

STATEMENT FOR THE RECORD

BY

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HEALTH CARE FINANCING ADMINISTRATION

ON

"CONSUMER INFORMATION IN MEDICARE MANAGED CARE"

SENATE COMMITTEE ON AGING

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## INTRODUCTION

Mr. Chairman and members of the Special Committee on Aging, I am pleased to submit testimony for the record which describes the Health Care Financing Administration's (HCFA) strategy to disseminate Medicare information to beneficiaries, particularly information involving managed care. One of our highest priorities is making sure that beneficiaries receive timely, accurate, and useful information about their health plan options. We certainly agree with the old saying, "knowledge is power." Beneficiaries who possess information about health care options have the ability to make wise decisions about their well being. Making wise choices about health care options can help beneficiaries receive preventive care, possibly avoid illnesses and costly treatments, and for many, recover from sickness. Expanding beneficiaries' knowledge, so that they can choose a health plan to best meet their needs, is cost-effective and the right approach.

Currently, HCFA is undergoing an internal reorganization designed to enhance our beneficiary-centered focus. The reorganization will be complete by this summer and will enable HCFA to respond more efficiently to rapid changes occurring in health care so that we can better serve our beneficiaries. Three separate HCFA divisions are being established to focus on our three primary audiences, which include our beneficiaries, the health care plans and providers who care for beneficiaries, and the states who partner with us in serving our Medicaid beneficiaries. This customer model is similar to markets in the private sector. It recognizes that driving forces behind current changes in the nation's health care system are not internal to the agency, but external. Just as in the commercial health care system, managed care is emerging as an integral and rapidly growing part of our operations. Therefore, it makes sense to integrate managed care and fee-for-service operations throughout the agency, rather than to maintain a separate Office of Managed Care, for example. Similarly, we are combining the Medicaid Bureau, survey and certification operations, insurance regulation, clinical laboratory regulation, and intergovernmental affairs into the Center for State Operations.

HCFA's new organizational structure focuses on the beneficiary as HCFA's ultimate customer by establishing, for the first time, a component dedicated explicitly to understanding and meeting the needs of beneficiaries. The Center for Beneficiary Services (CBS) will exist to protect, serve, and to be an advocate for beneficiaries. It is designed as the focal point for all of the agency's interactions with beneficiaries, their families, care-givers, and other representatives of beneficiaries. The CBS will provide information to help beneficiaries and concerned parties make informed decisions about their health care and program benefits administered by HCFA. It will assess beneficiary and consumer needs, design and implement beneficiary services' initiatives, and develop performance and evaluation programs for beneficiary services activities. The CBS will develop national Medicare policies and procedures for eligibility, enrollment, entitlement, coordination of benefits, managed care enrollment and disenrollment, and appeals. New methods to improve health care delivery systems from the perspective of our beneficiaries will be developed and tested through demonstrations and interventions. Contracts and grants involving customer service will be handled by the Center, and it will coordinate the activities of Medicare's contractors.

Our restructuring is moving HCFA in the right direction. As the Medicare and Medicaid programs evolved over the years, new programs and projects were layered onto existing structures. Over time, this became cumbersome and often confusing. Successfully implementing a more beneficiary responsive agency will facilitate our ability to effectively respond to the needs of beneficiaries. This is an important structural development as we build the bridge to the 21st Century.

This Administration is serious about promoting beneficiary and consumer information through ensuring a more beneficiary-centered agency. We have been working hard on strategic measures to strengthen this goal. Our overall strategy involves numerous initiatives such as making available comparative information about plans; strengthening beneficiary education through our Competitive Pricing Demonstration; conducting beneficiary surveys; offering beneficiary counseling and assistance; ensuring unrestricted medical communication; and making available many publications and resource materials. HCFA's initiatives are designed to ensure that our beneficiaries and consumers receive information necessary to compare fee-for-service or managed care options and enable them to choose the right plan for their needs. Under this Administration, HCFA's efforts are firmly focused on helping beneficiaries and consumers obtain information about their health care plan options. By furthering this goal, our beneficiaries will receive the best value for their investment.

#### **GAO's REPORT ON MANAGED CARE DATA**

Late, last year, the Senate's Special Committee on Aging released recommendations submitted by the General Accounting Office in a report entitled, "Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance." The Department of Health and Human Services and HCFA agree with the GAO that Medicare beneficiaries need more information and that informed beneficiaries can hold plans accountable for the quality of care. HCFA's beneficiary and consumer initiatives, which I will soon describe, have directly responded to GAO's suggestions and comments. We are confident that our current strategy is the right one in resolving GAO's concerns.

We believe that our numerous initiatives, programs, and publications are contributing to a stronger Medicare beneficiary-centered program and agency. Our efforts have already begun to make a significant difference in the way in which beneficiaries and consumers choose their health care plans. As we continue to develop and implement our strategies, beneficiary and consumer information about Medicare choices will be enhanced.

One of the GAO's recommendations was that we make disenrollment data available to our beneficiaries. Currently, we use plan specific disenrollment data generated by our systems to assist us in determining which plans need more focused reviews or monitoring. There are a number of reasons that beneficiaries disenroll. A careful analysis in the context of a particular plan's activities and its market of operation needs to be conducted before any meaningful

conclusions can be drawn from disenrollment data. We are currently evaluating the different ways in which disenrollment rates, across plans, can best be expressed and presented, so that beneficiaries can use this data, in conjunction with other plan-specific information, to make good choices among plans. Ultimately, we plan to provide appropriate disenrollment data in HCFA's comparability charts. At this time, I would like to describe some of our initiatives.

## **HCFA's BENEFICIARY AND CONSUMER INITIATIVES**

### **Comparative Information**

We wish to make comparative information available to all Medicare beneficiaries to assist them in making appropriate health care choices. Currently, some of HCFA's regional offices sponsor and disseminate comparative information for beneficiaries. For instance, HCFA's San Francisco, Seattle, Philadelphia, and Denver regional offices are in the process of distributing comparative information. Charts compare benefits offered by area plans, including payments for hospital coverage, physicians and specialists, home health care, emergency care, preventive services, pharmacy benefits, dental, and mental health coverage. In the near future, we plan to provide information regarding Medicare's managed care beneficiary satisfaction surveys and the Health Plan Employer Data and Information Set (HEDIS). HEDIS is designed to provide quantitative and qualitative data on the performance of health plans. This data source is helpful because it includes information about the effectiveness of care, access and availability of care, health plan stability, use and cost of services, and a description of health plans.

Building on these pilots, HCFA plans to make current, comparative data on cost and benefits, and other information available for all plans nationwide. We are working on making comparative information available on the Internet and to beneficiary insurance counseling centers, HCFA Regional Offices, and others with Internet access. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements. Individuals will be able to use HCFA's Internet Web site to retrieve data which will be helpful in making informed decisions about plan options. Currently, the majority of beneficiaries do not have a direct link to Internet. However, beneficiary and consumer advocates, insurance counselors, and public entities who are the most frequent sources of beneficiary advice and counseling do possess this technology, and it will become an even better source for helping to disseminate this data. Our beneficiaries will greatly benefit through this widely accessible and user-friendly data source.

Under the President's 1998 Budget Plan, we seek to further empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand. The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options -- both managed care and Medigap. To help beneficiaries compare various plans, standardized packages for additional benefits offered by managed care plans would be developed. Adjustments would then be made to the current standard Medigap packages to

make comparison easier for beneficiaries. Medigap plans would be required to operate under the same rules followed by Medicare managed care plans. Plans would be required to offer community rated policies and to participate in coordinated open enrollment periods. In addition, plans would be precluded from imposing preexisting condition exclusions.

### **Competitive Pricing Demonstration**

HCFA is currently working to implement a Competitive Pricing Demonstration located in Denver, Colorado, which includes three major components: 1.) Beneficiary education; 2.) Enrollment by a neutral third-party; and 3.) Bidding process for rates. The first and second components relate to beneficiary information. This demonstration is designed to enable Medicare to make the transition to operating like other large payers.

Medicare's beneficiaries in this demonstration will have a guaranteed open enrollment period, slated for the Fall of 1997, during which they will be able to enroll in any of the local Medicare managed care plans. This managed care demonstration will use competitive bidding to set payment rates and will help beneficiaries to be more informed consumers, which will foster competition among plans. A main feature of the project is an expanded, intensified information and education effort. It is designed to test a range of new educational and informational resources for beneficiaries --- including new formats of printed materials, in-person seminars, and a 1-800 hotline. We plan to provide area-specific health insurance option comparison charts, including detailed comparisons of the Medicare managed care plans available in the area. There will also be opportunities for beneficiaries to view brief educational video tapes and taped presentations of the seminars. A special contractor, BENOVA, Inc. of Portland, Oregon, not affiliated with any of the plans, will be available to counsel beneficiaries and will handle the enrollment functions. Beneficiaries wishing to remain in Medicare's fee-for-service or who are already enrolled in a Medicare managed care plan and want to remain in that plan will not need to take any action to retain their existing arrangement. The goal of these resources is to help beneficiaries understand their options under Medicare and to help them make the best choices for their circumstances --- whether it is choosing between fee-for-service and managed care or choosing among various managed care and Medigap options.

We believe that the Denver project will provide beneficiaries with everything they need to be informed consumers, which is essential for this competition to work. In addition, beginning in 1999, payments to managed care plans will be adjusted for risk based on health status measures. Plans will be paid more for enrolling people with disabilities, certain chronic health conditions, or expensive care needs. We expect to learn the fairest way to pay HMOs and to build upon the traditional American reliance on the free-market. It is anticipated that in 1999, we will implement similar competitive pricing demonstrations in two other sites, yet to be determined.

We are encouraged by the strong support of health care experts who believe that there is a right way to implement market-oriented concepts. We are disappointed that some health plans, despite their stated support for a market-oriented approach, oppose these demonstrations. We have been

and will continue to work with these health plans with the hope that plans will end up agreeing with us in this important area of intense study.

### **Survey of Managed Care Plan Enrollees**

In cooperation with HCFA, the Agency for Health Care Policy and Research (AHCPR) initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare managed care beneficiary satisfaction survey. This survey provides information from Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1, of this year, HCFA is requiring all health plans to use CAHPS. We plan to include the results of the beneficiary survey in HCFA's comparability charts so that beneficiaries have important information about particular plans.

### **Health Insurance Advisory Program**

The Health Insurance Advisory Program (HIA) is designed to develop and strengthen the capability of states to provide Medicare beneficiaries with information, counseling, and assistance on adequate and appropriate health insurance coverage. Funding for this program supports information, counseling, and assistance relating to Medicare and Medicaid matters, as well as Medigap, long-term care insurance, and other health insurance benefit information. The President's Fiscal 1998 Budget Proposal continues to provide funding for these health advisory services.

Over half of the states had attempted to deliver counseling and assistance services to Medicare beneficiaries before the HIA grant program began. The significant interest in this effort, shown by states, attests to the perceived need for such services. Currently, all 50 states, as well as the District of Columbia, Puerto Rico, and the Virgin Islands participate in the HIA grant program. Two-thirds of the HIA programs are administered by states' Department on Aging, and one-third of the programs are based in the states' Department of Insurance.

The primary modes of delivering HIA services to Medicare beneficiaries and their representatives are face-to-face counseling, telephone hotlines, and outreach activities. The majority of programs have incorporated a combination of these methods into their programs. In counseling sessions, beneficiaries usually come to a central meeting place, such as a senior center or library, to meet with an HIA volunteer. Counseling sessions focus on general information, education, enrollment, claims forms, and the appeals process. The HIA's volunteers often answer questions about what Medicare pays and assist in solving claims and billing problems.

We are pleased to report that the HIA program is helping to improve the lives of beneficiaries in this country. In Iowa, through the state's Iowa Department of Elder Affairs, the HIA program provides funds to the state's Insurance Division, Senior Health Insurance Information Program (SHIIP). Through this project, Iowa's senior volunteer counselors perform valuable services to beneficiaries.

Let me share with you an example of an HIA-related beneficiary experience. The caretakers of a beneficiary, which we refer to as Sarah, received advice from a SHIIP volunteer. Sarah had three long-term care policies, two Medicare supplemental policies, and five other health insurance policies of limited coverage. As a result of a volunteer's counsel, the caregivers canceled duplicative policies and saved Sarah more than \$4,400 in insurance premiums annually. The HIA program successfully serves beneficiaries in other states, such as in Louisiana where the state grantee is the Louisiana Department of Insurance, and the state counseling program is also known as SHIIP. Louisiana's program has 35 counseling sites located throughout the state, which provide counseling services to thousands of beneficiaries each year. It is estimated that during 1994 and 1995, this program saved clients in Louisiana over half a million dollars involving health insurance related concerns.

HCFA's regional offices have been instrumental in building partnerships with the HIA programs and other organizations directly affected by the HIA. For instance, HCFA's New York office sponsored a conference which brought together representatives from HIAs, peer review organizations, carriers and intermediaries, the Social Security Administration, and state and local Agencies on Aging. This event created a forum for the exchange of information and customer service techniques. The majority of beneficiary concerns, as reported by the HIA programs, continue to focus on Medicare supplemental insurance issues, including an explanation of the ten standardized plans and the process to determine which plan best fits a beneficiary's needs. Other issues that rank high among beneficiary concerns include what is covered under Medicare, obtaining prescription coverage, obtaining insurance for the disabled, and dealing with primary and secondary insurance issues. The HIA programs provide an invaluable service to HCFA, supplying much-needed information and assistance, as well as a vital link for HCFA, to the Medicare beneficiary.

### **Unrestricted Medical Communication**

The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, physicians who participate in the Medicare program are required to make beneficiaries aware of the full range of treatment options. Managed care enrollees are entitled to the same advice and consultation. This is a basic right of the patient.

This past November, we communicated the prohibition of gag clauses contained in managed care HMO contracts through an agency policy instruction to health plans. All of Medicare's risk contractors were sent HCFA's operational policy letter prohibiting the use of gag clauses. Last month, HCFA sent an administrative notification to all 50 State Medicaid Directors reminding them that gag clauses are prohibited. President Clinton has made it clear that he supports legislation to ensure that physicians who participate in managed care plans are free to discuss the full range of treatment options.

## **National Marketing Guidelines**

For the past year and a half, HCFA has been working with representatives of the managed care industry, such as the American Association of Health Plans, and senior advocacy organizations to clarify and to simplify the regulation of managed health care marketing activities to Medicare beneficiaries. This collaborative effort has produced the "National Marketing Guidelines for Medicare Managed Health Care Plans." These guidelines provide a uniform code of acceptable marketing practices which can be applied on a national basis to managed care entities participating in the Medicare program. As a result of this initiative, Medicare beneficiaries will receive marketing material that is consistent, accurate, and timely. In addition, the guidelines will clarify HCFA's policies regarding promotional materials, value added services, and marketing through health care providers.

We anticipate having this new national marketing initiative available on the Internet as early as this month. Medicare managed care health plans that are members of the American Association of Health Plans (AAHP) will be notified by that organization of this added service. Contracting health plans that are not AAHP members will be notified by HCFA. Interested parties may request a hard copy of the document to be mailed. Once the guidelines are available, there will be a 45-day interim period prior to implementation. During this interim period, HCFA and the contracting health plans will communicate directly to ensure that sales and marketing practices are consistent with the standards. Open communications will ensure that health plans properly understand the guidelines' criteria and instructions.

## **Beneficiary Information Dissemination**

HCFA's Consumer Information Program (CIP) is a highly visible public education campaign directed toward improving the health of Medicare and Medicaid beneficiaries. It is a nationwide effort led by HCFA in partnership with the Public Health Service. The program conducts public health campaigns, provides customer-friendly health education messages, and encourages greater use of HCFA's preventive health care benefits, such as flu and pneumonia immunizations and screening mammograms.

In addition, HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.

The Medicare Handbook includes useful beneficiary information regarding the Medicare program, supplemental Medigap insurance, and managed care plans. It describes who is eligible for Medicare, how to enroll for Medicare, and what hospital and medical expenses are covered by Medicare, including how much of the bill beneficiaries are responsible for paying. The handbook

provides a detailed description of the different services covered under Medicare Part A and Part B, including a listing of requirements which beneficiaries must meet. It is user-friendly, because the handbook includes numerous examples of services, benefits, deductibles, and copayments. An added feature of the handbook is a state-by-state telephone listing of insurance counseling centers, Medicare carriers, peer review organizations, and durable medical equipment regional carriers available for further information.

### **Community-based Medicare Information Resource**

This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall, and it is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also be available, using technology such as interactive video-conferencing and computerized information kiosks.

### **National Toll-free Hotline**

To assure Medicare's beneficiaries with quick and easy assistance or information, we are in the process of piloting a single, national toll-free telephone number for complete and accurate answers to beneficiaries' questions. Currently, beneficiaries must call different toll-free numbers depending on the issue. HCFA maintains or supports more than 150 toll-free numbers nationally, with the total annual volume of calls equaling 34 million. Our market research indicates that beneficiaries are unsure of whom to contact and often must call several toll-free numbers to reach an agent who can address their problem. However, as a result of HCFA's streamlined hotline system, we anticipate reducing beneficiary confusion and increasing the number of calls that are resolved on the first contact.

We are pleased to let you know that as a result of our existing hotlines and in collaboration with the DHHS's Office of Inspector General's hotline, beneficiaries are able to report potential cases involving Medicare and Medicaid fraud and abuse violations. As soon as these fraud cases are reported, prompt action is initiated by either HCFA's intermediaries, carriers, peer review organizations, or the states in the investigation of fraud allegations. The Office of Inspector General with the DHHS also plays a vital role in fraud investigations and corrective action. We believe that our single toll-free line will enhance our ability to combat fraud, because it will be easier for beneficiaries and concerned parties to make calls about potential fraud and abuse.

### **Information Needs for Consumer Choice**

In an effort to assist HCFA in creating information which is easily understandable by our

beneficiaries, we awarded the Research Triangle Institute (RTI) a contract to develop and test prototype materials. HCFA plans to have this prototype language available by midsummer which will be helpful in making our Medicare and Medicaid managed care beneficiary publications more user-friendly. This project determined what consumers find most helpful in selecting their health insurance coverage. The RTI examined different types of information consumers use involving plans, providers, and physicians and practitioners in making their chosen health care plan system work best for them. Information needs vary across insurance groups. In general, Medicare beneficiaries were concerned with their access to current providers and the specialists of their choice, providers' communication skills, technical quality of care, and specific benefits relevant to their circumstances. Medicaid eligibles were most interested in access to after-hours care, provider choice, waiting time, and providers' communication and interpersonal skills.

Medicare beneficiaries consistently preferred a combination of individual or group presentations with printed reference material. Medicaid eligibles wanted group counseling sessions, similar to sessions, which they currently receive, but with the addition of detailed information on available plans. All participants indicated that they prefer receiving information from unbiased, consumer-oriented sources. Overall, traditional health plan information, such as premium amounts and benefit coverage, was the most common type of data included in the consumers' materials reviewed.

## **CONCLUSION**

As the largest purchaser of health care, we believe that HCFA has a responsibility to ensure that beneficiaries have the information they need to make the best possible health care decisions. As our many consumer activities demonstrate, we are constantly improving our commitment to being a beneficiary-centered purchaser. Recently, this Administration included beneficiary and consumer information improvements within the President's Fiscal 1998 budget proposal submitted to Congress.

President Clinton is personally committed to ensuring that our beneficiaries, particularly seniors, receive accurate, complete, and timely information regarding their health care options. This Administration's proposals ensure that comparative information, involving fee-for-service, managed care, and Medigap, will be made available to beneficiaries. With the help of Congress, we hope to make a difference in the lives of our beneficiaries through enactment of our legislative proposals. In addition, we are confident that our current initiatives and programs are making it possible for numerous beneficiaries and consumers to be better informed.

We believe that our multiple initiatives, publications, and proposals represent an effective strategy for the dissemination of Medicare information to our beneficiaries and can serve as a model for other purchasers. We look forward to working with this Committee to further strengthen the Medicare program through improved information dissemination.

## **“Want Structural Reform of Medicare? Take a (Second) Look at the Clinton Plan”**

**By Gene Sperling, National Economic Advisor**

Submitted to Roll Call on April 3, 1997

Lost amidst the usual rhetorical back-and-forth on the President's budget is any acknowledgment of the comprehensive structural reforms President Clinton has proposed to Medicare. In Medicare alone, the President's budget trims over \$100 billion in spending over 5 years, extends the life of the Trust Fund to 2007, and meets the last Republican offer on Medicare savings half-way.

Yet, cutting the deficit and restoring solvency to the Medicare Trust Fund, is only part of the challenge. Just as important is the need to make the structural changes necessary to modernize Medicare as we enter the 21st century and prepare Medicare for the retirement of the baby boom generation.

The President's plan takes significant steps to meet these challenges head-on. It adopts important lessons from the private sector, which has developed new techniques to control health care costs and improve quality. It revamps Medicare to reflect technological advances in medicine and the overall changes in the nation's health care delivery system. It lays the foundation for Medicare of the 21st century by restructuring payment systems, offering more choices for managed care, shifting to collective bidding, encouraging prevention and offering consumers more information.

Below is a reader's guide to a few of the Clinton structural Medicare reforms:

### **1. Restructures the Payment System for Medicare's Fastest-Growing Services.**

Medicare costs are skyrocketing for home health care, skilled nursing facilities, and hospital out-patient services. Those services account for most of the excessive growth in Medicare spending. Why are these costs rising so quickly? Today, Medicare pays for these services after the fact. This approach, where we tell health care providers that “we'll cover your costs,” creates incentives that lack cost-consciousness. Efforts to nip and tuck at the current system do not get at the root of the problem. As a result, costs have escalated dramatically. The President's budget restructures the entire payment system so that we set rates in advance. That will prevent health care providers in these areas from charging too much. These prospective payment systems build on the success Medicare has had in controlling hospital costs.

2. **Offers Consumers More Choices for Managed Care:** The President's budget provides Medicare consumers with more health care plans to choose from. Under the current law, Medicare can contract with only a narrow range of managed care plans. By allowing Medicare to work with Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs), the budget opens up new options that have proved popular and cost-effective in the private sector. More providers create more competition, and we know that competition can cut costs and improve service. Finally, the budget eliminates some of the impediments to choice that exist today. Under today's rules, many older Americans are reluctant to try managed care for fear that, if they don't like it, they will be unable to return to their previous Medigap plan. The President's budget removes those impediments by providing annual Medigap enrollment that gives older Americans a choice that is meaningful.
3. **Broadens Availability of Managed Care and Ensures that Medicare Trust Fund Shares in the Savings:** While we seek to give more options for older Americans to choose managed care, it is vital that we make sure that it is available in all portions of the country, and that it has a payment system that ensures that the Medicare Trust Fund shares in the savings. Today, the Medicare Trust Fund actually loses money on the average beneficiary that enrolls in a managed care plan rather than fee-for-service. That happens because managed care tends to attract relatively healthier Medicare beneficiaries, and we pay managed care carriers too much money for insuring them. The President's plan takes steps to remedy this well-documented overpayment through a one-time reduction of about 5 percent in HMO payments in the year 2000. It also fixes a quirky payment methodology that has led most rural HMOs to be underpaid. As a result of this flaw, virtually no Medicare beneficiary in rural America today has access to managed care. By recalibrating the geographic payment scheme, the President's budget will provide greater incentives for managed care enrollment in America's rural areas.
4. **Introduces Successful Competitive-Bidding Strategies to Lower Costs.** The President's Medicare plan also brings free-market principles to bear in the program. By leveraging the government's enormous buying power in the health care sector, the President's plan would get taxpayers a better deal and keep costs down. The Health Care Financing Administration ("HCFA") is the largest purchaser of health care services in the United States. We need to use that clout to lower costs, but, under the current system, Medicare often lacks the legal authority to do so. As a result, HCFA too often pays far more for medical supplies and durable medical equipment, for example, than other purchasers. Our budget would institute competitive bidding at HCFA to introduce market pressures and bring down costs. The President's plan also builds on innovative cost-cutting pilot programs like "Centers of Excellence." In this program, we use new payment incentives for hospitals or health centers that provide outstanding service while keeping costs down. These incentives have achieved real savings of 12 percent on coronary bypass graft procedures with a higher quality of service. The President's budget makes these proven strategies a permanent part of the

Medicare program.

5. **Encourages More Prevention and Prepares for the Retirement of the “Baby Boomers”:** The private sector has learned that building prevention into health care coverage is smart business. Expanding coverage for relatively inexpensive preventive measures helps businesses save money down the road. The President’s budget builds on that lesson by ensuring that Medicare incorporates preventive measures that can cut costs and help people lead healthier lives. We expand coverage for mammographies and colorectal screening, and improve self-management of diseases like diabetes. To respond to the aging of America’s population, we also extend respite benefits that are increasingly important to our older Americans.
  
6. **Gives Consumers the Information They Need.** Unfortunately, many seniors today lack the basic information they need to make informed choices about their health care plans. Too often, they end up in an inefficient health care plan, simply because they didn’t know they had a choice. The President’s budget empowers America’s seniors to make educated choices about their health care. Under our budget, the Secretary of Health and Human Services would provide beneficiaries with comparative information on all managed care and Medigap plans in the area where they live. To help make those comparisons meaningful, the budget would create standardized packages for additional benefits to family members who are caring for Alzheimer’s patients.

These are just some of the more significant reforms the President’s plan institutes to address Medicare’s underlying problems. It will change the way government pays for health care for older Americans and people with disabilities, and how they choose their health care. The plan saves taxpayers an enormous amount of money, cuts the deficit, extends the life of the Trust Fund, and maintains Medicare’s commitment to affordable, quality care. Based on analysis by the Congressional Budget Office, taken together, these reforms will bring Medicare growth in line with private sector growth, and according to our actuaries, will increase voluntary managed care enrollment. Others may have their own ideas about how to expand choice and cut costs. We are willing to listen and to learn. But, to those who bemoan the lack of structural reforms in Medicare, we say, “Take a second look.”

## **MEDICARE STRUCTURAL REFORM IN THE PRESIDENT'S FY 1998 BUDGET**

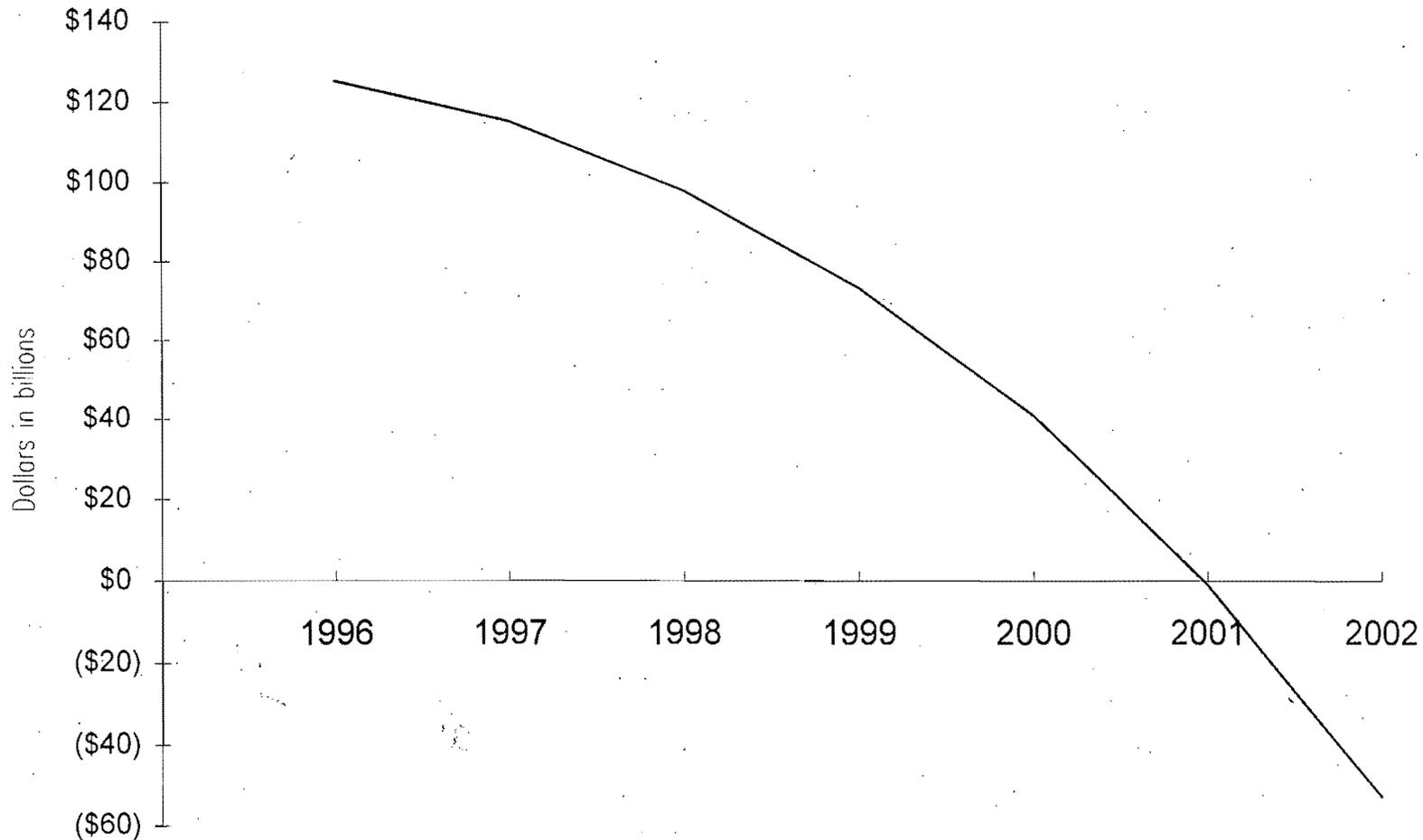
**WHY STRUCTURAL REFORM IS NEEDED**

**STRUCTURAL REFORM UNDER THE PRESIDENT'S BUDGET**

Fee-For-Service

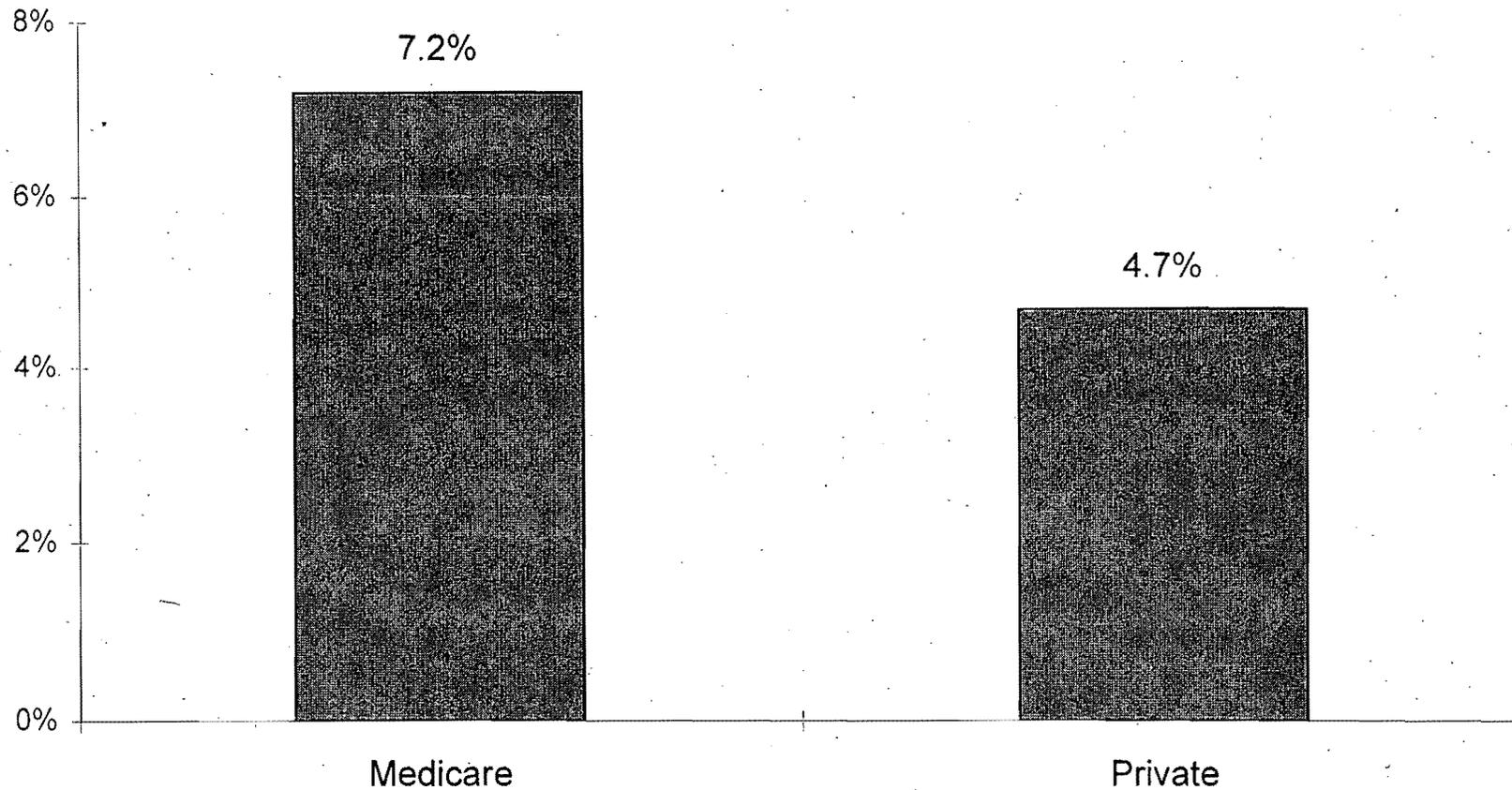
Managed Care

## Medicare Part A Trust Fund: End of the Year Balance



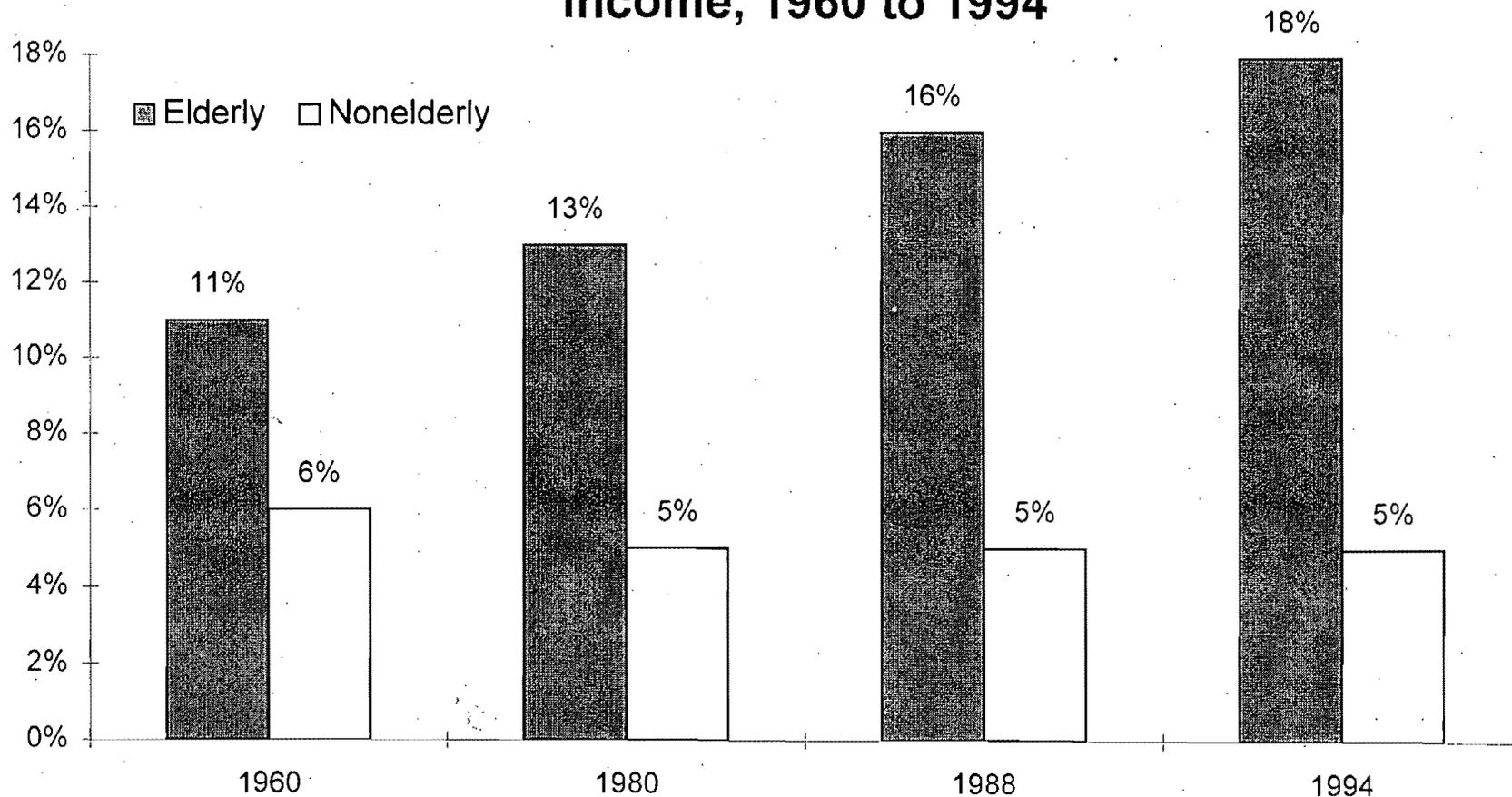
Source: HCFA Office of the Actuary President's FY 1998 Budget Baseline, fiscal years

## Growth in Medicare Spending per Beneficiary is Higher than Growth in Private Spending per Capita, 1997 - 2002



Source: CBO 1997 baselines; Medicare is for gross spending per Part A enrollee; Private is for private premium growth

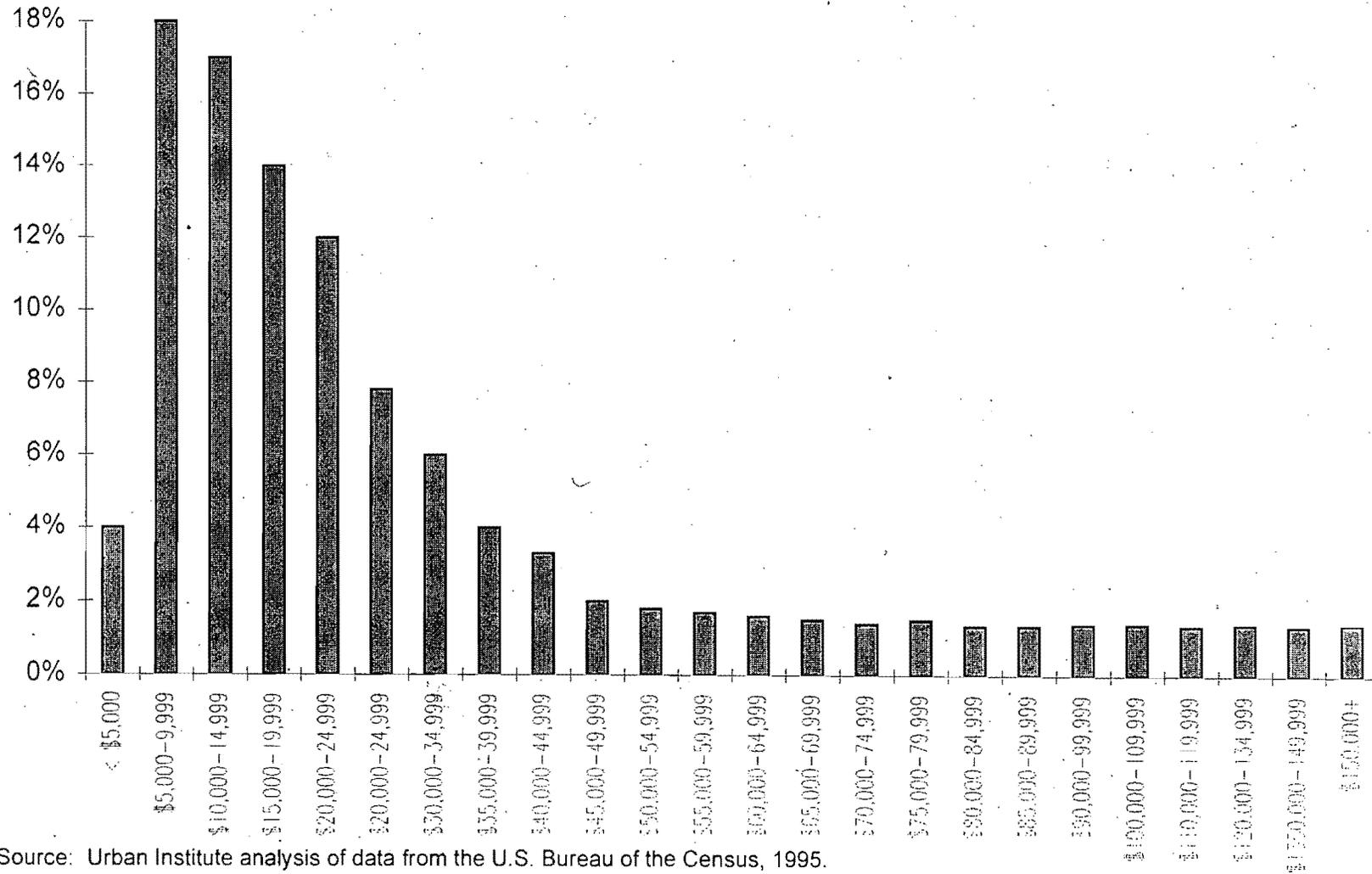
## Out-of-Pocket Health Spending for the Elderly Has Risen: Health Spending as a Percent of Income, 1960 to 1994



Note: The Urban Institute estimates that the percent of seniors' income spent on out-of-pocket health costs was 21% in 1996.

Source: Health Care Financing Administration, 1996, based on Consumer Expenditure Survey

## Income Distribution of the Elderly, 1994



Source: Urban Institute analysis of data from the U.S. Bureau of the Census, 1995.

## Reasons for Medicare Growth: Fee-for-Service

- **Realigning payments.** The lack of agreement on a budget in last three years has led to excessive, formula-driven reimbursement.
- **Outdated payment methods.** Fee-for-service Medicare still pays for some services on a retrospective cost basis.
  - Home health agencies, skilled nursing facilities, and hospital outpatient departments continue to receive cost-based payments. As a result, their costs have grown almost unabated.
  - Despite its large purchasing power, the Health Care Financing Administration does not have flexibility in how it pays for many items including durable medical equipment and laboratory services.

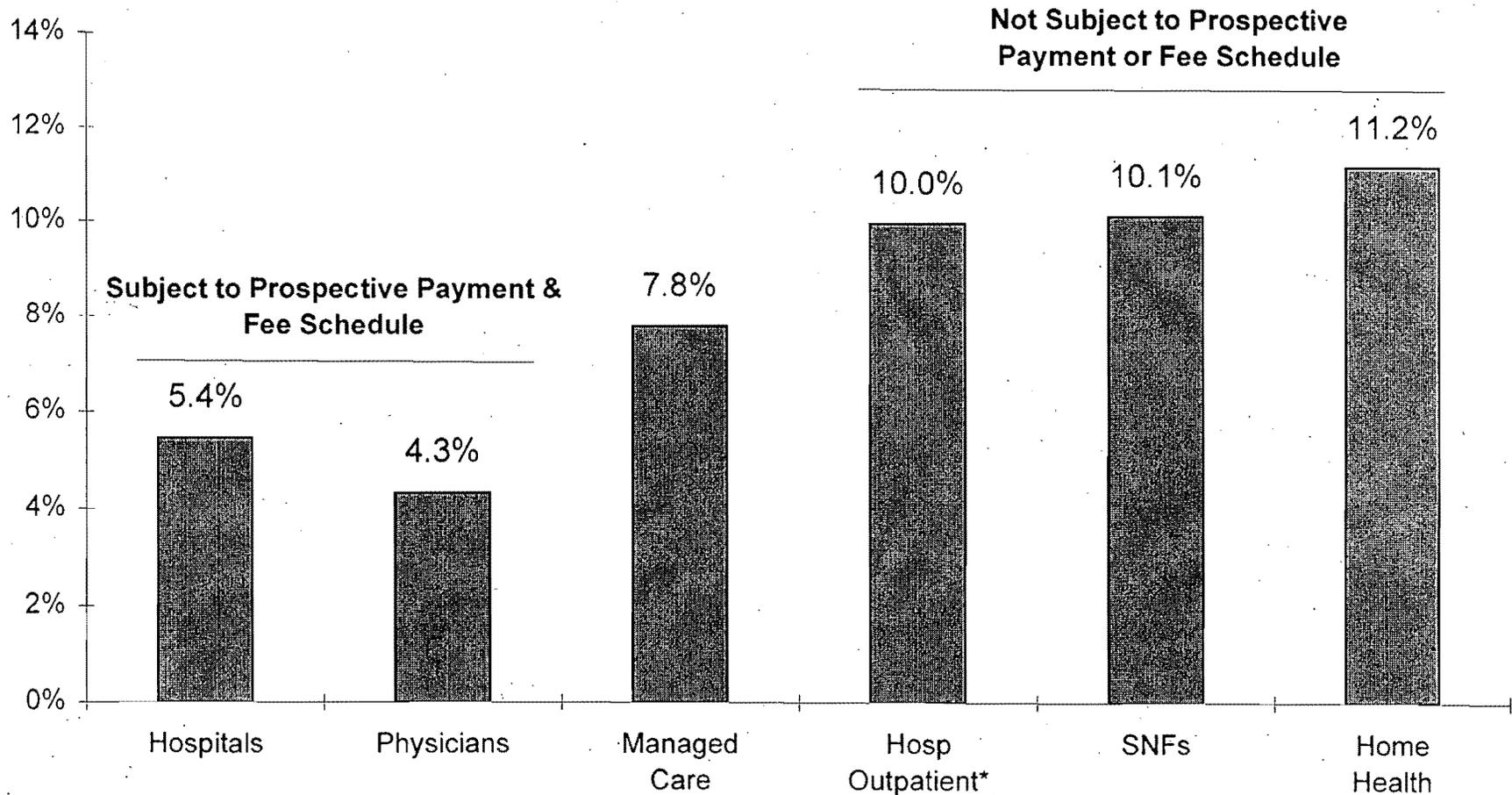
## Reasons for Medicare Growth: Managed Care

- Managed care payment rates need to be modernized.
  - Managed care plans are being overpaid according to the Physician Payment Review Commission, Prospective Payment Assessment Commission, the General Accounting Office, and the Health Care Financing Administration (between 5 and 40 percent above costs).
  - Since most managed care spending is for Part A services, these overpayments are exacerbating the Medicare Trust Fund problem.
  - Despite this, rates are not adequate enough in many areas, particularly in rural counties, to encourage managed care plans to offer benefits.
- Medicare has strict limits on the types of plans that can participate in managed care, limiting its enrollment potential.
- Beneficiaries have poor information on the choices currently available to them which makes them less likely to enroll in managed care.

## Structural Reform Under the President's Budget

- The Medicare proposal in the President's budget has two goals:
  - Extending the life of the Part A Trust Fund and contributing toward deficit reduction
  - Laying the foundation for long-term solutions that will be needed as the Baby Boom generation retires.
- The budget proposes to achieve these goals by adopting the best that the private sector and Medicare fee-for-service have to offer in terms of modernizing delivery systems, constraining costs and improving quality.

## Growth in Medicare Payments Per Beneficiary By Service, 1997 to 2002



SOURCE: CBO January 1997 Medicare Baseline; \* Includes laboratory services in hosp. outpatient departments and other services

## **The President's Proposal: Restructuring Fee-For-Service**

- Building on the hospital model, the budget implements prospective payment systems for:
  - Skilled nursing facilities
  - Home health
  - Hospital outpatient departments
- It also adopts successful approaches to purchasing other types of services, including:
  - Competitive pricing for durable medical equipment, laboratories, other items and supplies
  - Expanding "centers of excellence"
  - Increased flexibility from program rules in negotiating rates

## Modernizing Medicare Benefits

- The President's budget invests in expanding coverage of prevention. Specifically, the plan:
  - Expands mammography by:
    - Covering annual mammograms for beneficiaries age 40 and older
    - Waiving cost sharing for mammography services
  - Covers colorectal screening
  - Increases payments to providers for preventive injections
  - Establishes diabetes self-management benefit
  
- The President's budget also provides coverage for a limited respite benefit for families of beneficiaries with Alzheimer's disease and other related disorders. This benefit:
  - Supports not supplants caregiving by providing a limited benefit (32 hours per year)
  - Is accessible only to beneficiaries limited by both disability and disease

## **The President's Proposal: Restructuring Managed Care**

- The President's budget proposes to restructure Medicare managed care to capture the success that the private sector has seen in cost containment and informed beneficiary choice. It does this by taking the actions supported by recent research and by pursuing demonstrations that will guide managed care policy in the next century.

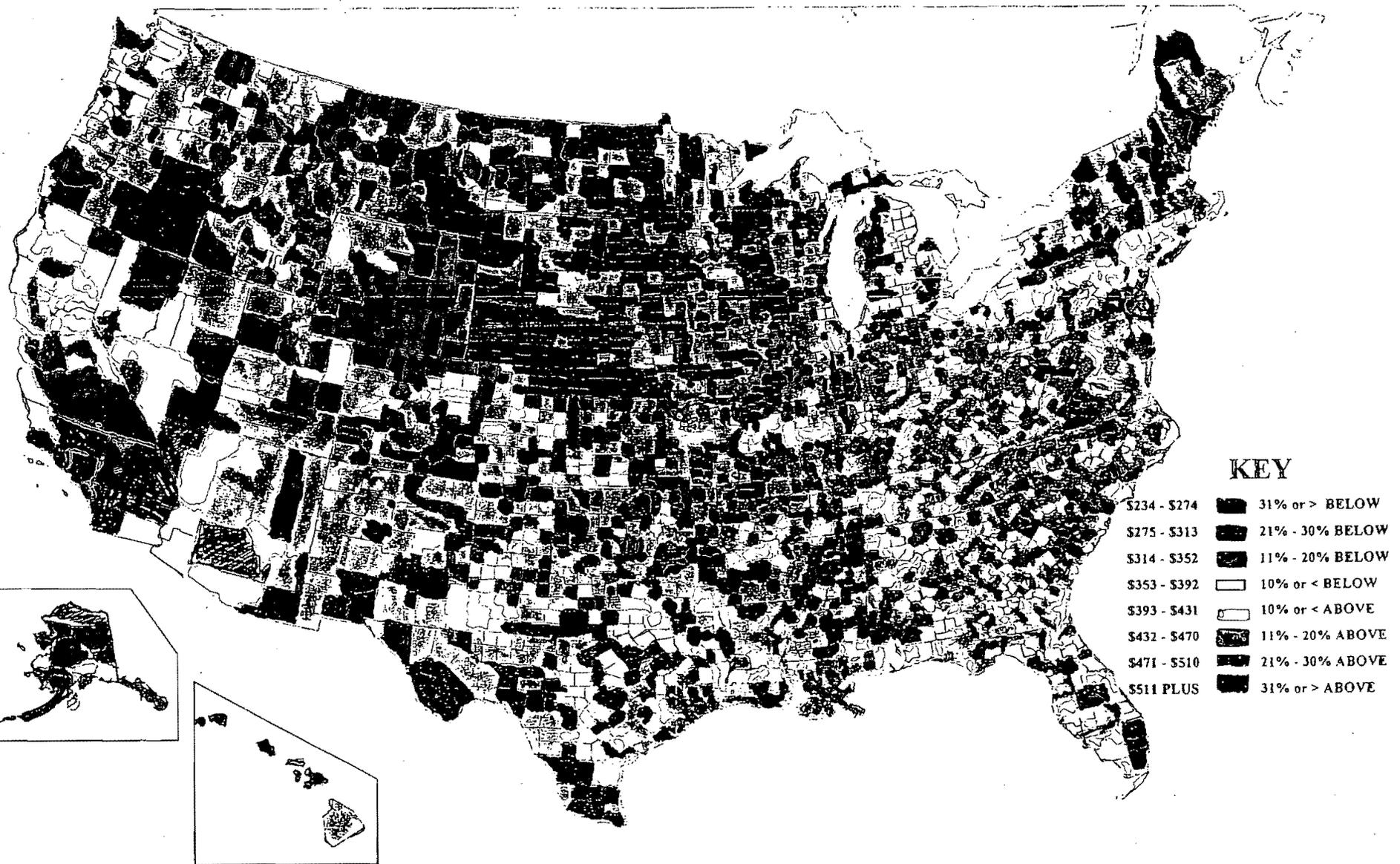
The budget:

- Recalibrates managed care payment rates to address widespread geographic disparities in payments
- Removes indirect medical education, graduate medical education, and disproportionate share hospital payments from the managed care rates
- Adjusts managed care rates for overpayments due to favorable selection
- Constrains growth in Medicare managed care spending
- Expands choices and consumer information

## Revising Medicare's Managed Care Rates

- The President's budget will implement the clearly warranted series of changes in how Medicare pays for managed care. Specifically, it:
  - **De-links rates from local fee-for-service spending**, thus reducing the tremendous variation in rates. It does this by:
    - Setting a minimum payment amount (\$350 per month in 1998)
    - Blending the local rate with a national rate (30 percent national rate by 2002)
  - **Carves out medical education payments** from managed care rates, directing the payments straight to teaching and disproportionate share hospitals
  - **Adjusts rates for overpayments.** Evidence suggests that Medicare currently overpays managed care plans, primarily due to favorable selection. The plan lowers rates by 5.3 percent in 2000, subject to certain minimums. This percentage reduction is the equivalent to a change from 95 to 90 percent of the adjusted average per capita costs (AAPCC).

# VARIATIONS IN MEDICARE PAYMENTS



## Constraining Growth in Managed Care Payments

- The President's budget achieves savings by linking managed care payments to growth in overall Medicare spending.
  - The President's budget reduces overall Medicare spending per beneficiary to around 5 percent, about the same rate of growth as in the private sector.
- The budget does not de-link growth from fee-for-service. It is premature to recommend such a change since:
  - There is no consensus on the "right" rate of growth for managed care
  - Setting an arbitrary growth rate risks overpaying plans if it is too high, or undermining the guaranteed benefits for Medicare if it is too low.

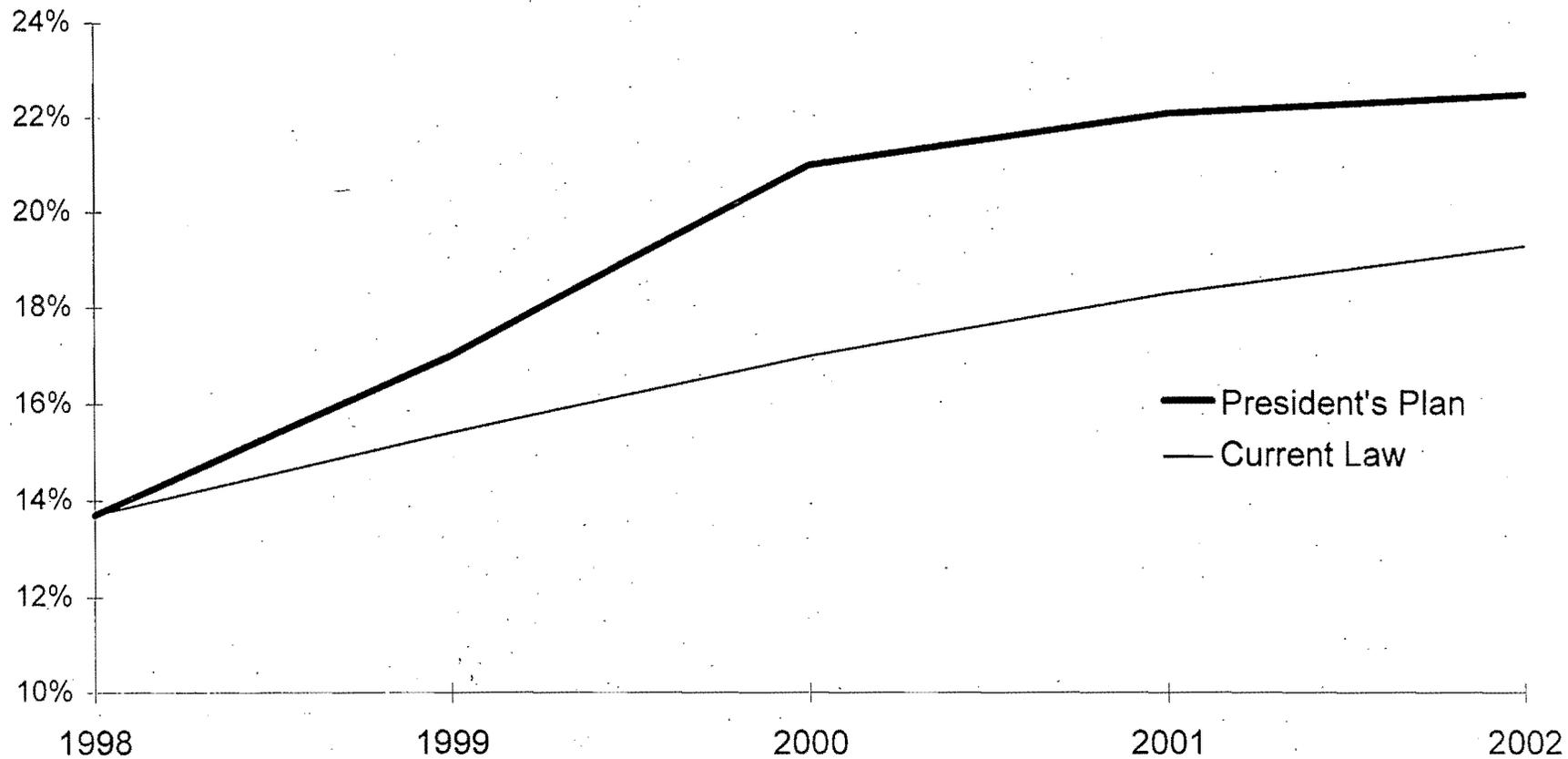
## Expanding Choices in Medicare Managed Care

- The President's budget restructures managed care to give Medicare beneficiaries more options and information.
  - Expanded managed care options:
    - Preferred Provider Organizations
    - Provider Sponsored Organizations
  - Comparative information on all choices
  - Bridge Medigap and Medicare managed care, allowing easier transitions between the two:

## **Effect of the President's Plan: Increase in Enrollment in Managed Care**

- The Health Care Financing Administration's Actuaries project that Medicare managed care enrollment will increase under the President's plan. This results from the combination of:
  - Raising rates in many counties through the reduction in geographic variation
  - Expanding managed care choices
  - Providing beneficiaries information on their choices

## Enrollment in Medicare Managed Care: Percent of Beneficiaries, 1998 to 2002



Source: HCFA Office of the Actuaries

## Continuous Efforts to Refine Medicare Managed Care Rates

- The President's budget takes the necessary and immediate action to correct Medicare managed care payment rates. However, we remain committed to examining alternatives as we prepare for the major changes that will occur when the Baby Boom generation retires.
- **Risk adjustment:**
  - Over 70 percent of Medicare's expenditures are incurred by only 10 percent of its beneficiaries — mostly, frail elderly and people with disabilities. Thus, aggressive managed care must be accompanied by a way to adjust for high-risk beneficiaries to ensure that payments are adequate and the sick are not left behind.
  - Because of its complexity, risk adjustment is being tested in the Medicare Choices demonstrations. Six demonstration have already begun to collect information needed to evaluation the state-of-the-art methodologies.
  - The Department of Health and Human Services will provide recommendations for an acceptable risk adjuster by 1999 to be implemented in 2001.
- **Alternative rate setting methodologies:** The Health Care Financing Administration is evaluating several innovative rate setting strategies.
  - For example, competitive pricing will determine how much managed care plans receive in Denver. Other demonstrations are testing the success of partial capitation and reinsurance.

## THE PRESIDENT'S MEDICARE STRUCTURAL REFORMS

The President's budget contains important structural changes necessary to modernize Medicare for the 21st century. It adopts the best innovations in the private sector, which has developed new techniques to control health care costs and improve quality. It also restructures Medicare, offering more choices for managed care, shifting to competitive pricing, enhancing preventive coverage, and offering consumers more information. The following are just some of the more significant reforms in the President's plan.

### **Restructures the Payment System for Medicare's Fastest-Growing Services**

- **Problem:** Medicare costs are skyrocketing for home health care, skilled nursing facilities, and hospital out-patient services. These services account for most of the excessive growth in Medicare spending. They are rising so quickly because Medicare pays after the fact, creating incentives for overutilization.
- **The President's budget** builds on the success Medicare has had in controlling hospital costs, restructuring the entire payment system so that rates are set in advance. This prospective payment system will prevent health care providers from charging too much in these areas.

### **Offers Consumers More Choices for Managed Care**

- **Problem:** Current law only enables Medicare to contract with a narrow range of managed care plans. Also, under today's rules, many older Americans are reluctant to try managed care for fear that, if they don't like it, they will be unable to return fee-for-service with their previous Medigap plan.
- **The President's budget:** By allowing Medicare to work with Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs), the President's budget opens up new options that have proved popular and cost-effective in the private sector. By providing annual Medigap enrollment without fear of higher premiums or penalties for pre-existing conditions, it also provides older Americans with a meaningful choice.

### **Broadens Availability of Managed Care and Ensures that Medicare Trust Fund Shares in the Savings**

- **Problem:** Today, the Medicare Trust Fund actually loses money on the average beneficiary that enrolls in a managed care plan because Medicare pays too much money to insure the relatively healthier Medicare beneficiaries in managed care plans.
- **The President's budget** takes steps to remedy this well-documented overpayment through a one-time reduction of about 5 percent in HMO payments in the year 2000. It also addresses the flawed payment methodology that has led to great geographical disparity, which has limited most of rural America's access to managed care.

## **Introduces Successful Competitive-Bidding Strategies to Lower Costs**

- **Problem:** Although the Health Care Financing Administration is the largest purchaser of health care services in the United States, Medicare often pays more for services and equipment because it lacks the legal authority to negotiate lower prices. Too often, Medicare pays far more for medical supplies and durable medical equipment than other purchasers.
- **The President's budget** institutes competitive pricing to introduce market pressures and keeps Medicare costs down by leveraging the government's enormous buying power in the health care sector. It also builds on innovative cost-cutting pilot programs like "Centers of Excellence," which use new payment incentives for hospitals or health centers that provide outstanding service while keeping costs down. In a Medicare demonstration, these incentives have achieved real savings of 12 percent on coronary bypass graft procedures with a higher quality of service.

## **Encourages More Prevention and Prepares for the Retirement of the "Baby Boomers"**

- **Problem:** Medicare does not cover many of the preventive services that can cut costs and help people lead healthier lives.
- **The President's budget** expands coverage for mammograms and colorectal screening, improves self-management of diseases like diabetes, and extends respite benefits that are increasingly important to our older Americans. These benefits will be good for beneficiaries and, over time, will save Medicare dollars.

## **Gives Consumers the Information They Need**

- **Problem:** Many seniors today lack the basic information they need to make informed choices about which Medicare plan to choose.
- **The President's budget** empowers America's seniors to make educated choices about their health care by providing beneficiaries with comparative information on all managed care and Medigap plans in the area where they live. To help make those comparisons meaningful, the budget would create standardized packages for additional benefits.

## Editorial

The New York Times  
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October 25, 1999

## Modernizing Medicare

### Forum

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**T**he Senate Finance Committee voted last week to put off consideration of legislative measures that would give Medicare the same tools that private **health** insurers commonly use to control costs and the quality of **care**. That probably means that debate on this crucial issue will be delayed to next year. The Clinton administration had proposed a comprehensive plan to improve Medicare, including a new prescription-drug benefit. Unless Congress acts, Medicare will not have the flexibility to create new choices of coverage for beneficiaries that will help reduce costs, for them and for the program.

Under the 1997 Balanced Budget Act, Congress greatly expanded the ability of Medicare enrollees to join **health** maintenance organizations. In three years the number of beneficiaries in H.M.O.'s has doubled, to seven million -- about 18 percent of the entire Medicare population -- largely because H.M.O.'s can offer lower deductibles and co-payments, more preventive **care** and drug benefits. The rest of Medicare still functions under the traditional fee-for-service approach that is rapidly disappearing in the private sector.

The expansion of Medicare H.M.O.'s has been a significant step forward in modernizing the program. But up to now, Medicare has not been able to offer beneficiaries much access to preferred provider networks, the dominant form of managed **care** now in the private marketplace. These networks, usually called preferred provider organizations, or P.P.O.'s, have become so popular that they surpass H.M.O.'s in number of enrollees.

P.P.O.'s are less restrictive than H.M.O.'s because they typically eliminate gatekeeping functions that prevent patients from seeing specialists and generally allow patients to see doctors outside the network for a higher fee. P.P.O.'s control costs by negotiating lower fees with doctors who want to be part of the P.P.O. panel and selecting doctors who have a record of providing good-quality, cost-effective **care**. Patients gain by paying lower out-of-pocket costs if they choose a preferred provider. With the private sector moving to this managed-**care** hybrid, Medicare enrollees should be allowed the same cost-saving option.

The administration also wants to offer special payment rates to competitively selected hospitals that have demonstrated expertise in complex medical procedures. Beneficiaries would not have to go to these centers, but they could be offered lower cost-sharing and other benefits if they do. The designated centers would benefit by being able to increase their market share in certain procedures. Other measures would increase Medicare's use of competitive bidding in purchasing goods and services, and establish a voluntary case management plan for beneficiaries in fee-for-service Medicare.

Doctors and hospital groups are nervous about giving Medicare any ability to pick and choose among providers. But ultimately, these strategies will give patients new incentive to select cost-effective **care**. The private sector has adopted these approaches. It is time that Medicare caught up.

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**OVERVIEW:**  
**PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE  
FOR THE 21<sup>st</sup> CENTURY**

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

**MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT.** Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare Trust Fund from 1999 to 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs; coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: \$25 billion over the next 10 years.
- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: \$8 billion over the next 10 years, starting in 2003.
- **Constrains out-year program growth, but more moderately than the Balanced Budget Act (BBA) of 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates, but are more modest than those included in the BBA. These proposals along with the modernization of traditional Medicare would reduce average annual Medicare spending growth from an estimated 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: \$39 billion over next 10 years (including interactions and premium offsets).

- **Takes administrative and legislative action to smooth out the BBA provider payment reductions.** The proposal includes a 7.5 billion “quality assurance fund” to smooth out provisions in the BBA that may be affecting Medicare beneficiaries’ access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions to moderate the impact of the BBA on some health care providers’ ability to deliver quality services to beneficiaries. Finally, it contains a legislative proposal to better target disproportionate share hospitals. Cost: \$7.5 billion over 10 years.

**MODERNIZING MEDICARE’S BENEFITS.** The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President’s plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the FY 2000 President’s Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare “Part D” prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:
  - Have no deductible and pay for half of the beneficiary’s drug costs from the first prescription filled each year up to \$5,000 in spending (\$2,500 in Medicare payments) when fully phased-in by 2008.
  - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the \$5,000 limit is reached.
  - Cost about \$24 per month beginning in 2002 (when the coverage is capped at \$2,000 in spending) and \$44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)
  - Ensure that beneficiaries with incomes below 135 percent of poverty (\$11,000/\$15,000 single/couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.
  - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

Most Medicare beneficiaries will probably choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, we estimate that about 31 million beneficiaries would benefit from this coverage each year. Cost: \$118 billion over the next 10 years, beginning in 2002.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost \$3 billion over 10 years and would:
  - Eliminate existing copayments and the deductible for preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.
  - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.
  - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.
- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save \$11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:
  - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.
  - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.
- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).
- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately \$300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The \$1.4 billion cost over 5 years is offset in the President's FY 2000 budget.

**STRENGTHENING MEDICARE'S FINANCING FOR THE 21<sup>ST</sup> CENTURY.** The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2027.** Dedicating 15 percent of the surplus (\$794 billion over 15 years) to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2027, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.
- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about \$118 billion over 10 years. Its budgetary impact would be fully offset by:
  - Savings from competition and efficiency. About 60 percent of the \$118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.
  - Dedicating a small fraction of the surplus. About \$45.5 billion of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:
    - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and
    - Less than the reduction in the Medicare baseline spending between January and June, 1999.

Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently stated their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success creating a strong economy and in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

**PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE  
MEDICARE FOR THE 21<sup>ST</sup> CENTURY**

- **Goals for Reform:**
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21<sup>st</sup> Century
- **Reduces Medicare spending for current services by \$72 billion over 10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.
- **Adds an optional prescription drug benefit.** This benefit would cost \$118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009 (net of premiums).
  - Over 60 percent of the costs are offset by the proposal's savings.
  - The remaining \$45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the \$374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.
- **Extends the life of the Medicare Trust Fund to at least 2027.** The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the estimated life of the Medicare Trust Fund for a quarter century from now, through at least 2027.

| <b>PRESIDENT'S PROPOSAL</b>                      |              |              |
|--|--------------|--------------|
| <i>(Dollars in Billions, Trustees' Baseline)</i> |              |              |
|  | <u>00-04</u> | <u>00-09</u> |
| <b>COMPETITION &amp; EFFICIENCY</b>              |              |              |
| Medicare Modernization                           | -5           | -25          |
| Competition                                      | -0           | -8           |
| Provider Savings                                 | -4           | -39*         |
| Provider Set-Aside                               | +4           | +7.5         |
| <b>Total</b>                                     | <b>-5</b>    | <b>-64.5</b> |
| <b>MODERNIZING BENEFITS</b>                      |              |              |
| Prescription Drug Benefit                        | +29          | +118         |
| Cost Sharing Changes                             | -2           | -8           |
| <b>Total</b>                                     | <b>+27</b>   | <b>+110</b>  |
| <b>DEDICATING FINANCING</b>                      |              |              |
| Contribution to Solvency                         | -28          | -328.5**     |
| <b>Surplus for Drug Benefit</b>                  | <b>-22</b>   | <b>-45.5</b> |
| <b>Surplus Allocation</b>                        | <b>-50</b>   | <b>-374</b>  |

\*Includes \$5.7 billion in interactions/premium offset  
 \*\* Does not count toward package

Option 1 would increase payment in 32 of the top 100 counties - - with 679,000 enrollees -- median increase would be 2.32% over current law 98 rate, max increase would be 5.65% (Honolulu). It would reduce payment in 68 counties with 2.7 million enrollees.

Option 2 would increase payment in 39 of the top 100 counties - - with 1,057 million enrollees -- median increase would be 2.44% over current law 98 rate, max increase would be 6.39% (Honolulu). It would reduce payment in 61 counties with 2.39 million enrollees.

Option 3 would increase payment in 37 of the top 100 counties - - with 986 million enrollees -- median increase would be 2.32% over current law 98 rate, max increase would be 6.18% (Honolulu). It would reduce payment in 63 counties with 2.46 million enrollees.

**TESTIMONY OF  
MIKE HASH, DEPUTY ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
before the  
HOUSE COMMERCE SUBCOMMITTEE ON HEALTH**

**February 25, 1999**

Chairman Bilirakis, Congressman Brown, distinguished committee members, thank you for inviting me here to discuss our efforts to pay health plans accurately and fairly. The Balanced Budget Act of 1997 requires Medicare to "risk adjust" payments to Medicare+Choice organizations, starting January 1, 2000. That means we must base payment to Medicare+Choice plans on the health status of their enrollees.

Risk adjustment is an essential component of the Medicare+Choice program, and represents a vast improvement over the current payment method. It helps assure that payments are appropriate and curtail the disincentive for plans to enroll sicker beneficiaries.

Under risk adjustment, data on individual beneficiaries use of health care services in a given year will be used to adjust payment for each beneficiary enrolled in a Medicare+Choice plan the following year. The payment adjustments are based on the average total cost of care for individuals who had the same diagnoses in the previous year. In order to prevent disruptions to beneficiaries and health plans, we will phase this change in over five years. Initially, we will use data on inpatient hospital stays and move in an orderly fashion, as envisioned in the Balanced Budget Act, to use of data from other health care settings.

We would like to thank plans for their cooperation in providing the data needed to implement this important advance.

Currently, some 6 million of Medicare's 40 million beneficiaries have chosen to enroll in Medicare+Choice plans. Risk adjustment will increase payment to plans for their sickest patients, and thus curtail the disincentive for plans to enroll these beneficiaries. It also will lower payment to plans for their healthier patients. Risk adjustment is an essential step forward for beneficiaries, taxpayers, and health plans.

*Risk adjustment will help beneficiaries* feel confident in all their Medicare+Choice options. It will assure beneficiaries that Medicare pays plans the right amount to provide all necessary care because payment to plans will take each enrollee's health status into account. That will help people with serious illnesses, such as cancer or cardiovascular disease, who can benefit most from the coordination of care health plans can provide.

*Risk adjustment will help taxpayers* by addressing the main reason that Medicare has lost rather than saved money on managed care. Many studies show that health plans enroll Medicare beneficiaries who, on average, are much healthier and therefore less costly than those who remain in traditional Medicare. This "favorable selection" of healthy beneficiaries has cost taxpayers \$2 billion a year, according to a 1997 report by Congress' Physician Payment Review Commission (now part of the Medicare Payment Advisory Commission).

*Risk adjustment will help level the playing field* among Medicare+Choice plans. It will temper the risk of significant financial loss when plans enroll beneficiaries who have expensive care needs, and focus competition more on managing care than on avoiding risk. Risk adjustment also will help plans by alleviating concerns among beneficiaries that plans have financial incentives to deny care.

### **Phasing-In Risk Adjustment**

The law requires us to proceed with risk adjustment starting January 1, 2000, and does not call for a transition. However, we believe we must implement these changes in an incremental and prudent fashion, as was done with other new major payment systems. We are, therefore, using flexibility afforded to us in the law to phase in risk adjustment over 5 years to prevent disruptions to beneficiaries or the Medicare+Choice program.

In the first year, only 10 percent of payment to plans for each beneficiary will be calculated based on the new risk adjustment method based on inpatient hospital diagnoses. The remaining 90 percent will be based on the existing method for calculating plan payments, which are flat amounts per enrollee per month based on the average cost to care for Medicare fee-for-service beneficiaries in each county and adjusted for basic demographic factors like age and sex. In 2001, 30 percent of payment amounts will be risk adjusted. In 2002, 55 percent of payment amounts will be based on risk adjustment. In 2003, 80 percent of payment amounts will be based on risk adjustment. By 2004, we and health plans will be ready to use data from all sites of care, not just inpatient hospital information, for risk adjustment. Then, and only then, will payment to plans be 100 percent based on risk adjustment.

### **Using Inpatient Data**

During the first year of data collection for risk adjustment, both the statute and practical issues require that we use hospital inpatient data alone. About one in every five Medicare beneficiaries is hospitalized in a given year. Data on these hospitalizations are relatively easy to gather, easy to audit, and highly predictive of future health care costs. We will use the data to pay plans more for beneficiaries hospitalized the previous year for conditions that are strongly correlated with higher subsequent health care costs. While we will eventually be using a broader data base for risk adjustment, that is simply not feasible at this time.

The Balanced Budget Act clearly stipulated that more comprehensive data on outpatient, physician, and other services could be collected only for services provided on or after July 1, 1998. That was prudent, because it has been no small task for plans to learn how to gather the inpatient data we are using for the initial phase-in of risk adjustment. Requiring plans to provide additional data on outpatient, physician and other services would have been unduly burdensome at this time.

This year, we will issue a schedule and guidance to plans for reporting other encounter data, such as outpatient information. The schedule will provide sufficient time for plans to gather accurate data and for HCFA to analyze and incorporate the data into accurate risk adjusted payments. We are now confident that by 2004 we will be using data on all health care encounters to assess beneficiary health status for risk adjustment. If we could base risk adjustment on more comprehensive data now, we would. But we cannot. The law requires us to move forward. And, even with its limitations, this initial risk adjustment system based on inpatient data alone will increase payment accuracy 5-fold.

The initial risk adjustment system uses only the approximately 60 percent of inpatient hospital diagnoses that are reliably associated with future increased costs. For example, beneficiaries hospitalized for conditions such as heart attacks in aggregate are at higher risk of subsequent cardiovascular problems, and they consistently have higher health care costs in the subsequent year. Hospitalizations for such diagnoses will lead to higher payments to plans in the following year under risk adjustment. Hospitalizations for acute conditions such as appendicitis, however, rarely lead to increased subsequent care costs. They will not lead to higher payments under risk adjustment.

The 60 percent of hospital admission diagnoses that are clearly associated with increased subsequent care costs account for about 30 percent of all Medicare spending the following year. It is important to note that, while risk adjustment is initially based only on inpatient data, the risk adjustment payments account for all costs of care associated with each diagnosis. It is also important to note that risk adjustment is not cost-based reimbursement; it is reimbursement adjusted for projected need based on health status in the previous year.

### **Determining Diagnosis Groups**

The relevant diagnoses will be used to classify beneficiaries into 15 different cost categories. One category is for beneficiaries who were not hospitalized the previous year with relevant diagnoses. For beneficiaries included in any of the other categories, plans will receive an additional payment to cover the increased risk associated with diagnoses in that category.

Payment will continue to be adjusted for demographic factors, such as age, gender, county of residence, and whether a Medicare beneficiary is also a Medicaid beneficiary. We have revised these demographic factors for use with risk adjustment, for example, by no longer including institutional status because the risk adjustment methodology itself does a good job of predicting expenses for nursing home residents.

Medicare will calculate a score for each beneficiary to determine the payment that will be made if they choose to enroll in a Medicare+Choice plan. For example, Medicare's average payment per year to health plans is \$5,800. Under risk adjustment, payment for an 85-year-old man will on average be \$6,414. It will be an additional \$2,060 if he is on Medicaid, another \$1,207 if he is disabled, and \$8,474 more if he was admitted to the hospital for a stroke the previous year, for a total of \$18,155. The score for each beneficiary will be calculated annually, and will follow them if they move from one health plan to another.

### **Protecting Program Integrity**

Most health plans operate with integrity and play by the rules, and we doubt that plans will compromise successful medical management programs that keep patients out of the hospital in order to game the risk adjustment system. However, plans themselves have raised concerns that risk adjustment based on inpatient data alone could create perverse incentives for unnecessary hospitalizations. We, therefore, have taken solid steps to prevent gaming of the system with inappropriate hospital admissions or attempts to inflate the data submitted for use in risk adjustment.

The risk adjustment system does not include hospital stays of just one day, in order to help guard against inappropriate admissions. And it excludes diagnoses that are vague, ambiguous, or rarely the principal reason for hospital admission. In addition, we will use independent experts to assess the validity and completeness of data plans submit to us by conducting targeted medical record reviews and site visits. This will help ensure that plans do not "upcode," or claim that hospital admissions were for more serious conditions that would result in higher payment.

### **Protecting Taxpayers**

It is essential to stress that risk adjustment will not and cannot be budget neutral if we intend to protect the Medicare Trust Fund and be fair to the taxpayers who support our programs. The whole reason for proceeding with risk adjustment -- and specifically with risk adjustment that is not budget neutral -- is that Medicare has not been paying plans properly.

There is considerable evidence that we have overpaid plans and continue to overpay plans, in large part because payments are not adjusted for risk.

The Physician Payment Review Commission, in its 1997 Annual Report to Congress, estimated that Medicare has been making up to \$2 billion a year in excess payments to managed care plans. This Congressional advisory body notes that, unlike the private sector where managed care has slowed health care cost growth, managed care has increased Medicare program outlays. The Commission's 1996 Report found that those who enroll in managed care tend to be healthy and those who disenroll tend to be unhealthy, exacerbating Medicare losses.

Mathematica Policy Research, which has conducted several studies on Medicare HMOs, says care of Medicare beneficiaries in HMOs costs only 85 percent as much as care for those who remain in traditional fee-for-service Medicare. That is 10 percent less than the 95 percent of the average fee-for-service costs plans were being paid.

The Congressional Budget Office has said managed care plans could offer Medicare benefits for 87 percent of Medicare fee-for-service costs, even though they were paid 95 percent.

Congress also recognized that plans have been paid too little for enrollees with costly conditions, and too much for those with minimal care needs. The simple demographic adjustments made now for age, gender, county of residence, Medicaid and institutional status, do not begin to accurately account for the wide variation in patient care costs. Risk adjustment will.

The vast majority of beneficiaries enrolled in Medicare+Choice cost far less than what Medicare pays plans for each enrollee. Medicare fee-for-service statistics make clear why risk adjustment must not be budget neutral. More than half of all Medicare fee-for-service beneficiaries cost less than \$500 per year, while less than 5 percent of fee-for-service beneficiaries cost more than \$25,000 per year, according to the latest available statistics for calendar year 1996. The most costly 5 percent account for more than half of all Medicare fee-for-service spending.

Since Medicare+Choice enrollees tend to be healthier than fee-for-service Medicare beneficiaries, the

ratio of high to low cost beneficiaries in health plans is even more stark. Clearly, care for the overwhelming majority of Medicare enrollees costs plans much less than what Medicare pays because our payments are predicated on the average beneficiary cost of care, calculated by county. This average includes the most expensive beneficiaries in fee-for-service, who generally do not enroll in managed care.

If risk adjustment was budget neutral, Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Accurate risk adjustment inevitably and appropriately must change aggregate payment to plans.

Budget neutral risk adjustment would cost taxpayers an estimated \$200 million in the first year of the phase-in, and \$11.2 billion over 5 years if health plans maintained their current, mostly healthy mix of beneficiaries. It is important to stress that actual savings to taxpayers from risk adjustment will vary to the extent that less healthy beneficiaries enroll in Medicare+Choice plans, resulting in higher payments than health plans receive today.

The amount of payment change will vary among plans and depend on each plan's individual enrollees. Total payment may be higher for some plans as they enroll a mix of beneficiaries that is more representative of the entire Medicare population. As part of our Medicare+Choice March 1 rate announcement, we will send a letter to each health plan with an estimate of how payment will differ from what they are paid now, based on their current mix of enrollees.

Overall, we project that payment to Medicare+Choice plans on average will change by less than one percent in the first year. How it will change over time depends on the mix of beneficiaries in each plan. Risk adjustment significantly changes incentives for plans and could well lead to enrollment of beneficiaries with greater care needs. That could result in plans receiving higher payments than they do now. Phasing in risk adjustment also substantially buffers the financial impact on plans. The federal government is forgoing \$1.4 billion in savings in the first year and as much as \$4.5 billion over the full 5 years because of the phase in.

Payment changes will be further buffered by an annual payment update for 2000 that our preliminary estimate suggests will be 5.2 percent. This is substantially larger than projections that were made last year. The final figure will be released March 1, 1999. This annual update is based on formulas set in law and projected expenditures for Medicare that are included in the President's fiscal year 2000 budget.

## CONCLUSION

Risk adjustment is an essential step forward for Medicare, beneficiaries, taxpayers and the Medicare+Choice program. It will help Medicare pay plans fairly and accurately. It will curtail disincentives to enroll less healthy beneficiaries. It will help taxpayers and the Medicare Trust Fund start saving, rather than losing, money on managed care. It will help level the playing field among plans. And it is required by law.

We are aware of the magnitude of the impact of risk adjustment and are, therefore, phasing in implementation to avoid undue disruptions. We are also taking proactive steps to prevent potential gaming of the system. We will closely monitor the impact on beneficiaries and plans. We will continue to consult with beneficiary groups, health plans and academic experts. Adjustments can be made each year as we proceed.

But, clearly, we must proceed. Risk adjustment is too important to postpone and too important to implement without a prudent phase-in that allows time for any necessary refinements. Again, I thank you for inviting us here today to discuss this, and I am happy to answer your questions.



[Return to Testimony](#)

Last Updated 04/23/1999

|                 |                      |                              |                         |                    |                 |
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American Association of  
HEALTH PLANS

Government Affairs Department  
1129 20th Street, N.W., Suite 600  
Washington, D.C. 20036

Main Telephone: (202) 778-3200  
Facsimile Telephone: (202) 778-8479

TO: Chris Jennings  
FAX: 456-~~777~~ 5557  
PHONE: 456-5560  
FROM: Julie Coon PHONE: 778-3260  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

TOTAL # OF PAGES (including cover page): \_\_\_\_\_

MESSAGE: Business letter supporting House  
position on payment -  
NAM  
U.S. Chamber - ps. 2  
APPWP - ps. 5  
Call when you can  
THX

**NAM** National Association  
of Manufacturers

Paul Howard

Senior Vice President

Policy/Communications Division

July 16, 1997

The Honorable Charles Grassley  
United States Senate  
135 Senate Hart Office Building  
Washington, DC 20510

Dear Senator Grassley:

The National Association of Manufacturers is strongly committed to a balanced budget and, to that end, supports House and Senate efforts to reform entitlement programs.

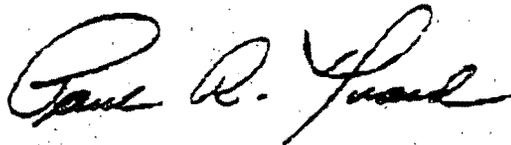
Two broad areas in the House and Senate budget reconciliation bills, however, would not achieve the desired savings. Rather, these provisions would result in decreased access to cost-effective managed care plans, reduce plan quality and shift costs in certain instances to private employer health plans.

**Health Plan Mandates.** Provisions added by the House Commerce Committee would prohibit health plans serving Medicare beneficiaries from determining the appropriate length of hospital stays for inpatient procedures and require plans to pay for any service which a health care provider considers medically necessary. Second, health plans would be limited in selecting the type of health care provider best suited to serve Medicare beneficiaries. These provisions would diminish the quality and cost-effectiveness of care provided to seniors and would likely raise costs for private employers contracting with these plans. Such provisions should be eliminated from the final legislation.

**Payment Rates for Medicare HMOs.** Current payment rates for Medicare HMOs are uneven across the country which has discouraged the growth of plans in certain areas and led to proliferation in others. Where the rates are generous, prescription drugs and other supplemental benefits have been offered by some HMOs inducing beneficiaries to join and raising overall enrollment nationwide. Both House and Senate bills have proposed revised payment methods aimed at increasing the growth of HMOs while cutting spending. While improving the payment method is important, the Senate proposal goes too far and would cut almost 25 percent from current rates. Such action would negatively affect the ability of HMOs to serve Medicare beneficiaries and result in seniors returning to costly traditional fee-for-service Medicare. In general, beneficiaries should be given incentives to choose quality managed care plans. Thus, the House proposal should be retained.

The NAM applauds your efforts to reform entitlement programs as an important part of balancing the federal budget. We are pleased to work with you toward this important goal.

Sincerely,



*Manufacturing Makes America Strong*

1331 Pennsylvania Avenue, NW, Washington, DC 20004-1790 • (202) 637-3112 • Fax (202) 637-3182

CHAMBER OF COMMERCE  
OF THE  
UNITED STATES OF AMERICA

R. BRUCE JOSTEN  
SENIOR VICE PRESIDENT  
MEMBERSHIP POLICY GROUP

July 11, 1997

1615 H STREET, N.W.  
WASHINGTON, D.C. 20062-2000  
202/462-8310 202/887-3403 FAX

The Honorable Michael Bilirakis  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Representative Bilirakis:

The U.S. Chamber of Commerce, the world's largest business federation representing an underlying membership of more than three million businesses and organizations of every size, sector and region, urges you to address specific concerns during conference on H.R. 2015, the Balanced Budget Act of 1997. The most significant among these are comprehensive Medicare reform and the House proposal for group health insurance purchasing for small businesses. The U.S. Chamber of Commerce strongly urges your support for these initiatives and attention to the concerns outlined below.

#### MEDICARE

The Chamber commends both Houses for advancing comprehensive Medicare reform. As co-chair of the Coalition to Save Medicare, the Chamber strongly supports the competition-based model for Medicare reform in which seniors will choose between existing fee-for-service Medicare and private health plan options. Under a limited experiment, some seniors will also be given the opportunity to select a medical savings account option. Competition will fuel innovation while reducing the rate of increase in Medicare costs.

As between the version adopted by the Senate and the two versions adopted by the House, the Ways and Means Committee bill successfully avoids provisions inconsistent with the market-driven competition that is so crucial to Medicare's future as well as provisions that will adversely affect the private marketplace. In addition, it provides for needed relief from the direct and indirect costs of medical malpractice litigation. The following are the Chamber's key concerns on the respective bills:

- **Eliminate Provisions Hostile to Private Health Plans.** With the understandable intent of protecting beneficiaries, all three congressional committees have sought to restrict private health plans to some degree. The worst of these proposals are amendments adopted by the House Commerce Committee, which would allow physicians to decide (1) what care is "medically necessary" (and therefore eligible for reimbursement); and (2) what is the appropriate reimbursable length of a Medicare-covered hospital stay. These amendments are dramatic departures from existing law. Worse, these amendments would short-circuit Medicare reform before it even begins by removing barriers to over-utilization. Conferees should oppose the House Commerce Committee's restrictions on private health plans.

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- **Adopt the House Provisions for Private Health Plan Reimbursement.** Although no senior will be compelled to leave existing "fee-for-service" Medicare, the future for Medicare clearly lies in the competitive, private marketplace. However, the Senate has adopted a number of provisions that would discourage competition. One provision calls for an additional 5 percent risk adjustment (reduction in reimbursement) for new enrollees in private health plans. Private health plans are already reimbursed 5 percent less per beneficiary than existing fee-for-service Medicare. Faced with additional reductions, private health plans may choose not to enter the market, cut back on benefits now offered, or leave the market entirely. The Ways and Means and Commerce Committee versions provide for appropriate reimbursement of private health plans. Conferees should oppose the Senate provisions for private health plan reimbursement.
- **Adopt the House Provisions for Medical Malpractice Reform.** Longstanding opponents of legal reform have questioned the House's decision to include medical malpractice reform with Medicare reform. The U.S. Chamber disagrees with this position, and specifically endorses inclusion of the malpractice reform provisions in the final package. It is particularly important now, as Congress and several states contemplate ill-advised expansions of medical malpractice liability to health plans, that reasonable medical malpractice reforms are enacted. Conferees should support the Ways and Means Committee provisions for medical malpractice reform.
- **Eliminate the Medicare Secondary Payer Look-Back Provisions.** A long-standing debate and much litigation has centered over responsibility for the respective obligations of Medicare and private employers for end-stage renal disease patients. The Ways and Means Committee version seeks to extend the time Medicare can seek contributory payments from employers or third party administrators. The Health Care Financing Administration should be required to conform to market standards for time limitations for look-backs, and should focus prospectively on better coordination between Medicare and private plans. Conferees should oppose the Ways and Means Committee provisions for Medicare Secondary Payer look-backs.
- **Solve the Transition Problems Posed by the Proposed Increase in the Medicare Eligibility Age.** While the Chamber understands the obvious necessity to realign the eligibility age for Medicare because of changes in lifespan and the ever increasing need for an experienced workforce, we have objected strongly to the lack of consideration of the costly transition issues involved. For example, the Senate bill proposes to gradually increase the eligibility age for Medicare from 65 to 67 over the next 24 years. While the phase-in would not begin until the year 2003, many employers in the private sector would face an immediate, catastrophic impact to their bottom line, threatening their continued commitment to retiree health benefits. Although the overwhelming House vote in opposition appears likely to settle the issue during conference, undoubtably it will return. Future consideration of this issue -- whether by Congress or commission -- should carefully consider its many implications.

-3-

**EXPANDED PORTABILITY AND HEALTH INSURANCE COVERAGE ACT**

Making health insurance coverage more affordable to small businesses is the critical need in our health care system today. The Chamber strongly commends the House for including the Expanded Portability and Health Insurance Coverage Act ("EPHIC," H.R. 1515/S. 729) in its version of the reconciliation legislation. These bills provide small businesses and self-employed individuals access to state mandate-exempt group purchasing of health coverage through association health plans. This bipartisan legislation is the Chamber's top health care priority.

Small businesses face significant obstacles in obtaining health coverage. Because of their size, individual small businesses lack sufficient purchasing power to bargain for lower health premiums. Unlike larger businesses who often self-insure, small businesses are faced with a bewildering array (more than 1,000 nationwide) of state benefit mandates and market interventions that greatly increase the cost of coverage. Indeed, 78 percent of respondents to a Chamber poll cited the cost of coverage as their greatest obstacle to obtaining and maintaining coverage. Left with few options, many small employers are unable to provide coverage for themselves, their workers and families, despite their desire to do so.

By combining the economies of pooled purchasing power with the strength and flexibility enjoyed under the federal ERISA (Employee Retirement Income Security Act) law, insurance coverage for workers, employers, self-insured individuals, and all of their families will be greatly increased. The economies of scale due to pooled purchasing will save an estimated 30 percent in administrative overhead costs and the ability to escape state benefit mandates through ERISA will drastically reduce the cost of health coverage.

The EPHIC bill is badly needed to advance coverage in the small business marketplace. The Chamber strongly urges conferees to adopt the House Education and Workforce Committee's EPHIC provisions.

The Chamber respectfully urges you to support the concerns outlined above on the EPHIC provisions and comprehensive Medicare reform in conference.

Sincerely,



R. Bruce Josten

# **APPWP**

Association of Private Pension and Welfare Plans

July 14, 1997

James A. Klein  
President

The Honorable Trent Lott  
487 Russell Senate Office Building  
Washington, DC 20510-2403

Dear Senator Lott:

The Association of Private Pension and Welfare Plans (APPWP - The Benefits Association) supports your efforts to achieve a balanced budget and reform the Medicare and Medicaid programs. APPWP's members represent the entire spectrum of the private employee benefits community and are committed to providing high quality, affordable health care coverage through the workplace.

We are concerned with several provisions in the House and Senate budget reconciliation bills which we urge you not to include in the final conference agreement. These provisions are particularly out of place in a process designed to achieve budget savings while relying on private health plans to deliver high quality services and better access to health coverage. None of this will be possible if we rekindle health care cost inflation or inhibit the ability of health plans to meet the high expectations of their public and private purchasers.

While we are heartened by reports that some of these matters are being resolved in the manner in which we recommend, we must reiterate our concern with the following provisions:

## **1. Medicare Eligibility Age**

We are encouraged by the recent vote in the House to retain the current eligibility age for Medicare beneficiaries and urge the conferees to reject the Senate provision to increase the age of eligibility to 67. While the Senate provision provides no budget savings for the five year period of this bill, it would have an immediate negative impact on the financial bottom line for many employers who agree to provide health coverage for early retirees until they become eligible for Medicare benefits. Even though the change would be phased in over a 24 year period, companies would be required to calculate and plan for their increased health benefit liabilities on a *present* value basis. Clearly, this issue more appropriately belongs on the agenda of the Bipartisan Commission on the Future of Medicare, the panel charged with making recommendations to Congress on the long term changes needed to prepare Medicare for the demographic impact of the Baby Boom generation.

## **2. Medicare Secondary Payer (MSP)**

Both the House and Senate bills would establish a three year period for the government to file claims with private payers for services which the government believes were inappropriately paid by Medicare. APPWP urges the adoption of the Senate provision which would provide that the three year filing period be effective *prospectively*, meaning that the government's extended period to recover payments from others should only apply to items and services furnished after the date of enactment of the budget reconciliation bill. Allowing the government to seek retroactive payments from private parties, as the House bill provides, would be directly contrary to a 1994 federal appeals court decision which held that the federal government -- like any other party -- must file its claims for payment within a private plan's filing deadline. Private plans which have appropriately relied on the court's 1994 ruling should not now be required to incur new liabilities for prior years due to legislative changes which apply retroactively.

We also urge the conferees to modify the MSP provision which would allow the government to seek payments directly from third-party administrators (TPAs). It is not appropriate to establish direct payment liability for TPAs because these organizations only provide administrative services to health plans and do not make payments with their own funds. We recommend that the provision be modified to clarify that a private plan has been properly *notified* of its MSP liability if the government's claim is sent to the plan's current TPA.

## **3. Health Plan Mandates**

We strongly urge the conferees to delete several provisions approved by the House Commerce Committee which would significantly inhibit the ability of managed health plans to ensure that appropriate care is provided to their members. Specifically, we recommend the removal of the provisions which eliminate the ability of health plans to determine the appropriate length of stay for inpatient hospital procedures and the requirement that plans pay for any service which a health care provider determines to be medically necessary. Another damaging provision would impose a variation of the "any willing provider" language. This proposal would restrict private health plans offered to Medicare beneficiaries from determining the type of health care professionals they feel will best meet the health care needs of their members. Taken together, these provisions are highly intrusive and would tie the hands of private plans serving Medicare and Medicaid beneficiaries. In addition, these provisions would almost certainly increase health costs for employers who frequently rely on the same health plans as the federal government and who would face the indirect burden of these counter-productive requirements.

## **4. Benefit Mandates for Children's Health Care Assistance**

Under a new child health care assistance program, the Senate bill would impose a specific minimum benefit package for the coverage provided to low income, uninsured children. In addition, the Senate bill also includes an extraordinarily broad mental health parity requirement which goes far beyond the parity provisions which Congress enacted just last year. The combined impact of these provisions would significantly increase the cost of

coverage for uninsured children, leaving many children with no health coverage at all. In addition, these provisions establish entirely unacceptable conditions for private health care plans which might otherwise be able to serve as a source of quality, affordable coverage for many of the children who the program intends to reach.

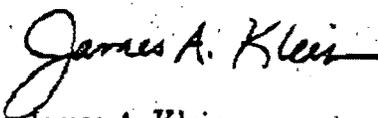
We also urge the conferees to clarify that assistance provided by states to purchase dependent coverage through employer group health plans should be based on *voluntary agreements* with participating employer plans. In particular, states should not be authorized to establish requirements on the content or operations of employer-sponsored health plans, consistent with the fundamental principle of ERISA which distinguishes between the state's authority to regulate the business of insurance while prohibiting it from interfering with other matters left to the discretion of employer plan sponsors.

#### **5. Adequacy of Payments to Medicare HMOs**

A rapidly increasing number of employers are turning to Medicare HMOs to provide comprehensive health care services to their retirees. We are very concerned that the collective impact of the provisions included in the Senate bill not only would increase costs for retirees and employers, but also would lower the level of services that Medicare HMOs typically provide, especially prescription drug coverage. While there is no doubt that the geographic disparities in Medicare's current payment formula need to be addressed, the Senate bill would only increase this level of distortion, providing unjustified windfall payments in some areas of the country while forcing other areas to suffer from inadequate payment levels. This is clearly an area which needs to be addressed by the conferees. Appropriate payment amounts for Medicare HMOs must be provided which avoid establishing disincentives for individuals to enroll in these highly effective private plans.

Again, we support your efforts to achieve entitlement reform and a balanced budget and we stand ready to assist you in accomplishing these important objectives. We look forward to working with you and the other conferees on the budget reconciliation bill as you continue your negotiations on this important legislation.

Sincerely,



James A. Klein  
President

BILL THOMAS, CALIFORNIA, CHAIRMAN  
SUBCOMMITTEE ON HEALTH

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## COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES  
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

*Medicare Home health File*

October 19, 1998

To: Ways and Means Democrats

From: Rep. Pete Stark

Re: Final Home Health provisions

Following is a press release from the Health Subcommittee that describes the final home health changes.

It may be helpful in answering mail, although the press release is critical of the Administration.

In fact, the Ways and Means Democrats voted for retroactive relief for the industry in Committee. Thus the Democratic proposal was better than the package reported out of Ways and Means. Over the weekend the Administration offered additional pay-fors to be used to provide a better package of relief for the home health industry than what is in the final Republican bill. The idea of larger pay-fors to provide more help was rejected by the Republicans. In other words, Democrats wanted to do more for the home health industry than the Republicans.

# NEWS

## FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE

October 19, 1998

CONTACT: Ari Fleischer or Trent Duffy

(202) 225-8933

### **Thomas Announces Agreement With White House on Medicare Legislation**

*Solution for Home Health Care;*

*"Safe Harbors" for Patient Financial Assistance; and  
Expansion of the Medicare Payment Advisory Commission*

**-Summary Chart of Home Health Changes Follows This Release-**

WASHINGTON -- The Congress today incorporated in its omnibus spending bill significant relief for Medicare home health care, "safe harbor" exceptions for patient financial assistance programs at certain medical facilities, and an increased number of commissioners serving on the Medicare Payment Advisory Commission (MedPAC).

"This agreement represents positive and needed reforms to the Interim Payment System for Medicare home health care services. This final product is the culmination of months of work that included our August 6<sup>th</sup> hearing, introduction of H.R. 4567, and the final House version of this bill which passed with a 412-2 vote on October 10, 1998. After months of reluctance to enter the debate, the Administration finally seized the opportunity to do something positive to ensure the well-being of the 38 million seniors who rely on Medicare home health care services," said Health Subcommittee Chairman Bill Thomas.

The home health care compromise changes the funding formulas to provide home health care agencies with more resources. It increases the per visit limits to 106 percent of the national costs. It also increases the per beneficiary limit for those agencies whose per beneficiary limit is below the input price adjusted national median limit. The adjustment is equal to one third of the difference between the agency's per beneficiary limit and the input price adjusted national median limit. Home health agencies who began treating Medicare patients on or after October 1, 1998 will have per beneficiary limits equaling 75 percent of the input price adjusted national median limit, with a two percent reduction. It also delays the 15% across the board reduction to coincide with the implementation of the prospective payment system and extends periodic interim payments for a year.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), designed to toughen fraud and abuse enforcement, will be improved in two ways. First, the Inspector General of Health and Human Services would be given the authority to create exceptions, also known as "safe harbors," to the fraud and abuse rules so as to exclude specific practices from the HIPAA provisions. Second, the bill will allow medical facilities to obtain advisory opinions from the Inspector General so as to provide them with legal and regulatory guidance on whether payment

of coinsurance or other premiums violates HIPAA's fraud and abuse provisions.

The bill also includes a measure to increase the number of commissioners on the Medicare Payment Advisory Commission from fifteen to seventeen.

Revenue offsets include a reduction in the home health market basket by 1.1 percentage points in fiscal years 2000, 2001, 2002 and 2003, and changes the rules for gambling winnings for purposes of determining the taxable year in which a qualified prize is to be included in income.

**CONGRESS IMPROVES MEDICARE  
HOME HEALTH CARE**

|   | <b>CURRENT LAW</b>                                  | <b>BUDGET AGREEMENT</b>  |
|---|---|--|
| <b>1) PER VISIT LIMITS</b>                                | 105% of National Median                             | 106% of National Median  |
| <b>2) PER BENEFICIARY LIMITS:</b>                         |   |  |
| Old Agencies  | 75% Agency + 25% Region<br><br>(minus 2% reduction) | <u>For agencies below the national median:</u><br><br>66.6 %BBA + 33.3% National Median<br><br><u>For agencies above the National median:</u><br><br>NO CHANGE |
| New Agencies  | National Median<br>with a 2% Reduction              | National Median  |
| Agencies Opening<br>After 10/1/98                         | National Median<br>with a 2% Reduction              | 75% of National Median<br>with a 2% Reduction  |
| <b>3) ACROSS-THE-BOARD 15% REDUCTION</b>                  | Applied on October 1, 1999                          | One Year Delay to Coincide With<br>Prospective Payment System  |
| <b>4) PERIODIC INTERIM PAYMENTS TO MAINTAIN CASH FLOW</b> | Eliminated October 1, 1999                          | One Year Extension   |

**DRAFT: COMPARISON OF HOUSE AND SENATE  
HOME HEALTH BILL & ALTERNATIVES**

| <b>POLICY</b>                 | <b>Republican Proposal</b>   | <b>Alternative 1</b>   | <b>Alternative 2</b>   | <b>Alternative 3</b>   |
|-------------------------------|--|--|--|--|
| <b>SPENDING PROVISIONS</b>    |  |  |  |  |
| <b>COST</b>                   | \$1.65 billion / 5   | \$1.65 billion / 5   | \$1.9 billion / 5  | \$2.2 billion / 5  |
| <b>PER VISIT LIMITS</b>       | 106% of median costs   | 106% of median costs   | <b>107%</b> of median costs  | <b>110?</b> % of median costs  |
| <b>PER BENEFICIARY LIMITS</b> |  |  |  |  |
| Old agencies                  | <u>For agencies below the national median:</u><br>66.6% BBA + 33.3% national median<br><u>For agencies above the national median:</u><br>No change | <u>For agencies below the national median:</u><br>66.6% BBA + 33.3% national median<br><u>For agencies above the national median:</u><br>No change | <u>For agencies below the national median:</u><br>66.6% BBA + 33.3% national median<br><u>For agencies above the national median:</u><br>No change | <u>For agencies below the national median:</u><br>66.6% BBA + 33.3% national median<br><u>For agencies above the national median:</u><br>No change |
| New agencies                  | National median  | National median  | National median  | National median  |
| Brand new agencies            | 75% of national median, reduced by 2%  |
| <b>15% ACROSS-THE-BOARD</b>   | One year delay   | One year delay   | One year delay   | One year delay   |

**THE WHITE HOUSE**  
**WASHINGTON**

October 16, 1998

**TO:** The Honorable Bill Thomas  
**FROM:** Chris Jennings  
**RE:** **SUMMARY OF ALTERNATIVE HOME HEALTH PROPOSALS**

Attached is a summary of the alternative proposals that we discussed tonight. We are confident that any one of these three options would receive strong support by the Democrats in both Houses of the Congress.

Based on our conversation with the Democratic leadership, we know that they share our desire to collaborate in the development of an acceptable, bipartisan compromise. We are encouraged that members of both parties recognize the importance of addressing the financing challenges facing the home health industry and desire to achieve this end prior to the adjournment of this Congress.

As we stated in today's conference call, we believe that the policies that you propose to address the home health interim payment system issues are administratable and viable, but we cannot support the proposal's financing. The Administration has consistently taken the position that any modification to the carefully constructed compromise that established the Roth IRA is unacceptable. However, as we hope we have made clear through the development of workable alternative proposals, we are committed to working with you to develop financing options that are acceptable on a bipartisan basis.

We look forward to hearing from you over the weekend on how best to proceed. We remain at your disposal to further explain our options and respond to your reactions.

Please do not hesitate to contact me or Jeanne Lambrew through the White House Signal Operator at 202 / 757-5000.

Testimony of Karen Ignagni

President and CEO

American Association of Health Plans

Medicare Reform  
Competition Rule

Before the House Subcommittee on Health and Environment

On Medicare+Choice: An Evaluation of the Program

August 4, 1999

**I. Introduction**

The members of the American Association of Health Plans (AAHP) appreciate the opportunity to submit testimony to assist in the Subcommittee's evaluation of the Medicare+Choice program. AAHP represents more than 1,000 HMOs, PPOs, and similar network health plans; our membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of beneficiaries in the Medicare+Choice program. Together, AAHP member plans provide care for more than 150 million Americans nationwide and have strongly supported efforts to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans.

Our plans have had a longstanding commitment to Medicare and to the mission of providing high-quality, comprehensive, cost-effective services to beneficiaries. Today, more than 17 percent -- or 6.2 million beneficiaries -- are enrolled in health plans, up from only six percent just five years ago. Recent research indicates that health plans are attracting an increasing number of older Medicare beneficiaries, and that Medicare beneficiaries are remaining in health plans longer. In addition, near-poor Medicare beneficiaries are more likely to enroll in health plans than higher-income beneficiaries. These health plans offer Medicare beneficiaries many benefits that are not covered under fee-for-service Medicare, such as full year's hospitalization, lower copayments and deductibles, and prescription drug coverage (Figure 1).

|                                       | Medicare+Choice | Fee-for-Service |
|---------------------------------------|-----------------|-----------------|
| Outpatient Prescription Drug Coverage | Yes             | No              |
| Deductible for Physician Visits       | No              | Yes             |
| Nominal Copayment for Physician Visit | Yes             | No              |
| Hospital Inpatient Cost-Sharing       | Typically, No   | Yes             |
| Annual Day Limit on Hospital Coverage | Typically, No   | Yes             |

With passage of the Balanced Budget Act (BBA) two years ago, Congress took significant steps toward the goal of providing Medicare beneficiaries with expanded coverage choices similar to those available in the private sector and toward ensuring the solvency of the Medicare trust fund. The establishment of the Medicare+Choice program was supported by AAHP and regarded as the foundation for moving forward with a program design that can be sustained for future generations of Medicare beneficiaries. Unanticipated events, however, have endangered this foundation and created structural issues that must be resolved quickly.

**II. Current State of the Medicare+Choice Program**

As members of the Subcommittee know, the first public sign of trouble in the Medicare+Choice program surfaced last fall when nearly one hundred health plans were forced to reduce or end their participation in the program, resulting in more than 400,000 beneficiaries losing their health plan choice. Fifty thousand of these beneficiaries were left with no other health plan option. At that time, AAHP and

others urged the Administration and Congress to make mid-course corrections, arguing that if program problems were left unaddressed, more health plans, many of which have participated in the program for years, would face the same difficult decisions in 1999 and beyond. The unfortunate reality is that we were right. Just two weeks ago, the Health Care Financing Administration (HCFA) announced that 327,000 beneficiaries in another ninety-nine health plans would lose their health plan on January 1, 2000. Of the 327,000 affected beneficiaries, 70,000 will have no choice but to return to the fee-for-service program because there is no other Medicare+Choice plan in their area.

In addition to these sobering events, an AAHP survey of its 26 largest members that participate in the Medicare+Choice program showed that among responding organizations, a substantial number of beneficiaries who will be able keep their plan next year will face increased out-of-pocket costs and reductions in benefit levels. Survey results, which were independently collected and tabulated by Peter D. Hart Research for AAHP, showed that premium changes to be instituted by 18 companies will affect nearly 1.5 million of the 3.86 million beneficiaries covered by the survey whose plans will remain in the program next year. Among these individuals, monthly premiums will increase by \$20 or more for 926,009 persons and \$40 or more for 400,757 of the 926,009 persons. Monthly premiums will decrease for just fewer than 12,000 individuals; in all instances, these decreases will be less than \$20. More than 1.3 million enrollees will face an increase in prescription drug copayments, while just 10,000 enrollees will have decreased prescription drug copayments next year. Additionally, about 600,000 individuals covered by the survey will face hospital inpatient copayments averaging \$275 next year.

### III. Sources of Medicare+Choice Program Instability

The health plans that announced their decisions to leave the Medicare+Choice program or to reduce benefits did not make their decisions lightly. Many of these plans worked up to the July 1<sup>st</sup> deadline to devise strategies that would enable them to maintain their current service area, to stay in the program next year, or to minimize benefit reductions. But for many of these plans, current problems with the Medicare+Choice payments and increased regulatory burdens were too overwhelming, and they were forced to reduce their participation, to withdraw from the program or to scale-back benefits.

#### Medicare+Choice Payment

The BBA limited the annual rate of growth in payments to health plans, producing \$22.5 billion in savings from the Medicare+Choice program. In addition, the BBA reduced geographic variation in payments to encourage the development of coverage choices in areas of the country with lower payments.

We supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund. We are deeply concerned, however, that unintended consequences of higher than anticipated inflation, the growing gap in funding between the Medicare+Choice and fee-for-service sides of the program, and administrative actions taken by HCFA affecting Medicare+Choice payments do not serve the best interests of beneficiaries and were not anticipated by Congress.

★ In 1998 and 1999, because of the low national growth percentage and the inability to achieve budget neutrality, no counties received blended payment rates. Spending on medical services furnished to Medicare-eligible military retirees by Department of Veterans Affairs (VA) and Department of Defense (DoD) hospitals continues to be omitted from the calculation of Medicare+Choice rates. A few years ago, the Prospective Payment Advisory Commission (ProPAC) estimated that health care provided in DoD and VA facilities to Medicare beneficiaries accounts for 3.1 percent of the total resource costs of treating Medicare beneficiaries. ProPAC concludes from its findings that the omission of the cost of care provided in DoD and VA facilities to Medicare beneficiaries leads to systematic errors in both the level and distribution of Medicare managed care payments. H.R. 2447, introduced by Congressman McDermott, would help address this problem by including these amounts in Medicare+Choice rate calculations.

In addition, the BBA sought to begin tackling some of the issues related to Graduate Medical Education (GME) reform by limiting the number of residents supported by the Medicare program and by providing incentives to hospitals to reduce the size of their training programs. However, a central BBA provision, the removal of GME funds from the calculation of payments to Medicare+Choice organizations, does not appear to address GME reform goals. AAHP opposed the removal of GME funds from the calculation of Medicare+Choice payments, particularly in the absence of broader, structural reforms to

GME financing. AAHP voiced concern that removal of GME funds could result in premium increases and/or benefit reductions for beneficiaries enrolled with plans already participating in the program, inhibit enrollment growth, and at worst could force some plans to leave the program.

This provision was intended to assure that beneficiaries have access to services at these facilities and that these facilities are compensated for their teaching costs. Studies show that health plan members do use teaching facilities and that plan payments for a given case in a teaching hospital greatly exceed payments for the same case in a non-teaching hospital. Although GME payments are being removed from Medicare+Choice payments, in many markets, the dominance of teaching hospitals limits health plans' ability to reflect the carve-out by making commensurate reductions in payments to teaching hospitals. Consequently, teaching hospitals are receiving GME payments from the Medicare program as well as higher payments from health plans. Ultimately, it is the Medicare beneficiary who bears the burden of these higher payments due to reductions in additional benefits that they otherwise would receive.

Furthermore, HCFA has chosen to implement its new risk-adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated *additional* \$11.2 billion over a five-year period beginning in 2000. This is an administratively imposed increase in the \$22.5 billion savings Congress expected from the payment methodology as enacted in the BBA. In fact, at the time of the BBA's approval, **the Congressional Budget Office (CBO) did not score the new risk-adjuster as saving money.** More recently, CBO stated that it had "previously assumed" that the health status-based risk-adjustment in the Medicare+Choice program would be budget neutral. *\$11.2 bn in CBO savings?*

AAHP analysis of PricewaterhouseCoopers projections of Medicare+Choice rates in each county over the next five years shows that a significant gap opens up between reimbursement under the fee-for-service program and reimbursement under the Medicare+Choice program. This Medicare+Choice Fairness Gap will be at least \$1,000 for two-thirds of Medicare+Choice enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment (Figure 2). This same Fairness Gap will exceed \$1,500 per enrollee in major Medicare+Choice markets, including Chicago, Los Angeles, Miami, New York, Boston, Pittsburgh, Cleveland, St. Louis City, Dallas, and Philadelphia. In Miami, the Fairness Gap will be \$3,500 per enrollee in 2004 and in Houston the gap will exceed \$2,500 per enrollee in 2004. In New Orleans, the Fairness Gap will exceed \$2,600 per enrollee in 2004.

For nearly half of Medicare+Choice enrollees living in the top 100 counties, government payments to health plans on behalf of beneficiaries will be 85 percent or less of fee-for-service Medicare payments in 2004, significantly exceeding estimates of so-called overpayment due to favorable selection by plans (Figure 3). When AAHP examined the top 101 to 200 counties as ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be \$1,000 or more in 2004.

A large percentage of the Fairness Gap is attributable to HCFA's new risk-adjuster, the design of which is severely flawed. Rather than measuring health-status, HCFA's risk-adjustment measures inpatient hospital utilization. This design penalizes health plans that use disease management programs designed to reduce hospitalizations for chronically ill patients who would have otherwise been treated in inpatient settings. These programs are designed to prevent costly hospitalizations by treating patients in alternative settings.

An AAHP analysis of PricewaterhouseCoopers projections that incorporate the effect of the risk-adjustment methodology, when it is phased-in at 10 percent, indicate that nearly half of current Medicare+Choice enrollees live in areas in which year 2000 payments will increase by 2 percent or less over 1999 payments. This situation will likely worsen in 2001 when HCFA will base 30 percent of Medicare+Choice payments on its risk-adjustment methodology. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk-adjustment methodology will be to restrict new market entrants and leave beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs. AAHP has found that the impact of HCFA's risk-adjuster on Medicare+Choice payments to rural and urban counties is similar — rural areas with Medicare+Choice beneficiaries are cut by about 6 percent, while urban areas are cut by about 7 percent.

AAHP also has significant concerns about the funding of the Medicare beneficiary information campaign. While it is reasonable for health plans and their enrollees to contribute to funding HCFA's education and information dissemination initiatives, their contribution should be in proportion to their participation in the Medicare program. Last year, Medicare risk HMOs and their enrollees represented

14.3 percent of the program, but shouldered 100 percent of the cost of the information campaign.

The FY1999 \$95 million funding level represents an annual cost of \$2.40 per beneficiary if it is spread over the entire Medicare population of 39 million beneficiaries. It represents an annual cost of \$15.43 per beneficiary if it is spread over only those beneficiaries who have enrolled in a Medicare+Choice plan. On average, generating the \$95 million authorized by the BBA will require a tax of \$1.90 each month for each beneficiary enrolled in a Medicare+Choice plan (the tax is collected over only the first nine months of the year). This \$1.90 per month per beneficiary tax represents 18% percent of the average monthly 1998 to 1999 payment increase under the new BBA payment methodology.

AAHP supports the goal of providing beneficiaries with accurate information that allows them to compare all options and select the one that best meets their needs. Last year's campaign did not meet Congressional expectations. Many beneficiaries received incorrect or confusing information and some plans were left out of the brochure altogether. AAHP urges Congress to ask HCFA for an accounting of its use of resources for educational purposes. We also urge Congress to adopt MedPAC's recommendation to fund this program through HCFA's operating funds rather than a tax on Medicare+Choice enrollees. AAHP continues to believe that the entire beneficiary information program should be reevaluated and streamlined.

### Stabilizing Payment Will Help Stabilize the Medicare+Choice Program

The present state of the Medicare+Choice program is not what Congress expected when the BBA was approved two years ago. Rather than having expanded coverage choices, beneficiaries face fewer coverage choices. Additional benefits offered by plans that are not available in the fee-for-service program are being jeopardized. Some have argued that HCFA overpays health plans and that plans withdrawing from the market are simply making "business decisions." In response, first let me say this: overpaid health plans do not leave a market. Overpaid health plans do not reduce benefits. Second, payment and regulatory requirements dictate the type of environment in which health plans participate in the Medicare+Choice "business." So yes, the current payment and regulatory environment is forcing plans to make difficult business decisions regarding their participation in the Medicare+Choice program.

The Bilirakis-Deutsch bill, H.R. 2419, would go a long way toward stabilizing the payment situation in both urban and rural areas by requiring that HCFA implement the new risk-adjuster on a budget-neutral basis, which is in keeping with Congressional intent. The bill also would ensure that national updates to government payments for beneficiaries choosing a Medicare+Choice plan grow at the same rate as government payments for beneficiaries choosing fee-for-service Medicare. H.R. 2419 represents an equitable restoration of funding by increasing the total dollars available in setting Medicare+Choice payment rates. This approach will help ensure that the BBA goal of expanding coverage choices for all beneficiaries is met.

Another way that payments could be stabilized is through establishment of a true payment floor. As discussed earlier in this testimony, Medicare+Choice payments are falling drastically relative to fee-for-service Medicare payments — in many areas, payments are falling to 80 percent or less of fee-for-service payment. To prevent this, a true floor could be set such that Medicare+Choice payments would not fall below a specified percentage of fee-for-service per capita payments in a county.

### Medicare+Choice Regulatory Environment Contributes to Program Volatility

The challenges facing the Medicare+Choice program do not result from payment alone. HCFA's approach to overseeing the program and the structure of the Medicare+Choice program are contributing to the volatility in the program. Taken together, the issues of payment and regulation have challenged plans' abilities to maintain their health care networks. In some cases, providers simply have told health plans that given low payments and increased regulatory requirements on them, that they are better off just seeing beneficiaries under the fee-for-service program.

**HCFA Roles as Purchaser and Regulator in Conflict.** HCFA's dual roles as purchaser and regulator are, at times, in conflict. Nowhere has this conflict been more evident than in HCFA's implementation of the BBA. The situation plans faced in the fall of 1998 serves to illustrate the inherent conflict between HCFA's traditional role as a regulator and its changing role as a purchaser. HCFA published the Medicare+Choice regulation, which was more burdensome than expected, nearly a month and a half after the date plans were required to file their 1999 adjusted community rate proposals (ACRs) last year.

This situation and the unrealistic compliance deadlines combined with the reduced rate of increase in payments and the uncertainty created by the new risk-adjustment model, caused plans across the country and across model types to become deeply concerned last fall about the viability of the benefits and rates included in their ACRs on the originally mandated May 1<sup>st</sup> deadline. This led our members to make an unprecedented request to HCFA to allow plans to resubmit parts of their ACRs. In some service areas, the ability to vary copayments -- even minimally -- meant the difference between a plan's ability to stay in the Medicare+Choice program or to pull out of a market.

While this request presented HCFA with a complicated situation, AAHP strongly believes that an affirmative decision would have been better for beneficiaries. As a purchaser, HCFA had a strong motivation to maintain as many options as possible for beneficiaries by responding to health plans' concerns and adopting a more flexible approach to Medicare+Choice implementation. As a regulator, however, HCFA had concerns about criticism that could result from reopening bids, and thus chose not to allow any opportunity for adjustment of ACRs. HCFA's decision in part contributed to the withdrawal of nearly 100 health plans from the program, affecting more than 400,000 beneficiaries. These role conflicts remain unresolved, even largely unaddressed. Until ways are found to reconcile them, however, they will stand in the way of designing and delivering a Medicare+Choice program that really works for beneficiaries.

**Need For Fair Regulations.** Beneficiaries should have confidence that all options, including both Medicare+Choice plans and the Medicare fee-for-service program, meet standards of accountability that ensure that they will have access to all Medicare benefits and rights regardless of the coverage choice they make. All Medicare+Choice options offered to Medicare beneficiaries should be required to meet comparable standards in such areas as quality of care, access, grievance procedures, and solvency.

These standards should be implemented through regulatory requirements that make the best use of plans' resources to ensure that beneficiaries receive the maximum value from the program. This means that when requirements are established, their benefits must outweigh their costs. While we appreciate HCFA's efforts to address concerns about certain aspects of the Medicare+Choice regulation over the past several months, the fact remains that health plans are having to devote substantial human and financial resources toward compliance activities, which in turn means fewer resources devoted to additional benefits.

AAHP renews its request that HCFA undertake an immediate analysis to develop a full understanding of the relationship between the costs associated with the full array of Medicare+Choice requirements and their value to beneficiaries and the Medicare program. We believe strongly that more of these resources should be available for benefits and patient care.

**Specific Areas of Concern with Medicare+Choice Legislative and Regulatory Requirements.** Beyond the issues presented above the following specific areas are among those that remain problematic:

- **Discontinuation of Flexible Benefits Policy.** Prior to enactment of the BBA, Medicare HMOs were allowed to vary premiums and supplemental benefits within a contracted service area on a county-by-county basis, and to customize products &ndash; or offer "flexible benefits" &ndash; to meet beneficiary and employer needs and the dynamics of individual markets. The BBA and HCFA's Medicare+Choice regulations are both more restrictive than this policy, and require that Medicare+Choice plans offer uniform benefits and uniform premiums across a plan's total service area without regard to different county payment levels. The result is that plans are less likely to continue or begin serving lower-payment counties, just the opposite of expanding coverage choice. HCFA developed a transition policy for existing contractors, which allows Medicare+Choice organizations to segment service areas and offer multiple plans in an effort to mitigate the effect of moving away from the flexible benefits policy. While this transitional relief has alleviated this problem in the short term, a permanent solution is needed. AAHP encourages the Committee to revise the statute so as to revert to the prior policy allowing flexible benefits within plan service areas.
- **HCFA's QISMC Standards Disregard Experience of Private Sector.** One area of significant concern to AAHP member plans is HCFA's Quality Improvement System for Managed Care (QISMC). QISMC is designed to establish a consistent set of quality oversight standards for health plans for use by HCFA and state Medicaid agencies under the Medicare and Medicaid programs, respectively. AAHP has long advocated coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. While AAHP believes

that QISMC could have been designed to contribute to this important goal, our members have a number of serious concerns regarding HCFA implementation of this program. Furthermore, we are also concerned that the Medicare program is not providing equal attention to the overall quality of care furnished under the fee-for-service program.

One of our primary concerns is that QISMC lacks clear coordination with existing public and private sector accreditation and reporting standards. Rather than coordinate with existing standards, QISMC establishes an entirely new system of requirement that not only are far more stringent, but also are unreasonable in their timeframes. Meeting two competing sets of standards adds to administrative cost while detracting from health care quality improvement.

### III. Solving the Problems that Undermine the Success of the Medicare+Choice Program

AAHP and its members applaud the Subcommittee for holding this hearing and implore the Subcommittee to move immediately in taking measures to restore stability to the Medicare+Choice program. In doing so, AAHP members urge the Subcommittee to consider the following four principles.

- **First, Congress must ensure that Medicare+Choice payments are adequate and stable and that they are comparable to those in fee-for-service Medicare.** Federal contributions to Medicare+Choice organizations should be adequate and predictable to promote expanded coverage choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established.

The Administration projects that its approach will cut Medicare+Choice payments by an additional \$11.2 billion over a 5-year period and thus endanger the very choices, broader benefits, and out-of-pocket protections these beneficiaries enjoy. As is now apparent, the BBA payment formula, in combination with the Administration's new risk-adjuster, will not achieve this goal. Instead, AAHP analysis shows a dramatic gap opening up between payments for beneficiaries in the Medicare+Choice program and their counterparts in fee-for-service Medicare.

AAHP urges of swift approval of the bipartisan H.R. 2419, the Medicare+Choice Risk-Adjustment Amendments of 1999, introduced by Congressman Bilirakis and Congressman Deutsch. A budget-neutral risk-adjuster brings greater equity to payments without penalizing plans or destabilizing the program.

- **Second, HCFA's beneficiary information and education effort should be re-examined and refocused to meet beneficiary interests and needs.** AAHP supports the goal of providing beneficiaries with accurate information that allows them to compare all options and select the one that best meets their needs. AAHP urges Congress to ask HCFA for an accounting of its use of resources for educational purposes. AAHP continues to believe that the entire beneficiary information program should be reevaluated and streamlined.
- **Third, Congress must promote and enforce a responsive regulatory environment.** Without a doubt, the present instability has undermined beneficiaries' confidence in the Medicare+Choice program. Unless action is taken to restore their confidence, it is unlikely that the goals of the BBA will be achieved. Beneficiaries deserve a well-run program that is responsive to their needs. Unfortunately, the conflict between HCFA's roles as a purchaser and regulator often prevent the Agency from acting more nimbly in the best interests of beneficiaries.

HCFA's implementation of the BBA highlights the tension between these roles. To increase consumer confidence in all aspects of the Medicare program, HCFA should take immediate steps to improve administration and regulation of the Medicare+Choice program. During the first year of Medicare+Choice implementation, HCFA promulgated more than 800 pages of new regulations and issued countless operational policy letters. The Medicare+Choice regulation should be re-examined to ensure that the value to beneficiaries justifies the resources required for compliance.

### III. Conclusion

For over a decade, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these coverage choices are at risk.

Congress and the Administration should act immediately to create a level playing field between the payments under the Medicare+Choice program and the Medicare fee-for-service program, and a regulatory environment based on the principles of ensuring that the value to beneficiaries justifies the resources required for compliance and equal accountability under the Medicare+Choice and Medicare fee-for-service programs.

We urge you to address the Fairness Gap, and the problems we have identified with HCFA's implementation of the Medicare+Choice risk-adjuster, and with regulation of the program. We are in the process of conferring with the members of the Subcommittee and your staff about AAHP's specific suggestions &ndash; some of which we have mentioned today &ndash; for solving these problems.

Our concern last year that without action, more beneficiaries would lose access to their plan and that others would face reductions in benefits has become a dismal reality. Further delay could render the Medicare+Choice program beyond repair or salvage. This outcome would be a loss not only for the beneficiaries who have chosen a Medicare+Choice plan, but also for future beneficiaries who would be denied the opportunity to do so.

Competition reform

50% work change

people

= Administration of AAHP in lock step

Risk reduction

= Why come here. Common interest. Making Multinational. Make it more efficient & responsive. Bring it into 21st century, Finance & adaptability.

insurance reform

Options  
Trade of  
Risk

= Long-Term Financing Protects Against Future Costs

= Payments of Govt payments based on competition, not regulation

- Design of other benefits actually explicitly & implicitly

✓ 10-20% more  
Performance all over more

- Payments geographically adjusted

- Repayment / stability / Partners

→ Fair down hill (power edge)

→ Low Nichols

→ Private vs Public Rates

→ Fraud

→ Full cost of appeal

→ Risk Adjustment - / World of total  
Finance Mee

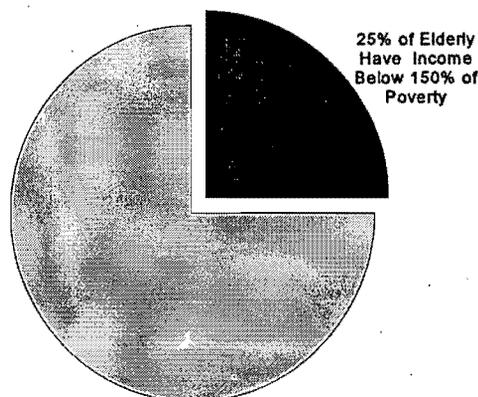
Excess benefits but  
Common risk

High option of  
substantive contract  
Retail inquiries

## MEDICARE PREMIUMS IN THE BUDGET AGREEMENT

- **Maintains 25% Premium.** The Budget Agreement includes significant structural reform in Medicare. It keeps the Medicare Part B premium at its current level of 25 percent of program costs. This is far below the 31.5 percent premium that the President vetoed in 1995.
- **Premiums Well Below Vetoed Budget.** These premiums are very reasonable and significantly below the vetoed 1995 Republican budget's premiums — around \$20 below per month in 2002 or around \$240 per year.
- **Home Health In Premium.** The Agreement gradually includes home health spending transferred to Medicare Part B in the premium.
  - **Small increase.** The premium only increases by an average of \$1 per month per year over the next several years due to the phase in.
  - **Beneficiaries contribute to Medicare's solvency.** By paying slightly more, beneficiaries help extend the life of the Medicare Trust Fund. Transferring home health to Part B of Medicare, combined with the structural reforms in Part A, extends the life of the Trust Fund for a decade.
- **Low-Income Protections.** Medicaid's premium protection for low-income Medicare beneficiaries is expanded from its current 120 percent to 150 percent of poverty. Over 8 million Medicare beneficiaries have income below 150 percent of poverty.

### One In Four Medicare Beneficiaries Assisted With Medicare Premiums



REVISED: May 5, 1997