

NEW VERSION
Rep Medicare
Package

Medicare Provisions which Compromise Beneficiary Protections

Outlined below are provisions included in the Republican Medicare agreement which would compromise beneficiary protections.

1. **Private Fee for Service Plans.** The Republican Medicare agreement includes a private fee-for-service option under the Medicare Choices program. The Administration supports increasing Medicare beneficiary choices but does not support putting beneficiaries at risk of substantial out-of-pocket costs. The proposed private fee-for-service option lacks beneficiary protections such as quality requirements, limits on the beneficiary premium, and limits on what a doctor can charge a beneficiary. As all of these protections apply to current Medicare risk plans, the question remains why these plans and beneficiaries should be treated differently.
2. **Medigap.** The Republican Medicare agreement fails to guarantee Medigap coverage for beneficiaries who try managed care and does not provide Medigap options for newly Medicare-eligible disabled beneficiaries.

- a. *Assure Medigap Coverage for Seniors and Disabled Persons who Try Managed Care.* Currently, Medicare beneficiaries who disenroll from health plans are not guaranteed Medigap coverage. Beneficiaries, therefore, are reluctant to try managed care since they may not be able to get Medigap again if they disenroll. The Administration's proposal addressed this problem by guaranteeing Medigap coverage to all beneficiaries who disenroll from managed care and making Medigap part of an annual open enrollment process.

The Republican agreement fails to address this Medigap problem. The Republican agreement differentiates between Medicare members currently enrolled in managed care and beneficiaries currently in traditional Medicare. For beneficiaries who are currently enrolled in managed care, the agreement provides no guarantee for Medigap coverage. Beneficiaries who join a health plan in the future, however, will be assured Medigap coverage if they disenroll in the first twelve months. This Medigap protection for new managed care members applies only once - to the first time a beneficiary chooses a health plan. The Republican agreement fails to address this Medigap coverage issue in a meaningful way. Further, the Republican agreement fails to encourage Seniors and disabled persons to take advantage of Medicare choices and, by failing to guarantee Medigap coverage, places beneficiaries at risk of unexpected out-of-pocket costs.

- b. *No Coverage for Newly Enrolled Disabled Persons.* Currently, disabled persons under age sixty-five are not guaranteed Medigap coverage. The Administration addressed this problem by guaranteeing that disabled persons, like Seniors, may purchase Medigap when they become eligible for Medicare. The Republican agreement fails to guarantee issue

Medigap coverage for newly enrolled disabled Medicare members. This means that Medigap insurers could continue to deny coverage to disabled people or charge unaffordable premiums. Disabled members, therefore, face high out-of-pocket costs as they may not be able to obtain Medigap coverage. The President's plan follows the lead of eleven states which have already guaranteed Medigap coverage for disabled persons.

3. **Medical Savings Accounts (MSAs).** The Republican agreement establishes a MSA demonstration for 500,000 beneficiaries. Beneficiaries choosing an MSA will be required to buy an insurance plan with an annual deductible of up to \$6,000 and will deposit the remaining funds in a medical savings account (MSA). The beneficiary may withdraw from the MSA to pay for medical expenses. The beneficiary may also withdraw funds, subject to a penalty, for non-medical expenses. The Republican MSA demonstration places beneficiaries in a precarious position. If a beneficiary experiences an unexpected illness or accident, he/she may not have adequate funds in their MSA to make an out-of-pocket payment as high as \$6,000 when they require medical care.
4. **Mammography Copays.** The Republican agreement requires Medicare beneficiaries to pay a co-payment for mammography services. The Administration does not support requiring women to make out-of-pocket payments to receive cost effective and essential mammograms. Research indicates that cost-sharing deters women, particularly lower income women, from getting mammograms. The Administration is committed to women taking advantage of this important and effective preventive benefit without additional out-of-pocket cost.
5. **Durable Medical Equipment (DME) Upgrade.** The Republican Medicare agreement allows durable medical equipment (DME) suppliers who accept assignment to bill beneficiaries beyond their 20% coinsurance for "upgraded" DME items. This breaks a long-standing precedent of providers who accept assignment accepting Medicare's payment as payment in full. The Administration recognizes the potential for suppliers to take advantage of beneficiaries by promoting the sale of items that are upgraded, thus placing beneficiaries at risk of substantial out-of-pocket costs. Further, the provision is unnecessary since beneficiaries already have the option of choosing upgraded DME on unassigned claims.
6. **Private Agreements Between Physicians and Beneficiaries.** The Republican agreement allows physicians who do not participate in Medicare to require beneficiaries to enter into "private contracts" with them in order to receive services. In signing the agreement, the beneficiary agrees not to submit a claim to Medicare for the services. The beneficiary would be obligated to pay the entire bill out-of-pocket, without collecting any money that Medicare would have paid, even though the beneficiary has full Medicare coverage. Under this proposal, beneficiaries are at risk of substantial out-of-pocket payments.
7. **Establish \$1,500 Physical and Occupational Therapy Cap.** The Republican proposal establishes a \$1,500 limit to apply to PT/OT that beneficiaries receive in rehabilitation agencies, skilled nursing facilities, home health agencies, and physician offices. The

Administration opposes this provision which would either increase out-of-pocket payments or result in a significant reduction in services. The \$1,500 limit represents 15-20 PT/OT visits. In many cases, an individual who has suffered from a stroke has 35 visits. In order to receive these services integral to their recovery, the beneficiary would have to pay for the remaining visits out-of-pocket.

"Medicare Conference"

LEADERSHIP COUNCIL of AGING ORGANIZATIONS

Media Advisory

Date of Event: Monday, June 23
Time: Noon
Site: National Press Club, Holeman Lounge, 13th Floor

The Aging Community Speaks Out Against Drastic Proposed Senate Changes to the Medicare Program

The Leadership Council of Aging Organizations (LCAO), a coalition of more than 40 national organizations representing hundreds of millions of older adults and their caregivers, will discuss its dismay over the impact of the Senate Finance Committee Medicare proposals on beneficiaries. These proposals have particularly severe implications for low-income beneficiaries, older women and minorities. Several Senate Finance Committee proposals depart dramatically from both the bipartisan budget agreement and the House package.

Moderator: James Firman, LCAO Chair, President and CEO, The National Council on the Aging

Speakers:

Steve Protulis, Executive Director, National Council of Senior Citizens, on the impact of the Senate Finance Committee Medicare proposals on low-income older persons

Johnetta Marshall, President, Older Women's League, on the impact of the Senate Finance Committee Medicare proposals on older women

Samuel Simmons, President, National Caucus and Center on Black Aged, on the impact of the Senate Finance Committee Medicare proposals on older minorities

Martha McSteen, President, National Committee to Preserve Social Security and Medicare, on the proposal to means-test the Medicare deductible

Media Contact: Michael Reinemer, The National Council on the Aging, 202-479-6975

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THE NATIONAL COUNCIL ON THE AGING

409 Third Street SW Washington, DC 20024 TEL 202 479-1200 TDD 202 479-6674 FAX 202 479-0735 <http://www.ncoa.org>

For Immediate Release

Contact: Howard Bedlin, 202/479-6685

NCOA Statement on Senate Finance Committee Medicare Proposals

Washington, DC June 19, 1997--James P. Firman, president and chief executive officer of The National Council on the Aging (NCOA), today protested action by the Senate Finance Committee to alter the Medicare program. Said Dr. Firman:

The National Council on the Aging strongly opposes the Senate Finance Committee Medicare proposals that depart dramatically from the bipartisan budget agreement and the House proposal. Taken together, these four Senate provisions are unworkable, unfair, and would harm vulnerable, low-income beneficiaries.

The proposal to means-test Medicare deductibles makes no sense and is administratively unworkable. Anyone who thinks seriously about this proposal would have to conclude that it should be dead on arrival on the Senate floor. How can anyone tell when beneficiaries with different incomes meet different deductible amounts? Will Medigap insurers be forced to collect income tax returns in order to sell policies? While NCOA does not oppose making our health system more progressive for people of all ages, this means-testing proposal cannot work.

NCOA also is extremely concerned about the impact on low-income beneficiaries of the Senate Finance Committee proposal to increase premiums (without the \$1.5 billion in new protections promised in the budget agreement) and to impose new home health copayments. It is important to remember that home health users and beneficiaries with incomes just above the poverty line are disproportionately widows over age 75. These individuals already spend, on average, almost four times more of their income on health care than persons under age 65—31 percent vs. 8 percent.

Under the Senate Finance Committee proposal, by 2004, monthly premiums would be about \$23 higher than under current law (\$77.50 vs \$54.60). New home health copayments in that year could be as high about \$1,100. The combined impact of these two proposals means that a beneficiaries with incomes of only about \$13,000 in 2004 could be faced with an increase in out-of-pocket spending of almost \$1,400 more than under current law. *We do not need to take almost \$1,400 out of the pockets of poor, sick widows in order to balance the federal budget.*

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NCOA Reacts to Senate Finance Committee Medicare Proposals, Add One

Finally, the Senate Finance Committee decision to increase the Medicare eligibility age to 67 would significantly increase the number of older persons without basic health insurance. Without insurance reforms on guaranteed issue and community rating, many older workers downsized prior to retirement would be excluded from or priced out of the private health insurance market. Unlike Social Security, Medicare beneficiaries could not receive reduced benefits prior to age 67. The complex, far-reaching implications of this issue have not been sufficiently discussed and should be left to the Medicare Commission charged with addressing the future of the program.

MEDICARE BUDGET SIDE BY SIDE

	BUDGET AGREEMENT	HOUSE PROPOSAL	SENATE PROPOSAL
NEW LOW-INCOME PROTECTIONS	\$1.5 BILLION SET ASIDE	\$600 MILLION SET ASIDE	NOTHING SET ASIDE
PART B DEDUCTIBLE	NO CHANGE (\$100)	NO CHANGE (\$100)	MEANS-TESTED \$540 at \$50,00 for singles, \$75,000 for couples; \$2,160 at \$100,000 for singles, \$125,000 for couples
COPAYMENTS	NO CHANGE (NO HOME HEALTH COPAYMENT)	NO CHANGE (NO HOME HEALTH COPAYMENT)	\$5 PER VISIT HOME HEALTH COPAY, CAPPED AT HOSPITAL DEDUCTIBLE
AGE OF ELIGIBILITY	NO CHANGE (AGE 65)	NO CHANGE (AGE 65)	GRADUALLY INCREASED TO AGE 67

The National Council on the Aging (NCOA) is a center of innovation, leadership, and nationwide expertise in the issues of aging. NCOA is an association of more than 7,500 members—organizations and individuals—who work with, for, and on behalf of older persons. NCOA welcomes members who share this commitment to promoting the dignity, self-determination, well-being, and contributions to older persons.

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National Council of Senior Citizens

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PRESS RELEASE



FOR IMMEDIATE RELEASE
June 20, 1997

Contact: Daniel Schulder
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Senior Leader Calls for Defeat of "Medicare/Medicaid Dismantling Bills"

WASHINGTON, D.C.—Calling the pending House and Senate 1997 Reconciliation bills, "congressional plans to dismantle Medicare and Medicaid," Steve Protulis, Executive Director of the the National Council of Senior Citizens (NCSC) called for "grassroots action" to defeat the proposals. Protulis said that the 1997 Medicare revisions backed by the Republican Congressional leadership "are no different in intent" than the failed 1995 effort to cut back Medicare by \$270 billion. The NCSC leader said that the "only difference between now and 1995 is the pace of dismantling Medicare."

"The Republican leadership is simply hiding its goals with a slower schedule," he said. Protulis cited Congressional Budget Office (CBO) projections that Medicare outlays would be cut by over \$400 billion over the next 10 years under the budget agreement with an initial cut of \$115 billion over the first five years.

The NCSC statement listed rapidly rising Medicare premiums which will double over the next seven years, lack of low-income protection against rising premiums and the means-testing of Medicare deductibles as major problems in the budget bills. NCSC also included the Senate proposal to raise the age of eligibility for Medicare to age 67, the imposition of new \$5 a visit co-payments for home health services and the introduction of Medical Savings Accounts (MSAs) into Medicare as unacceptable parts of the pending bills.

The NCSC Executive Director said that MSAs would push Medicare toward privatization while creating publicly funded private savings accounts which users could spend for non-medical purposes. He said that MSAs would cost the Medicare program \$2 billion in extra payments. Protulis said, "Low-income seniors could use that \$2 billion for premium protection or pharmaceutical benefits."

Protulis cited the \$88 billion tax cut bill as the real cause of Medicare and Medicaid cutbacks. "They needed cash to give to the top five percent of wealthy families and Medicare and Medicaid are being sacrificed for the tax cuts in capital gains and estate taxes."

NCSC called on its national network of 3,000 activists and clubs to urge Representatives and Senators to vote against the Reconciliation bills if the damaging provisions affecting Medicare and Medicaid stay in. He said that seniors would be calling and visiting House and Senate offices with demands that Medicare and Medicaid be preserved without hurting the most vulnerable citizens. Protulis urged the NCSC membership to tell the Congress that they "will not allow Medicare and Medicaid to be destroyed for the seniors of the future—our children and grandchildren."

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PRESS RELEASE



FOR IMMEDIATE RELEASE
June 23, 1997

Contact: Daniel J. Schulder
Telephone: (301) 578-8839

STATEMENT OF STEVE PROTULIS, EXECUTIVE DIRECTOR NATIONAL COUNCIL OF SENIOR CITIZENS ON THE PROPOSED AMENDMENTS TO MEDICARE AND MEDICAID

WASHINGTON, D.C.—THE PROPOSED 1997 RECONCILIATION AMENDMENTS TO THE MEDICARE PROGRAM ARE A FUNDAMENTAL ATTACK ON THE CONCEPT OF UNIVERSAL HEALTH CARE COVERAGE FOR SENIORS EMBODIED IN THE 1965 AMENDMENTS TO THE SOCIAL SECURITY ACT, WHICH CREATED BOTH MEDICARE AND MEDICAID.

THESE CHANGES ARE NOT A LITTLE NIBBLING AT THE EDGE. THEY GO TO THE CORE OF THE MEDICARE PROGRAM, WHICH IS THE NATION'S MOST EFFICIENT HEALTH INSURANCE PROGRAM SERVING ALMOST 40 MILLION OLDER AND DISABLED PERSONS.

LIKE THE CONGRESSIONAL TAX BILLS, THESE CHANGES ARE WEIGHTED AGAINST AVERAGE- AND LOWER-INCOME SENIORS WHO ALREADY ARE SPENDING 20% TO 30% OF THEIR ANNUAL INCOMES FOR HEALTH CARE EVEN WITH MEDICARE AND MEDICAID. THE \$5 CO-PAY FOR HOME HEALTH VISITS WILL FALL ON THESE PERSONS THE HEAVIEST. THESE CHANGES WILL DRIVE EVEN MORE SENIORS AND FAMILIES INTO POVERTY.

WHEN THE HOSPITALS WHICH SERVE THE LARGEST PROPORTIONS OF LOW-INCOME SENIORS AND YOUNG PERSONS, THE DISPROPORTIONATE SHARE HOSPITALS, ARE SEVERELY CUT-BACK IN FEDERAL FUNDS, TENS OF THOUSANDS OF LOW-INCOME MEDICARE BENEFICIARIES WILL FEEL THE PAIN FIRST.

WHEN PART B PREMIUMS RISE AND ALMOST DOUBLE OVER THE NEXT SEVEN YEARS, SENIORS AND YOUNGER DISABLED PERSONS WITH INCOMES UNDER \$10,000 A YEAR, WILL NOT HAVE AN EXPANDED SLMB PROGRAM TO DEPEND ON FOR HELP, IF THE SENATE BILL PREVAILS...AND THE HOUSE BILL IS LITTLE BETTER.

IF AND WHEN THE CONGRESS PASSES ANY LEVEL OF MEDICAL SAVINGS ACCOUNTS IN THE MEDICARE PROGRAM, MEDICARE WILL SUFFER A LOSS OF FUNDS FOR THE REGULAR PROGRAM AND WE CAN PREDICT THAT SICKER AND POORER PERSONS WILL BE THE LOSERS.

IT IS THE PERSON WHO WORKED IN TOUGH JOBS OR WHO GOT DOWNSIZED IN HIS OR HER LATE FIFTIES OR EARLY SIXTIES WHO WILL FEEL THE STING OF PUSHING THE AGE OF ELIGIBILITY TO 67. RIGHT NOW, ONLY ABOUT 16% OF MEN AND 8% OF WOMEN CONTINUE TO WORK IN FULL-TIME OR PART-TIME JOBS AFTER AGE 65. PUSH THE AGE FOR MEDICARE TO 67 AND WE WILL CREATE ANOTHER 300,000 OR MORE AMERICANS WITH NO HEALTH COVERAGE AT A TIME WHEN THEY NEED IT THE MOST.

HOW DID THE HOUSE AND THE SENATE GET THIS FAR WITH THESE AND OTHER HUGE BITES OUT OF THE STRUCTURE AND FUTURE OF THE SENIOR'S HEALTH NETWORK?

OVER, PLEASE...

THEY DID IT AGAIN WITHOUT HEARINGS THIS YEAR ON THE PROPOSALS JUST AS THEY DID IN 1995.

MEMBERS OF THE NATIONAL COUNCIL OF SENIOR CITIZENS (NCSC) WERE ARRESTED IN 1995 FOR SIMPLY ASKING FOR HEARINGS ON THE SAME KINDS OF DESTRUCTIVE PROPOSALS THAT WE SEE TODAY.

BUT THE 1997 STRATEGY IS THE SAME—TO UNDERMINE AND EVENTUALLY PRIVATIZED THE MEDICARE AND MEDICAID SYSTEMS.

THE SENATE DOES NOT REALLY CARE ABOUT MEANS-TESTING THE MEDICARE PROGRAM FOR FEWER THAN ONE AND A HALF MILLION AFFLUENT MEDICARE USERS. IT WILL RAISE VERY FEW DOLLARS. THEY WANT TO UNDERMINE GENERAL SUPPORT FOR THE PROGRAM AMONG YOUNGER EARNERS WHO WILL SEE MEDICARE AS A BAD DEAL IN THE FUTURE.

NCSC SAYS WE SHOULD SUPPORT MEDICARE THROUGH A MORE PROGRESSIVE TAX SYSTEM AND WE WANT TO SEE THE AFFLUENT SENIORS PAY THEIR FAIR SHARE, BUT NOT THROUGH A MEANS-TESTING OF PREMIUMS OR DEDUCTIBLES.

WHILE CUTTING MEDICARE OUTLAYS BY \$115 BILLION OVER FIVE YEARS COMPARED TO \$270 BILLION OVER SEVEN YEARS IN 1995 MAY APPEAR TO BE "REASONABLE," PLEASE NOTE THAT THE CONGRESSIONAL BUDGET OFFICE (CBO) PROJECTS CUTS OF OVER \$400 BILLION OVER A TEN YEAR PERIOD. IT IS ONLY A QUESTION OF PACE, NOT INTENT.

NCSC IS ASKING EVERY SENIOR, EVERY YOUNG PERSON, EVERY WORKING FAMILY TO CONTACT TODAY BOTH OF THEIR SENATORS AND THEIR REPRESENTATIVE TO DEMAND A REJECTION OF THESE PROPOSALS.

WE ASK THE PRESIDENT TO CONTINUE TO PRESS TO HAVE THESE ANTI-SENIOR AND ANTI-CONSUMER PROVISIONS TAKEN OUT OF THE 1997 RECONCILIATION PACKAGE. WE ARE GLAD THAT HE WARNED THE CONGRESS TO CLEAN UP THEIR BILLS AT THE G-7 PRESS CONFERENCE IN DENVER OVER THE WEEKEND. IF THEY STAY IN, WE ASK THE PRESIDENT TO AGAIN USE HIS VETO PEN AS HE DID IN 1995.

THESE DESTRUCTIVE PROPOSALS MUST FAIL.

OWL PRESS RELEASE

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FOR IMMEDIATE RELEASE
Monday, June 23

OWL BLASTS MEDICARE PROVISIONS AS "HORRIFYING" FOR WOMEN

OWL President Says Increased Premiums and New Co-Payments Will Rob
Older, Poorer Chronically Ill Beneficiaries of Access To Care

Dr. Johnetta Marshall, President of OWL, an organization representing women 40 years of age and over, today (Monday, June 24) assailed provisions in the Senate Finance Committee version of the budget spending bill's Medicare provisions that would levy a \$5 co-payment on home health care visits--most often beginning the first visit, and would increase Part B premiums to unaffordable levels for old, chronically ill women.

Citing the fact that a typical Medicare home health care recipient is female, 75 years or older, and with a median income of \$8,365, Marshall asserted that the increased cost, added to a proposed increase in Part B premiums, could add as much as \$1100 per year in health care costs. Coupled with the absence of any protections for low-income beneficiaries in the bill, this combination would, according to Marshall, place an "horrifying" burden on "frail, elderly and often alone elderly women who are least able to bear the burden of the additional expense they will have to incur, or the loss of the care they will have to do without."

Additionally, "the home health care patient is already contribute to the cost of her home care" through services provided by family caregivers, often spouses or children who "often find it necessary to leave jobs to stay home and provide care." These caregivers not only lose income, she said but "time in the workforce building up their Social Security and pension accounts."

The complete text of Dr. Marshall's remarks follows:

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OWL Medicare Statement

Statement of Dr. Johnetta Marshall

OWL is the voice of the 58 million American women who are over 40. We are here today to express our rage at Senate Finance Committee proposals that could rob many older women of their access to health care.

These proposed changes to the Medicare program will bring fundamental change the most basic principles underlying the Medicare program. These proposals are a "meat-axe in the night" act. A horrifying attack on the poorest and most vulnerable among us -- most of whom are women.

Members of the Senate Finance Committee: America does not treat its Mothers and Grandmothers so coldly. And, we as women mid-life and older, are here today to say that we will fight this with every fiber of our being.

First, a few facts. Because women live an average of seven years longer than men, they comprise 60% of Medicare recipients. Since 1980, the female population has increased in age by 35%, with the largest increase in those over 85--and the expectation is that by 2030 the elderly population will increase another 20%. Older women are poorer than older men. In fact, 75% of all elderly poor are women. In 1995, almost 14 percent of elderly women were poor, compared with slightly more than 6 percent of elderly men. Clearly, women will be most damaged by changes in Medicare.

Faced with this dismal reality, several of the bill's provisions are particularly harmful to older women. The first is a proposal to change Part B to require a \$5 beneficiary copayment for each home health care visit--beginning with the first one. A typical Medicare homecare patient is female and 75 years of age or older, with a median income of \$8,365. The copayment alone would place an additional burden of up to \$760 a year on a chronically-ill woman. In fact, she is already paying more than one-third of her home care expenses out-of-pocket.

The Committee's proposal to raise Part B premiums will almost double premiums in seven years, from \$43.80 per month, to \$82.60. Then add to this the extra cost of the home health care copayment, and the proposal to eliminate \$1.5 billion in assistance for low income beneficiaries that would help pay the Part B premium for the poorest older people. The result is a mean-spirited attack on America's most vulnerable older women. For example, a sick elderly woman who lives on a fixed income of less than \$10,000 a year, faces the combined effect of these proposed changes that adds up to a potential

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3-3-3

OWL Medicare Statement

\$1100 a year increase in out-of-pocket health care costs. What this really means is that the poorest and frailest older women can lose their Part B coverage for desperately needed services.

The White House has said that the \$5 copayment is not necessary to balance the budget. The change will have no impact on the economy, but it will do great damage to those frail, vulnerable and often alone elderly women who are least able to bear the burden of the additional expense they will have to incur, or the loss of the care they will have to do without.

Medicare is a part of a social insurance contract between our government and its citizens, who have met their part of the bargain. That contract is supposed to provide a guarantee that their health care needs will be met as they age. The Senate Finance Committee is proposing to break that contract.

I must make note that is the first time we have had to fight this battle without Dr. Arthur Flemming, a beloved, long-time champion for health care access, who passed away this year. Dr. Flemming, we miss you and OWL and the others who join us here today will fight this battle in your memory. As you, we will fight to protect older Americans from "the hazards and vicissitudes of life".

We are in a strong economy. The deficit and the unemployment rate are both lower than they have been in years. In a strong economy, we should be working to provide better programs for the poor, not raiding current successful programs to provide further tax breaks for the wealthy. We urge the full Senate to reject the mean-spirited Senate Finance Committee proposals to undermine Medicare.

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Statement by

**Samuel J. Simmons
President and Chief Executive Officer
National Caucus and Center on Black Aged, Inc.**

At

**The Leadership Council of Aging Organizations (LCAO)
Press Conference**

On

The Senate Finance Committee's Medicare Proposals

Washington, DC

June 23, 1997

Thank you very much. I enthusiastically welcome the opportunity to stand with my good friends from the Leadership Council of Aging Organizations to send a message to the Senate Finance Committee concerning its ill-conceived proposal to raise the Medicare eligibility age from 65 to 67.

My emphatic message is "no"! No to unfairness! No to heartlessness! No to attempts to balance the budget on the backs of aged African Americans and other low-income older Americans!

This proposal is like a dagger ready to pierce Medicare's heart and the fragile hearts of those who depend either exclusively or primarily upon Medicare to provide protection against the high cost of illness.

The National Caucus and Center on Black Aged (NCBA) stands foursquare against the Senate Finance Committee proposal to raise the Medicare eligibility age from 65 to 67. The main reason is that African Americans and other low-income groups have a considerably shorter life expectancy and are more likely to be the victims of disabling injuries or illnesses than the general population and White, non-Hispanics. The harsh reality is that many African Americans do not live long enough to receive Medicare protection, even though they have worked all their lives to support this valuable program by paying the Medicare Hospital Insurance tax. Raising the eligibility age will only intensify the problem. Life expectancy at birth for African American males is 65.0 years -- 8.2 years shorter than for White males. In short, African Americans will be cheated by this proposal because of their

shorter life expectancy. Each year that the eligibility age is raised will only widen the existing health care gap between African Americans and White, non-Hispanics.

Aged African Americans will suffer disproportionately from this proposal because they are more likely to depend upon Medicare exclusively to cover their out-of-pocket health care costs since they are substantially less likely to have private health insurance to supplement Medicare. One major reason is that older African Americans must live on substantially less income in retirement than other older Americans. This fact makes it difficult, if not impossible, for large numbers of elderly African Americans to purchase medigap policies. In addition, African Americans are less likely to work in jobs where their employers provide carryover health insurance coverage in retirement to supplement Medicare. The net impact is that non-Hispanic Black, Mexican-American, and Puerto Rican elderly persons are twice as likely to rely solely on Medicare than aged non-Hispanic Whites: 36 percent vs. 18 percent.

NCBA also believes that it is wrong headed and heartless to postpone health coverage for poorer and sicker older Americans who depend so much upon Medicare. The facts speak for themselves when it come to African Americans:

- o In 1994, three out of every seven (44.4 percent) African Americans aged 65 years or older considered their health to be poor or just fair. Only one out of every four aged Whites (26.6 percent) had this same perception.

- o Older African Americans had good reasons to support these perceptions because they were confined to a bed approximately 98 percent more, on the average, than aged Whites: 26.3 days vs. 13.3 days. Their average number of restricted days attributable to acute and chronic conditions is considerably higher than for elderly Whites: 45.0 days vs. 32.8 days in 1992.
- o The death rate from all causes for African Americans 65 years of age or older was nearly 11 percent (10.9 percent) higher in 1991 than for aged Whites.
- o African Americans are much more likely to be disabled than White, non-Hispanics, in large part because African Americans have worked in more hazardous or physically debilitating occupations or have been exposed to more harmful elements on the job. African Americans account for 18 percent of all persons receiving Social Security disability benefits, although they represent 12 percent of the U.S. population.

One final note from a positive standpoint. NCBA urges Congress to include Medicare beneficiaries with income under 150 percent of the poverty threshold in the SLIMB (Specified Low-Income Medicare Beneficiary) program so that Medicaid can pay the Part B premiums for this deserving group. This added coverage is needed because the Medicare Part B premium may jump by 34 percent by 2002 -- to \$69 a month or \$828 annually. Elderly persons with incomes between 100 and 150 percent of the poverty thresholds spend

approximately 30 percent of their limited incomes on out-of-pocket health care costs, including the Part B premium.

Thank you very much. We can drive our powerful message home to the Senate Finance Committee if we stand together and inform the American public about the impact of these measures. With your support, I believe that we can succeed.

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE

FOR IMMEDIATE RELEASE

HOME CARE COPAYMENTS HIT THOSE WHO NEED HOME CARE THE MOST AND CAN LEAST AFFORD IT

WASHINGTON, D.C. (June 23, 1997) — The National Association for Home Care (NAHC) released the following statement today at a news conference concerning the Senate Finance Committee's budget reconciliation proposal to impose a copayment on Medicare Part B home health care visits. The conference was sponsored by the Leadership Council of Aging Organizations, a coalition of more than 40 national groups representing Older Americans and their caregivers of which NAHC is a member.

"The National Association for Home Care (NAHC) strongly opposes the provision in the Senate Medicare reconciliation bill, which would impose copayments on Medicare home health care services. Copays would hit exactly the wrong people—the oldest, the poorest, and the sickest individuals who need home care the most.

Instead of discouraging the inappropriate use of home care, this regressive benefit reduction would take home care away from those who desperately need it, but are least able to afford the added expense. Millions of frail and disabled Medicare beneficiaries would be forced to pay more for services they currently receive.

The Senate package would require all home care patients to pay a new charge of \$5 for every home care visit they obtain, until the amount of the hospital deductible (\$760 in 1997) is met each year. Only patients receiving home care following a three-day hospitalization would be excluded from this provision. This means that every Medicare beneficiary who needs home care, but did not receive hospital care, or was admitted to a hospital only for a one- or two-day stay, will be forced to pay the additional charge, starting with the very first home care visit.

Under this proposal, the average Medicare home care patient will pay \$400 more a year for home care. Statistics show that home care patients are older, poorer, and sicker than the average Medicare beneficiary. Two-thirds of all home health beneficiaries are over age 75, compared to one-third of all Medicare patients. Most of the older beneficiaries are women who live alone and have lower average incomes than the general Medicare population."

Founded in 1982, NAHC is the largest trade association serving the nation's home care agencies, hospices, and home care aide organizations that provide health and supportive services to more than seven million patients receiving care in their homes due to acute, long-term, or terminal health conditions.

For more information, contact Suzanne Kieffer or Margo Gillman in NAHC Public Relations at 202/547-7424.

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June 23, 1997

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SENATE BUDGET PROPOSALS ON MEDICARE WILL HURT VULNERABLE ELDERLY

Home Health Copayment is an especially serious problem

The Alzheimer's Association is disappointed that the Senate Finance Committee has included in its budget reconciliation package several proposals that would be harmful to the poorest and sickest older Americans. The Association calls upon the Senate to reject these proposals when it considers the budget bill this week.

One of the most damaging proposals is one that would impose a \$5 copayment on beneficiaries for each home health visit after the first 100 visits. This copayment is targeted to those who are the sickest and the least able to afford additional out-of-pocket costs. This new copayment would cost the average Medicare beneficiary who uses the home health benefit an additional \$400 per year in medical expenses and could cost individuals as much as \$760 in additional expense.

The additional copayment would be especially burdensome to people like Mrs. G, a resident of Methuen, Massachusetts, who suffers from Alzheimer's disease and other ailments. Mrs. G is not covered by Medicaid, so additional costs of care must come out of her own pocket. The new copayment would cost Mrs. G \$760 in additional expense, which is more than 7 percent of her entire income. This new copayment could force Mrs. G to cut back on necessary services or, worse, force her into a nursing home where she would quickly become Medicaid eligible, thereby making all of her care the responsibility of the government. (See attached description of Mrs. G).

The Senate bill also includes a proposal to link the Medicare Part B deductible to income, which is a tax on the sick, and to raise the age of eligibility for Medicare, which could leave millions of vulnerable older Americans without necessary health care. Raising the costs of health care for the sick or forcing them to wait to become eligible will not address the larger goal of improving Medicare to better meet the health care needs of those with chronic illness and disability. The revenue generated by these proposals will finance deficit reduction and tax cuts. It will not be used to enhance Medicare services.

-more-

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION, INC.

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We applaud both the House and Senate bills for creating a **Bipartisan Commission on Medicare**, which will include a focus on chronic disease. It is this commission that should address long term structural reforms to ensure we have a Medicare program that is affordable to both taxpayers and beneficiaries.

The bipartisan budget agreement and the House budget reconciliation package did not include a copayment for home health services, nor did they include the other drastic changes to the Medicare program included in the Senate bill. We urge the Senate to reject the home health copayment and the rise in Medicare eligibility age and to make changes in the Medicare program that are not more dramatic than those included in the House budget reconciliation bill.

The Alzheimer's Association is the only national voluntary health organization dedicated to conquering Alzheimer's disease through research and providing support and assistance to those afflicted with the disease and their caregivers.

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Impact of Proposed Medicare Home Health Copayment on Mrs. G

Mrs. G, a 77-year-old widow from Methuen, Massachusetts has a primary diagnosis of Alzheimer's disease with secondary diagnosis of anemia, hypertension, pneumonia and ovarian cysts. She worked for Western Electric for over 20 years and receives \$850 per month from a small pension and social security, which are her only sources of income. She is not currently enrolled in the Medicaid program.

Mrs. G is cared for by her daughter with no other family support. A Medicare reimbursed home health aide visits 10 times per week because Mrs. G. needs assistance from two people for dressing, hygiene and mobility. Also, once a month a Medicare reimbursed nurse provides a B-12 shot, venipuncture to determine blood and kidney function, assesses cardio-pulmonary function, does a neuro assessment, assesses skin integrity and does a gastro-intestinal assessment. She attends adult day care three times per week which is not covered by Medicare. Mrs. G. is confined to a wheelchair 90% of the time.

Under the proposed co-payment, Mrs. G. would use up her allotted first 100 visits within the first two and one-half months and then pay \$5.00 per visit up to a total of \$760. Because Mrs. G's income is so low, and she has other medical expenses not covered by Medicare (adult day care), the new co-payment (over 7% of her annual income) could force her into a nursing home where she would quickly become Medicaid eligible and all of her care would then become the government's responsibility.

American Federation of Labor and Congress of Industrial Organizations



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FOR IMMEDIATE RELEASE

Statement by John J. Sweeney President, AFL-CIO on Senate Medicare Cuts June 23, 1997

At a time when health coverage for working families is disappearing for many and increasingly unaffordable for even more, it is unconscionable that senators would vote to dump millions more Americans into the ranks of the uninsured by raising the Medicare eligibility age to 67.

The fact that this cruel and hasty action has nothing to do with fulfilling the budget agreement makes it especially disrespectful to people who have worked hard all their lives and are already struggling to pay for health care.

The senators' vote to means-test Medicare coverage is a direct threat to the integrity of the program. It adds another division over health care when, more than anything, the country needs to be brought together.

A strong consensus exists in support of a full review and discussion of what is needed to strengthen and preserve Medicare as well as Social Security. Shame on those senators who would short-circuit the process and undermine basic protections for American working families.

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NEWS AFSCME NEWS AFSCME NEWS

**FOR IMMEDIATE RELEASE:
Monday, June 23, 1997**

**FOR MORE INFORMATION, CONTACT:
Tony Copeland, 202/429-1130**

**Statement by AFSCME President Gerald W. McEntee
on Congressional Efforts to Dismantle Medicare/Medicaid**

Washington, D.C. -- Congress will vote this week on a plan to cut Medicare and Medicaid. Gerald W. McEntee, president of the American Federation of State, County and Municipal Employees had this to say:

“Once again, conservative members of Congress have shown their contempt for America’s elderly and disadvantaged. These proposed cuts to Medicare and Medicaid will erode the health security of millions of middle class senior citizens and low-income families so that the wealthiest Americans can receive billions of dollars in tax breaks. Their proposals would set a higher age for eligibility for Medicare benefits, raise Part B premiums and home health care co-pays, and reduce Medicare and Medicaid reimbursements to hospitals serving the poor. It’s a bad plan, and bad public policy.

“This proposal will increase the Part B premium paid by seniors \$16.20 per month over the next seven years. As a result, Part B premiums in 2004 will be a whopping \$82.60 per month. That may not sound like much to members of the House Ways and Means Committee, but it’s a lot of money to our nation’s elderly, who often have little income beyond Social Security or SSI. In addition, these proposals would charge higher deductibles to the few seniors making over \$50,000 per year – a move which turns Medicare into a welfare program, and does little to generate new revenue.

“If these proposals are implemented, seniors will be burdened with copays for home health care. Currently, Medicare charges no copays for covered home health care services. But with the proposed budget plan retirees would begin paying copays, the first step in eroding this vital benefit. Those hurt the most would be the oldest and most ill seniors, primarily elderly women.

“The House and Senate budget plans also introduce Medical Savings Accounts (MSAs) to Medicare. This will encourage the youngest, healthiest and wealthiest seniors to opt out of Medicare, leaving the program with fewer dollars to care for the oldest and sickest seniors. It’s a recipe for Medicare bankruptcy.

“Americans were outraged when House Speaker Newt Gingrich announced that the Republican-controlled Congress would let Medicare ‘wither on the vine.’ Americans are equally outraged that these same politicians are now trying to dismantle programs that provide healthcare to their elderly family members.”

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**NARFE**

National Association of Retired Federal Employees

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NEWS

FOR IMMEDIATE RELEASE
June 19, 1997

CONTACT: (202) 234-0832

Charles R. Jackson
President

NARFE HITS MEDICARE MEANS-TEST SCHEME

The National Association of Retired Federal Employees (NARFE) today criticized the means-testing plan for Medicare approved by the Senate Finance Committee.

The Committee included language in its Medicare "reform" legislation on June 17 to require individuals making at least \$50,000 and couples making \$75,000 to pay a \$540 deductible each year rather than the current \$100 for all Medicare recipients. For individuals with income over \$100,000 and couples with income over \$125,000, the annual deductible would be \$2,160.

NARFE has joined AARP and other senior groups in attacking this scheme as unfair and unworkable, for several reasons:

- The means-testing Medicare deductible was never part of the May 2 budget accord between President Clinton and the Congressional leaders. Indeed, the agreement clearly said that beneficiary copayments ought to be limited.
- It penalizes those who have worked hard during their careers. We can understand the rationale for subsidizing Medicare costs for low-income seniors but we cannot understand penalizing those who are being rewarded for lifelong job performance.

-- MORE --

- It sets a bad precedent. The Congress and President Johnson made a promise in 1965 to provide health security to all Americans from age 65 -- regardless of income -- as long as they contributed to this program with payroll deductions and federal taxes. Raising the Medicare deductible is a breach of this promise since program eligibility has never been based on income. In the future, the means-testing threshold could be lowered below the levels proposed by the Finance Committee Medicare bill.
- The scheme attempts to divide and conquer the senior community. Older Americans who are compelled to pay higher deductibles may drop Medicare Part B. Absent their participation, these former beneficiaries may no longer be vocal supporters of the health security program. Presently, Part B costs are minimized by spreading the risk of health care expenses among a large community of coverage. Savings achieved by risk sharing could be lost if departures from Part B significantly reduce the size of this community.
- Higher Medicare deductibles could destabilize the Federal Employees Health Benefits Programs (FEHBP). For Medicare-eligible federal retirees, their FEHBP plan becomes "Medigap" coverage that pays all deductibles. If costs from increased Medicare deductibles are shifted to FEHBP, insurance carriers could be compelled to hike premiums and cut benefits for the nine million federal employees, retirees and dependents who participate in the program and hike premiums paid by their employer, the federal government.
- Although the May 2 budget agreement called for adding more health care choices in Medicare, this proposal could deny choice. That is because enrollment in a Medicare HMO might be the only way beneficiaries can participate in Part B without paying a higher deductible. As a result, beneficiaries could not remain with the physician of their choice.
- The logistics of imposing Medicare means testing is unrealistic and would result in the creation of an entirely new bureaucracy and additional red tape.

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Will Medicare Help the Chronically Ill Stay Home?

Despite the express recognition by the Health Care Financing Administration (HCFA) and other policy makers that long-term home care for chronic conditions is an increasingly needed, fiscally sound, and humane method of providing care, current proposals to change Medicare and to encourage the use of managed care would diminish significantly the Medicare home care benefit and limit home care services. Proposals to tie some home health care coverage to a hospitalization and to cap the overall number of coverable visits may save some Medicare dollars in the short run but will eventually lead to additional institutionalizations and greater financial and human costs. Some of the proposals being considered which will result in disastrous consequences include:

- limiting eligibility for coverage for beneficiaries in the name of reducing fraud and abuse in the provision of services;
- limiting the amount and duration of services available to beneficiaries;
- narrowing the definition of part-time and intermittent care;
- restricting the ability of chronic care patients to use the home health benefit;
- making the appeals process more restrictive by shifting services from Part A to Part B;
- including the possibility of co-payments and higher premiums; and
- making access to services more restrictive by possibly severely limiting the definition of "homebound" for purposes of the home health benefit.

The proposals to limit Medicare coverage will only be exacerbated by increases in managed care utilization by Medicare beneficiaries. Results of a four year study reported in the October 2, 1996 *Journal of the American Medical Association* "sound a cautionary note to policy-makers who expect overall experience to date with HMOs to generalize to specific subgroups, such as Medicare beneficiaries or the poor. Patients who were elderly and poor were more than twice as likely to decline in health in an HMO than in a fee-for-service plan" (p.1046).

The national debate about Medicare ought to include serious consideration of new ways to increase funding to allow coverage for the actual needs of our increasingly aged and disabled population. Suggestions include permitting certain adults under age 65 to purchase Medicare, increasing the Medicare payroll tax for employers and/or employees, and graduating the premium so that those beneficiaries with high incomes pay more than those of modest means. These may not be welcome options, but they should at least be offered to the public along with a clear message that the alternative *will* be the absence of Medicare coverage for necessary services in the near future.

The Center for Medicare Advocacy appeals Medicare denials for thousands of poor beneficiaries who have been denied coverage for necessary home care services. These individuals are often women, over 80 years old, and living alone; others who are younger are living with multiple sclerosis, Parkinson's disease, or traumatic brain injuries. They need basic, hands-on home health aide services and occasional nursing or therapy care in order to remain at home. Currently, Medicare will pay for these services as long as they are medically necessary. But in the near future this may well change.

As HCFA reported in its May, 1996 *Profiles of Medicare*, "an important trend to note is that the Medicare population is growing older and more disabled" (p.9). HCFA also reported that the number of Medicare beneficiaries is increasing, living longer with more chronic conditions, and needing more long-term care. "The result is a significant shift in spending by type of service: Inpatient hospital payments represented two-thirds of Medicare in 1980 and less than half of total Medicare expenditures in 1995. ...Skilled nursing facilities' share of program spending-increased from 1.2% of the total in 1980 to 5.2% in 1995. Home health payments represented 2.2% of the total in 1980 and 8.5% in 1995" (p.70).

As the Robert Wood Johnson Foundation has determined, 96% of all home care visits are for persons with chronic conditions. (*Journal of American Medical Association*, (November 13, 1996, p. 1478). Another Robert Wood Johnson study found that "there is a profound mismatch between the chronic care services we need and the way financial resources are allocated. Unless the system changes, the needs of America's aging and increasingly disabled population cannot be met by the available resources." (*Chronic Care in America: A 21st Century Challenge*, (August 1996, p.12).

HCFA's *Profiles of Medicare* study reported that "the majority of Medicare spending is for beneficiaries with modest incomes: 38% of program spending is on behalf of those with incomes of less than \$10,000; 76% of program spending is on behalf of those with incomes of less than \$25,000. Nearly one-quarter of Medicare beneficiaries live alone, and they are disproportionately female and poor: 51% have incomes under \$10,000" (p. 11). These poor, very old women and their younger, chronically disabled counterparts, are most likely to need home care and to depend upon Medicare to meet their basic health care needs. They are also the most likely to be unable to receive the care they need, particularly if it is to be provided within the structure of a managed care framework. They are the clients of the Center for Medicare Advocacy.

As proposals to "reform" Medicare once again enter the national debate, we urge Congress and the President to consider the impact of these "reforms" on home care and on the most vulnerable elderly and disabled home care beneficiaries. These people are not strangers to you. They are your grandmother, or your friend, or your father. Someday they could be you. Let us make conscious, educated choices about the future of Medicare and the health care that will be available as we age.

6/13/97

June 23, 1997

Dear Senator:

The Senate will soon consider the budget reconciliation bill, which would restructure the Medicare program. While we have deep concerns about a number of provisions in this bill that we believe jeopardize the ability of Medicare to meet the needs of seniors and persons with disabilities, this letter concerns the issue of Medicare Medical Savings Accounts (MSAs). We oppose the introduction of MSAs into the Medicare market, since they threaten to expose many Medicare beneficiaries to an unacceptably high level of out-of-pocket costs, erode the quality of care provided to people with traditional Medicare coverage, and drain at least \$2 billion from the federal treasury.

We urge you to support Senate Finance Committee efforts to minimize the potential harm from Medicare MSAs when the budget reconciliation package is considered on the Senate floor. The Senate Finance Committee took a major step toward protecting seniors and the disabled, with bipartisan support, when it adopted Senator Graham's amendment to reduce the demonstration size from 500,000 to 100,000, and when it adopted Senator Rockefeller's amendment to reduce deductibles from a maximum of \$6,000 to a level between \$1,500 and \$2,250. Without this substantial reduction of maximum deductible level, many of our nation's most vulnerable seniors and persons with disabilities would have faced insurmountable financial barriers to health care -- a state of affairs that the Medicare program was created to avoid. The amendment also established a cap on out-of-pocket covered expenses of \$3,000, another substantial protection, reducing the maximum of \$6,000 absent the amendment. The \$3,000 cap is important in limiting beneficiaries exposure to out-of-pocket costs, especially since MSA participants are totally unprotected against any fees their providers charge that are above the Medicare approved rate.

These limits that were adopted by the Finance Committee parallel the limits that were adopted in last year's Kassebaum/Kennedy bill for the MSA demonstration program for people under 65. We strongly urge you to support offering Medicare beneficiaries the same protections that exist in law for people under age 65. Seniors and the disabled should not be second-class citizens in this rapidly changing health care marketplace.

Sincerely,

AIDS Action Council
Alzheimers Association
American Geriatrics Society
American Network of Community Options and Resources
American Nurses Association

- American Public Health Association
- Association for Gerontology & Human Development, Historical Black Colleges & Universities
- Association of Jewish Aging Services
- Bazelon Center for Mental Health Law
- Center on Disability & Health
- Church Women United
- Committee for Children
- Consumer Federation of America
- Consumers Union
- Families USA
- Human Rights Campaign
- International Union of Electronic Workers (IUE)
- Eldercare America, Inc.
- LDA, The Learning Disability Association of America
- National Association of Foster Grandparent Program
- National Association of People With AIDS
- National Association of Protection & Advocacy Systems
- National Association of School Psychologists
- National Association of Social Workers
- National Council for Community Behavioral Healthcare
- National Council of Senior Citizens
- National Council on the Aging
- National Education Association
- National Episcopal AIDS Coalition
- National Farmers Union
- National Gay and Lesbian Task Force
- National Hispanic Council on Aging
- National Puerto Rican Coalition
- National Senior Citizens Law Center
- National Women's Health Network
- Neighbor to Neighbor
- NETWORK: A Catholic Social Justice Lobby
- Older Women's League
- Service Employees International Union, AFL-CIO, CLC
- The ARC
- The National Caucus and Center on Black Aged, Inc.
- UAW
- United Church of Christ, Office for Church in Society
- Universal Health Care Action Network
- Women's Legal Defense Fund

June 23, 1997

Dear Senator:

The undersigned organizations, representing a wide range of constituencies, strongly urge you to oppose a proposal in the Senate Finance Committee budget reconciliation package that would impose a \$5 copay on Part B home health visits, capped at the amount of the hospital deductible (\$760 in 1997). As the White House indicated in its recent letter, a home care "copayment could limit beneficiary access to the benefit.." and "...is not necessary to balance the budget."

Home care plays an important role in the American health care system. Home care patients tend to be older and poorer than the average Medicare beneficiary, and in great need of care. Copays would penalize the most vulnerable Medicare beneficiaries because of their illnesses.

While individuals over age 75 account for about one-third of the total Medicare population, they account for two-thirds of all home health beneficiaries. Medicare beneficiaries who use home health services tend to be in poorer health than other Medicare beneficiaries. Two-thirds are women, and one third live alone. Forty-three percent have incomes under \$10,000 per year.

The elderly already spend nearly twice as much more of their incomes on health care costs than they did before Medicare began. Most home health patients will have paid \$1,900 or more for Medicare premiums, deductibles and current copays even before the first home health copay comes due.

Long-stay patients are particularly at risk because they receive most visits and would pay the most in copays. These Medicare patients tend to be older, more functionally impaired, and have multiple acute and chronic care needs. A Medicare home care copay would be a "sick tax" on this group, requiring those with the most medical needs to pay the most.

For disabled Medicare beneficiaries, out-of-pocket spending for home care can be an extremely heavy burden, as Medicare does not cover all their needs and many must purchase additional home care. In fact, elderly home care patients paid more than one-third of their home care expenses out-of-pocket in 1992.

Family members are often trained by home care providers to change dressings, give injections, bathe and transfer home care patients, as well as provide tube feeding, catheter care, and IVs. Medicare would have to pay for these services in the hospital and nursing home settings.



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 12

Date: 6/4/97

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REMARKS: _____

HEALTH CARE FINANCING ADMINISTRATION
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Washington, DC 20201

Hearing Summary
"The FEHBP as a Model for Medicare Reform"
Senate Finance Committee
May 21, 1997

Members Present

Republicans: Chairman William Roth (DE), John Chafee (RI), Charles Grassley (IA),
Alfonse D'Amato (NY), Jim Jeffords (VT), and Connie Mack (FL).

Democrats: Ranking Minority Member Daniel Moynihan (NY), Jay Rockefeller (WV),
John Breaux (LA), Carol Moseley-Braun (IL), and Richard Bryan (NV).

Witnesses

Panel I

Senator Judd Gregg (R-NH); and

Senator Ron Wyden (D-OR).

Panel II

Stuart Butler, Ph.D., Vice President for Domestic Research, The Heritage Foundation;

Robert Reischauer, Ph.D., Senior Fellow, The Brookings Institution; and

Kenneth Thorpe, Ph.D., Professor, Tulane University School of Public Health and Tropical
Medicine, New Orleans, Louisiana.

Panel III

Richard Anderson, Vice President, Health Policy, Kaiser Permanente, Oakland, California;

Edwin Husted, Senior Vice President, Hay/Huggins, Inc., and Former Chief Actuary, U.S. Office
of Personnel Management (1972-1980); and

Peter Wyckoff, Executive Director, Minnesota Senior Federation-Metropolitan Region, and
Board Member, National Council on the Aging as Liaison for the National Coalition of Consumer
Organizations of Aging.

Opening Statements

Chairman Roth stated that both chambers of Congress will vote this week on budget resolutions
which call for \$115 billion in Medicare savings over the next five years. However, this proposal
contains minor reforms and fails to address Medicare's long-term fiscal problems. The Chairman
added that it is most important for Congress to immediately initiate a step-by-step process of

fundamentally updating the Medicare program. The purpose of today's hearing is to consider using a modified Federal Employees Health Benefit Program as a model for modernizing and strengthening Medicare. The FEHBP has worked well during its 40-year history, requiring little Congressional oversight. Its ten million federal enrollees have consistently reported their satisfaction. The FEHBP offers a wide range of options in a competitive marketplace, and members receive standardized information annually during open season. The FEHBP has kept cost increases below the private sector, without onerous government price fixing.

Chairman Roth stated that during the previous Congress, the Finance Committee reported its Medicare plan which restructured Medicare to be a health benefits system very similar to the FEHBP. In 1995, the Senate passed this plan. This type of plan would have fostered competition among health plans with incentives to providers to deliver more efficient and higher quality care to our seniors. Beneficiaries would have access to coverage for additional benefits. Roth was pleased to announce that Senator Breaux has also expressed support in consideration of the FEHBP as a model for Medicare.

Ranking Minority Member Moynihan expressed concern with the future of teaching hospitals and medical schools being able to continue to provide public health services such as medical research and care to the poor. According to a Professor of Medical Ethics with the University of Florida, medical market forces are creating significant financial pressures on teaching hospitals. Moynihan added that the growth of managed care is also contributing to this fiscal burden. The Senator hopes that this year, Congress will consider establishing a teaching hospital trust fund.

Breaux thanked the Chairman for today's hearing in an effort to achieve a solution to Medicare's crisis. Without implementing any changes to Medicare, the program will become insolvent by 2001. Although the budget resolution proposes to save Medicare \$115 billion over the next five years and extends the Trust Fund's solvency until 2008, it fails to achieve any fundamental reforms. The Administration's plan continues to call for a 1965 style of medicine and fails to propose measures to keep pace with modern medicine. The current Medicare proposal reduces payments to hospitals and physicians. Breaux warned that this approach will result in physicians not treating seniors because of reduced reimbursements. Therefore, fundamental reforms are needed to protect our seniors. The Senator explained that every year more than nine million federal employees receive a standardized comparison of options in the FEHBP. There are hundreds of plans competing to offer federal employees health care. The FEHBP is market based and works well. Breaux indicated that our 38 million seniors should also be able to participate in a similar program involving risk adjusters which provide competitive prices, choices, and high quality.

Grassley explained that different types of plans help keep inflation under control. Since the FEHBP has been so successful for the federal government, we should offer this same type of health service to Medicare's beneficiaries.

Testimony of Panel I

Gregg testified on behalf of his legislation known as the Choice Care plan which was introduced during the previous Congress and reintroduced earlier this year. This bill is designed to implement a market approach to Medicare. Seniors would be able to choose from a range of health care options as federal employees do today. The federal government would guarantee seniors a certain amount for their health services, and if a senior purchases a plan that costs less than the federal contribution, the senior would receive 75 percent of the savings and the remaining 25 percent would go into the Medicare Trust Fund.

Gregg stated that CBO has scored his Choice Care bill as producing approximately \$10 billion in savings over five years, \$28 billion over seven years, and \$93 billion over ten years. The current budget resolution being considered by the Senate specifically mentions this plan as a type of reform which we should strive to include in the reconciliation process. The Senator explained that his proposal would provide seniors with the option to remain in the traditional Medicare program if they wish. Traditional Medicare would be strengthened by infusions of revenue resulting from choices by other seniors. **Gregg** emphasized that the bill would begin to reduce the inequities in the reimbursement levels for Medicare benefits throughout different regions of the country. Per-capita health care costs would grow more quickly in regions that are currently spending below the national average.

Wyden testified that the Medicare program is trying to deliver a 1965 style of medicine in a 1997 informed market. Seniors receive less than they need, and Medicare costs taxpayers and beneficiaries more than it should. While private costs have risen at a rate of just over 2 percent per capita, Medicare's costs have increased three times this rate. Medicare threatens to consume the federal budget.

Wyden described the success of Oregon's use of case management and utilization review systems. The Senator indicated that members of the Committee have a special interest in the operating policies of the FEHBP. His testimony described the benefits of the FEHBP. **Wyden** warned against giving seniors a defined payment to purchase their health care, because too many older, frailer, and poorer seniors would be at risk. Rather, he urged passage of his bill, S. 386, designed to create an FEHBP office within Medicare. His legislation ensures competitive bidding among plans in selected, high-payment communities, improves beneficiary information, and revises the AAPCC. He testified that most importantly through the development of a new HMO payment formula, Medicare beneficiaries in rural America would enjoy the same variety and range of plans available in urban America. Decreasing risk selection and ensuring greater access to choices must be a fundamental thrust of Medicare reform. **Wyden's** bill also streamlines the appeals process and provides qualitative reports on the performance of plans.

Testimony of Panel II

Butler's testimony indicated that the FEHBP offers a wide range of plans, with a variety of

by a competitive bidding process. He recommended including risk adjustment provisions and retaining Medicare's fee-for-service option. Thorpe concluded that long-term structural changes are needed to realign Medicare with the private sector, prevent higher beneficiary costs, and to continue improved quality of care.

Questions and Answers

Chairman Roth inquired about HCFA bidding out Medicare's fee-for-service to private contractors. Reischauer recommended against this approach, because it would result in increased political pressure upon Congress to expand benefits. Rather, plans such as PPOs and PSOs should be permitted to provide a fee-for-service option. Butler agreed that contracting would be a wise approach, because the Medicare system is too vast for a bureaucracy to micromanage every aspect of fee-for-service. Plans should compete on their ability to deliver health care services through an open, competitive market. The Chairman inquired about a Medicare budget strategy. Thorpe suggested that we can continue to decrease payments to providers or develop a system which promotes competition among managed care plans to achieve savings.

Moynihan inquired about a drop in private health care costs. Thorpe explained that private premium reductions have occurred as a result of a 20 percent increase in managed care participation. If Medicare is restructured in the same way as managed care, Medicare's premiums would drop to about 4.7 percent annually. Moynihan asked about how teaching hospitals have been affected by managed care. Thorpe acknowledged that increased competition has created savings, but this has resulted in increased pressures on the uninsured. He recommended that Congress may wish to respond to these added pressures through increased GME payments. Moynihan concluded that increased competition is adversely affecting the public good, because more teaching hospitals are undergoing mergers. Thorpe agreed that more mergers are occurring.

Breaux explained that Medicare is currently overpaying HMOs. Medicare pays HMOs around \$2 billion annually, because its reimbursement is based on fee-for-service and not competition. The current system of Washington bureaucrats trying to micromanage health care is not working, because we do not know which drugs or services should receive reimbursement. Breaux urged Medicare reform based on competition which includes risk adjusters and standard benefits. Reischauer agreed that these problems should be corrected. Butler added that the government should not micromanage health care. He explained that the FEHBP model allows for payment variations. Breaux concluded that the FEHBP model offers more opportunities for beneficiaries than the current system. **Roth** commented that 41 percent of FEHBP enrollees are retirees which is a good indication that this approach is applicable for our seniors.

Mack inquired about concerns with the FEHBP model. Butler expressed concern with a lack of fixed benefits, but that this can be addressed through negotiations. Reischauer emphasized the importance of competition and the need to reduce regional reimbursement variations. Competitive bidding and risk adjusters are needed. **Bryan** agrees that the current Medicare system is inadequate, and a competitive model is needed. Bryan inquired if an FEHBP model will result in

an increase or decrease in beneficiaries' payments. Butler explained that it would be better to allow plans to address beneficiary needs and the level of payment depends upon the government's contribution. Reischauer added that savings achieved could be used to enrich the benefits package. Bryan indicated that higher beneficiary costs are not politically acceptable. Reischauer emphasized that Congress must build Medicare's infrastructure to meet the next century's needs. With an establishment of a competitive market, beneficiaries will become more familiar with a new system by 2005. Medicare's benefits could be gradually expanded.

Jeffords inquired about Medicare fraud and abuse. Reischauer stated that through a capitated system, fraud and abuse will be controlled by plans. This approach would be more effective than HCFA's anti-fraud efforts. Butler added that employees under the FEHBP demand quality standards information. Thorpe believes that the FEHBP model ensures that quality measures will be collected and provided in an understandable manner. **Moseley-Braun** indicated that seniors are concerned about quality issues and the FEHBP model appears to be a single payer system. Butler replied that he grew up under a single payer system in Great Britain and assured the Senator that the FEHBP model is significantly different. Reischauer agreed that it is not a single payer system. Thorpe added that the majority of FEHBP participants are very satisfied with their plans. **Moseley-Braun** stated that the FEHBP's quality measurements are not timely. Thorpe acknowledged that improvements are needed.

Rockefeller expressed concern with the possibility of Medicaid expansions forcing insured beneficiaries out of private insurance. Thorpe indicated that this has not been the case. Rockefeller emphasized the importance of ensuring that our seniors have health insurance portability.

Testimony of Panel III

Anderson testified that the FEHBP has been an effective model for Kaiser Permanente in providing integrated health care to its members. He recommended that an FEHBP model for Medicare should ensure that prices will reflect efficient costs, reward beneficiaries who join efficient, high quality plans, and competition should not be based on gaming which cause markets to fail. It is critical that Medicare discourages inappropriate bidding, such as low-balling. Competition should allow flexibility to respond to enrollees and group purchasers, and competition should achieve market stability. Anderson confirmed the need to include risk adjusters, open enrollment, and greater standardization and efficiency in quality measurement.

Hustead's testimony indicated that the Office of Personnel Management conducts annual, intensive negotiations with the FEHBP's health plans regarding benefits, premiums, and communication. Enrollees have open annual enrollment. Medicare's beneficiary costs are almost triple the cost for an FEHBP participant. Hustead explained that this is due largely to the fact that the average income for Medicare's enrollees is much lower than for the FEHBP population. He stated that the FEHBP and the private sector have experienced low health care expenses because of tighter management controls. The FEHBP plan is about 10 percent lower than the average

value of a private sector health plan, because of lower dental reimbursements. The FEHBP is able to respond more effectively to developments in health care design and financing more rapidly than Medicare. Major changes in Medicare require an extensive legislative process. He does not believe that an open bidding process will work for Medicare. Husted concluded that a reasonable goal for competition in Medicare would be to provide three nationwide options involving fee-for-service, PPOs, and HMOs with point of service options.

Wyckoff testified that the National Council of the Aging is studying the benefits of a Medicare Consumer Cooperative. If an MCC could bargain on behalf of older persons, seniors would be able to obtain the benefits of purchasing as part of a group which would mean lower costs or enriched benefit packages. The National Council is working closely with HCFA to explore the possibility of implementing an MCC demonstration. Wyckoff stated that purchasing cooperatives are one innovation which has shown promise for reforming the health care market. For instance, Florida and California have state-sponsored purchasing cooperatives for employers. Wyckoff added that the FEHBP is also an important example of a purchasing alliance. He indicated that a properly structured MCC could allow for market forces to address the risk adjustment issue. MCCs have broad support because this approach is market oriented and involves collective bargaining.

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TO: JULIE JAMES Gre CJ

Medicare/FEHBP

I still want to

have these materials on
all of them in one
place. Thank you

(CJ)

STATEMENT OF
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MAY 21, 1997

Introduction

Mr. Chairman and members of the Senate Finance Committee, I am pleased to be here to examine the potential role of the Federal Employees Health Benefit Program (FEHBP) as a model for the Medicare program. Adopting an FEHBP style approach within the Medicare program would, according to its supporters, increase the number of plans beneficiaries could choose, provide a structural change in the program that would provide the opportunity for on-going cost savings, and would create incentives for continuous improvements in the quality of care. My comments will focus on three areas; first, what transitional steps would be required to move the Medicare program closer to an FEHBP type mode?. Second, if Medicare adopted an FEHBP type model, what changes in policy should be considered, and finally would an FEHBP style approach promote the three policy goals I noted earlier?

Prior to examining these issues, it seems critical to outline briefly the case for and against large-scale structural changes in the Medicare program. As I noted above, the case for structural reforms in the program may, in part, be judged against several criteria including their ability to contain long-term program costs, increase choice of plans and providers for beneficiaries, and to continuously improve the quality of care provided Medicare beneficiaries. These issues are examined briefly below.

Cost Containment

One of the goals of a restructured Medicare program would be to re-align the per enrollee growth in Medicare spending with the growth in private health insurance. At least through 1993, per enrollee growth in Medicare spending has been lower than the private sector. The recent substantial shift of private sector workers and their families from fee-for-service to managed care over the past three years changed this trend. Between 1993 and 1995, private health insurance increased 3.5 percent per enrollee compared to 9.7 percent for the Medicare program (see Figure 1). With respect to the future, the Congressional Budget Office projects that private health insurance will rise at 4.7 percent per enrollee and Medicare at 7.5 percent per enrollee. However, the recent budget agreement between the President and Congress would reduce the per enrollee growth in Medicare spending to 4.4 percent over the next five years-- 0.3 percentage points below that expected in the private sector. Thus, the case for structural reform, it would appear, seems to hinge on the ability of the reforms to sustain this rate of growth past the year 2002. Alternatively, it could be argued, the more incremental changes made recently to Medicare payments to HMOs under its risk program could, if coupled with continued savings generated in provider payments, yield a similar rate of growth that the broader structural changes would yield. However, even with Medicare rising at rates slightly below the expected growth in the private sector, the Medicare HI trust fund is still expected to be exhausted before the year 2010. In short, simply re-aligning the growth in Medicare spending with the growth

in private health insurance spending will not, by itself, provide a long-term solution to financing problems plaguing the HI trust fund.

Despite this limitation, the question is whether an FEHBP type structure could mirror the expected growth in private sector premiums overall. By the nature of how the FEHBP negotiates premiums with the locally rated managed care plans, the answer is likely *yes*. The FEHBP currently uses a version of *most favored customer* status where managed care plan premiums charged the FEHBP have to be substantially similar to those charged in the commercial market. In addition to the bargaining power exerted by the Office of Personnel Management, this process allows the program to piggyback on savings generated more broadly by other private sector purchasers.

The recent experience with the growth in FEHBP premiums has been favorable. Premiums for the Blue Cross standard option plan were virtually the same in 1995 and 1997. Across all plans, the growth in premiums have averaged under 4 percent per year, similar to growth among private sector managed care plans.

Though recently the FEHBP has reduced the growth in health insurance premiums, the methods used to determine both the government's contribution and the fact that the fee-for-service plans must charge a single, national premium have resulted in some anomalies. The national rate charged by the fee-for-service plans creates substantial pricing pressure for the locally rated managed care plans in high health care cost areas while allowing managed care plans in low health care cost areas more pricing flexibility. In high health care cost areas, the national (standard option) fee-for-service plans are generally the lowest priced plan in the market. This places substantial competitive pressure on locally rated managed care plans to lower their premiums, either by reducing the administrative costs, in some cases providing less generous benefits, or simply increasing the efficiency in which they provide services. In contrast, managed care plans in relatively low health care cost markets are able to shadow price the national fee-for-service plan.¹ As a result, the variation in managed care premiums across the country are compressed relative to the variation in premiums observed among managed care plans in the private sector as well as the variation in the Medicare AAPCC (see Table 1).²

Table 1. Variation in State Average FEHBP and Private Sector Health Insurance Premiums

	Low	Average	High
FEHBP	.86	1	1.13
Private Health		.72	1.25

¹In low cost areas, managed care plans have an incentive to increase benefits since consumers pay 25 percent of each additional dollar in premium costs. In contrast, in high cost areas where premiums are often above the maximum dollar federal contribution, the incentive to add benefits is reduced as consumers must pay the full dollar for each dollar of additional benefits added.

²Medicare AAPCC payments exhibit substantially greater variation relative to the FEHBP for two reasons; first the FEHBP fee-for-service plans charge a single national rate, whereas the fee-for-service Medicare program pays locally. Second, Medicare uses the county as the unit of payment while the FEHBP relies on a larger unit of plan payment, the plan service area. Use of the larger market area in the FEHBP reduces the variance in premiums. By the same token, there would be less variation in Medicare payments to HMOs if a larger market area were used to determine plan payments.

Plans

SOURCE: Office of Personnel Management, and survey results from the Health Insurance Association of America, KPMG Peat Marwick and InterStudy.

The results in Table 1 highlight the relative lack of variation in managed care premiums in the FEHBP program relative to premiums quoted in the commercial market. Whether alternative plan rating decisions (for instance, allowing the fee-for-service plans to locally rate) would reduce the growth in FEHBP spending remains an empirical issue.³

Plan Choice

FEHBP eligibles often face several different health plans to select from, including fee-for-service plans, HMOs and point-of-service plans. Several choices are common in less densely populated and more rural areas; for instance FEHBP eligibles living in the Hudson Valley (north of New York City up through Albany) could have 10 to 20 different plans to choose from. The FEHBP experience here contrasts sharply with the experience of the number of plans offered by private employers. As of 1996, 50 percent of private sector employees were offered only 1 health plan.

Plan Satisfaction and Quality

Few direct measures of the quality of care are available within the FEHBP. The OPM does, however, survey members concerning their satisfaction with over 300 health plans. These reports are available widely to FEHBP eligibles during the open enrollment season. Member satisfaction with plans seems relatively high (see Table 2). Only 15 percent of members noted their were dissatisfied with their health plan.

Table 2. Percent of FEHBP Respondents Satisfied with Fee-for-service and prepaid health plans, 1995

	<u>Fee for Service</u>	<u>Prepaid</u>
Extremely Satisfied	20%	19%
Very Satisfied	43%	45%
Somewhat Satisfied	22%	22%
Dissatisfied or Neither Satisfied or dissatisfied	15%	14%

SOURCE: Checkbook Guide

³The impact of the FEHBP contribution formula is one of several institutional features of the program currently part of an on-going two year study at Tulane funded by the Robert Wood Johnson Foundation.

While the brief discussion above suggests an FEHBP type model has, relative to other private sector approaches, performed competitively, adopting this approach within the Medicare program would require several substantial changes in Medicare policy. Indeed, several critical differences exist between the FEHBP and current Medicare policies, including;

- ☐ The FEHBP conducts an annual open enrollment, whereas most HMOs in the Medicare program have continuous open enrollment, allowing beneficiaries to join at anytime. Beneficiaries can also disenroll each month.
- ☐ The methods used by Medicare and the FEHBP to pay plans differ significantly. Medicare payments are set in advance based on the Average Adjusted Per Capita Cost (AAPCC). The AAPCC is based on the experience of the fee-for-service sector. In contrast, the FEHBP pays each plan a fixed dollar amount up to 75 percent of the plan premium. The fixed dollar amount is set at 60 percent of the average premium charged by the Big Six plans.
- ☐ Plan rating differs substantially between the FEHBP and Medicare risk HMOs. Under the FEHBP, fee-for-service plans (for example Blue Cross standard option) charge a single national premium. The FEHBP pays \$134.83 per month for each person enrolling in the Blue Cross standard option plan, with the FEHBP enrollee paying \$44.94 per month for single coverage in New York City, New Orleans or even Indiana, Pennsylvania. In contrast, managed care plans are rated locally. As Medicare payments to hospitals, physicians and other providers in the traditional program vary across and within states, the AAPCC also varies dramatically. As a result, there is substantially greater variation in payments to managed care plans under the Medicare program than exists in the FEHBP.
- ☐ The FEHBP does not make risk adjusted payments to health plans, while Medicare attempts to account for risk using the AAPCC.

With these differences in mind, I turn next to issues concerning a transition from the current Medicare program to one using the FEHBP as a model.

Transitional Steps

As my discussion above illustrates, several important changes are required to move Medicare from its current program structure to an FEHBP like model.

- ☐ *Expand the number and variety of health plans available to Medicare beneficiaries.*

Under current law, HMOs are generally the only choice Medicare beneficiaries seeking alternatives to traditional Medicare currently have. In contrast, managed care arrangements in the private sector and the FEHBP include a broader array of plans, including several hybrid plans such as point-of-service and preferred provider plans. The majority of private sector employees and their families enrolled in managed care plans are enrolled in these hybrids (41 percent versus 33 percent in HMOs). Efforts should continue to expand the range of plans offered, and their diffusion across currently underserved areas.

☐ Redefine Managed Care Market Areas

Managed care plans in the private sector negotiate rates with purchasers over an entire plan service area, which often includes entire metropolitan statistical areas or even further. This is also the case with the locally rated managed care plans--the FEHBP negotiates premiums with such plans within a service area. Medicare uses the county as the payment catchment area. This allows health plans to selectively pick their areas of activity; perhaps choosing to offer services in high AAPCC counties and not in lower AAPCC counties within the same general geographic area.

☐ Risk Adjustment Demonstrations

The FEHBP does not risk adjust payments to health plans. This has generated substantial self-selection. Selection is exacerbated by the existence of both high and low option plans operating the same market. As the number and variety of plans expand, the next generation of the AAPCC will be needed. Several promising approaches that improve on the current method are in progress, including Ambulatory Care Groups and Hierarchical Co-existing Conditions (HCC). Blended approaches mixing fee-for-service and capitation may also prove promising.

Key Design Features of an FEHBP Model As Applied to Medicare

As the discussion above highlights, the adoption of an FEHBP-like model within the Medicare program would require fundamental changes in the program. These changes, and the policy options surrounding them, are outlined briefly below.

☐ Annual Open Enrollment. The FEHBP provides an opportunity for members to select their health plan each year. Medicare beneficiaries currently enjoy nearly continuous enrollment and disenrollment opportunities. Moving toward an annual enrollment process would represent a major change in policy, and would require fundamental changes in the manner in which beneficiaries interact with the Medicare program.

☐ Submission of Bids By Health Plans. Health plans develop their bids for the Medicare program by estimating their costs of providing Medicare benefits (the adjusted community rate) and comparing it to Medicare's AAPCC based average payment rate (APR). This is a formula-based approach to determining plan premiums. In contrast, the FEHBP accepts bids from the Big Six plans, and then negotiates rates locally with managed care plans. Movement to an FEHBP style program would change the process of generating plan premiums from a formula based approach to a competitively bid/negotiated one.

☐ Establishing Medicare Payments to Health Plans. Perhaps the most controversial, and certainly among the most important issues a structural change in Medicare faces is how the program would determine payment rates to health plans. Within a competitive bidding process, the Medicare program would face several policy design options. A common element across each of these options is de-linking Medicare's payments to health plans from the experience in the fee-for-service sector. In establishing its contribution, Medicare could:

• Solicit bids from health plans in each area, and base its contribution on the lowest bid in each market. Alternatively, Medicare could base its contribution on the second lowest bid, or some percentile of the bids (e.g. the 50th percentile);

• Solicit bids from health plans in each area, and bargain multilaterally with each plan over the premium charged and scope of benefits offered. The bidding process would stop when either the Health Care Financing Administration (HCFA) or the health plan agreed on a counterproposal;

• Solicit bids from health plans, but link their contribution to an external index such as the consumer price index, the projected growth in per capita private health insurance, or changes in gross domestic product;

• Use an approach similar to the current FEHBP model. Here, HCFA could demand that health plans quote (with appropriate adjustments) a rate similar to that offered through the commercial market. This would ensure that the growth in managed care premiums within the Medicare program and the private sector increased at similar rates (this would be similar to the current "most favored customer" approach used by the FEHBP);

☐ *The Role of Medicare's Traditional Fee-for-service program.* Another critical design issue facing any reform of the Medicare program is the structure of Medicare's fee-for-service program. Structural changes in the program along the lines of an FEHBP program present at least two choices:

• Retain the current fee-for-service program as administered by HCFA or;

• Contract with health plans to provide the fee-for-service benefits;

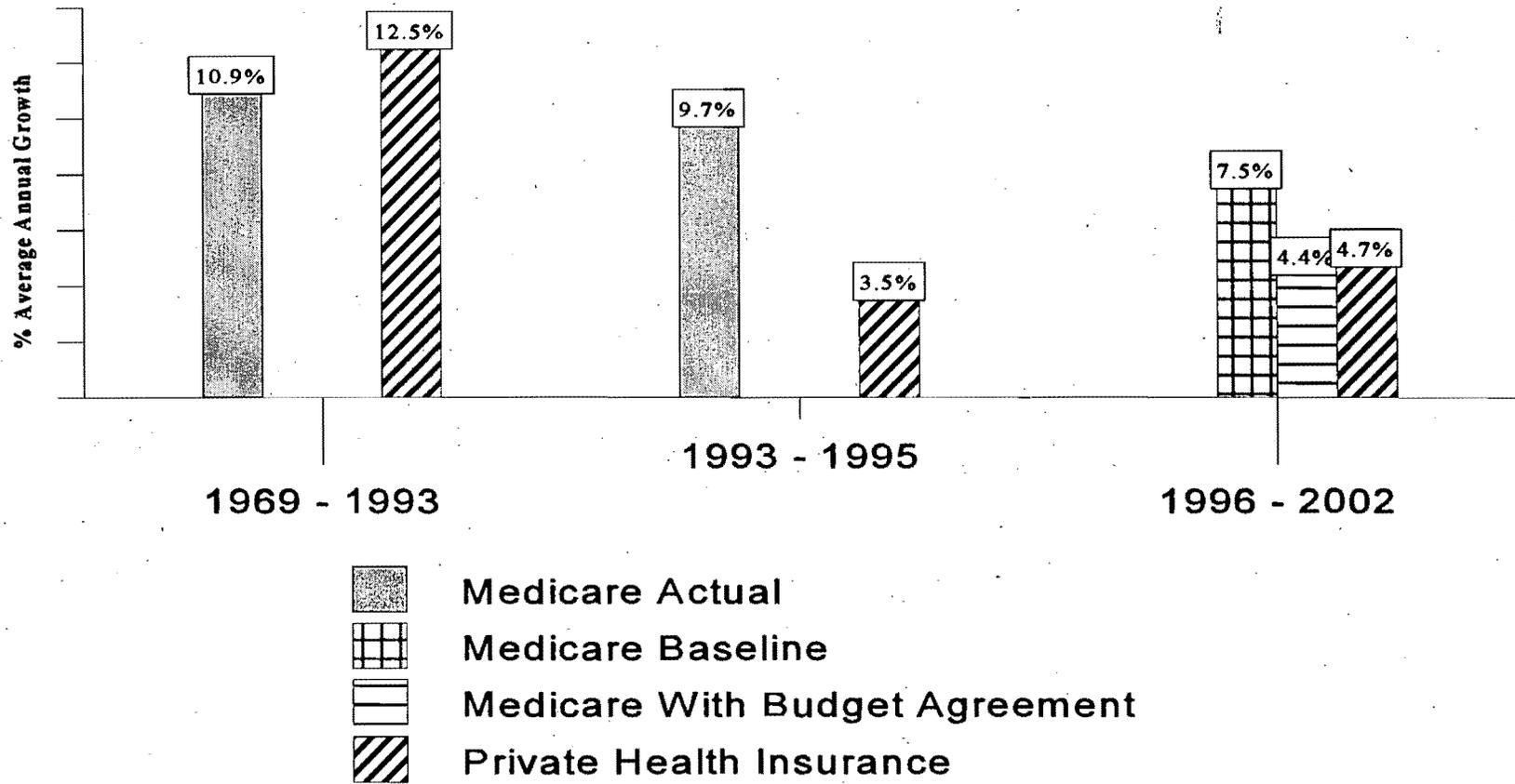
The second option is how fee-for-service benefits are provided within the FEHBP. These are the most popular plans in the program (approximately 30 percent of enrollees select one of the managed care options). A key issue if Medicare adopted this approach for providing fee-for-service benefits is whether the plans would face substantial adverse selection, undermining their ability to compete effectively with the managed care plans. If this approach were selected, it should be accompanied by an improvement in Medicare's current approach for risk adjustment (thus it seems key to include some form of risk adjustment demonstrations as part of any transitional step toward competitive bidding).

☐ *Beneficiary Protections.* Under current law, Medicare beneficiaries are provided information on plan benefits, premiums, cost-sharing, lock-in requirements, protection against balanced billing as well as grievance mechanisms. Improvements in these protections, many of which are in the planning and early stages of implementation in the Department of Health and Human Service (HHS), will be required. These include methods for distributing information to Medicare beneficiaries, as well as guidelines providing clear, consistent and accurate information concerning plan marketing during the open enrollment season.

Conclusions

As I mentioned at the beginning of my testimony, the recent budget agreement between the Congress and the President would re-align the expected growth in per enrollee Medicare and private health insurance expenditures. If desired, this should provide an opportunity for the Congress and the Administration to study, design and implement changes in the structure of the Medicare program for the next century. These structural changes will alter substantially how Medicare pays health plans, the role of HCFA, how health plans interact with Medicare and how beneficiaries interact with the program. In light of magnitude of these changes, a substantial transition period will be required to design relevant changes in the program, evaluate their performance within the Medicare program, and make appropriate changes. While creating an approach that will re-align the growth in Medicare with the private sector is a desirable policy objective, great care should be paid to assure that beneficiaries do not face high out-of-pocket costs and that the quality of care they receive continually improves.

Table 1: Historic and Projected Growth In Per Capita Private Insurance and Medicare Spending



Source: HCFA and CBO Projections