Monitoring of the HCFA Common Procedure Coding System (HCPCS) Codes.** The HCPCS codes are currently updated on a yearly basis only. One of the possible abusive areas in HME is in questionable coding practices. By legislatively mandating HCFA to prospectively change the coding system quarterly, Congress could eliminate problems that have occurred in similar situations with support surfaces.

Furthermore, the Office of Inspector General is currently expending significant resources in an attempt to prove that providers abused the system by filing lymphedema pump claims under "high-priced codes"; in fact, HCFA's system of codes simply failed to keep up with technology.

NAMES also would advocate that Congress create a **Manufacturer and Provider Advisory Committee** to assist HCFA in setting the HCPCS Codes and recommend appropriate descriptors to help identify emerging technology.

- **Optional Electronic Preauthorization.** Assistive technology and special wheelchair systems require building and delivery prior to claims submittal. HCFA has no set time period for claim adjudicating and guaranteed payment. We have received information which suggests that some providers may be submitting claims and paperwork indicating the equipment has been delivered, when in fact they have not even begun constructing the equipment. Providers will do this in order to get advanced assurance of Medicare coverage and payment for costly, complex equipment that has been prescribed by the physician.

  By requiring HCFA to set up an optional 5-day response electronic preauthorization system for rehab/assistive technology for equipment costing over $1,000, Congress could avoid any incentives to engage in this practice, by reassuring the provider that their services will not go unpaid.

- **Equipment Upgrades.** Currently, a Medicare beneficiary with a prescription who wishes to purchase certain pieces of equipment may be unable to do so. For instance, a beneficiary who has a prescription for a full-electric hospital bed to meet his/her physical needs is prohibited by Medicare to purchase the bed. Although Medicare will pay for the rental of a semi-electric bed, a full-electric bed is deemed medically unnecessary, even as originally prescribed by the physician. In essence, regardless of the patient's medical needs or a physician's prescription, Medicare makes the final medical need and payment decisions.

  When a beneficiary needs an item of medical equipment the provider will bill Medicare for the item and Medicare may deny payment and instead substitute another item that costs Medicare less. In addition Medicare denies the beneficiary the ability to "upgrade" to his/her equipment of choice. NAMES strongly supports legislative efforts to allow equipment upgrades for Medicare beneficiaries.

NAMES also is working with the Coalition of Associations United Against Fraud and Abuse to enact strict legislation creating an environment that discourages fraudulent providers from participating in the health care system and encourages quality and cost-effective health care. Please see the attached summary of the Coalition's proposal (Appendix C). NAMES highly endorses this proposal as a way to potentially save billions of Medicare dollars.

By enacting the suggested provisions, Congress could potentially save the Medicare program money that could be used to reduce the federal deficit.

Competitive Bidding

As HME services providers and business owners, NAMES members recognize the need to balance the federal deficit. But in the rush to develop new ways to pay for such reform, one dubious proposal, competitive bidding for HME services, is continuously under consideration.

Congress should consider the fact that competitive bidding for certain selected HME items under Medicaid has been tried previously and subsequently abandoned in a number of states. States found competitive bidding to impair freedom of choice for recipients, to render the States incapable of utilizing the expertise of all vendors, and to impede competition and access.

- Ohio Medicaid officials concluded that competitive bidding was unworkable after issuing a request for purchase.

- Montana abandoned competitive bidding because the program was found to deny access to beneficiaries and impair the ability of the State to tap the expertise of all providers.

- South Dakota backed away from a decision to implement competitive bidding after deciding it could reduce Medicaid costs in other, more effective, ways.

A competitive bidding program is extremely complicated. At this time, the Health Care Financing Administration (HCFA) has no plan for administering such a program. Such an endeavor would require HCFA to invest in a significant new bureaucracy and ultimately could cost more to create and operate the bureaucracy than would be saved from competitively bidding the products and services.

Competition and competitive bidding are not synonymous. True competition compares service and price. Competitive bidding looks only for the lowest price. It does not address issues of service, choice, or quality. Winner-take-all competitive bidding may even destroy competition by driving many HME companies out of business.

Competitive bidding compromises quality, access and choice. Medicare patients do not seek HME such as oxygen therapy as a matter of discretion. When service is interrupted, consumers must receive prompt service or be forced to enter the hospital. Quality home medical equipment service companies maintain 24-hour, seven day a week patient support so that service is never interrupted. That level of service would be improbable to maintain in a competitive bidding environment. Patients with emergencies end up entering the hospital at additional Medicare program costs. In fact, service has been shown to decrease significantly in areas where HME providers are forced to competitively bid.

The worst result for Medicare beneficiaries would be to establish a structure that would permit low bidders to offer inferior quality at below market prices, without providing the level and quality of support and service that is essential to basic patient care.

In short, all evidence suggests it is virtually impossible to design and administer a competitive bidding process without damaging the market, compromising quality and leading to higher prices in the long run. With policymakers now considering various mechanisms to reform Medicare by moving more beneficiaries into managed care, it is illogical to create a new scheme at this time just for HME services that removes the entire concept of competition out of the marketplace altogether.

Conclusion

In closing, NAMES recognizes the difficulties faced by Congress and this Committee in developing a responsible legislative package that will reduce the Federal deficit and still address America's critical health care needs. At the same time, NAMES submits that enacting legislation which does not work is counterproductive to our common goals of allowing people to be discharged sooner from institutions and

permitting people with severe disabilities to lead productive lives. Such obviously cost-effective and compassionate means of providing health care in the home should be encouraged and fostered where possible and clinically appropriate.

HME providers do much more than just deliver home medical equipment to Medicare beneficiaries and others. This high level of home care service must be encouraged — not destroyed. HME services providers are willing to do our part to assist Congress in reducing Medicare expenditures, but the federal budget cannot be balanced through repetitive consideration of proposals that have been rejected time and time again, such as competitive bidding. The budget can be balanced by following the industry suggestions we have presented.

We will be pleased to answer any questions you may have. Thank you for allowing us to submit testimony.

APPENDIX A

NAMES
National Association for Medical Equipment Services

NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

SURVEY

MEDICARE PAYMENT FOR SELECTED HOME MEDICAL EQUIPMENT ITEMS

1985 - 1995

(Released - July 17, 1995)

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Executive Summary

In April of 1995, the National Association for Medical Equipment Services (NAMES) conducted a survey of its longstanding members to obtain information on Medicare fees paid on selected items over the preceding ten years. NAMES member home medical equipment (HME) services providers across the country were asked to provide actual Medicare payment information on the following HME items: Oxygen Concentrators; Portable Oxygen Add-On; Commodes; Standard Wheelchairs; Total Electric Beds; and Semi-Electric Beds. In addition to the Medicare payment amount, HME services providers were to provide a copy of an actual Medicare Payment Remittance Advice Notice, sent to the provider by the Medicare carrier making the payment, as confirmation of the Medicare payment amount reported as received.

Two hundred and forty-two members (242) were surveyed and fifty-one responses were received. Verifiable information varied the number of states represented in the survey results for each selected item. The survey results are:

Oxygen Concentrators - In 1985, the average Medicare monthly payment was $302.50. After a high of $318.39 in 1989, the average Medicare payment fell to a low of $280.18 in 1990. In 1995, the average Medicare payment is $303.54, or $1.04 more than Medicare's average payment ten years ago. If oxygen concentrators payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $596.91. Medicare is therefore paying $294.37 below an estimated market price for oxygen concentrators. **This represents a 50% decrease in equipment payment over the last ten years.** Note that until 1989, Medicare also paid an additional monthly amount for the liquid or gaseous content used by the beneficiary in any back-up or portable system. This amount was based on a per pound or per cubic foot basis and varied, depending on actual usage.

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NAMES SURVEY - MEDICARE PAYMENT FOR SELECTED HOME MEDICAL EQUIPMENT ITEMS, 1985 - 1995 (Released - July 17, 1995)

Executive Summary (continued)

Portable Oxygen Add-On - Medicare pays a monthly "add-on" for the additional equipment needed to provide portable oxygen to those patients with an accepted medical necessity. In 1985, the average Medicare monthly payment was $46.25. After a high of $50.30 in 1990, the average Medicare payment fell to a low of $45.99 in 1994. In 1995, the average Medicare payment is $46.98, or $.73 more than Medicare's average payment ten years ago. If portable oxygen add-on payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $91.27. Medicare is therefore paying $44.92 below an estimated market price for portable oxygen add-on services. **This represents a 49% decrease over the last ten years.** Note that until 1989, Medicare also paid an additional monthly amount for the liquid or gaseous content used in the portable system. This amount was based on a per pound or per cubic foot basis and varied, depending on actual usage.

Commodes - In 1985, the average Medicare payment was $80.26. In 1995, the average Medicare payment is $94.08, or $13.82 more than Medicare's average payment ten years ago. If commode payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $158.38. Medicare is therefore paying $64.30 below an estimated market price for commodes. **This represents a 41% decrease over the last ten years.**

Standard Wheelchairs - In 1985, the average Medicare monthly rental payment was $32.45. In 1995, the average Medicare payment is $47.11, or $14.66 more than Medicare's average payment ten years ago. If standard wheelchair payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $67.29. Medicare is therefore paying $20.18 below an estimated market price for standard wheelchairs. **This represents a 30% decrease over the last ten years.**

Total Electric Beds - In 1985, the average Medicare monthly payment was $135.60. After a high of $182.05 in 1990, the average Medicare payment fell to $160.32 in 1993. In 1994, the Medicare carriers determined that no patient diagnosis or medical condition overcame the "convenience" denial exception to Medicare coverage and payment. Any billed total electric bed is now automatically reduced to a semi-electric bed for payment purposes. Medicare still computes a total electric fee, however, which in 1995 was an average of $166.57. If total electric bed payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $267.56. Medicare would therefore be paying $100.99 below an estimated market price for total electric beds and, in downcoding and paying the average semi-electric bed payment amount, is actually paying $129.60 less. **This represents a 48% decrease over the last ten years.**

Executive Summary (continued)

Semi-Electric Beds - In 1985, the average Medicare monthly payment was $118.23. After a high of $154.61 in 1990, the average Medicare payment fell to $126.76 in 1992. In 1995, the Medicare average payment is 137.96 or $19.73 more than ten years ago. If semi-electric bed payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $233.29. Medicare is therefore paying $95.33 below an estimated market price for semi-electric beds. **This represents a 41% decrease over the last ten years.**

Conclusion

Medicare payment amounts for the selected HME items have remained relatively unchanged during the previous ten years. Administrative and statutory changes in the payment methodology for HME has arrested and deflated HME fees as compared to possible increases based on actual medical Consumer Price Index changes over the same period. Any increase in overall Medicare outlays for HME over the same period must be related to other factors, such as increased patient access and utilization of Medicare benefits. Further attempts to control or reduce HME fees will not address the high utilization causes. Efforts to keep HME fees artificially low by using a fee setting methodology not responsive to market forces may actually contribute to increased utilization.

Recommendation

Based on the survey's findings and the factors described above, NAMES recommends that any contemplated legislative or administrative changes to achieve further reductions in HME payment amounts in 1995 not occur. This survey is evidence that lowered prices do not control the increase in aggregate Part B Medicare outlays.

NAMES

National Association for Medical Equipment Services

NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

SURVEY

MEDICARE PAYMENT FOR SELECTED HOME MEDICAL EQUIPMENT ITEMS

1985 - 1995

(Released - July 17, 1995)

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I. Introduction

Early in 1995, former National Association for Medical Equipment Services (NAMES) Chairman of the Board (1993 - 1994) Richard Doherty, correctly forecast that the impending Congressional debate on Medicare reform would invariably include a discussion of adjusting yet again the payment amounts received by Medicare providers. Since 1985, Congress has acted on seven different occasions to reduce or limit the growth of home medical equipment (HME) services Medicare fees. These actions include a rebasing of HME fees in 1990 (OBRA 1990), a freeze of Medicare allowables in 1986 and 1988, payment deductions in 1989 and 1990 (Gramm-Rudman-Hollings), limitations on Consumer Price Index (CPI) updates to the HME fees (OBRA 1990) and changing the payment methodology calculation to lower fees (OBRA 1993). On its own initiative, the Health Care Financing Administration (HCFA) has acted at least twice to lower HME fees, including a fee rebasing in 1986 (Inflation Index Charge Application) and a change in payment methodology in 1987 (Lowest Charge Level Reduction).

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Congress and HCFA took each of the preceding measures to limit growth in individual HME item Medicare payments presumably to slow and/or reverse the aggregate increases in Medicare expenditures for HME. Given the continuing presumption that Medicare HME fees are too high, Mr. Doherty questioned the effectiveness of these fee limiting initiatives to control Medicare outlays. Using his own company's experience (Comprehensive Home Health Company, Avon, Massachusetts), he conducted a survey on selected HME items to determine the actual impact these Congressional and Administrative actions have had on his Medicare payment amounts over the last decade. The results showed that, in the majority of cases, HME fees have remained relatively flat or, in some cases, actually decreased.

Based on his company's experience, Mr. Doherty concluded that the perception of high individual payments was incorrect and that increased fee amounts were not the cause of an aggregate increase in Medicare payments for HME over the last decade. Mr. Doherty requested that NAMES repeat this survey on a national basis, and the Association undertook such an effort in April of 1995. The results NAMES obtained mirrored Mr. Doherty's. An explanation of those results and how the survey was conducted are described in the following report.

II. Methodology

A. HME Item Selection

i. Items Selected Based on Provider Experience

For purposes of the survey, NAMES selected a variety of items that represent a reasonable cross section of the majority of items placed with Medicare beneficiaries by an average HME services provider. The items are:

Oxygen Therapy and Oxygen Concentrators - Oxygen therapy is medically necessary oxygen administered via liquid oxygen, compressed gas or oxygen concentrators. Effective as of 1989, the statutory payment methodology for oxygen therapy is modality neutral. One monthly fee amount is made in payment of approved oxygen therapy, regardless of the administration method. Prior to 1989, Medicare paid separate amounts for liquid oxygen equipment, gas equipment and concentrators. In addition, prior to 1989, Medicare paid for the actual liquid or gas contents used in the equipment on a per pound or per cubic foot basis. Even patients using an oxygen concentrator as their primary delivery modality must have a gas or liquid oxygen back up system. Many also use a portable system, which is explained below. Since 1989, there is no additional or separate Medicare payment for the contents used in a back up or portable system.

Portable Oxygen - Medicare pays a minimal monthly "add-on" for the additional equipment needed to provide portable oxygen to those patients with an accepted medical necessity. Portable oxygen can be delivered either by a compressed gas system -- small "E" size tanks, not refillable by

the patient and replaced when empty -- or by a liquid oxygen system -- a small portable liquid oxygen unit, refilled by the patient from a stationary liquid reservoir as needed. This add-on is not for the contents, but for the equipment. Since 1989, any content payment is considered included in the monthly allowable payment for the stationary unit.

Commodes - A bedside commode is covered and paid for by Medicare for patients whose medical condition confines them to their bedroom or otherwise makes them incapable of using regular toilet facilities.

Standard Wheelchairs - A wheelchair is covered if the patient's condition is such that without the wheelchair the patient would otherwise be bed confined.

Full Electric Hospital Beds - A full electric bed contains an electric motor with a hand-held controller permitting the patient to adjust the angle of elevation of the head and foot. Additionally the patient can adjust the bed height as needed for transfer into and out of the hospital bed. Since 1994, the Medicare carriers have considered electric bed variable height adjustment as a non-covered "convenience" feature, not medically necessary under any circumstance. When such beds are billed, they are automatically down-coded by the carrier (reduced to the next least expensive covered item) to the semi-electric bed payment amount. (Although the carrier's do not pay for full electric beds, HCFA still maintains billing codes and publishes annual Medicare fees for full electric beds. Providers are required to truthfully bill the equipment placed with the beneficiary, even in the face

of the automatic downcode. Differences in prices cannot be charged to patients when the claim is taken on an assigned basis when the item is downcoded, as opposed to an outright denial of Medicare coverage which makes the beneficiary liable for the item.)

Semi-Electric Hospital Beds - A semi-electric hospital bed contains an electric motor with a hand held controller permitting the patient to adjust the angle of elevation of the head and foot. Changes in the bed height as needed for transfer of the patient to and from the bed is accomplished by means of a handcrank located at the foot of the bed on the under carriage.

II. Selected Items Compared With HCFA Payment Experience

Based on HCFA provided information for 1991 on the "top 100" HME items in terms of aggregate Medicare payments, the amount paid in allowed charges by HCFA for oxygen therapy delivered via the oxygen concentrator modality only ranked 1, 2, 3 and 4 ($378.8 million), portable gaseous oxygen systems ranked 11 ($39.6 million), commodes ranked 22 ($14.1 million), standard wheelchairs ranked 17($20.6 million), full electric hospital beds ranked 9 ($45.7 million) and semi-electric hospital beds ranked 5 ($54.2 million). (See HCFA Request for Proposal - Durable Medical Equipment Regional Carriers, Attachment J.10, May 14, 1992.)

B. Methodology

i. The Survey Instrument

NAMES developed a questionnaire for each of the selected HME items. Respondents were asked to indicate the state being reported, since each state has a separate fee schedule for HME. This is a holdover from the pre-regional carrier, pre-"national" fee schedule era when each state had a separate Part B Medicare claims processing contractor (carrier) for durable medical equipment claims. (Each state still maintains a separate Medicare carrier for physician claims.) On the survey document, respondents were asked to indicate the Medicare carrier in 1985 and any change in the carrier through 1995. For each year, the respondents were asked to provide a paid Medicare amount for the selected item. Respondents were asked to attach to the survey a Payment Remittance Advice Notice as received from the carrier to verify the reported payment amounts for each of the ten years, 1985 through 1995.

ii. The Respondents

NAMES used its membership database to identify HME services providers in business at least ten years, from which NAMES chose HME services providers with at least ten years of ongoing NAMES membership. Accounting for several database updates over the last ten years, we were able to identify 242 potential members fitting this criteria across the country. A general mailing to this group resulted in the return of 51 usable responses. Further refinements resulted in usable state-by-state information as shown on the following table.

Table 1 - Number of Respondents and Number of States Represented, By Category

Oxygen Concentrators -	46 responses representing 21 states
Portable Oxygen -	39 responses representing 17 states
Commodes -	24 responses representing 8 states
Standard Wheelchairs -	18 responses representing 11 states
Full Electric Beds -	18 responses representing 6 states
Semi-Electric Beds -	31 responses representing 13 states

iii. Data Manipulation

Information from the various respondents was collated by item. Responses not verified by an attached Payment Remittance Advice Notice were not included. HCFA Common Procedure Coding System (HCPCS) codes were compared for the reported payment amounts as shown on the Remittance Advice to assure that like items were being reported and considered. Not every respondent was able to provide a payment amount in each of the ten years for a selected item. In computing the average yearly price, this lack of data was accounted for so as not to artificially deflate the derived yearly average payment amounts. For full electric beds, no received payment amounts for 1994 and 1995 were reported. The average of HCFA's computed fee schedule amounts was substituted for this missing data. For comparative purposes, the Consumer Price Index (CPI) for All Urban Consumers for Medical Care (U.S. city average) from 1982 to 1994 was obtained from the United States Department of Labor, Bureau of Labor Statistics. The derived average for 1985 was

used as a base year and the Medical Care CPI for each year was applied to that base average amount to establish the average "market price" for the HME items.

III. Results

The data spread sheets for each of the items are attached. In summary, the results are as follows:

Oxygen Concentrators - In 1985, the average Medicare monthly payment was $302.50. After a high of $318.39 in 1989, the average Medicare payment fell to a low of $280.18 in 1990. In 1995, the average Medicare payment is $303.54, or $1.04 more than Medicare's average payment ten years ago.

If oxygen concentrator payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $596.91. Medicare is therefore paying $294.37 below an estimated market price for oxygen concentrators. This represents a 50% decrease in equipment payment over the last ten years. The decrease in the payment made to the provider by Medicare is even greater if amounts received for content usage in back up or portable systems is added to the monthly amount paid the provider during the years 1985 through 1988.

NAMES Survey - Medicare HME Payment Amounts, 1985 -1995
(Released - July 17, 1995)

Portable Oxygen Add-On - In 1985, the average Medicare monthly payment was $46.25. After a high of $50.30 in 1990, the average Medicare payment fell to a low of $45.99 in 1994. In 1995, the average Medicare payment is $46.98, or $.73 more than Medicare's average payment ten years ago.

If portable oxygen add-on payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $91.27. Medicare is therefore paying $44.92 below an estimated market price for portable oxygen add-on services. This represents a 49% decrease over the last ten years. The decrease in the payment made to the provider by Medicare is even greater if amounts received for portable content usage is added to the monthly amount paid the provider during the years 1985 through 1988.

Commodes - In 1985, the average Medicare payment was $80.26. In 1995, the average Medicare payment is $94.08, or $13.82 more than Medicare's average payment ten years ago.

If commode payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $158.38. Medicare is therefore paying $64.30 below an estimated market price for commodes. This represents a 41% decrease over the last ten years.

Standard Wheelchairs - In 1985, the average Medicare monthly rental payment was $32.45. In 1995, the average Medicare payment is $47.11, or $14.66 more than Medicare's average payment ten years ago.

If standard wheelchair payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $67.29. Medicare is therefore paying $20.18 below an estimated market price for standard wheelchairs. **This represents a 30% decrease over the last ten years.**

Total Electric Beds - In 1985, the average Medicare monthly rental payment was $135.60. After a high of $182.05 in 1990, the average Medicare payment fell to $160.32 in 1993. Since 1994, Medicare carriers automatically downcode full electric beds to semi electric beds. HCFA still computes a total electric fee, however, which in 1995 was an average of $166.57.

If total electric bed payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $267.56. Medicare would therefore be paying $100.99 below an estimated market price for total electric beds and, in downcoding and paying the average semi-electric bed payment amount, is actually paying $129.60 less. **This represents a 48% decrease over the last ten years.**

Semi-Electric Beds - In 1985, the average Medicare monthly rental payment was $118.23. After a high of $154.61 in 1990, the average Medicare payment fell to $126.76 in 1992. In 1995, the Medicare average payment is 137.96 or $19.73 more than ten years ago.

If semi-electric bed payments had kept pace with the Consumer Price Index (CPI) for medical care (U.S. city average), the current average payment amount should be $233.29. Medicare is therefore paying $95.33 below an estimated market price for semi-electric beds. **This represents a 41% decrease over the last ten years.**

IV. Conclusion

Over the last ten years, Congress and HCFA have undertaken a variety of pricing control measures to reduce the outlays in Part B Medicare for home medical equipment and services. Their collective efforts have, at several different times, arrested the growth of allowed payment amounts (allowed charges) for HME to Medicare. Medicare payment amounts for the items selected in the survey have remained relatively unchanged over the preceding ten years. On average, Part B Medicare pays 43% less for HME than does a current free market consumer. Any increase in the amounts expended by Medicare do not appear to be caused by runaway increases in the prices Medicare is charged for HME. With the passage of the fee setting methodologies for HME in 1987 (the so-called "Six-Point Plan" contained in the Omnibus Reconciliation Act of 1987), increases based on submitted charges were removed from Medicare's calculation of HME fees. Any connection of

market forces to fee inflation was thereby broken. There must be other factors in play to account for the perceived increases in Part B Medicare expenditures for HME.

According to the U.S. House Committee on Ways and Means' 1994 Green Book -- Overview of Entitlement Programs, the number of Part B Medicare enrollees is expected to rise from 22 million in 1985 to 31 million in 1995, an increase of 9 million. Over the same period the annual amount spent by Medicare Part B per enrollee is expected to rise from $733 to $1,806. Given the survey results, this per enrollee increase is not a result of rising HME prices. Yet, given the overall increase in eligible beneficiaries, a potentially valid assumption is that more individuals are receiving HME, driving up utilization and thereby increasing outlays. Given the improvements in HME technology that have made many more medical treatment options in the home setting available than ever before, this would be a plausible assumption. A survey by NAMES in 1991 ("Coming Home", A Nationwide Survey By NAMES, 1991) showed that a majority of individuals preferred to receive medical treatment in their own homes if that option were available. Finally, given the built-in disincentive in the Part A Medicare payment methodology to unnecessarily extend a patient's hospitalization, efforts to keep HME fees artificially low by using a fee setting methodology not responsive to market forces may actually contribute to increasing HME utilization.

V. Recommendation

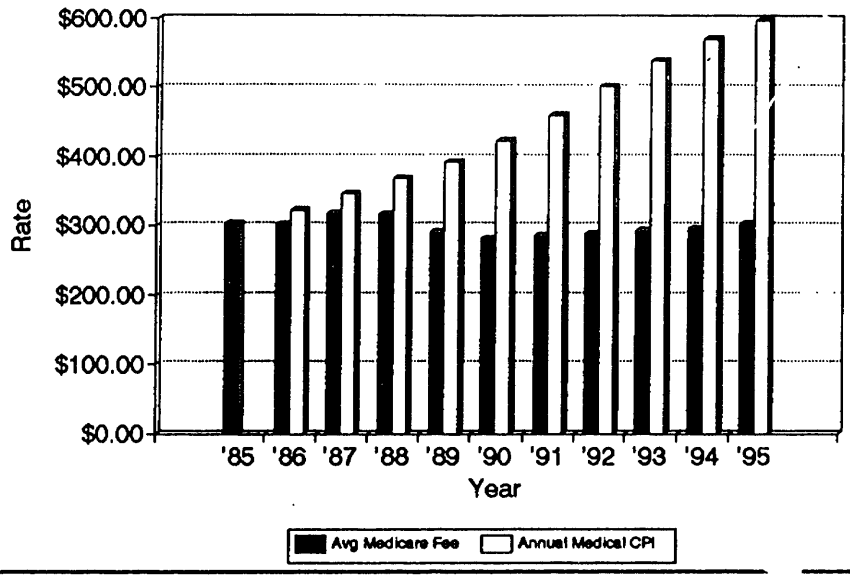
Based on the survey's findings and the factors described above, NAMES recommends that any contemplated legislative or administrative changes to achieve further reductions in HME payment amounts in 1995 not occur. This survey is evidence that lowered prices do not control the increase in aggregate Part B Medicare outlays.

VI. Charts and Graphs

The charts and graphs for the collected data appear on the following pages.

NAMES
National Association for Medical Equipment Services

Oxygen Concentrator
Reimbursement Rates 1985-1995



	'85	'86	'87	'88	'89	'90
Medicare Avg	$302.50	$300.91	$318.39	$316.23	$289.66	$280.18
Medical CPI		$321.56	$345.68	$368.49	$392.44	$422.66

	'91	'92	'93	'94	'95
Medicare Avg	$285.70	$288.73	$292.79	$295.89	$303.54
Medical CPI	$460.70	$500.78	$537.84	$569.57	$598.91

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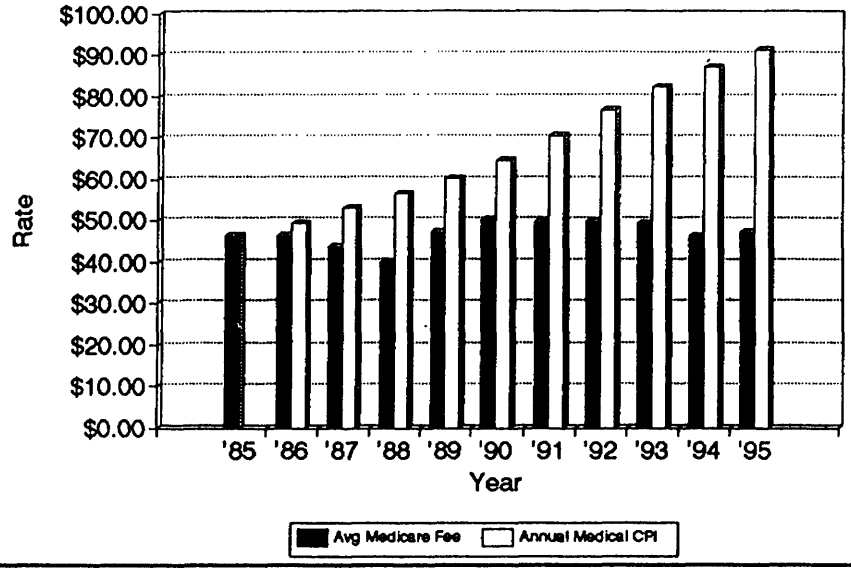
NAMES
National Association for Medical Equipment Services

Portable Oxygen Add-On
Reimbursement Rates 1985-1995



	'85	'86	'87	'88	'89	'90
Medicare Avg	$46.25	$46.21	$43.46	$39.86	$47.02	$50.30
Medical CPI		$49.17	$52.85	$56.34	$60.00	$64.62

	'91	'92	'93	'94	'95
Medicare Avg	$49.47	$49.79	$49.16	$45.99	$46.96
Medical CPI	$70.44	$76.57	$82.23	$87.09	$91.27

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NAMES
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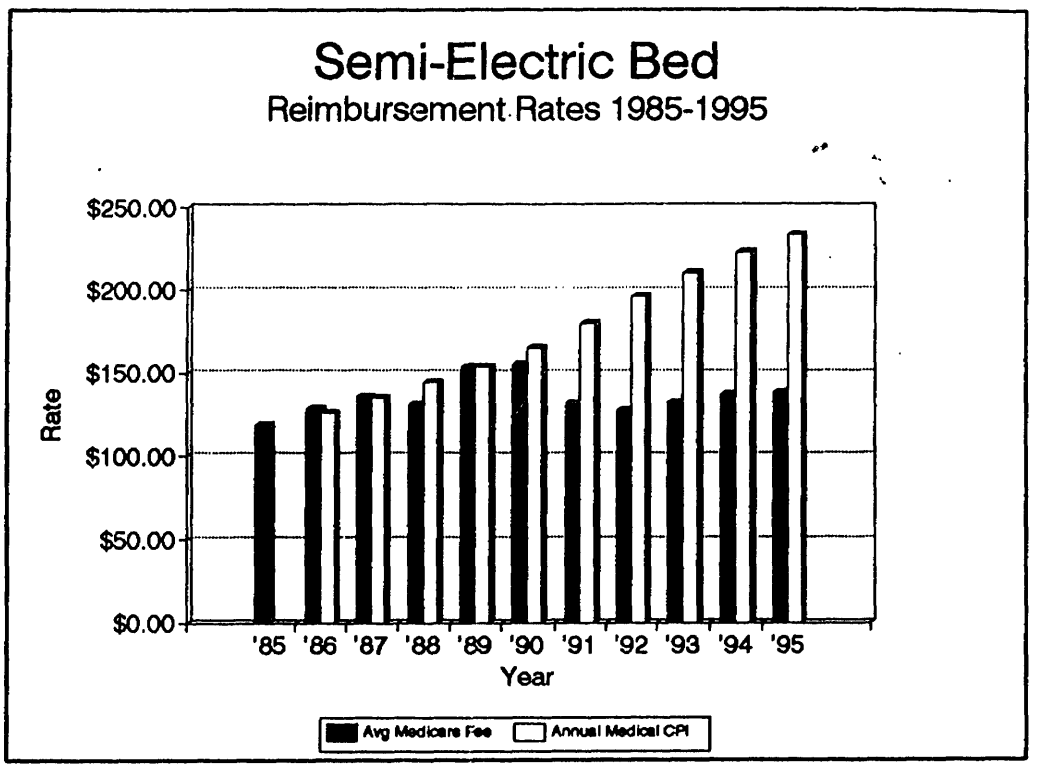

	'85	'86	'87	'88	'89	'90
Medicare Avg	$118.23	$128.26	$135.66	$130.75	$153.38	$154.61
Medical CPI		$125.68	$135.10	$144.02	$153.38	$165.19

	'91	'92	'93	'94	'95
Medicare Avg	$131.47	$126.76	$131.93	$136.69	$137.96
Medical CPI	$180.06	$195.72	$210.21	$222.61	$233.29

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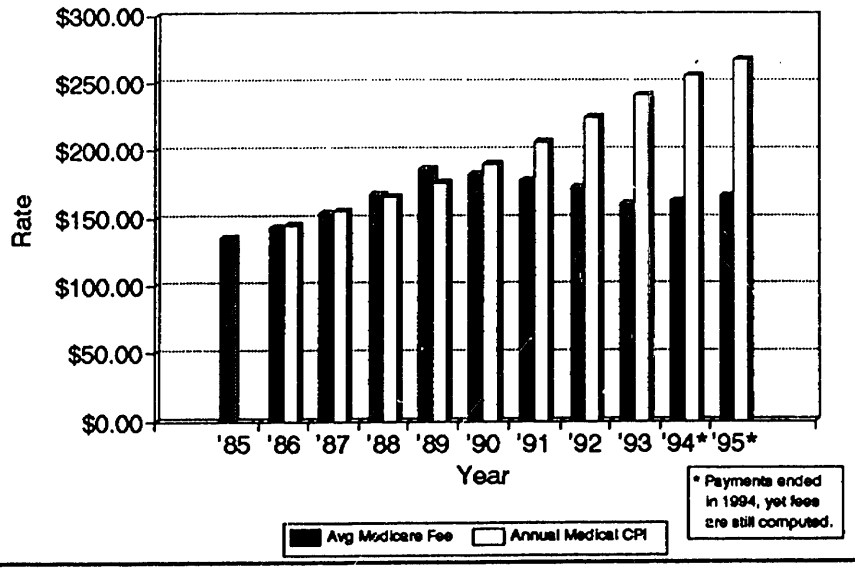
Total Electric Bed
Reimbursement Rates 1985-1995



	'85	'86	'87	'88	'89	'90
Medicare Avg	$135.60	$142.76	$153.39	$167.32	$165.48	$182.05
Medical CPI		$144.14	$154.95	$165.17	$175.91	$189.46

	'91	'92	'93	'94*	'95*
Medicare Avg	$177.70	$171.94	$160.32	$162.51	$166.57
Medical CPI	$206.51	$224.47	$241.08	$255.31	$267.56

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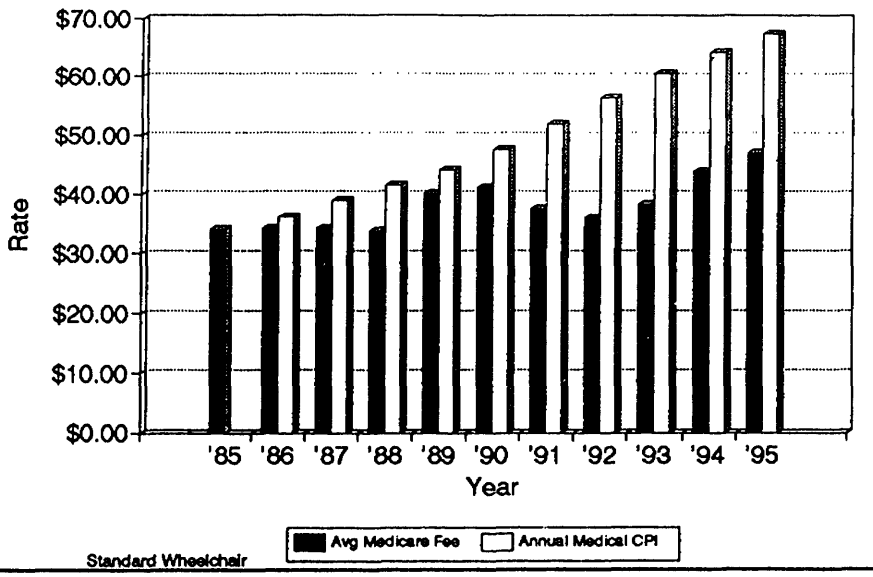
Standard Wheelchair
Reimbursement Rates 1985-1995



Standard Wheelchair

	'85	'86	'87	'88	'89	'90
Medicare Avg	$32.45	$32.57	$32.68	$32.10	$38.14	$39.16
Medical CPI		$36.25	$38.97	$41.54	$44.24	$47.65

	'91	'92	'93	'94	'95
Medicare Avg	$35.69	$34.25	$36.37	$41.90	$47.11
Medical CPI	$51.93	$56.45	$60.63	$64.21	$67.29

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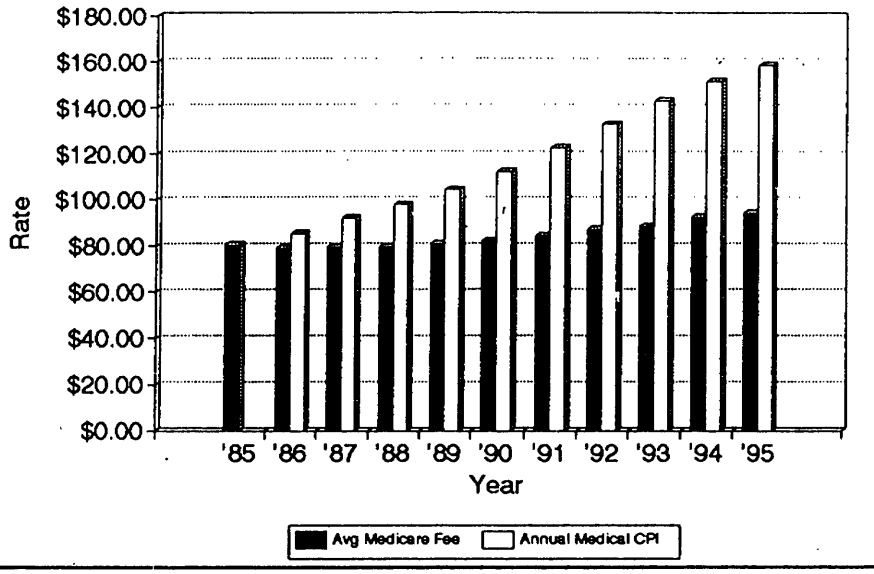
Commode

Reimbursement Rates 1985-1995



	'85	'86	'87	'88	'89	'90
Medicare Avg	$80.26	$79.06	$79.31	$79.33	$80.73	$81.89
Medical CPI		$85.32	$91.72	$97.77	$104.13	$112.14

	'91	'92	'93	'94	'95
Medicare Avg	$84.31	$86.79	$88.42	$92.15	$94.08
Medical CPI	$122.24	$132.87	$142.70	$151.12	$158.38

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SUMMARY OF HME SERVICES INDUSTRY CUTS/FREEZES

o 1985	Least Costly Systems Payment Reduction;
o 1986	Inflation Index Charges/Freeze;
o 1986	Concentrator Equivalency Limits/Freeze;
o 1986-1988	Gramm-Rudman-Hollings Cuts;
o 1987	Lowest Charge Level Reduction;
o 1987	OBRA '87 mandated the establishment of fee schedules;
o 1988	Inherent Reasonableness/Freeze;
o 1989	OBRA '89 eliminated inflation updates for DME, reduced payments for seat-life chairs and TENS by 15%, and directed that motorized wheelchairs be treated as routinely purchased items;
o 1989	Six-Point Plan;
o 1989	PRN Cuts;
o 1986-1990	Freezes;
o 1990	OBRA '90 established ceiling and floors to the HME fee schedules to make payments more uniform, prohibited suppliers from distributing completed or partially completed CMNs; and
o 1991-1993	CPI Cuts.

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Coalition of Health Associations United Against Fraud and Abuse

The Coalition is made up of organizations that represent health care providers and suppliers who want to work with Congress and the Administration to help eliminate fraud and abuse.

The Coalition believes that existing fraud and abuse statutes must:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;
- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;
- Protect Federal health care programs from unnecessary cost, utilization, and the failure to deliver appropriate levels of care;
- Be appropriate for the changing health care market; and
- Separate willful from technical violations.

The Coalition further urges Congress to adopt the following proposals to help eliminate health care fraud and abuse.

I. **Tools of Enforcement**

Federal Regulators should have the ability to prosecute fraudulent health care providers and suppliers.

A. **Establish a new health care fraud statute in the criminal code.** Providing penalties of up to ten years in prison, or fines, or both for willfully and knowingly executing a scheme to defraud a health plan in connection with the delivery of health care benefits, as well as for obtaining money or property under false pretenses from a health plan will help as a deterrent to fraud.

B. **Provide for the creation of an Anti-fraud and Abuse Collection Account.** An account subject to the congressional appropriations process will provide the Office of the Inspector General and the Federal Bureau of Investigation with the resources necessary to prosecute fraudulent providers and suppliers, and to provide guidance to those who seek to comply with the law.

C. **Clarify Antikickback Statute.** The current antikickback statue is vague and not focused on fraudulent activity. This provision would ensure that the antikickback law applies to those who intentionally defraud the government by codifying the Hanlester Network VS. Shalala decision. In this case, the court ruled that "knowingly and willfully" committing a fraudulent act should be the basis of federal prosecution. In addition, there is a clarification to the longstanding issue that an action is illegal,if a "significant or substantial reason" for making a payment is to induce referrals.

D. **Additional Enforcement Tools.** In addition to criminal prosecution, regulators are given the following enforcement tools to punish those found to commit a health care fraud offense:

1. **Exclusion from Federal and State Health Care Programs.** Mandatory exclusion from Medicare and state health care programs to those convicted of a health care felony. Increase existing permissive exclusion and apply it to an officer in an entity that has been convicted of a health care offense, if that officer is found to have a "reason to know" that the crime was committed; and

2. **Expansion and increase in civil monetary penalties.** Expanding penalties will serve as an appropriate deterrent.

II. **Health Care Fraud and Abuse Guidance**

It is the belief of the coalition that the vast majority of providers and suppliers seek to comply with the complex laws of Medicare and Medicaid. We further believe that much of the "noncompliance" can be resolved with education and guidance. The following provides mechanisms for further guidance to health care providers on the scope and applicability of the anti-fraud statutes.

A. **Safe Harbors.** Updates existing safe harbors and creates new ones.

B. **Fraud Alerts.** Establishes a formal process for the request and issuance of special fraud alerts.

C. **Advisory Opinions.** Advisory opinions assist providers and others engaged in the delivery of health care to ensure that they remain in compliance with health care statutes and regulations.

III. **Medicare Claims Process**

The General Accounting Office (GAO) in its report entitled "Medicare Claims _ Commercial Technology Could Save Billions Lost to Billing Abuse" (May 1995) stated "Flawed payment policies, weak billing controls, and inconsistent program management have all contributed to Medicare's vulnerability to waste, fraud, and abuse." The following provisions will improve that process.

A. **Medicare Transaction System (MTS).** Downgrade the priority or terminate the development of the Medicare Transaction System.

B. **Commercial Automatic Date Processing Equipment (ADPE).** Require Medicare carriers to acquire commercially made Commercial Automatic Data Processing Equipment.

C. **Reduce number of Medicare Carriers to ten.** Upon implementation of the ADPE, HCFA should be required to study and report to Congress on reducing its 32 Medicare Part B carriers to 10 such as the Durable Medical Equipment Regional Carriers (DMERCs) that were reduced to four. This will help to foster better communication between HCFA and the Regional Carriers.

D. **Contractor/Provider Relationships.** Prohibit Medicare carriers and intermediaries from reviewing claims of provider organizations when the Medicare contractor has an investment in that organization;

E. **Study Fraud and Abuse Under Managed Care.** The rise in managed care brings new forms of fraud and abuse. For example, the government and beneficiaries may be defrauded through withholding necessary services. The Institute of Medicine should undertake a study on the types of fraud that it may encounter under managed care and to begin ways to detect and combat such fraud.

Submitted by: Jack J. Tawil, Ph.D.
President
Research Enterprises, Inc.

MODERNIZING MEDICARE IN THE INFORMATION AGE

With Medicare facing bankruptcy in just seven years, the search is on for a way to place Medicare on a sound financial footing without reducing its benefits to the elderly. My statement describes a new method for delivering health care that fully energizes free markets with a system of incentives, which requires relatively minor changes to the current system, and which brings unprecedented levels of competition to local health care markets. It is a system that would allow Medicare enrollees to take charge of their own health care by giving them a powerful monetary incentive to seek the best health care values in the market place, and then by empowering them with prices, outcomes and other information so that they can find the best values. This system totally restructures the perverse incentives that currently make the current Medicare system so costly. A hallmark of this system is that it can drive down health care costs more than any other system—including all of those that have been proposed to the Congress—while significantly improving the quality of health care delivered. This bold claim rests on the ability of this system to produce the most vigorous market competition. Moreover, this system would give the elderly unlimited choice of physicians for treatment—indeed, they could go to any licensed doctor anywhere in the world. The importance of this feature is highlighted by a just-released CNN poll, in which the elderly rated freedom to choose their doctors as their top concern. This system also eliminates administrative burdens, including utilization review, thereby liberating providers to re-concentrate their efforts on the practice of medicine. Finally, the discipline imposed by a highly competitive market would allow government to refocus itself on what it does best (which is neither providing nor regulating health care).

In the following paragraphs, I describe how local health care markets can be transformed into veritable hotbeds of competition, with providers lowering prices and raising the quality of health care they deliver to gain an edge over their competitors. In the second section, I describe how this plan for making health care markets competitive is integrated with a patented, all-electronic information system that is without peer in achieving high efficiency. Finally, in the third section, the potential cost savings from this system are summarized.

Bringing Vigorous Competition to Health Care Markets

My company, *Research Enterprises, Inc.*, has developed three key concepts that would: a) give Medicare enrollees a powerful monetary incentive to seek the best health care values; b) empower them with the information they need to find these values; and c) provide them with this information in the most effective way possible. This is truly a new system—the unique way in which information would be collected, processed and disseminated to enrollees and others is sufficiently innovative to have been awarded a United States patent.

The easiest way to see how the *Research Enterprises'* Medical Incentive (*R·E·MEDI*) system functions is to follow a patient — I'll call her Julie Joyce — as she travels through it. Julie feels ill, so she makes an appointment with Dr. Greene, a physician in her managed care health plan. He also happens to be her family doctor.

Julie makes a small payment — say, $5 or $10. This is her share of the cost of the office visit, her examination, and all of the tests needed to diagnose her illness. After Julie has

been diagnosed, Dr. Greene will administer any routine (low-cost) care she may need. If she needs some medicine, Dr. Greene will write a prescription for her, which she will have filled at a pharmacy on her way home. Up to this point, our system operates just like a health maintenance organization (HMO). Moreover, experience shows that most initial medical encounters in our system would conclude in just this way.

However, should Julie need additional treatment — usually an indication that her illness is relatively serious — then any further similarity between *R·E·MEDI* (pronounced *remedy*) and an HMO disappears. Under the *R·E·MEDI* system, Dr. Greene prepares for Julie a written treatment plan, which lists each procedure she needs for her treatment, an expiration date (to encourage Julie to be treated before the illness worsens and becomes more costly to treat), and the benefit amount for that procedure. Dr. Greene does not normally perform these procedures himself; rather, Julie can choose any other licensed doctor in the world to perform them. Thus, whenever Julie's medical problems are serious, her choice and access are no longer limited to her managed care network.

This separation of treatment from diagnosis eliminates unnecessary medical procedures since Dr. Greene has no incentive to include them in his treatment plans. But more important, it creates a unique opportunity to bring intense competition to Julie's local health care market. This is accomplished with an innovative way of paying for health care benefits and with a rich composite of consumer information.

Medicare usually requires enrollees to pay a small fraction of the cost of their covered health care. The theory underlying these co-payments is that they make enrollees price-sensitive. In practice, however, the co-payment method fails for three reasons: first, enrollees usually have a doctor already and have little incentive to change; second, they rarely know what prices different doctors are charging for their procedures, so they have no basis for comparison shopping; and, third, the co-payment requirement is typically small, thereby substantially weakening any incentive the enrollee might have to comparison shop. The first two reasons are the result of a paucity of accessible information. The third reason is a deficient method of paying for benefits: just imagine how transportation costs would soar if a third party paid 80% of the cost of our next automobile purchase.

If we are to make health care markets highly competitive, then we must adopt the principles that underlie intense market competition. The first principle is that consumers must bear the full incremental cost of their purchases and not some small fraction of the cost. We can achieve this in health care markets by establishing a fixed dollar benefit for each procedure or illness—i.e., a fee schedule. Thus, if the provider charges more than the benefit amount, the enrollee would have to pay the difference out-of-pocket. But, on the other hand, if the provider charges less, under *R·E·MEDI* the enrollee would be sent a rebate check for the full savings. Allowing enrollees to keep *all* of their savings is key to health care reform.

Highly competitive markets are also characterized by accurate and complete information on the prices and quality of goods offered for sale. The more timely is this information and the less costly it is to obtain, the more effective will it be in stimulating market competition.

We have developed a unique way of producing health care information that enrollees would find especially useful, timely and easy to acquire. A handy guide we call *The Doctor Shopper*™ (see attached) lists the latest credentials, prices, and patient outcomes for several doctors whose offices are closest to the enrollee's home.

The DOCTOR SHOPPER℠

YOUR DIAGNOSIS IS: 996.01 Pacemaker Malfunction

RECOMMENDED DOCTOR: P.T. Graph

REFERRAL EFFICIENCY INDEX

Dr. Harvey M. Greene	86.3
Average, All Diagnosticians	84.2

DOCTOR PRICES

CPT	DESCRIPTION	QTY	HAINES	BOSCH	WILLIAMS	GRAPH	THURGOOD	OSCAR	CORDELL	AARON
	BENEFIT		$ 2540	$ 2,230	$ 2,350	$ 2,275	$ 2,628	$ 2,730	$ 2,570	$ 2,630	$ 2,315V
	BUNDLED PRICE										
	UNBUNDLED PRICES										
90060	Office Visit, Intermediate	3	$ 120	$ *75*	$ 105	$ 105	$ 120	$ 135	$ 150	$ 135	$ 105
93503	Swan-Ganz Line	1	$ 1,450	$ 1,325	1,355	*1,315*	1,445	1,515	1,430	1,480	1,325V
33206	Pacemaker, Insert Perm Repl	1	$ 1,015	*910#*	920	915	1,020	1,115	990	1,050	915V
	ONE-STOP-DOCTOR TOTALS		$ 2,585	$ *2,310*	$ 2,380	$ 2,335	$ 2,585	$ 2,765	$ 2,570	$ 2,665	$ 2,345V
	EXPIRATION DATE OF GUARANTEED PRICE			3/31/95	--	--	6/31/95	--	--	--	--
NET PAYMENT TO INSURED <	BUNDLED PRICE		$ *310*	$ 190	$ 265	$ 15	$ -190	$ -30	$ -90	$ 225	
	UNBUNDLED PRICES		$ *275*	$ 205	$ 250	$ 0	$ -180	$ -185	$ -80	$ 240	

NOTES:

Bold Face denotes that the doctor guarantees the price; expiration date of the guarantee is reported.
Italics identify the low-cost provider of each procedure.
# denotes that the doctor *may* have performed the indicated procedure fewer than 15 times.
V indicates that the doctor's price for this procedure varies from patient to patient.

DOCTOR PERFORMANCE

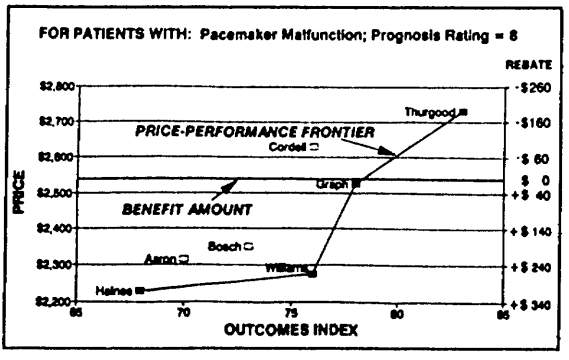
The *R·E·MEDI* system provides three measures of a doctor's performance: 1) The Patient Satisfaction Index (PSI) measures the overall satisfaction of a doctor's patients (100 is perfect); 2) the Nurses Index (NI) is the number of different nurses, and their family members, that a doctor has treated in the past 12 months; and 3) the Outcomes Index (RI) indicates how well patients with your diagnosis and your prognosis rating have recovered under that doctor's care (100 is perfect). For more information on what the Outcomes Index measures and what it means with regard to your diagnosis, please see the receptionist.

	PSI[1]	NI[2]	OI[3]
1. Aaron, GM	87	3	70
2. Bosch, RL	90	3	73
3. Cordell, TF	93	9	76
4. Graph, PT	94	10	78
5. Haines, JM	81	0	68
6. Oscar, OM			
7. Thurgood, TC	95	19	83
8. Williams, RD	85	6	76
Community Avg.	87	6	72

[1]Patient Satisfaction Index
[2]Nurses Index
[3]Outcomes Index (PR = 8)

PRICE-PERFORMANCE CHART

This chart has been constructed for your particular diagnosis and prognosis rating. The bundled price each doctor charges for the treatment you need is shown on the left scale, and your extra charge (-) or rebate (+) on the right scale. The lines connecting the solid boxes make up the *Price-Performance Frontier*. If a doctor is on this frontier, then no other doctor on this chart has better average outcomes for a lower price. The receptionist can also print for you a Price-Performance Chart showing a greater number of doctors over a wider area.



••• ALL DATA ARE HYPOTHETICAL •••

The DOCTOR SHOPPER[SM]

DOCTOR CREDENTIALS

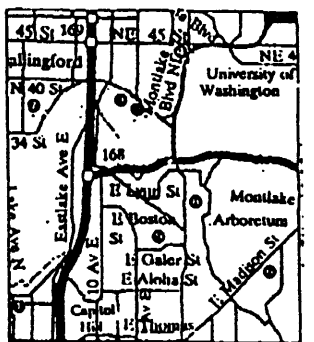
Doctor	Sex Age	Medical Specialty[1]	Yrs Practice	Medical School Name/Degree/Rank[2]	Class[3] Rank/Size	Residency	Malpractice Suits[4] Lost	Settld	Hospital Affiliation	HCI[5]	University Affiliation	Other[6]
Aaron, GM	M46	+Cardiology	15	U of Chic/MD/ 6	62/ 87	VA Mason	2	3	VA Mason	116	--	MC MA A
Bosch, RL	M46	+Cardiology	15	U of WA /MD/ 30	23/ 76	Mt. Sinai NYC	2	4	University	105	--	MC MA
Cordell, TF	F41	+Cardiology	10	Indiana U/MD/ 54	32/ 54	Deaconss, Spok	1	3	Pacific	102	--	MC A
Graph, PT	M52	+Cardiology -Radiology	15	J Hopkins/MD/ 2	10/ 22	Vtrns, SDiego	1	1	University Pacific	113 102	U of Wash	A
Haines, JM	M33	-Cardiology	1	PA S U /MD/ 70	12/ 19	VA Mason	0	1	Overlake	96	--	MC MA NP
Oscar, OM												
Thurgood, TC	M64	+Cardiology	21	Harvard /MD/ 1 *Montreal* /--/ 4	18/ 45 6/ 33	MA General	0	1	Children's Humana	115 112		MC P A
Williams, RD	F38	-Cardiology	8	U of MD /MD/ 58	8/ 28	Balt Co	1	4	Overlake	96	--	MC MA

OFFICE ADDRESSES/CREDIT CARDS

1. G.M. Aaron, 1622 24th Ave., 684-7632
   MC, V, AX
2. R.L. Bosch, 1959 NE Pacific St., 548-4921
   MC, V, DS
3. T.F. Cordell, 1832 NE Pacific St., 548-6896
   MC, V
4. P.T. Graph, 3427 NE 45th St., 525-1379
   MC, V
5. J.M. Haines, 164 E Galer St., 684-4715
   MC, V, AX
6. O.M. Oscar, 3211 E Madison St., 323-4932
7. T.C. Thurgood, 480 Pacific St., 632-4513
   MC, V
8. R.D. Williams, 2379 4th Ave., 684-0811

NOTES TO *The DOCTOR SHOPPER*

1. +/- indicates that the doctor (is/is not) board certified in the specialty.
2. School Rank: As reported in Gourman (*Gourman Report: A Rating of Graduate and Professional Programs in American and International Universities*, 5th ed. NES, 1988); 126 U.S., 16 Canadian, and 86 foreign (excl. Canada) medical schools are ranked; *italics* identify foreign medical schools.
3. Class Rank/Size: Reports the doctor's academic ranking within his graduating class; for example, 5/25 means that the doctor ranked 5th in a graduating class of 25 students.
4. Malpractice Suits: Number of suits lost and settled within the past 3 years; but the reported number may be for fewer than 3 years for a newer practice.
5. HCI = Hospital Cost Index for procedures relating to the patient's diagnosis; examples: 115 denotes that the hospital's costs are 15% above the average of hospitals within the region; 96 denotes that the hospital's costs are 4% below average.
6. Other: MC = accepts Medicare patients; MA = accepts Medicaid patients; NP = new practice: w/ aggressive pricing; P = Personal Health Care Manager; A = patient's share of treatment cost is payable at the time of treatment.



Location of Providers

*** ALL DATA ARE HYPOTHETICAL ***

To see just how effective this information can be in stimulating market competition, we return to Julie who is receiving her treatment plan from Dr. Greene because her pacemaker is malfunctioning and she needs further treatment. Because Dr. Greene diagnoses Julie but does not treat her, we call him a *Diagnostician*. Once Dr. Greene determines that Julie needs further treatment and determines her diagnosis, he immediately prints out and hands her her own personalized copy of *The Doctor Shopper*.

The Doctor Shopper contains all of the information Julie needs to select a doctor—better information than supplied by any other health care plan. The first section of *The Doctor Shopper* lists the prices of several doctors with offices near Julie's home. This information is of special interest to *R·E·MEDI* patients since under *Ca$hback Coverage* they pay the full incremental cost of and receive the full incremental savings from their choice of doctors. *The Doctor Shopper* prominently displays within the double-box the doctors who will cost Julie out-of-pocket and those that will gain her a Medicare rebate. If, for example, Julie chooses the bundled-price option and receives all of the treatments from Dr. Thurgood, she would have to pay Dr. Thurgood $190 out of her own pocket; but if instead she should choose Dr. Williams, she would receive cash rebates totaling $265.

The *bundled price* refers to the single price a doctor charges to carry out the complete treatment, while the unbundled prices are his charges to perform the individual procedures. Therefore, a single benefit amount (in this case, $2,540) is paid under the bundled price option, while separate benefit amounts are listed for the individual procedures in the treatment plan. Julie may choose either the bundled or unbundled price option, but if she chooses the unbundled price option, her doctor may deviate from the treatment plan prepared by Dr. Greene. Otherwise, he will be reimbursed only for the procedures he performs that are specifically listed in the treatment plan.

The next section of *The Doctor Shopper* reports three measures of how well a doctor performs. The Patient Satisfaction Index measures the overall satisfaction of a doctor's patients. The Nurses Index is based on the premise that nurses are "insiders" with good information, and that they will seek treatment from only the most competent doctors. *The Doctor Shopper* reports the number of different nurses, and their family members, that a doctor has treated in the past year.

The third performance measure is the most powerful. It is the Outcomes Index, and it provides an unbiased, risk-adjusted measure of just how effective doctors are in enhancing the recovery of their patients. The Outcomes Index is based on the unique structure of the *R·E·MEDI* system, and, in my opinion, it measures a doctor's performance more accurately than any other measure available in the market place today. Here is how it works.

The Diagnostician's knowledge of a patient as well as of her illness singularly qualifies him to assess her prognosis. Therefore, after diagnosing a patient, the Diagnostician assigns to her a "prognosis rating," measured on a scale of one to ten, with ten indicating the most optimistic prognosis. The prognosis rating is the Diagnostician's *prediction* of how quickly and completely the patient will recover if treated by a doctor with average capabilities, all things considered.

After the patient has been treated and is well along the path to recovery, her medical records are accessed and she is contacted by telephone to determine how well she has in fact responded to the doctor's treatment. Based on criteria previously established for each illness by a panel of medical experts, the patient's recovery is mechanically scored on a scale

of ten, with a ten indicating the quickest most complete recovery. Since we know which doctors have treated which patients, an Outcomes Index can be constructed showing for the doctors listed in *The Doctor Shopper* how successful each has been in treating past patients with the current patient's illness and for her particular prognosis rating. *This is precisely the information that patients require to find the most effective doctors to treat their specific illness.*

The third section of *The Doctor Shopper* contains *the* key decision tool for the health care consumer. It is the *Price-Performance Chart*; it combines the performance information with the price information discussed earlier. I believe that this tool will truly revolutionize health care markets.

The Price-Performance Chart shown in the attached copy of *The Doctor Shopper* pertains specifically to Julie's diagnosis (a pacemaker malfunction) and to her prognosis rating (8). The doctors listed in *The Doctor Shopper* are represented on the chart by boxes. The axes of the chart are the bundled treatment price, and the Outcomes Index. A horizontal line representing the total benefit amount for treating the illness is also shown on the chart. The doctors' treatment prices are measured on the left scale, and the enrollee's extra charge (-) or rebate (+) is shown on the right scale.

The best doctors, in terms of both price and performance, are represented on the chart by the solid boxes. These are connected by a line we call the price-performance *frontier*. If a doctor is on this frontier, then no other doctor on the chart shows better patient outcomes at a lower cost. We call this line a frontier because all of the doctors are either on this boundary line or to the "northwest" of it. Over time, the frontier will tend to shift toward the "southeast". This shift occurs whenever, say, a new technology, a new medical procedure or a new pharmaceutical enables a doctor to move beyond the current frontier by producing a better outcome and/or by lowering his price.

The price-performance chart provides a highly effective way to represent *value*. It lets the patient know the cost of quality by showing how many dollars she must give up to purchase better performance. In my view, the choice between price and quality properly belongs to the patient, rather than to her employer, her health plan, or to a government bureaucrat.

The freedom to choose between price and quality is a fundamental freedom in a market economy, and *Ca$hback Coverage* would give Medicare enrollees the freedom to choose between making out-of-pocket payments for higher-quality care and accepting lower-quality care but with cash rebates. Unlike many types of managed care plans, with their "one-size-fits-all" prescription, the *R·E·MEDI* system preserves this freedom to choose and makes this freedom even more valuable by providing superior information about the available choices. Moreover, as long as consumers are free to purchase health care at market-clearing prices, there can *never* — repeat, *never* — be (non-price) rationing of health care services.

We have created the necessary conditions for vigorous competition in health care markets: strong incentives to seek the best health-care values, and the information to find them. Whether this competition actually would occur depends only on whether Medicare enrollees, prior to selecting a doctor for treatment, would consult *The Doctor Shopper* — which is *handed* to them at the Diagnostician's office. That they would ignore it I find simply not believable, given the importance that the elderly place on health care quality and the impact of their choice on their budget.

It is not difficult to see how *The Doctor Shopper* and *Ca$hback Coverage* will create intense competition among providers. Doctors whose prices are high compared with their performance will have relatively empty waiting rooms, while doctors whose prices are low, given their success, will have more business than they can handle. Consequently, prices will adjust, with the less successful doctors lowering their prices. Under this market test, doctors who are incompetent probably will not be able to remain in practice — a result that has yet to be achieved through a regulatory approach. Of course, the best doctors will be able to raise their prices. Overall, however, the vigorous competition will cause prices to fall. Indeed, if other markets are any indication, medical prices should fall substantially—witness airline, trucking and long-distance telephone prices following deregulation.

A multitude of other major benefits also can be expected. Because patients will tend to avoid doctors who are not near or on the price-performance frontier, doctors will have to compete intensely to position themselves on it. And a doctor has only two ways of moving toward the frontier: reducing his prices and improving the outcomes of his patients.

Providers will avoid any treatments that are not cost-effective (unnecessary) since these will cause them to move away from the price-performance frontier. An implication of this is that utilization review no longer will be needed to control health care costs; providers acting in their own self-interest will perform the same function, only more effectively. Similarly, providers acting in their self-interest will apply a sound economic rationale for acquiring new medical technology: only technologies that help them move toward or beyond the price-performance frontier will be acquired. By rejecting other technologies, they terminate the medical arms race—and without regulation. This is indeed one of the major ways in which *R·E·MEDI* controls future health care costs.

Another beneficial result is that *R·E·MEDI* enrollees are immune to cost-shifting because providers who increase their prices without a commensurate performance improvement also move themselves away from the frontier. Finally, the competition stimulated by the price-performance chart will render superfluous many government regulations for controlling health care costs or for assuring quality or safety. *R·E·MEDI* markets encumbered by fewer of such regulations will deliver equivalent or better health care at lower cost.

By now it should be apparent that the price-performance chart is not just another pretty chart. Indeed, in the hands of patients, it is the most powerful tool there is for imposing vigorous competition on the local health care market and subjecting its competitors to the strict discipline of the market place.

The Doctor Shopper contains one other performance measure that will further encourage doctors to strive toward the price-performance frontier: the *Referral Efficiency Index*. It measures the suitability of doctors that a Diagnostician recommends to his patients. At the top of *The Doctor Shopper* we see that Dr. Greene has recommended that Julie go to Dr. Graph for treatment. *The Doctor Shopper* also shows that Dr. Greene's REI is 86.3, compared with the average REI of 84.2 for all Diagnosticians in the local market (100 is perfect). Diagnosticians with high REIs will have their recommendations taken seriously by their patients, and they will have an edge when their contracts come up for renewal.

The REI is based on two factors: the "distance" of the recommended doctor from the price-performance frontier, and the patient's satisfaction with this doctor. Because doctors will want to receive as many referrals as possible from Diagnosticians, they will make a special effort to locate themselves on or near the price-performance frontier, and to please

their patients. Indeed, I would expect doctors to voluntarily improve their practice skills, for example, by attending more medical refresher courses, by adopting the treatment techniques of their more successful colleagues, and by being more attentive to new advances reported in the professional medical literature.

The back page of *The Doctor Shopper* lists the doctors' credentials and other information.

We conclude this section with a few comments about Diagnosticians. Diagnosticians may be primary care providers or specialists, and they may refer patients among themselves to facilitate reaching a diagnosis. Moreover, I believe that the patient should be able to choose whether her initial visit for an episode should be with a primary care Diagnostician or with a Diagnostician who is a specialist. In fact, I favor letting patients choose any Diagnostician in the system, with the right to change Diagnosticians whenever they see fit.

The network of Diagnosticians could be organized as an independent practice association, with independent practitioners providing part-time diagnostic services to *R·E·MEDI* enrollees. Diagnosticians also could be organized to operate out of a single facility on a full-time basis, as in a group-model HMO; however, I believe that most Diagnosticians will want to treat patients as well as to diagnose them, which they may do as long as they do not treat the patients for whom they prepare treatment plans.

Only in two situations would Diagnosticians be permitted to treat patients whose treatment plans they prepared: if the delay in obtaining treatment from a downstream doctor would compromise the patient's recovery; or if the patient is willing to pay a premium to be treated by the Diagnostician. Separating treatment from diagnosis results in major savings, so the premium should reflect this loss of savings.

In evaluating the separation of treatment from diagnosis under the *R·E·MEDI* system, it is important to keep in mind that the great majority of initial medical encounters will conclude with the visit to the Diagnostician. However, the necessity of preparing a treatment plan usually means that the patient's illness is relatively serious. It seems to me that in this situation Medicare enrollees would highly value the opportunity to receive information that would enable them to select the best doctor for their particular situation.

Both the Diagnostician and downstream doctor are responsible for the validity of the diagnosis and the treatment plan; therefore agreement is essential. Disagreement serves to raises a warning flag that the diagnosis may be incorrect or that the patient may be inappropriately treated. Our conflict-resolution process to resolve disagreements is designed to work to the best interest of the patient. Because a high incidence of agreement be between Diagnosticians and downstream doctors is essential, Diagnosticians should be selected from those doctors within the local community who command the highest respect among their colleagues. One way of achieving this would be to select Diagnosticians from a slate of doctors supplied for this purpose by the local medical association.

I know of no other health care system—either proposed or in operation—that comes close to producing market competition as intense as that created by *R·E·MEDI*. Consequently, my many years of experience studying competitive markets makes me highly confident that none of these other health care systems are likely to achieve the cost savings and quality improvements attainable under the *R·E·MEDI* system.

To underscore this point, I note that just 10 percent of all medical cases account for 70 percent of all health care expenditures. If only we could cause these 10 percent of cases

to be treated by providers who are in vigorous competition with one another, much could be accomplished in reducing health care expenditures. Within Medicare, the proportion of high-cost cases is even greater, and, therefore, so are the potential savings.

I now turn to the second prominent feature of the *R·E·MEDI* system: its ultra-efficient way of processing health care information. I believe that besides being the world's most competitive health care system, *R·E·MEDI* is also the world's most efficient.

Ultra-Efficient Electronic Information Processing

Integrated into the free-market health care system just described is a streamlined system for collecting, processing and distributing health care information that fully exploits the capabilities of our electronic age. Information is entered into this system only once, yet it is available to all participants, on a restricted basis, when they need to have access to it.

The *R·E·MEDI* claims processing system, which we call *QuickSafe*, has the following features. It

- eliminates the need for manual claims review;
- processes virtually all claims on personal computers at a cost as little as one cent per claim or less;
- eliminates all paperwork and claims filing for enrollees;
- provides overnight reimbursement to providers via electronic funds transfers (EFTs)
- issues *Ca$hback Coverage* rebate checks t=o enrollees within twenty-four hours;
- enables providers to produce and file claims with just a few keystrokes;
- allows customized personal computers to be placed at provider sites for as little as a few hundred dollars per year; and
- eliminates most fraud and abuse.

When a person is enrolled in the *R·E·MEDI* system, he is issued a small computer disk upon which is recorded his personal medical history and other information that medical personnel could find useful should he become involved in a medical emergency. Whenever the enrollee visits a doctor or other health care provider, he brings his disk along so that pertinent health care information can be recorded on it. This includes: data from physical examinations, diagnostic test results, prescribed/performed medical procedures, laboratory reports, medical graphics such as X-rays and EKGs, drug prescriptions and medical notes. Thus, the enrollee's complete encrypted and password-protected clinical record is readily available for review by any provider to whom the enrollee gives access. A provider has access to only the portion of the patient's medical record that is relevant to him, though the patient is able to grant access to other portions of his record. Because under *R·E·MEDI* the patient is always in possession of his medical records, duplication of tests and other medical procedures can be eliminated.

When a patient arrives at the office of a Diagnostician, he presents his computer disk to the receptionist. After the patient enters his password, the computer verifies that the patient

is eligible for insurance benefits and determines the scope of benefits. (Eligibility lists of local residents are maintained on each Diagnostician's computer and are updated nightly.) The patient's medical records are then copied into the Diagnostician's computer. After the Diagnostician reviews this information, he examines the patient. All new test results, notes, and other medical information are added to the patient's electronic medical record. Electronic prescriptions also may be issued for automated processing at a local pharmacy. If the patient needs further treatment, the Diagnostician assigns a prognosis rating to the patient and prepares a treatment plan. This plan and other additions to the patient's medical record are copied onto the patient's disk. Another copy of these records is retained in the Diagnostician's computer for automatic collection by the claims processing center that night, and a third copy is kept for the Diagnostician's own records.

If the patient requires a treatment plan, doctors who can perform the procedures in the treatment plan are identified by the Diagnostician's computer, and a list of the doctors with offices closest to the patient's home or place of work is compiled. Also in the Diagnostician's computerized database are: the latest prices being charged by these doctors; their Outcomes Index for the patient's diagnosis and prognosis rating; and, in most cases, the credentials of these doctors. Finally, a map locating the doctors' offices is prepared and all of the information is printed out for the patient in a personalized copy of *The Doctor Shopper*. The patient also receives at this time a cover letter discussing her illness and a printed copy of the treatment plan.

When the patient arrives with his computer disk at the office of the doctor he has selected to perform the treatments, he again enters his password. Once his eligibility is confirmed, the appropriate medical information is released from his disk.

After the doctor reviews the patient's medical records, examines him, and performs some or all of the procedures in his treatment plan, he transforms this plan into a *treatment record*. This is done simply by adding to the treatment plan his charge for each procedure he performs and the current date. Typically, each of these two entries is made with a single keystroke with our proprietary software. The medical transactions are then recorded automatically on the patient's disk and copied to a special area in the doctor's computer for later retrieval by the claims processing center. Another copy is maintained for the doctor's own records. Finally, a copy of the treatment record is printed out for the patient.

With just a few keystrokes, the doctor has prepared a complete treatment record, which is also his insurance claim. For him this represents a major reduction in the time and effort required to prepare a claim and to maintain his records. Indeed, I know of no other system in which a claim can be prepared with as little effort.

Most activities at the claims processing center occur after normal business hours. First, the treatment plans from the Diagnosticians are collected electronically and processed. Any price changes that are found are recorded for future use. The treatment records are then collected and compared with the procedures prescribed in the underlying treatment plan. If a treatment record shows that a procedure was performed, but that it is not specified in the master file, then it will not be reimbursed—unless the patient has selected the bundled price option.

Because the Diagnostician's treatment plan serves to pre-authorize all procedures in it, and because the Diagnostician has no incentive to include unnecessary treatments, there is little risk of paying for overtreatment. And because under *Ca$hback Coverage* the patient is

responsible for any overcharges, there is simply no reason for the claim to be manually reviewed. In fact, this arrangement is so efficient that the average claim can be fully adjudicated with *QuickSafe* in under one-half second on a *personal computer,* and overnight reimbursement can be offered to the provider. At this rate, it takes this computer about 12 hours to process over 85,000 claims, which is the number produced on an average day by a population of more than four million people.

While the treatment plans and treatment records are being collected, and while the computer at the claims processing center is still connected to the computers of Diagnosticians and providers, electronic information packets are exchanged. The claims processing computer collects packets containing changes in patient information (e.g., address changes) and returns to the local computers data updates. These data updates include changes in patient eligibility, as well as any changes in provider prices, performance measures and credentials. After the data exchanges take place, the revisions are processed on the local computers, and the updated databases are ready for use first thing each morning.

Finally, *QuickSafe* coordinates benefits and issues payments—*Ca$hback Coverage* payments to enrollees, which are mailed the following morning, and electronic deposits to providers. Mailing *Ca$hback Coverage* payments is perhaps the most important function performed at the claims processing center. Competition under the *R·E·MEDI* system is driven by enrollees making cost-effective choices, and *Ca$hback Coverage* payments exert a major influence on these choices.

At the beginning of this statement, I suggested that the *R·E·MEDI* system would free physicians from many administrative hassles so that they might re-concentrate their efforts on the practice of medicine. Currently, physicians are overburdened with a maze of regulations, and they are the target of utilization review personnel. *R·E·MEDI* renders many if not most regulations superfluous, because the strict discipline of a competitive market place rich in information usually will prove more effective in controlling costs without sacrificing quality. Indeed, we have seen how a *R·E·MEDI* market place would pressure providers to lower prices, raise quality, and adopt only those technologies that significantly enhance value. We have also shown how administrative functions, such as record keeping and claims preparation are made dramatically less burdensome by *QuickSafe*. Finally, we have seen that utilization review would be eliminated, since the goals of utilization review are achieved under *R·E·MEDI* solely as a result of providers acting in their own self-interest.

Potential Savings from the R·E·MEDI System

Besides streamlining health care for the next century, *R·E·MEDI* will substantially reduce the cost of health care while at the same time significantly increasing health care quality. The figure below summarizes our predicted cost savings by category, showing the percent reduction in total personal health expenditures in the first year of operation and the annual cost savings after the *R·E·MEDI* system has been operating for a few years. These are conservative estimates of cost savings from current spending levels, and not from some projected increase in spending. While these estimates are based on the U.S. population, savings in Medicare would be comparable.

The net cost savings shown in the figure are the relative savings in personal health care expenditures within the market served by the *R·E·MEDI* system. The savings are projected to total about 16 percent in the first year of operations and rise to nearly 50 percent by the fifth year. These results assume that the total cost of implementing and operating the

R·E·MEDI system is 8 percent of the value of claims processed, using current medical prices as the baseline.

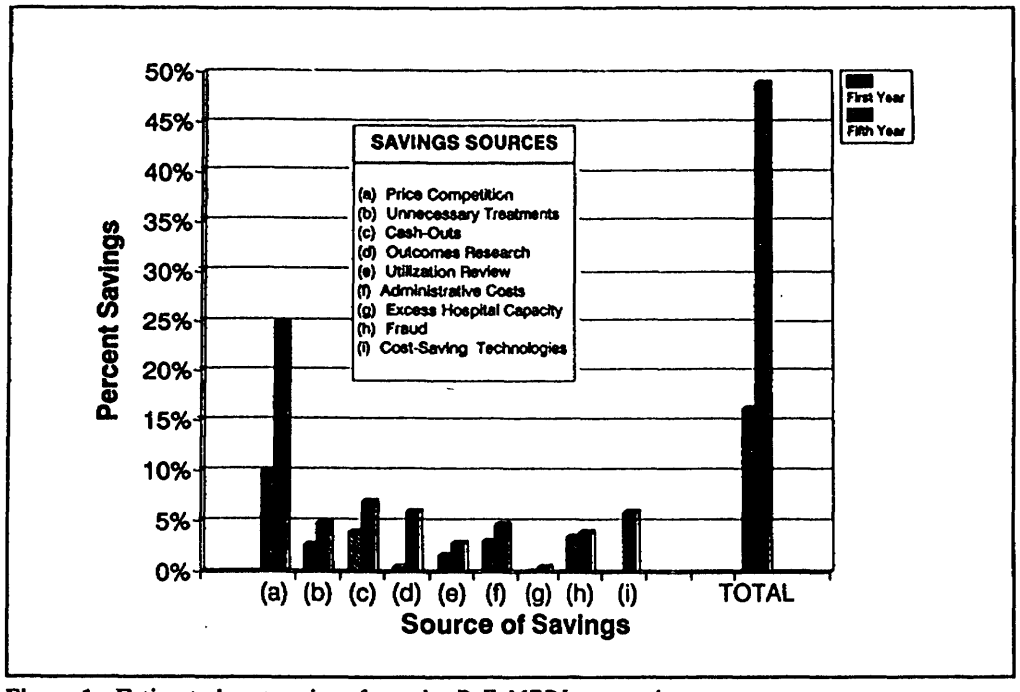


Figure 1. Estimated cost savings from the *R·E·MEDI* system, by source.

The largest savings from the *R·E·MEDI* system come from greatly enhanced price competition, which accounts for nearly two-thirds of the savings in the first year and about half of the savings by the fifth year. Except for "cash outs," the other savings categories are self-explanatory. "Cash Outs" refer to the dollars that are removed from the health care pipeline as a result of *Ca$hback Coverage* payments. Most of this money will be spent on goods and services outside of the health care sector and therefore cause a reduction in total health care expenditures.

Details of the analysis on which the figure is based can be found in the reference volume cited below. Space limitations prevent me from describing: how enrollees who do not wish to make their own health care decisions could instead utilize the services of a Personal Health Care Manager to orchestrate their treatment and recovery; how *R·E·MEDI* would dramatically reduce opportunities for fraud and abuse; how benefit levels can be determined to control future Medicare costs; how MediSave accounts can be greatly enhanced with *R·E·MEDI*; how malpractice suits would be reduced; and how the *R·E·MEDI* system would cause more physicians to set up practice in rural areas. These and other topics are addressed in the following reference.

REFERENCE: *Reinventing Health Care* by Jack J. Tawil and Frederick Bold, 1994, Research Enterprises, Inc., Publishing Segment, P.O. Box 3081, Richland, WA 99352).

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