

THE WHITE HOUSE

WASHINGTON

February 27, 1995

MEMORANDUM TO BRUCE LINDSEY

FROM: CAROL H. RASCO *CHR*
SUBJECT: Mark Pryor's Proposal on CPT Codes for Medicare *file*

As part of the Regulatory Review Initiative of Reinventing Government II, a "health industry" working group is considering ways to simplify Medicare coding and reimbursement. I have forwarded to them Mark Pryor's proposal to revise the current procedural terminology (CPT) code definitions.

CPT is a systematic listing and coding of more than 7000 physician services that provides uniform language to describe these services for physicians, payors and patients. CPT codes are used by both public programs and private insurers. Mark Pryor proposes to simplify CPT code definitions for the Medicare program so that payment would be linked only to diagnosis.

While the health industry working group has found that there is certainly room for improvement in Medicare billing, my initial view is that this proposal is not the best way to reduce costs and complexity in the Medicare program. First, many of the problems identified in Mark Pryor's letter have already been solved by revisions in CPT (as he acknowledges). In addition, a system that limits payment for a procedure to a specific diagnosis will not reflect the complexities and variation in medical practice. The same diagnosis can require different treatment options depending, for example, on a patient's condition. The system he envisions might automatically deny payment for a treatment if it is not *the* treatment linked to *the* diagnosis. Finally, because the CPT system is used by private payors as well as Medicare and Medicaid, a change in Medicare will require payors to maintain two coding systems and may actually increase paperwork and costs.

Please let me know if you have any additional questions or concerns. Also, please feel free to contact Jennifer Klein at 6-2599.

TO: Carol Rasco
FROM: Jennifer Klein *J.K.*
DATE: 2/25/95
RE: Letter from Mark Pryor on Medicare CPT Codes

Attached please find a suggested response from you to Bruce Lindsey. I apologize for the delay, but I had trouble getting Elaine Kamarck and Marjorie MacFarlane to respond. In fact, they have still not responded but told me that they do not think they have an opinion about this.

Please let me know if there is anything else I can do on this.

February 3, 1995

MEMORANDUM

To: ✓ Carol Rasco
Elaine Kamarck

From: Bruce Lindsey *Bruce Lindsey*

Subject: Executive Order for Medicare

FEB - 6 1995

I know HHS has had some discussions regarding this matter. I don't know enough about the substance to know whether this proposal has merit, but it sounds like something we should evaluate.

J. KLEIN (please coordinate w/ Elaine per my Email)
PLEASE evaluate and do
short response to BRUCE
for CHR by 2/17.
Thanks.

ROZ : TICKLER

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January 31, 1995

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Mr. Bruce Lindsey
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

VIA UPS NEXT DAY AIR

RE: Executive Order For Medicare

Dear Bruce:

Enclosed for your review is a draft Executive Order. It provides for a way to cut Medicare, Part B, costs while not reducing Medicare services.

Since Medicare is different from most government programs, let me offer this brief explanation of the problem and the solution. By way of background, the foundation for the Medicare Part B reimbursement payments is the Current Procedural Terminology (CPT) Codes developed by the American Medical Association as medical records codes and adopted by the Health Care Finance Administration (HCFA) as reimbursement payment codes. These codes have some imprecision and incompleteness as payment codes and HCFA has been slow to make adjustments. As an example, it has been estimated that 30 percent of the reimbursement payments in the Medicare Part B system are improperly coded.

This proposal would revise the CPT code definitions based on input from the provider level, so that those codes are accurate reimbursement codes. If implemented, a private group would delineate and define each medical action, technology, and method in concise language that is understood by HCFA, providers and carriers. Then, each would be connected to a medically necessary diagnosis and each definition/diagnosis would be tied directly to a single reimbursement payment code.

In addition to fixing a faulty foundation, other benefits of this proposed request for proposals would be:

WRIGHT, LINDSEY & JENNINGS

Mr. Bruce Lindsey
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- Achieve roughly six percent reduction (over \$3,000,000,000) in current Medicare Part B reimbursement payments, without reducing medical services.
- Curtail the roughly eleven percent potential growth (more than \$6,000,000,000) resulting from "gaming" the present codes.
- Reduce the "hassle factor" and claim rejections for providers, therefore getting payments to them sooner and increasing their claims efficiency.
- Provide methods to adopt to future changes in clinical protocols in medical technologies.
- Establish a continuing educational communications system at the grass roots level and at the carrier level.
- Establish an ongoing monitoring system for identifying errors and abuses.
- Provide accurate data for HCFA in making future decisions.

For your review, I am providing a few examples of coding problems with Medicare Part B. Please note that some of these problems have already been corrected by HCFA, but they are illustrative of what is going on out there in the field. As you can tell, this proposal could save billions of dollars in Medicare.

I pass along this rough draft executive order as a starting point. I certainly understand that it is important for the White House to feel comfortable with its language. Please feel free to contact me if you have any questions or suggestions or feel free to get some of the staff in touch with me if they have questions.

PLEASE NOTE. It is my belief that time is of the essence with this proposal. Since we last talked, this idea has been shopped around with several majority members' staffs at the House of Representatives. In addition to individual members, the Ways and Means Committee staff has also seen information relating to the proposal. They are aware that we have passed along a draft executive order, but it was not provided to them. I am told there is a high degree of interest on Capitol Hill in this proposal. Also, the Democratic staff for the Senate Aging Committee has been contacted about the same idea.

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Mr. Bruce Lindsey
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It is my belief that this proposal fits neatly into the reinventing government program pushed by this Administration. In that regard, I have passed this same rough draft of the executive order along to Marjorie MacFarlane at the Vice President's office.

I hope you will give this matter strong consideration and send it through the proper channels at the White House.

We look forward to working with you, the White House staff and the Vice President's staff to make these reforms become a reality. If I can be of any further assistance, please do not hesitate to contact me.

Cordially,

WRIGHT, LINDSEY & JENNINGS



Mark L. Pryor

MLP:jas
Enclosures

I:jas1235.064



STATEMENT OF
BRUCE VLADECK
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
FEBRUARY 15, 1995

To: Carol
From: Chris

As requested.

File Medicare

Mr. Chairman and Members of the Subcommittee

I am pleased to be here today to begin a dialogue with this Subcommittee about the current state of the Medicare program and, more importantly, about its future. The members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable population that we serve, and have contributed to major improvements in the program over the years. Medicare is a popular and successful program. I believe we need to work together to improve on the program's success and strengthen it for its beneficiaries and the taxpayers who support it.

We in HCFA have been working very hard to make the Medicare program an effective, affordable and "customer friendly" program for beneficiaries. At the same time, we have been working to implement administrative and program improvements which maximize the efficiency and cost effectiveness of the program. I want to begin by reviewing some of our recent efforts and successes and then provide you with an overview of our efforts in the area of managed care. Finally, I would like to discuss some of our initiatives to improve the administration of the Medicare program.

I. SUCCESSES

Medicare is the world's largest health insurance program and by many measures one of the most successful. It began in 1966 as a Federal health insurance program for the elderly and was expanded in 1972 to cover disabled persons and those with End Stage Renal Disease (ESRD). The Medicare program was established because our vulnerable populations had difficulty obtaining private health insurance coverage.

Medicare is administered largely by private contractors under our supervision. In 1994, Medicare served almost 36 million persons under Parts A and B of the program. Aged Medicare beneficiaries number 32 million, 3.6 million are disabled and 77,000 have ESRD. Medicare has agreements with over 65 contractors to process beneficiary claims. In FY 1994, over 750 million claims were processed and Medicare paid more than \$159 billion for medical services, treatment and equipment.

Today, we maintain Medicare's commitment to serve the most vulnerable. Medicare is the largest payor of the elderly's health care expenses. As the Subcommittee examines the future of the Medicare program, I would urge you to consider the following important facts about Medicare beneficiaries.

- o Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less

than \$25,000. (CHART 1)

- o Currently, 20 percent of our beneficiaries are either seniors age 85 and older, most of whom are women, or persons with disabilities including End Stage Renal Disease (CHART 2).
- o Third, per capita health care spending for aged beneficiaries is 4 times the average for the under 65 population.

Medicare is successfully fulfilling its mission and beneficiaries continue to express a high degree of satisfaction with the program. Millions of elderly and disabled Americans now have health care coverage and a quality of life that they would otherwise lack, thanks to the Medicare program.

Innovative Program Administration

Despite the size of the Medicare program, we have maintained a high level of consumer satisfaction with low administrative costs, less than two percent of program outlays. In contrast, private insurance administrative expenses are about 25 percent in the small group market and about five percent in the large group market.

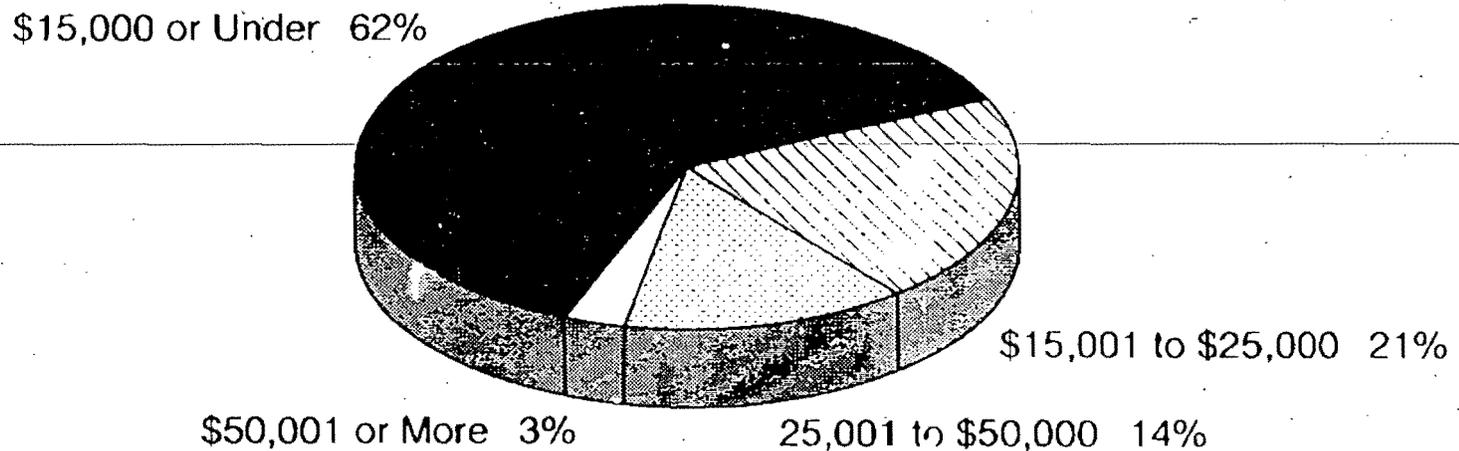
Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission: Ninety percent of Medicare's hospital and skilled nursing facility claims and 67 percent of its physician claims are submitted electronically. In contrast, 60 percent of Blue Cross' hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is 10 percent for all claims. (CHART 3)

We have focused attention on reducing the paperwork burden on health care providers, working closely with the health care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs). Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

Decline in the Medicare Baseline

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's FY 96 Budget, the projected annual average rate of growth for 1996 - 2000 is 9.1 percent. In contrast, six months ago in the Mid-Session Review, the projected annual average rate of growth for the same period was 10.3 percent. The

Share of Program Expenditures by Income Of Medicare Individuals or Couples, 1992



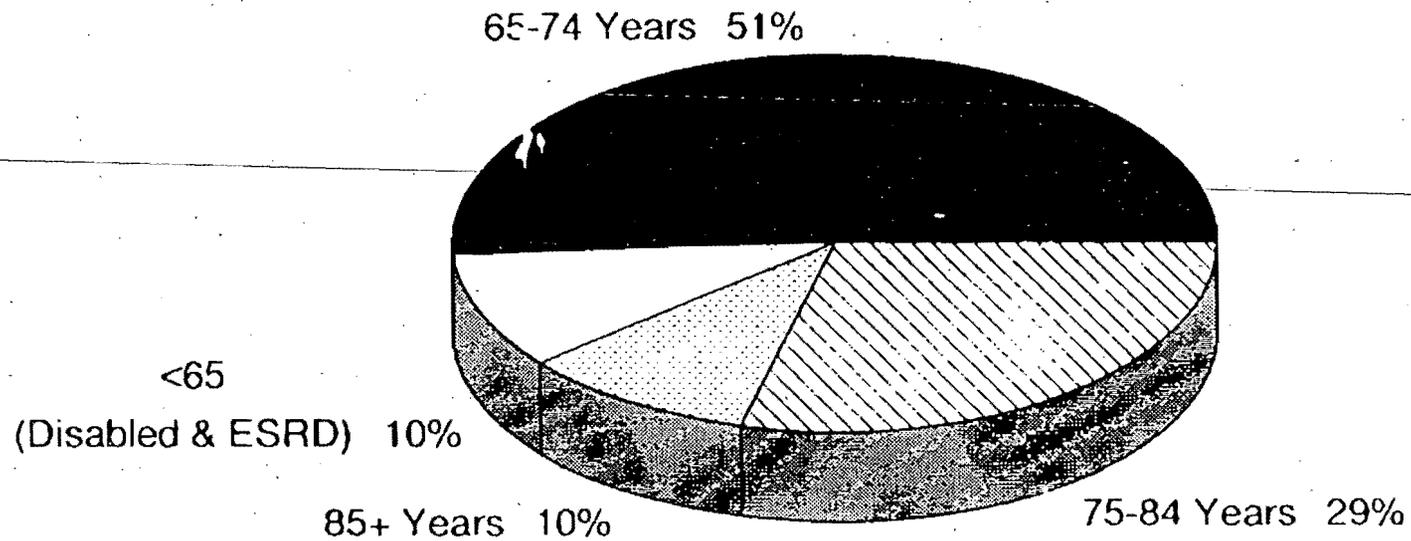
83% of Expenditures: Annual
Income of \$25,000 or Less

Excludes 2.2% not reporting income.
Also Excludes HMO enrollees (9%).
Source: HCFA/OACT

Chart 1

The Composition of the Medicare Population, 1992

Elderly, Disabled and ESRD



Total Beneficiaries=35.6 Million

Source: HCFA/BDMS

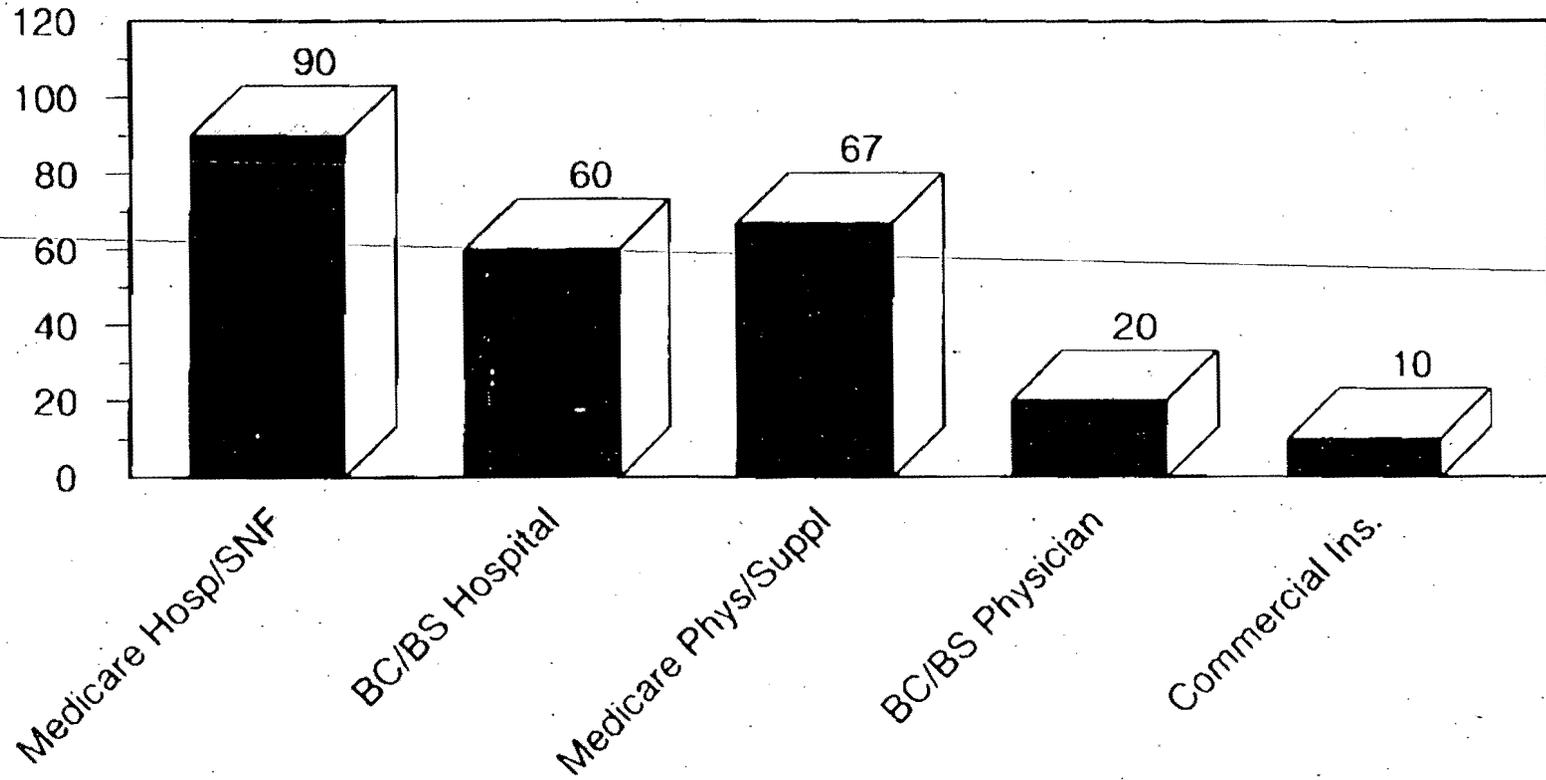
P78 HCFACT4

Chart 2

Electronic Submission of Claims

Medicare vs. Private Insurance

Percent Electronic



1994

Source: HCFA/BPO; Blue Cross Assoc.

P78 HCFACHT2

Chart 3

primary contribution to lower Medicare projections is slower growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.

II. MANAGED CARE AND THE MEDICARE PROGRAM

Today, any discussion of the quest to enhance cost effectiveness, as well as the accessibility of quality medical care for beneficiaries, must include managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options available to the general insured population. The cornerstone of our policy is informed choice in a fair marketplace, in which beneficiaries have full and objective information and are not discriminated against on the basis of relative need.

Managed care is not a new concept for the Medicare program. Since its inception in 1966, a portion of Medicare beneficiaries have received care through managed care arrangements. Enrollment is increasing, and we anticipate continued strong growth as newly entitled beneficiaries, who are more familiar with managed care, enter the Medicare program.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. 1994 was a year of impressive growth in Medicare managed care, we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in both the Medicare and Medicaid programs. The movement to managed care cannot outpace the capacity of managed care plans to serve large

numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way Medicare pays managed care plans. Managed care currently costs the Medicare program rather than achieving savings. Our evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that they attract the healthier members of the Medicare population whose health care costs are lower. Efforts are underway to improve the current payment methodology so it doesn't act as a barrier to the expansion of managed care. We have initiated several research projects and demonstrations to address this situation and we expect to have preliminary results later this year.

Medicare beneficiaries themselves must determine the pace of their movement to managed care. The emphasis must be on choice. Managed care will succeed as managed care plans are able to prove the value of their products and as beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

NEW MANAGED CARE OPTIONS

Medicare SELECT

Experience with Medicare SELECT should be part of our efforts to improve current managed care options under Medicare. We believe, however, that any expansion of SELECT should be preceded by a serious examination of our experience under the 15-State demonstration. We have looked at this experience and have two areas of concern.

One major concern is with the adequacy of beneficiary protections under Medicare SELECT. There is no requirement for States to review the actual operations of the SELECT plans once they are approved to assure that quality and access standards are being met. We feel strongly that beneficiaries should not have to worry about the quality and access provisions of their Medicare choices. We look forward to working with the Subcommittee on this important issue.

Our second concern is whether Medicare SELECT will make any contribution to increasing the efficiency of the Medicare program. As you know, Medicare SELECT was designed to create a hybrid of managed care and Medigap that would be beneficial both to beneficiaries and to Medicare. Our experience under the demonstration, however, is that plans generally achieve savings for beneficiaries through hospital discounting arrangements rather than the active management of care or the efficiency of

the SELECT networks. More than half of the current SELECT plans are hospital only networks. We believe that such plans do little to contribute to the increased efficiency of the Medicare program and the Congress should understand this as it considers making the SELECT program permanent. Some advocates of SELECT have proposed to expand the discounting arrangements to Part B services. We would oppose such a modification since it would actually increase Medicare costs, as physicians increase utilization to recoup their discounts.

Given the impending deadline for the expiration of the authority for Medicare SELECT demonstration and the need to examine the demonstration experience, the Congress may want to consider a quick extension of the demonstration for existing plans through the rest of the calendar year. This 6 month extension would address the current uncertain state of the existing Medicare SELECT plans and provide ample time to examine the experience under the demonstration and to determine the changes to SELECT that should be made based on demonstration experience.

PPO Option

We want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time, if they were willing to pay the cost-sharing.

In developing a PPO option for Medicare, we hope to learn from our experience with the Medicare SELECT demonstration. Medicare SELECT plans have limited incentives to manage total costs. Under the PPO option, plans would be at some risk for Medicare benefits. Our objective is to ensure the same quality, access, grievance and appeal procedures as we do now in Medicare risk and cost plans. We hope to be able to work with the Subcommittee on the PPO option in the months ahead.

Beneficiary Education

We need to do a better job of informing beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion which works against managed care options. To understand their choices, beneficiaries have to negotiate through differences in benefit packages, cost-sharing structures and premium amounts. Beyond this need for information, beneficiaries are also be faced with enrollment periods that vary by plan and, in the case of Medigap, with

health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one time option for open enrollment in Medigap.

We would like to do everything possible to make managed care options very attractive to beneficiaries. We think we can do a better job of helping them to understand the advantages of these plans.

Quality and Managed Care

Today, managed care organizations providing services to Medicare and Medicaid beneficiaries are required to have internal quality assessment and improvement programs to identify ways to improve the delivery of health care services and the health care itself. We also require independent external review of quality of care delivered to our beneficiaries.

HCFA is working in collaboration with the industry on a long term effort of developing a single set of measures that could be used by all payors to address the full range of a health plan's membership and performance.

The first phase of this effort centers on major performance measurement projects underway in both Medicare and Medicaid. These are designed to help us develop measures that are focused on the special needs of our diverse populations.

In Medicaid, we are working collaboratively with National Committee for Quality Assurance (NCQA), State Medicaid agencies, consumer advocates and managed care organizations to adapt the commercial sector's state-of-the-art performance measurement tool HEDIS (Health Plan Employer Data and Information Set) to the needs of the Medicaid program.

We chose HEDIS as the template for our Medicaid effort for several reasons:

- o HEDIS is viewed by most of the leading state managed care programs as the appropriate model for Medicaid. Some states are already adopting HEDIS. We feel it is important to provide some national leadership.
- o We want to coordinate with the private sector and take advantage of the significant analytical groundwork already produced by NCQA, so as to minimize potential reporting burdens on our managed care plans, many of which are adopting HEDIS.

In Medicare, we are beginning to pilot test a new, performance based approach to Peer Review Organization (PRO) review of HMOs developed under contract with the Delmarva

Foundation. These measures reflect the special health needs of an elderly and disabled population, for example, in management of chronic conditions. These measures will then be considered in conjunction with the broader HEDIS effort.

Payment/Competitive Bidding

As I discussed above, concerns about the payment methodology for risk contractors has been long standing. Currently, we determine rates on a yearly basis, and plans decide whether or not to enter into a contract each year based on the rates. These rates, called the Adjusted Average Per Capita Cost (AAPCC), are developed for each county and are based on fee-for-service costs in the area. County rates are then adjusted for age, sex, institutional and Medicaid status; no adjustment is made for health status per se. Plans have been concerned with the adequacy, stability and equity of the AAPCC. Early on, when I became Administrator of HCFA, I invited the industry to come up with alternatives to the AAPCC. We still have no significant alternatives.

One concept that has recently received widespread support and attention from industry, academia and commercial payers is that of "competitive bidding." Proponents of competitive pricing models claim that the methodology will result in payments that more accurately reflect the true costs of doing business, in addition to promoting efficiency through greater competition among health plans.

We think that this is a promising idea, and we would like to test variants of it as demonstrations in a number of geographic areas. In order for the demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas. As always, beneficiaries will still have the ability to choose to enroll in managed care plans or remain in fee-for-service. We would be interested in working with the Subcommittee on the structure of a competitive bidding demonstration.

III. IMPROVED PROGRAM MANAGEMENT

Managed care options while of growing importance to the administration of the Medicare program are not the whole story. We are actively working to improve management throughout the program and to make continued innovations in the fee-for-service program.

Customer Service Initiatives

Under the leadership of President Clinton, Vice President Gore and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million beneficiaries (Medicare

and Medicaid) receive the health care they need when they need it. This means that beneficiaries come first in all that we do. HCFA has undergone significant internal and external changes to insure that the "customer first" philosophy becomes a reality. Throughout the agency, we are working to improve communications with beneficiaries -- whether it be one-on-one in person, on-line through the computer, over the telephone, through our numerous publications or through the media.

The nature of the Medicare program is such that there are numerous other people and organizations that have closer contact with beneficiaries than HCFA. They are also our customers and our partners in providing health care services - providers such as hospitals, nursing homes, home health agencies, physicians and medical suppliers; contractors (carriers and intermediaries) that process and pay Medicare claims; and, Peer Review Organizations that assure the quality of health care services.

We have developed a set of customer service standards that apply to our interactions with beneficiaries and our partners. These standards apply to all of our communications, claims processing activities, customer satisfaction, consumer choice, health care quality and program administration. For example, we are working with our customers to make our publications and notices easier to understand. We are simplifying Medicare claims administration so that claims determinations will be more consistent. We are placing a premium on measuring and improving customer satisfaction through the use of surveys, focus groups and meetings.

We also believe that the need for integrating delivery systems will become more and more critical as our population becomes increasingly diverse and older with more chronic care needs. In order to meet these needs, it is clear that HCFA must maintain a collaborative relationship with its partners in the provider community and assist them to improve their focus on customer service. Several such initiatives are already underway. HCFA is examining all of the long-term care services provided by both Medicare and Medicaid and is considering ways that these services can be better coordinated with one another and with the acute care system. A similar review of home health care programs has also been undertaken.

Fraud and Abuse

Starting at the Office of the Administrator and at every level of HCFA, we have expanded and strengthened our efforts to root out fraud and abuse against Medicare and Medicaid and to vigorously pursue those who commit such illegal activities. We operate in a partnership, not only with the Department's Office of the Inspector General, but with the Department of Justice, including the FBI, state and local law enforcement agencies, and

our contractors. Further, HCFA is increasingly exercising its authority to suspend payments to providers and suppliers when evidence of fraud exists.

In addition, HCFA is reviewing and changing programs and policies that have been found most vulnerable to abuse. For example, in order to better monitor fraud and abuse related to durable medical equipment (DME), HCFA has changed the procedures for claims processing. Four carriers are now responsible for DME claims processing rather than the previous 33 carriers, a system which provided DME suppliers opportunities to submit claims to the carrier whose payment policy was most liberal. The new system of using four regional carriers reduces the chance for fraudulent billing because suppliers must submit claims to the carrier in the region where the beneficiary resides.

The use of more sophisticated data processing systems, such as the MTS system, that I discussed earlier, further increases the chances of detecting aberrant patterns that might indicate abusive behavior. The MTS system will greatly improve HCFA's ability to screen Medicare claims for errors and fraud.

IV. CONCLUSION

For thirty years, Medicare has been insuring the nation's elderly and disabled. We know from our focus groups, and I think you are all aware from interactions with your constituents, that beneficiaries feel a certain ownership of the program. This feeling is justified. We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We look forward to working with this Subcommittee as we expand choices available to beneficiaries without compromising quality, access or value.

THE WHITE HOUSE

WASHINGTON

March 15, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: CAROL RASCO *CR*
LAURA TYSON *LT*

SUBJECT: Medicare Managed Care *file*

As you know, the most recent HHS projections for the Medicare and Medicaid baseline between 1996 and 2000 were \$94 billion lower than the estimates in the August 1994 Midsession Review. Of this \$94 billion, \$40 billion of the savings were for Medicare spending.

You mentioned in your March 3rd press conference that Medicare managed care contributed to this reduction in the baseline. Secretary Shalala has made similar suggestions in the past, although she now understands that Medicare managed care as currently structured is not producing Medicare savings. The reduction in the HHS Medicare baseline was actually the result of other factors, including programmatic changes implemented during your Administration that have improved efficiency and reduced fraud and abuse, and the lowering of overall inflation in the economy.

BACKGROUND

As currently designed, Medicare managed care actually increases program spending. While the industry argues persuasively that they are able to reduce costs with managed care, the Federal Government is not enjoying comparable savings. Instead the savings achieved by Medicare HMOs are largely passed along to beneficiaries in the form of Medigap benefits, e.g., prescription drugs, hearing, vision, and/or retained by the HMOs themselves in the form of higher earnings/profits. There are two features of current Medicare managed care programs that explain why they do provide inadequate savings for the Federal government.

First, CBO and OMB now believe that Medicare's current reimbursement rate for HMOs is too high and actually loses money on each beneficiary enrolled. Medicare now pays participating HMOs a capitated payment that is calculated at 95 percent of the cost of providing care to fee-for-service beneficiaries in an area. At the time of the enactment of the Medicare HMO law (TEFRA - 1972), there was too little experience in the program to know what level of reimbursement was appropriate. The 95 percent number was chosen to provide an incentive for HMO participation in the program while capturing some savings for Medicare.

The current reimbursement formula does not adequately control for the fact that, on average, people who enroll in HMOs are healthier (their costs if they had remained in fee-for-service Medicare are often less than 95 percent of the average), and subsequently Medicare overpays HMOs for the cost of providing care to them. In fact, CBO estimates that Medicare pays 5.7 percent more for beneficiaries in managed care than it would if they had remained in the fee-for-service sector. In regions where fee-for-service costs are disproportionately higher than managed care costs -- which happens in areas with very competitive managed care markets -- the payment formula overpays HMOs even more.

The second characteristic in the Medicare managed care program that may increase costs is the option for beneficiaries to disenroll every 30 days. There is anecdotal evidence indicating that beneficiaries disenroll from an HMO and seek care in the fee-for-service sector once they get seriously ill. The underlying theory behind managed care savings, however, is that capitated payments provide incentives to keep costs down when enrollees become sick. When enrollees can leave managed care arrangements when they get seriously ill, the incentives faced by HMOs to manage care effectively are minimized. Under this scenario, managed care could potentially further increase Medicare costs.

Many Republicans in the Congress have suggested that significant savings can be achieved through the utilization of managed care in the Medicare program. While they have yet to release details, proposals that could guarantee savings of the magnitude that are being discussed would restrict choice, particularly for lower income beneficiaries. It is therefore not surprising that elderly advocates are particularly wary of proposals for capped vouchers that have been suggested by Republican analysts. The HMO industry also is not likely to lead the charge toward initiating any significant changes to the program since, for the reasons outlined above, they are generally quite satisfied with the current Medicare payment arrangement.

FUTURE ADMINISTRATION ACTIONS

We are conducting an intensive review of managed care options to develop an Administration position on this issue. There is a strong commitment to moving forward on the managed care front by OMB and HHS, and the Department has testified to this effect in recent weeks. In contrast to the approaches being advocated by some Republicans, the managed care models-- such as a new Medicare PPO model--that have been referenced in Administration testimony would increase the use of managed care by expanding the choice of plans available to beneficiaries. But the Administration proposals would not restrict beneficiaries' ability to remain in the fee-for-service system. Without modifications in the reimbursement methodology, however, such proposals would probably cost money -- at least over the short-term. We are currently studying the political and policy feasibility/advisability of alternative managed care options that would significantly reduce the growth of Medicare spending.

We are also soliciting input from private sector managed care firms (such as FHP), and we believe this relationship has the potential to yield some interesting results. While any viable managed care proposal is unlikely to generate significant Medicare savings in the short term, we believe that movement toward managed care in the Medicare program has the potential to produce savings over the long term. We will keep you apprised of the status of our work in this area.

file

MEDICARE TRUST FUND SOLVENCY PROBLEM

Unlike the Republicans, This is Not a Problem Democrats Just Discovered. The President, his Administration and the Democrats have been concerned about Medicare trust fund from the beginning. OBRA 1993 and economic improvements resulting from this legislation have strengthened the trust fund and pushed out the insolvency date by three years. Furthermore, in the context of broader reforms, the Administration's proposal would have extended the life of the trust fund another 5 years. **The Republicans rejected each and every initiative that would have strengthened the Medicare Trust Fund.**

The Medicare Trust Fund is a Long-Term Problem that Needs to be Addressed. Of course with the aging of our population, there is a long-term solvency problem for the Medicare trust fund. This is nothing new, but it needs to be addressed. It needs to be addressed thoughtfully, outside the budgetary process, and independent of partisan politics.

In Contrast to the Democrats, the Republicans Have Just Discovered this Issue. In the last two years, all the Republicans have done has been to oppose our efforts to improve the Trust Fund. As a matter of fact, the only proposal they have put forth (their tax cut for the highest income seniors -- the top 13 percent) actually exacerbates the problem.

The Republicans are Using the Trust Fund as a Smoke Screen for Cuts. Let's be clear: Their proposals have nothing to do with the long-term solvency issue; they do not address the underlying problems of an aging population. The Republicans want to use the Medicare program as a bank for their tax cuts for the wealthy and to fulfill their campaign promises.

When they Finally Put Forth a Detailed Budget and Commit to Dealing with Medicare in the Context of Serious Health Care Reform, the President Stands Ready to Work Toward a Real Solution: Currently, the issue of Medicare is only being addressed by Republicans as they face a political crisis to find funds to pay for large tax cuts for the well-off and fulfill their campaign budget promises. When Republicans finally put forth a budget that is detailed and makes clear they are not slashing Medicare to pay for tax cuts, the President stands ready to work with Republicans to address the real problems facing the Trust Fund and the American people in the health care system.

REPUBLICAN MEDICARE CUTS

Republicans are considering proposals that would cut Medicare funding by between \$250 billion and \$305 billion between now and 2002. Slashing Medicare at this level translates into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans -- the elderly and disabled.

COERCION INSTEAD OF CHOICE: Managed care simply cannot produce anywhere near the magnitude of Federal savings being suggested by the Republicans without turning Medicare into a fixed voucher program. That would put Medicare's 36 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. With a fixed and limited voucher, beneficiaries would have to pay far more to stay in the current Medicare program if large savings are to be realized. That's not choice, that is financial coercion.

ADDING TO ALREADY HIGH COSTS FOR SENIORS: Today, despite their Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, the typical Medicare beneficiaries already dedicate a staggering 21% (or \$2,500) of their incomes to pay for out-of-pocket health care expenditures.

\$3,100-\$3,700 Out-of-Pocket Payments: If the Republican cuts (\$250 billion to \$305 over seven years) are evenly distributed between health care providers and beneficiaries, the cuts would add an additional \$815 to \$980 in out-of-pocket burdens to Medicare beneficiaries in 2002. Over the seven year period, the typical beneficiary would pay between \$3,100 to \$3,700 more.

Reduce Half of Social Security COLA: The Republicans say they aren't cutting Social Security, but these Medicare cuts are a back-door way of doing just that. By 2002, the typical Medicare beneficiary would see 40 to 50 percent of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries will have all or more than all of their COLAs consumed by the Republican beneficiary cost increases.

\$40-\$50 Billion in Cost-Shifting: Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians and other providers would be targeted with between a \$125 billion to \$150 billion cut over seven years. In 2002 alone, a \$33 billion cut in providers would be needed. Even if only one-third of Medicare provider cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of \$40 billion to \$50 billion in increased premiums and health care costs between now and 2002.

Rural and Inner City Hospitals At Risk: Cuts of this magnitude, combined with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result, quality and access to needed health care would be threatened.

THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
 - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about one percentage point faster than private health insurance.
 - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

MAJOR BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
 - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
 - Significant cuts in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are already substantial local subsidies.
 - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
 - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

UNDERMINES URBAN SAFETY NET

- Large reductions in Medicare payments would have a devastating impact on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care. On average, Medicare accounted for a bigger share of net operating revenues for these hospitals than did private insurance payers.

REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by \$160 to more than \$190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if \$160 to \$190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

LIKELY IMPACTS: So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut \$160 to \$190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE; and**
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE; and**
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the \$190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by \$10.7 to \$12.8 billion.

**MEDICARE/MEDICAID CUTS:
BUSINESS, PROVIDER AND ADVOCACY GROUPS' RESPONSES**

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Eastman Kodak says:

"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)

American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or close its doors." (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

American Association of Retired Persons says:

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

Medicare cuts "would mean that over the next 5 years older Americans would pay at least \$2000 more out of pocket than they would pay under current law. And over the next seven years they would pay \$3489 more out of pocket." (March 6, 1995)

"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)

The National Council of Senior Citizens says:

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about to go belly-up; a seven-year window does not merit a panic button."

"The levels of the cuts in Medicare contemplated by the Senate and House Budget Committees will not just devastate the finances of millions of older citizens, but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)

Older Women's League says:

"We receive hundreds of letters from women who are already forced to choose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)

Children's Defense Fund says:

"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)

Catholic Health Association says:

"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)



Congressional Research Service · Library of Congress · Washington, D.C. 20540

April 21, 1995

TO : Senate Committee on Finance
Attention: Kathy King

FROM : Jennifer O'Sullivan
 Specialist in Social Legislation
 and
 Sharon Kearney
 Technical Information Specialist
 Education and Public Welfare Division

SUBJECT : Solvency of Trust Fund for Medicare Part A (Hospital Insurance)

Medicare is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Recent projections by the trustees of the Hospital Insurance Trust Fund show that Part A is confronting major financing problems. A Medicare trustee report in 1982 warned that the Hospital Insurance Trust Fund could become insolvent by 1987. Congress enacted many changes over the following years, which, when coupled with better economic conditions, improved the outlook somewhat. The 1995 report projects that the Fund will be insolvent by 2002, only a year later than that projected in the 1994 report.

The following table shows for each trustee report issued in the last 25 years the date the trustees projected that the Fund would become insolvent.

TABLE 1. Year in Which the Hospital Insurance Trust Fund was Projected to Become Insolvent in Past Trustees' Reports

<u>Year of Trustees' Report:</u>	<u>Year of Insolvency:</u>
1970.....	1972
1971.....	1973
1972.....	1976
1973.....	none indicated
1974.....	none indicated
1975.....	late 1990s
1976.....	early 1990s
1977.....	late 1980s
1978.....	1990

CRS-2

TABLE 1. Year in Which the Hospital Insurance Trust Fund was Projected to Become Insolvent in Past Trustees' Reports

<u>Year of Trustees' Report:</u>	<u>Year of Insolvency:</u>
1979.....	1992
1980.....	1994
1981.....	1991
1982.....	1987
1983.....	1990
1984.....	1991
1985.....	1998
1986.....	1996
1986 amended.....	1998
1987.....	2002
1988.....	2005
1989.....	*
1990.....	2003
1991.....	2005
1992.....	2002
1993.....	1999
1994.....	2001
1995.....	2002

*Contained no long-range projections.

Source: Intermediate projections of various Hospital Insurance trustees' reports, 1966-95.

THE WHITE HOUSE
WASHINGTON

CC: ~~Jones~~
Rosen
APR 20 1995
Jennings
NMM
4/24/95

17 April 1995

MEMORANDUM TO ERSKINE BOWLES
CAROL RASCO
GEORGE STEPHANONPOULOS
MARK GEARAN
BILLY WEBSTER

FROM: Harold Ickes *(initials)*

SUBJECT: 30th Anniversary of the enactment of the Medicare Program *fill*

Attached is a copy of a self-explanatory 6 April 1995 letter to me from Lawrence F. O'Brien, III pointing out that July of 1995 is the 30th Anniversary of the enactment of the Medicare Program and suggesting that we try to take advantage of it.

Lawrence F. O'Brien, III

April 6, 1995

Mr. Harold Ickes
Deputy Chief of Staff
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Re: Medicare - Thirty Years Young

Dear Harold:

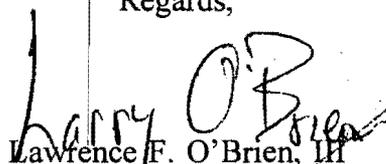
You and I have had occasion to speak previously about Medicare and the potential virtue of anniversary dates related to the creation thereof.

July of 1995 constitutes the 30th anniversary of the enactment of the Medicare program. I am not sure which Democrats are still around who may have been active in support of founding the program (John Dingell, for one, perhaps) but if memory serves, I seem to recollect that one now very prominent Republican, Bob Dole, has been on the scene long enough to have recorded a vote against Medicare back in 1965 (as a member of the House). A little research may reveal a few others.

A well conceived and orchestrated "celebration" of the 30th birthday of Medicare's creation might contain many virtues. Amongst those, a planned event or series of events could serve to dramatically drive home which political party was basically for it and which one was not and also point up that "the one" that was not supportive wants today, in the Congressional majority, to entrust to itself an effort to scale back or reshape the program. Something about a fox and the chicken coop might promptly come to mind. A run of punchy radio ads aimed at Medicare concentrated populations may also be suggestive, as part of a birthday bash.

The Democratic Party has a lot in which it can take pride. Medicare is assuredly one of our prime accomplishments in the modern era and it was achieved only after a bitter battle. Why not get some fresh political mileage out of Medicare's history?

Regards,


Lawrence F. O'Brien, III

cc: The Honorable Chris Dodd
The Honorable Martin Frost
The Honorable Don Fowler

Carol -

I'm so sorry that this is so late. I was waiting until we would have something better to say (we were working with ASIM) but I should have realized long ago that that day would never come. Again, I'm sorry.

Jen

THE WHITE HOUSE

WASHINGTON

November 2, 1995

Alan R. Nelson, M.D.
Executive Vice President
American Society of Internal Medicine
2011 Pennsylvania Avenue, N.W.
Suite 800
Washington, D.C. 20006

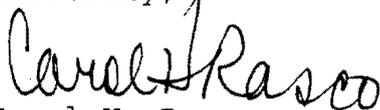
Dear Dr. Nelson:

Thank you for writing to share your views about vouchers for Medicare beneficiaries. I am sorry it has taken me so long to respond. I know that in the interim you have had ongoing conversations about this and other issues with Chris Jennings and Marilyn Yager.

As you know, the Clinton Administration has expressed real concerns about the Republican voucher proposals. We firmly support increased choice for Medicare beneficiaries, including managed care options. However, we do not support any plan that forces Medicare beneficiaries to pay more to keep their current fee-for-service option.

I know that you share the Administration's concerns about the level of Medicare and Medicaid cuts proposed by the Republicans. I hope that we can continue to work together to improve the efficiency of the Medicare program while preserving and protecting it for future generations.

Sincerely,



Carol H. Rasco
Assistant to the President
for Domestic Policy

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: KLEIN

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: 2/9/8

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

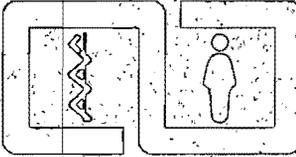
Designee to attend: _____

Remarks: _____

ROZ: TICKET 2/9/8

AUG 16 1995

asim



american society of internal medicine

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Portland, Oregon

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Executive Vice President
ALAN R. NELSON, MD

Thirty-ninth Annual Meeting
Washington, D.C.
October 18-22, 1995

REPRESENTING
Internists and
All Subspecialists
of Internal Medicine

August 16, 1995

Ms. Carol Rasco
Director
Domestic Policy Council
West Wing
The White House
Washington, DC 20500

Dear Ms. Rasco:

Late last month, the American Society of Internal Medicine issued a set of proposals for reforming Medicare. An executive summary and complete set of recommendations is enclosed for your information. As ASIM states in the executive summary, our principal aim in offering this plan is to ensure that all participants in the Medicare program share the responsibility for preserving this pillar of the nation's commitment to its elderly citizens well into the next century.

ASIM continues to believe that changes in Medicare should ideally be made in the context of other health system reforms—insurance market reforms, changes in medical liability, due process for patients and physicians in all health plans—that will promote an environment in which changes made to Medicare will not adversely affect beneficiaries. Nevertheless, as calls have grown for specific changes in Medicare, ASIM has attempted to respond to these requests by outlining those immediate changes we feel should be made in Medicare's current financing and the existing risk contracting program and those reforms we believe are necessary for the long term survival of the program.

Many of the changes we are proposing in the current Medicare system are consistent with several of the administration's policies set out in last year's Health Security Act. These include: increasing the choice of managed care plans under the risk contracting program to include preferred provider organizations (PPOs) and point-of-service (POS) plans; giving beneficiaries comparative information on risk contracting plans; improving financing of Medicare through increased taxes on tobacco products and alcohol as well as limitations on the tax deductibility of health insurance beyond an average premium cost; revising the disproportionate hospital share system of payments; and creating an all payer funding pool to finance graduate medical education and decreasing the number of residency positions funded by the federal government.

However, in light of increasing budgetary pressures and a growing Medicare population, ASIM believes that the creation of a voluntary voucher program, albeit with certain safeguards, will not only broaden the choice of coverage options now available to beneficiaries but will introduce additional market incentives that can control rising costs under Medicare. ASIM understands that the administration has expressed reservations over voucher proposals. As outlined below, ASIM has

attempted to address in its recommendations several of the major criticisms lodged against a voucher system for Medicare.

1. Vouchers will take away the broad choice of physician and provider that beneficiaries now enjoy under traditional Medicare.

ASIM agrees that beneficiaries should **not** be deprived of their choice of physician. Under our proposal, beneficiaries could remain in traditional, fee-for-service Medicare. The voucher program would be entirely voluntary. Indeed, a voucher program might enhance choice of physician if beneficiaries discover that the physician they wish to see is participating in a health plan that had heretofore been ineligible to contract with the Medicare program.

In addition, ASIM is recommending that voucher plans with networks of providers be required to offer to prospective enrollees the chance to buy a point-of-service rider that would allow the beneficiaries to seek care from non-network physicians. ASIM further recommends that this POS rider be priced at an actuarially-determined level because many studies have shown that the additional costs of POS are modest. Imposing this limit on the cost of POS riders would protect beneficiaries from excessive charges for going out of a health plan network.

2. Vouchers will leave beneficiaries exposed to "cherry-picking", deceptive marketing and other practices designed by insurers to avoid covering the sickest of patients.

ASIM wholeheartedly agrees that discriminatory insurance practices should be eliminated, not only for Medicare patients, but for all segments of the population. The insurance reform measure recently reported out of the Senate Labor and Human Resources Committee is a step in the right direction. Insofar as a Medicare voucher system is concerned, though, ASIM addresses problems with insurance industry discrimination by requiring voucher plans to guarantee acceptance to beneficiaries seeking enrollment, by requiring voucher plans to provide the range of benefits now covered under Parts A and B, along with preventive care services, by requiring plans to submit their marketing materials to the Department of Health and Human Services for review and by establishing a reinsurance mechanism to cushion plans with large numbers of seriously ill enrollees.

3. Vouchers will fail to keep pace with the costs of medical care, increasingly reducing beneficiaries' selection of affordable health plans and/or subjecting beneficiaries to greater and greater out-of-pocket costs.

ASIM agrees that, if the government's contribution is set too low, such as the lowest priced plan in a region, or at some national average, this could adversely affect the ability of many beneficiaries to buy a satisfactory health plan. ASIM believes that by setting the voucher amount according to regional health costs and adjusting it for age, sex, and disability, ESRD and institutional status, this will avoid a situation in which the voucher is set at such a level as to render it basically worthless to most beneficiaries. Furthermore, as noted above, requirements that **all** voucher plans offer the services covered under Parts A and B, plus preventive care, should ensure that all beneficiaries, no matter how modest of means, will receive the benefits to which they are now accustomed under the Medicare program.

ASIM also believes that the voucher must be updated to keep pace with the costs of providing services to beneficiaries and does not support capping or limiting the voucher according to some arbitrary formula. In the event that spending for the voucher program exceeds estimated budget goals, ASIM would prefer that an independent body be established to examine the reasons for

that cost overrun and to propose a response that does not solely rely on cuts to providers and increased costs to beneficiaries. In addition, ASIM states that Congress should commit itself to increasing funds for the voucher program if spending under that side of Medicare is deemed to have derived from provision of medically necessary services.

To the contention that a voucher system would subject beneficiaries to excessive out-of-pocket costs should they choose to remain in the traditional fee-for-service sector or if they want to go outside a plan's network of physicians, ASIM is proposing the use of its "competitive pricing, informed choices" proposal for Medicare beneficiaries who wish to remain with fee-for-service or to use a POS option. As described in item 9 of ASIM's recommendations, using the competitive pricing approach would give beneficiaries "up front" the information they need concerning physicians' charges so that they could decide for themselves how much they were willing to pay to see a particular provider.

ASIM also urges that, with regard to traditional Medicare or under voucher plans using a fee schedule either for their regular plan or for their point-of-service option, charges in excess of Medicare's payment amounts be forbidden under the following circumstances: where beneficiaries' income falls below a certain level; in emergency situations; when beneficiaries have little choice in selection of a hospital-based physician; or in areas of the country where there is little or no competition for a particular medical specialty.

I hope that you find ASIM's recommendations for Medicare reform useful and would welcome the opportunity to discuss our proposal with you further. If you or your staff have additional questions, please feel free to contact ASIM's Vice President for Government Affairs and Public Policy, Robert Doherty at 202-466-0283 or Susan Prokop, ASIM's Director, Health Care Policy at 202-835-2746, ext. 259.

Sincerely,



Alan R. Nelson, MD
Executive Vice President

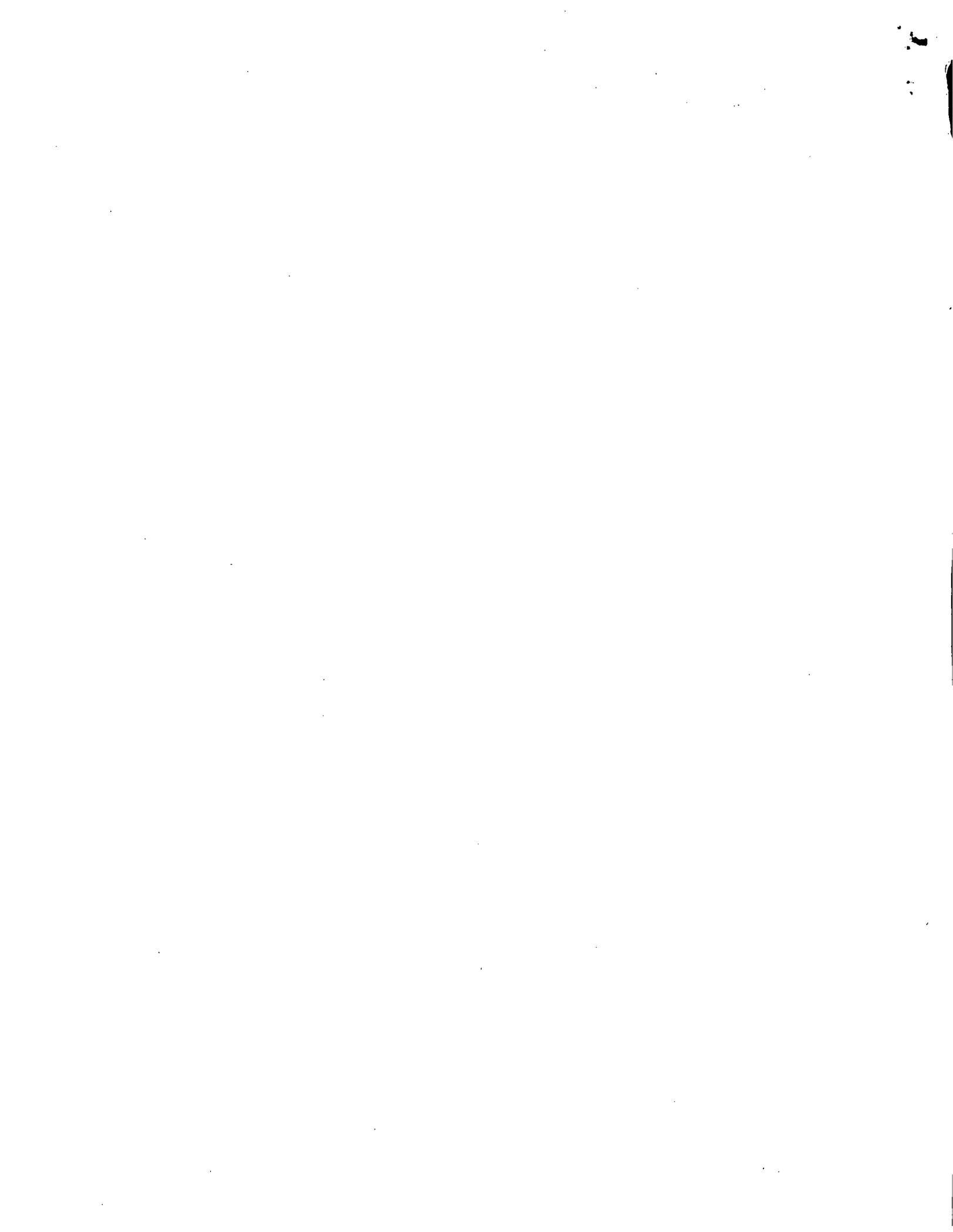
rasco.895

ASIM TODAY

KEEPING MEDICARE AFFORDABLE

**RECOMMENDATIONS OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE**

July 1995



**KEEPING MEDICARE AFFORDABLE
RECOMMENDATIONS OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE**

EXECUTIVE SUMMARY

Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in the knowledge that health care services will be accessible to them. The American Society of Internal Medicine, representing the nation's largest medical specialty and the principal providers of medical care to Medicare beneficiaries, is committed to preserving this contract with older Americans. However, in the face of changing demographics, burgeoning costs and the need to restrain overall federal spending, the Medicare program is facing an unprecedented challenge. Responding to this challenge will require both immediate changes in the program's financing and current risk contracting program as well as long-term reforms to broaden beneficiaries' choice of insurance options, control costs through enhanced competition and instill a sense of responsibility among all those involved with and affected by its policies.

This set of recommendations is ASIM's response to policymakers calls for proposals to address the need for fundamental changes in the Medicare program so that it may continue to be a reliable source of medical care for the nation's elderly well into the new century. For ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared responsibility.

Physicians have a responsibility to deliver care to greater numbers of Medicare patients under health care delivery systems that will increasingly require them to accept financial risk and to be accountable for the cost and quality of their clinical decisions--and to compete within this new system on the basis of cost and quality.

Medicare patients have a responsibility to consider the costs of alternative sources of health care coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive coverage and--for those who can afford to--to contribute more to the financial support of Medicare so that those of lesser means can afford coverage.

Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and introduce positive incentives into the health care system including a limit on the tax deductibility of employer paid insurance and increased taxes on tobacco.

The insurance industry has a responsibility to compete in the new system--not solely on price or risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect beneficiaries who choose private insurance coverage.

And the federal government has a responsibility to assure that the government's contribution remains adequate to guarantee that all beneficiaries can obtain high quality coverage through traditional Medicare and private sector alternatives--and to provide sufficient oversight over the market to protect patients' interests.

Changing the Medicare Financing System

Steps can be taken now to reform the current Medicare program so that future efforts to change the system need not be enacted in an atmosphere of crisis. These steps include:

1. increasing the eligibility age for Medicare to align it with eligibility for Social Security.
2. increasing the amount contributed by upper income beneficiaries to financing the Medicare system.
3. applying the Part B coinsurance to home health services.
4. including in taxable income the value of health insurance benefits beyond a set value of insurance premium.
5. limiting disproportionate hospital share (DSH) payments only to those facilities that, in fact, care for a disproportionate share of Medicare patients.
6. increasing federal excise taxes on alcohol and tobacco if the revenues from changes identified above prove inadequate to finance an appropriate level of benefits.
7. creation of a national all-payor funding pool for GME.
8. increasing the direct GME weighting factor for general internal medicine and other primary care residency positions while decreasing the weighting factor for others.
9. creation of a private sector physician workforce planning initiative.
10. decreasing the number of funded residency positions to 110 percent of U. S. medical school graduates.

Instilling Market-based Incentives in the Medicare Program

Additional steps can be taken to improve the existing Medicare risk contracting program so that this mechanism designed to enhance market competition can operate as it was intended until more substantial reforms are implemented. These steps include:

1. changing the adjusted average per capita cost (AAPCC) formula used to pay health plans.
2. applying risk adjustments--such as severity of illness--in setting payments to risk contracting plans.
3. broadening managed care choices for beneficiaries to include HMOs with point-of-service and preferred provider organizations (PPOs), instead of limiting

participation only to health plans that require beneficiaries to obtain services from contracted physicians and other providers.

4. requiring that beneficiaries be provided comparative information concerning all Medicare risk contracting plans that are available to them.

5. giving beneficiaries one opportunity per enrollment year to disenroll from a Medicare risk contracting within 60 days of enrollment. Once a beneficiary has been in a plan more than 60 days, he or she should be required to wait until the next open enrollment period.

6. mandating reasonable, non-punitive increases in premiums and other cost sharing for beneficiaries who choose to remain with the traditional fee-for-service Medicare program.

Medicare Vouchers

Changing the existing fee-for-service Medicare program and improving the current risk contract program will help to stabilize Medicare for the short term. However, major restructuring of Medicare is necessary to achieve a system that relies on competition to control costs and broaden beneficiary choices, that instills individual responsibility for the appropriate use of scarce medical resources and that assures the program's long term survival. One way to accomplish this is through the creation of a voucher program.

ASIM supports creation of a voucher system and believes that the following elements are necessary to any voucher program designed for Medicare to ensure that beneficiaries have access to the widest range of cost-effective, high quality health plans, physicians and providers.

1. Medicare beneficiaries should be given the option of staying in the current Medicare program or using a voucher to buy any private health plan that meets certain conditions of participation.

If a plan purchased with a voucher becomes insolvent, or ceases operation in a beneficiary's area, beneficiaries should be able to enroll in another plan. When the annual enrollment period occurs, beneficiaries should be able to return to the traditional Medicare program at that time.

2. Under a voucher program, beneficiaries should have access to a variety of plans ranging from indemnity models to staff model HMOs. All voucher plans that restrict enrollees to the use of network providers should be required to offer at an actuarially-determined level an optional rider that would provide point-of-service access to non-network physicians for those enrollees. Enrollees should be able to select from among a network plan's panel of physicians an internal medicine subspecialist as their primary care physician and plans should be prohibited from discriminating against physicians in their selection processes based on a physician's patient population.

3. Beneficiaries should have the option of using their government contribution--e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to purchase coverage through a health plan. The MSA would:

a) be coupled with a catastrophic health insurance policy purchased through a purchasing group to help preserve community rating;

b) be comprised of a fund from which a beneficiary could pay deductible medical expenses and catastrophic health insurance to cover expenses that, in the aggregate, exceed the catastrophic insurance deductible;

c) permit accumulation of unspent balances within the fund;

d) allow state and federally tax exempt distribution of funds only for medical expenses, health insurance premiums and/or long term care.

4. Voucher plans should be required to accept all applicants during an open enrollment period to minimize adverse risk selection. Beneficiaries should be required to remain in a plan after the first 60 days until the next open enrollment period. Beneficiaries should be explicitly informed of this requirement by the health plan and should be required to sign a written acknowledgement of the conditions of enrollment.

A reinsurance mechanism should be available to those plans subject to adverse risk selection or to a sudden influx of voucher enrollees whose previous plan has gone bankrupt.

5. The defined contribution--or voucher--should be set at a level that would produce incentives for beneficiaries to consider cost in choosing a health plan without forcing them into the cheapest plans that are most restrictive of choice of physician. The voucher should not be set at the cost of the lowest priced plan in a region.

The voucher amount should be adjusted according to age, sex, disability status, institutional status, and Medicaid-buy in status and applied by region. Once the regionally adjusted voucher amount was established, HHS or HCFA would accept applications from health plans to participate in the voucher program.

6. The voucher should be updated on a regular basis to keep pace with the costs of providing services to beneficiaries. In the event that spending under the voucher program exceeds estimated savings goals or targets, the voucher should not be subject to arbitrary caps. Mechanisms to keep spending within designated limits or to recoup excess expenditures, such as a "look back sequester", should be rejected. Instead, an independent board or commission should be established that would involve all participants in the health care system in devising a response to cost control that would not focus solely on cuts to providers and increased costs to beneficiaries. If spending is greater than projected due to development of valuable new technologies or increased patient utilization of services deemed medically necessary, there should be a commitment to increasing the amount of

funds devoted to the voucher program in order to ensure vouchers retain sufficient purchasing power and to assure appropriate medical outcomes.

7. A reassessment of the voucher program should be required after five years. This reevaluation should be undertaken by an agency or commission not responsible for funding Medicare.

8. Beneficiaries opting for the voucher program should be provided incentives that encourage their selection of an economically priced plan but that do not force enrollees into those plans that are most restrictive of choice of physician and that impose the strictest limits on access to services. Incentives should come in the form of additional benefits or services provided by the health plan and not in the form of a cash rebate. With rules in place to ensure that all beneficiaries have access through voucher plans to the full range of Medicare covered benefits and services, beneficiaries should pay the difference between the voucher amount and any premium charged by a plan that exceeds the voucher amount.

9. Reasonable cost sharing under voucher plans -- both fee for service and managed care -- should be imposed to assure consumer cost consciousness in utilization of services. Lower cost sharing should be imposed on clinically-proven preventive services so that people are not unduly discouraged from obtaining beneficial care. Preventive services should be subject only to copayments, not deductibles. Copayments for preventive services should be set lower than those for other services.

To avoid unjustified restrictions on choice of physician, POS voucher plans should not impose unreasonable coinsurance on services provided by out-of-network physicians. To prevent beneficiaries who seek out-of-network care from being subject to unexpected out-of-pocket costs, POS plans and physicians should be required to establish their own conversion factors to be used against an improved resource based relative value scale (RBRVS). This would determine the rates the POS plan would pay and the fees the physicians would charge for their services. Plans and physicians would be required to supply enrollees in the POS plan with information based on these conversion factors to enable enrollees to determine in advance how much they would pay in going out of the plan's network of physicians.

As an incentive to promote greater price consciousness in the traditional Medicare program and to encourage the movement of beneficiaries into the voucher system, those who choose to stay in the traditional Medicare program should be subject to reasonable and non-punitive increases in cost-sharing. As with POS plans, in order to buffer beneficiaries from unexpected costs, a requirement could be imposed under traditional Medicare that physicians must establish their conversion factor for their services each year concomitant with the announcement of Medicare's conversion factor. Enrollees in traditional Medicare would be supplied annually with information comparing the charges of physicians in their area to Medicare's fees based on their respective conversion factors. In this fashion, beneficiaries would know in advance whether or not they would have to pay out-of-pocket for services charged under traditional Medicare.

Beneficiaries should not be subject to charges in excess of Medicare's payment amounts under the following circumstances: in the case of low income beneficiaries; emergency situations; when the beneficiary has little voice in the selection of a physician or in areas of the country where there is no competition for a particular medical specialty.

10. To qualify as a voucher plan under Medicare, health plans should have to: offer a standard minimum Medicare benefits package that includes preventive services; meet certain utilization review and quality assurance standards; involve participating physicians in development of the plan's utilization review (UR) and quality assurance (QA) and provider selection policies and procedures; disclose their utilization review and quality assurance policies, restrictions on choice, risk arrangements and provider selection criteria; establish due process mechanisms in selection of plan providers; meet certain solvency standards; report certain information -- such as premium costs, out-of-pocket liability, consumer satisfaction and the percentage of premium dollars devoted to administration versus benefits -- to a central data collection entity so that this information can be distributed to beneficiaries and use uniform claims forms and standard billing and claims processing procedures.

Health plans that selectively contract with physicians should be required to offer enrollees the opportunity to buy a rider that provides point-of-service access to non-network physicians, in addition to meeting the foregoing standards.

11. Because Medicare is a federally funded program, the federal government must continue to ensure that health plans are accountable for the care they give to beneficiaries and that they abide by standards set out for Medicare plans. HCFA or another federal agency should be responsible for contracting with health plans; reviewing marketing materials; disseminating to beneficiaries objective data about each plan in a region in a standard format; ensuring health plan compliance with certain standards governing their rules and operations; and ensuring that health plans meet certain quality standards. However, private accreditation agencies should be able to achieve "deemed" status to fulfill the role played by HHS in approving voucher plans. Mechanisms should be available for patients and physicians to pursue grievances against health plans for denial of medically necessary care. Patients and physicians should retain access to fair hearing and judicial review processes at least comparable to those now available under traditional Medicare.

12. Self-referral restrictions affecting shared laboratory facilities and group practices should be removed and antitrust reforms enacted to enable physicians and providers to negotiate on an equal footing with health plans and purchasers.

**KEEPING MEDICARE AFFORDABLE
RECOMMENDATIONS OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE**

Introduction

1 Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not
2 be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in
3 the knowledge that health care services will be accessible to them. The American Society of
4 Internal Medicine, representing the nation's largest medical specialty and the principal providers of
5 medical care to Medicare beneficiaries, is committed to preserving this contract with older
6 Americans. However, in the face of changing demographics, burgeoning costs and the need to
7 restrain overall federal spending, the Medicare program--as well as all those affected by its
8 policies--is facing an unprecedented challenge.

9
10 Earlier this year, the trustees for the Hospital Insurance Fund declared that the Part A fund which
11 finances hospital care will be bankrupt by the year 2002. What few realize is that the fund has
12 already begun to run a deficit. Bankruptcy is merely the end product of the red ink that is
13 beginning to accumulate in the system today.

14
15 As the population of Medicare eligible individuals grows, the ratio of working Americans who
16 support the program with their payroll taxes to beneficiaries has diminished. Whereas today there
17 are five working-age persons for each person over 65, by 2030--when today's workers retire and
18 their children are wage earners--the ratio will be three working-age persons for each American
19 over 65. Without any policy changes, Medicare SMI (Part B) will grow to more than 7 percent of
20 the payroll tax base by 2030--up from one percent today. Although beneficiaries overall continue
21 to have ready access to physicians and other providers, disturbing trends have been identified by
22 the Physician Payment Review Commission (PPRC) and other organizations tracking the Medicare
23 program. For example, the PPRC notes in its 1995 report to Congress "those over age 85,
24 individuals living in poverty areas and the disabled continue to experience access barriers" that
25 existed prior to the latest round of Medicare reform. The Employee Benefits Research Institute
26 (EBRI) recently issued data showing that the number of Medicare patients seen each week by
27 internists has been declining steadily since 1989. At the same time, there has been a significant
28 increase in internists contracting with managed care plans. In the wake of continuing cuts in
29 Medicare reimbursement to control program costs, physicians may be entering practice
30 environments where the degree of involvement with Medicare patients is limited.

31
32 Indeed, cuts already enacted in previous budget reconciliation measures that are now being
33 implemented will reduce payment levels to physicians over the next seven years by 17 percent,
34 even before the impact of inflation is taken into account. Under one of the savings options
35 proposed by a subgroup of the House Budget Committee, the reductions in payment levels for
36 physician services will increase to 31 percent over the next seven years. If the debate beginning
37 now in Congress is about making sure the elderly have access to appropriate, high quality health
38 care into the next century, continued reductions of this type will only undermine this promise and
39 create a Medicare program that guarantees access in name only.

1 If no action is taken, the hospital side of Medicare will go broke in less than a decade, the
2 supplemental medical insurance portion of Medicare will consume increasing amounts of the
3 federal budget and beneficiaries may face increasing difficulty in obtaining needed health care.
4 This is clearly not a viable option.

5
6 Policymakers could continue with the historical approach to attempting to reign in Medicare's
7 costs--enacting cuts in provider payments and imposing increasing regulatory rules on the
8 program as part of massive year-end budget reconciliation measures. This, of course, does not
9 address the underlying reasons for increasing costs under the program and will only serve to
10 exacerbate many of the growing problems in Medicare.

11
12 The third option is to reform the Medicare program so that its financing is placed on a sound
13 basis and to introduce the kind of marketplace incentives that have enjoyed success in the private
14 sector in holding down the growth of health care costs. ASIM strongly believes that this is the
15 only option that Congress should consider.

16
17 ASIM recognizes the urgent need for reforming the Medicare program and restraining growth in
18 spending under other federal health care programs. However, internists also believe that
19 significant changes in these programs *ideally* should be made in the context of other health
20 system reforms. Medical liability reform, insurance market reform, measures to broaden and
21 protect choice of plan and physician, and steps to ensure due process for patients and providers
22 in health plan operations and clinical decisions are important system-wide reforms that will foster
23 an environment in which changes in Medicare will have a positive impact. Nevertheless, the
24 following set of recommendations is ASIM's response to policymakers calls for proposals to
25 address the need for fundamental changes in the Medicare program so that it may continue to be
26 a reliable source of medical care for the nation's elderly well into the new century.

27
28 The recommendations propose both immediate and longer-term reforms in the following areas:

- 29
30 1. Immediate changes in Medicare financing and the current Medicare risk
31 contracting program.
- 32
33 2. Longer term reforms to expand beneficiaries' choice of insurance options through
34 enactment of a defined federal contribution--or voucher--program.

35 36 **Changing the Medicare Financing System**

37
38 Many analysts and policymakers contend that only complete transformation of the Medicare
39 program can solve its financing problems. Any type of restructuring, however, will be the subject
40 of considerable debate and, given the realities of the policymaking process, could take a number
41 of years to implement. In the meantime, the red ink will grow and problems of access will be
42 exacerbated. Steps can be taken now to reform the current Medicare program so that future
43 efforts to change the system need not be enacted in an atmosphere of crisis.

44
45 Last December, a report on entitlement reform options was issued by staff from the Bipartisan
46 Commission on Entitlement and Tax Reform (hereinafter referred to as the Commission). That
47 report identified a number of measures that could be enacted in the existing Medicare program to
48 stem the imbalance in funding. These improvements can be made with or without enactment of

1 other long term reforms, such as a voucher program. Among those improvements ASIM supports
2 are:
3

4 1. increasing the eligibility age for Medicare to align it with eligibility for Social
5 Security. By early in the next century, the eligibility age for Social Security will be
6 67. It would make sense, both financially and administratively, to couple the
7 eligibility age for Social Security with that for Medicare. However, such a change
8 must come in concert with insurance market reforms and other measures to assist
9 those elderly under 67 with chronic, but not disabling, illnesses in maintaining
10 insurance coverage.

11
12 2. increasing the amount contributed by upper income beneficiaries to financing
13 the Medicare system. The Commission staff proposed reducing the Part B
14 premium subsidy and creating a new Part A premium indexed according to growth
15 in program costs. ASIM believes this premium should instead be indexed to
16 income. This would avoid imposing an excessive burden on those with modest
17 means while concomitantly calling for appropriate contributions from those with
18 greater ability to finance their health care.

19
20 3. applying the Part B coinsurance to home health services. Current law requires
21 no cost sharing by beneficiaries for these services. Home health care has been
22 among the fastest growing parts of the Medicare budget and cost sharing has
23 been demonstrated effective in stemming overutilization of services.

24
25 4. including in taxable income the value of health insurance benefits beyond a set
26 value of insurance premium. Today, employers and workers benefit from a system
27 that gives preferential tax treatment to high cost health plans. Placing a limit on
28 the tax deductibility of such health insurance will promote the purchase of cost-
29 effective but moderately priced health plans and would bring in significant revenue
30 into the health care financing system.

31
32 5. limiting disproportionate hospital share (DSH) payments only to those facilities
33 that, in fact, care for a disproportionate share of Medicare patients. The
34 Commission staff report cited studies showing that DSH payments, intended to
35 compensate hospitals for services provided to low income individuals, have been
36 used by some states for purposes beyond its original intent. Without harming
37 those hospitals truly in need of these payments, the formula should be changed--
38 e.g. elimination of DSH payments for hospitals whose disproportionate share index
39 is below the 80th percentile--to avoid inappropriate uses of federal payments.

40
41 In accord with ASIM's longstanding policy that Medicare trust fund reserves should be augmented
42 through a combination of expenditure reductions, program efficiencies and revenue increases,
43 ASIM also supports:

44
45 6. increasing federal excise taxes on alcohol and tobacco if the revenues from
46 changes identified above prove inadequate to finance an appropriate level of
47 benefits. Not only would these additional revenues help to support the program
48 but they would discourage certain behaviors that result in increased public and
49 personal health costs.

1 Historically, Medicare has served as a major source of financing for training of this nation's
2 doctors. However, changes have been proposed in Medicare's funding of graduate medical
3 education (GME) as another avenue for achieving significant savings in the program's budget.
4 One proposal offered by the Health Care Working Group of the House Budget Committee would
5 cut direct and indirect GME spending by \$27.24 billion over seven years.
6

7 ASIM believes it is time to rethink Medicare funding of graduate medical education, not simply as
8 a device to reduce federal spending, but in order to respond to the changing health care delivery
9 environment—and to ensure that all components of the health care system that benefit from highly
10 trained physicians contribute to the cost of their education. To those ends, ASIM supports:
11

12 7. creation of a national all-payer funding pool for GME. All payers and health
13 plans should contribute a percentage of their premiums to a financing pool for
14 graduate medical education. With managed care plans and other health delivery
15 organizations seeking qualified, well-trained physicians for their networks, they, as
16 well as all payers interested in providing the best care possible for their insureds,
17 have a stake in the education of the physicians that will contract with their plans.
18 Until now, no one has asked these health plans and insurers to help support the
19 cost of training this nation's physicians. However, given Medicare's financial
20 condition, the federal government can no longer be viewed as a major source of
21 funding for the future supply of doctors.
22

23 8. creation of a private sector physician workforce planning initiative. The
24 American Medical Association has proposed that a taskforce be established with
25 participation of both public and private sectors to offer recommendations to
26 Congress about the physician workforce supply and the future of GME. If the all-
27 payer GME pool is established, such a task force will be necessary to advise how
28 the funds in the all-payer pool would be distributed.
29

30 9. increasing the direct GME weighting factor for general internal medicine and
31 other primary care residency positions while decreasing the weighting factor for
32 others. Currently, direct medical education payments are based on hospital-
33 specific, per resident costs multiplied by the number of residents. Proposals have
34 been offered in past Congresses to reimburse hospitals more for primary care
35 residents than for specialty residents in order to encourage training of more
36 primary care physicians. The need for more primary care physicians has grown
37 with the increase in the elderly population as well as with the desire of health plans
38 for physicians to manage the care of their enrollees. Alterations in the financing of
39 medical education will encourage changes in training programs to meet those
40 needs.
41

42 10. decreasing the number of funded residency positions to 110 percent of U. S.
43 medical school graduates. The Physician Payment Review Commission has
44 recommended that the number of funded residency positions in the United States
45 be reduced in order to respond to the fact that the country is facing, in general, an
46 excess of physicians. By taking this action, the U. S. would cut the oversupply of
47 physicians while at the same time—if the other steps are taken—increase the
48 proportion of primary care physicians relative to the population.
49

1 **Instilling Market-based Incentives in the Medicare Program**

2
3 The current Medicare program includes an optional program intended to use competition among
4 health plans as a means to moderate costs. The Medicare risk contracting program--in which
5 Medicare contracts with health plans and pays them a capitated payment based on less than 95%
6 of the adjusted actual per capita costs of caring for Medicare patients--was intended to encourage
7 health plans to control utilization of services and, subsequently, costs. Because of flaws in the
8 formula for paying risk contracting plans and because healthier beneficiaries are more likely to
9 enroll in these health plans than other beneficiaries, the risk contracting program has not been as
10 successful at reducing Medicare spending as originally anticipated.

11
12 Again, steps can be taken to improve this existing mechanism designed to enhance market
13 competition until more substantial reforms are implemented. These include:

14
15 1. changing the adjusted average per capita cost (AAPCC) formula used to pay
16 health plans. The current AAPCC is based on historical, fee-for-service costs in an
17 area. This has resulted in overgenerous payments to health plans in high cost
18 areas and modest payments to health plans in regions where health care costs
19 have been kept relatively low. Changes in the AAPCC should reward cost effective
20 health plans in areas with historically low utilization rates instead of penalizing
21 such plans with less generous AAPCC payments.

22
23 2. applying risk adjustments--such as severity of illness--in setting payments to risk
24 contracting plans. This change should be coupled with other reforms in the
25 AAPCC to avoid driving away from the program managed care plans that might
26 attract more seriously ill patients and to make regional plan payments more
27 equitable.

28
29 3. broadening managed care choices for beneficiaries to include HMOs with point-
30 of-service and preferred provider organizations (PPOs), instead of limiting
31 participation only to health plans that require beneficiaries to obtain services from
32 contracted physicians and other providers. Under the current risk contracting
33 program, beneficiaries have a limited range of health plans from which to choose
34 and are precluded from taking advantage of the numerous managed care products
35 that have arisen in recent years in the private market.

36
37 4. requiring that beneficiaries be provided comparative information concerning all
38 Medicare risk contracting plans that are available to them. In order for
39 beneficiaries to make fully informed choices about their health plan, they should be
40 provided sufficient data that will enable them to compare these plans on costs,
41 physicians and other providers, quality and benefits.

42
43 5. giving beneficiaries one opportunity per enrollment year to disenroll from a plan
44 within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days,
45 he or she should be required to wait until the next open enrollment period. Under
46 current law, beneficiaries may disenroll from a health plan with only a 30 days
47 notice. This makes it difficult for many risk contracting plans to anticipate costs for
48 a health plan year. It is also contrary to most enrollment policies effective in the
49 private sector which call for enrollment or disenrollment during a particular "open

1 season". Asking beneficiaries to stay with a plan until the next open season once
2 they have been in a plan for two months would offer additional stability to a risk
3 contracting plan without limiting too severely beneficiaries' ability to change their
4 minds about managed care. Such a requirement would make Medicare more
5 consistent with the private sector in which workers are required to make an annual
6 selection of a health plan and to stay with that plan for an entire year. Limiting the
7 disenrollment opportunity to one per year would also prevent cases in which
8 people jump from plan to plan every so often prior to the 60 day deadline.
9 Medicare patients should accept the same degree of responsibility in choosing a
10 health plan that is expected from those under 65.

11
12 6. mandating reasonable, non-punitive increases in premiums and other cost
13 sharing for beneficiaries who choose to remain with the traditional fee-for-service
14 Medicare program. With improvements in the risk contracting program, it is
15 reasonable to expect that those who choose to remain with the higher cost fee-for-
16 service side of Medicare should bear a portion of those higher expenditures.

17
18 The current risk contracting program would be repealed upon enactment of a voucher program as
19 described below.

20 21 **Medicare Vouchers**

22
23 Making changes in the existing fee-for-service Medicare program and improvements in the current
24 risk contract program will help to stabilize the program for the short term. However, to achieve a
25 system that relies on competition to control costs and broaden beneficiary choices, that instills
26 individual responsibility for the appropriate use of scarce medical resources and that assures the
27 long term survival of Medicare, major restructuring of the program will be required. One way to
28 do this is for the government to offer beneficiaries the opportunity to take a defined government
29 contribution—or voucher—and purchase private insurance coverage with those funds.

30
31 There are a number of issues that must be addressed for any voucher plan to be successfully
32 implemented. ASIM supports creation of a voucher system and believes that the following
33 elements are necessary to any voucher program designed for Medicare to ensure that
34 beneficiaries have access to the widest range of cost-effective, high quality health plans,
35 physicians and providers.

36
37 1. Medicare beneficiaries should be given the option of staying in the current
38 Medicare program or using a voucher to buy any private health plan that meets
39 certain conditions of participation.

40
41 If a plan purchased with a voucher becomes insolvent, or ceases operation in a
42 beneficiary's area, beneficiaries should be able to enroll in another plan. When the
43 annual enrollment period occurs, beneficiaries should be able to return to the
44 traditional Medicare program at that time.

45
46 Transition to a voucher program should be done gradually to account for the fact that some areas
47 of the country may not have the degree of managed care penetration necessary to make
48 competition among health plans work. Retaining traditional Medicare would provide reassurance

1 to beneficiaries while serving as a spur to voucher plans to make their products attractive enough
2 to encourage enrollment by Medicare recipients.

3
4 2. Under a voucher program, beneficiaries should have access to a variety of
5 plans ranging from indemnity models to staff model HMOs. All voucher plans that
6 restrict enrollees to the use of network providers should be required to offer at an
7 actuarially-determined cost an optional rider that would provide point-of-service
8 access to non-network physicians for those enrollees. Enrollees should be able
9 to select from among a network plan's panel of physicians an internal medicine
10 subspecialist as their primary care physician and plans should be prohibited from
11 discriminating against physicians in their selection processes based on a
12 physician's patient population.

13
14 Under the present Medicare system, beneficiaries are entitled to receive all covered benefits from
15 any provider of their choice. A voucher system could undermine this basic premise of the
16 program. For example, depending on the amount of the voucher and other rules governing the
17 voucher program, beneficiaries could find their choice of health plan in reality to be quite limited.
18 Furthermore, if the voucher is inadequately funded, some beneficiaries may be compelled to
19 select a plan that limits the physicians and providers they may see for services. Adequate choice
20 of physician and health plan can be promoted by offering beneficiaries a wide menu of plans and
21 by establishing the federal contribution at a level that does not force patients to choose the
22 cheapest plan available, as discussed below. By requiring voucher plans that use a network of
23 physicians to offer enrollees the opportunity to buy a point-of-service rider, enrollees who want the
24 flexibility to go outside the network will be able to select this option while those beneficiaries who
25 wish to choose a closed-panel HMO may do so. In addition, a POS rider requirement for all
26 health plans with restricted provider networks might ameliorate adverse risk selection arising from
27 the tendency of very ill beneficiaries in an area to gravitate toward traditional Medicare and/or one
28 plan with point-of-service.

29
30 3. Beneficiaries should have the option of using their government contribution--
31 e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to
32 purchase coverage through a health plan. The MSA would:

33
34 a) be coupled with a catastrophic health insurance policy purchased through a
35 purchasing group to help preserve community rating;

36
37 b) be comprised of a fund from which a beneficiary could pay deductible medical
38 expenses and would be coupled with purchase of catastrophic health insurance to
39 cover expenses that, in the aggregate, exceed the catastrophic insurance
40 deductible;

41
42 c) permit accumulation of unspent balances within the fund;

43
44 d) allow state and federally tax exempt distribution of funds only for medical
45 expenses, health insurance premiums and/or long term care.

46
47 Since 1987, ASIM has supported the concept of medical savings accounts and the idea of
48 integrating medical savings accounts into an overall health system in which people could choose
49 among a variety of health plans, including medical savings accounts. These accounts are useful

1 as part of a continuum of health care coverage options, particularly for their impact in enhancing
2 consumers' awareness of the costs of health care.

3
4 ASIM feels strongly, however, that MSAs should not be used as the sole source of health care
5 coverage but should be established in concert with a catastrophic health insurance policy.
6 Furthermore, ASIM agrees with the concerns of some MSA critics that these accounts would
7 adversely affect community rating of insurance and diminish the potential for widening insurance
8 coverage. Ways to ameliorate these effects include ensuring that money in an MSA be used only
9 for health care, including long term care, and making MSAs available for purchase only through
10 purchasing groups to address problems with community rating.

11
12 ASIM acknowledges that MSAs appear to run counter to the trend in the health care system
13 toward managed care. On the other hand, a spokesman for the American Academy of Actuaries
14 Workgroup on MSAs predicted that managed care plans may respond "creatively" to these
15 savings accounts by offering managed care products compatible with MSAs. Because MSAs
16 appeal to so many patients and physicians, ASIM believes efforts should be made to include them
17 in the menu of coverage options available to beneficiaries. To make medical savings accounts a
18 reality under the Medicare program, however, will require many more provisions than the outline
19 provided above. To implement MSAs, answers will be needed to questions such as: how will the
20 government ensure that the funds in an MSA are, in fact, used for health care purposes?; will
21 beneficiaries be able to contribute their own money to MSAs and, if so, will there have to be
22 separate accounts established for private funds and the federal contribution?; can the savings
23 instrument into which the government contribution is placed be protected against adverse market
24 downturns so that beneficiaries do not lose their medical coverage?; should copayments be
25 required as part of the catastrophic coverage?

26
27 4. Voucher plans should be required to accept all applicants during an open
28 enrollment period to minimize adverse risk selection. Beneficiaries should be
29 allowed one opportunity per enrollment year to disenroll from a plan within 60 days
30 of enrollment. Once a beneficiary has been in a plan over 60 days, he or she
31 should be required to wait until the next open enrollment period. Beneficiaries
32 should be explicitly informed of this requirement by the health plan and should be
33 required to sign a written acknowledgement of the conditions of enrollment.

34
35 A reinsurance mechanism should be available to those plans subject to adverse
36 risk selection or to a sudden influx of voucher enrollees whose previous plan has
37 gone bankrupt.

38
39 Another set of problems related to choice of physician and plan has to do with the response of
40 health plans to those beneficiaries holding vouchers. To avoid circumstances in which health
41 plans sought to avoid covering the very ill, all plans should be required to enroll any beneficiary
42 with a voucher who seeks entrance into the plan. On the other hand, mandated acceptance and
43 the ability of beneficiaries—under current Medicare risk contract rules—to enroll and disenroll
44 outside of any prescribed enrollment period leaves plans vulnerable to unanticipated costs. In
45 such a scenario, beneficiaries' right to choice of plan/physician conflicts with health plans' needs
46 to maintain their cost and utilization control. The Congressional Budget Office has suggested that
47 an annual enrollment period with a point-of-service policy "would permit Medicare enrollees to go
48 to providers outside [a managed care plan's] panel when they wanted to and yet it need not
49 increase benefit costs for either the [the plan] or Medicare." To avoid circumstances in which

1 beneficiaries enroll in and disenroll from plans multiple times using the 60 day window, there
2 should only be one opportunity during an enrollment year to disenroll from a plan within two
3 months, after which the beneficiary would have to wait for the next open enrollment period.
4 For such changes to work, beneficiaries must be given enough information at the outset to
5 understand that, in signing up for a managed care plan, they must remain with that plan until the
6 next open enrollment period once they have been in a plan over two months. This puts the
7 burden of education on the managed care plan and the decision in the hands of the beneficiary.
8 In addition, such an approach would make managed care more palatable to both beneficiaries
9 and physicians.

10
11 5. The defined contribution--or voucher--should be set at a level that would
12 produce incentives for beneficiaries to consider cost in choosing a health plan
13 without forcing them into the cheapest plans that are most restrictive of choice of
14 physician. The voucher should not be set at the cost of the lowest priced plan in
15 a region.

16
17 The voucher amount should be adjusted according to age, sex, disability status,
18 institutional status, and Medicaid-buy in status and applied by region. Once the
19 regionally adjusted voucher amount was established, HHS or HCFA would accept
20 applications from health plans to participate in the voucher program.

21
22 If the voucher is set too high it will have little impact on controlling Medicare costs. Set too low
23 and beneficiaries choosing the voucher option may find their choice of plan and, ultimately choice
24 of physician, quite limited. In addition, for a segment of the Medicare population, a voucher will
25 not cover what a health plan would spend on treating them. This would seem to call for some
26 type of adjustment in the value of the voucher through mechanisms that are reasonably simple
27 and inexpensive to administer. Otherwise, health plans might attempt to discourage certain
28 beneficiaries from selecting that plan by adopting discriminatory policies or marketing strategies.

29
30 A voucher set at some national average would fail to reflect the appropriate regional differences in
31 costs of health care delivery. Setting a regional voucher amount is a more accurate way for the
32 voucher to reflect local health care costs, would be less likely to drive people into restrictive
33 health plans and would ensure that there would be at least one plan in a region that could serve
34 Medicare beneficiaries for the price of the voucher. Any process used to set the voucher amount
35 in which plans submit their premiums to the government and the government then sets the
36 voucher on some portion of those premiums must ensure that the resulting voucher is not so low
37 as to make it worthless to most beneficiaries.

38
39 6. The voucher should be updated on a regular basis to keep pace with the costs
40 of providing services to beneficiaries. In the event that spending under the
41 voucher program exceeds estimated savings goals or targets, the voucher should
42 not be subject to arbitrary caps. Mechanisms to keep spending within designated
43 limits or to recoup excess expenditures, such as a "look back sequester", should
44 be rejected. Instead, an independent board or commission should be established
45 that would involve all participants in the health care system in devising a response
46 to cost control that would not focus solely on cuts to providers and increased
47 costs to beneficiaries. If spending is greater than projected due to development of
48 valuable new technologies or increased patient utilization of services deemed
49 medically necessary, there should be a commitment to increasing the amount of

1 funds devoted to the voucher program in order to ensure vouchers retain sufficient
2 purchasing power and to assure appropriate medical outcomes.
3

4 The way in which the voucher is updated will determine to a large extent how much purchasing
5 power the voucher continues to give beneficiaries. Given too great an increase and the voucher
6 will be ineffective in controlling health costs. Given too little, and the voucher may drive some
7 beneficiaries into lower quality, more restrictive health plans. There is also always a risk that the
8 voucher update could fall victim to budget politics and be "frozen" or "capped" at some point to
9 meet deficit reduction targets.

10
11 If spending under a voucher program is higher than anticipated because valuable new
12 technologies or treatments have become available and patients have sought to take advantage of
13 these advances in medicine, it does not make sense to penalize physicians by cutting their
14 payments when costs increase for legitimate reasons. Furthermore, if beneficiaries do not
15 participate in the voucher program in numbers sufficient to keep costs down, physicians should
16 not be held financially responsible for beneficiaries' independent decisions. In addition, across-
17 the-board cuts in physician and provider payments do not target those areas where health care
18 costs have inappropriately increased and penalize caregivers who may in fact have kept their
19 costs down. Arbitrary reductions in payments will serve only to perpetuate inequities in the
20 Medicare payment system and compel physicians to limit their exposure to Medicare patients.
21

22 Finally, a cap on spending for the voucher implies a lack of confidence in the ability of the market
23 to control the cost of health plan premiums and may have the unintended consequence of
24 becoming a "floor" rather than a ceiling. If health plans know that the government's contribution
25 will be capped at a certain percentage rate of growth, this may serve as an incentive to those
26 plans whose rates of growth are lower than that percentage to allow their premiums to rise to
27 meet the government's growth rate.
28

29 In the event federal health program costs remain uncontrollable, some entity -- such as a
30 commission or board -- should be established separate from any government financing office to
31 involve all parties in the health care system in devising a response to cost control that would not
32 focus solely on cuts to providers and increased costs to beneficiaries. If beneficiaries are to be
33 assured of getting all the necessary care they need when they need it, the voucher amount
34 should keep pace with the costs of providing services. If the value of the voucher is allowed to
35 erode over time, beneficiaries may lose access to many high quality health plans offering
36 comprehensive services or they may be forced to pay increasing amounts out-of-pocket to
37 maintain a certain level of service. This would be especially detrimental for those beneficiaries of
38 low and moderate-income who may be unable to bear an increasing financial burden. If the
39 market is unable to deliver health care to patients within a predetermined cap, this should not be
40 used as an excuse to diminish the government's commitment to Medicare beneficiaries.
41

42 7. A reassessment of the voucher program should be required after five years.
43 This reevaluation should be undertaken by an agency or commission not
44 responsible for funding Medicare.
45

46 Given the untried nature of a voucher program for Medicare, there should be an evaluation of the
47 program relatively early in its life. There was little comprehensive evaluation of the original
48 Medicare program in its early stages and many of the present troubles in the system derive from
49 that oversight. If the voucher program does not seem to be living up to its expectations,

1 Congress and the administration should not merely tinker at the edges to provide short term fixes
2 but should step back, take a hard look at the program and even consider starting all over again.
3

4 8. Beneficiaries opting for the voucher program should be provided incentives that
5 encourage their selection of an economically priced plan but that do not force
6 enrollees into those plans that are most restrictive of choice of physician and that
7 impose the strictest limits on access to services. Incentives should come in the
8 form of additional benefits or services provided by the health plan and not in the
9 form of a cash rebate. With rules in place to ensure that all beneficiaries have
10 access through voucher plans to the full range of Medicare covered benefits and
11 services, beneficiaries should pay the difference between the voucher amount and
12 any premium charged by a plan that exceeds the voucher amount.
13

14 Some analysts contend that beneficiaries should be provided incentives to select a health plan
15 that costs less than the federal contribution amount, or voucher. These incentives typically fall
16 into two categories--cash rebates or additional services. Giving beneficiaries a cash rebate if their
17 premium is less than the voucher amount would remove funds from the health care system that
18 ought to be providing for health care services. Instead, any excess value should be returned to
19 the beneficiary in the form of additional benefits such as coverage of additional services,
20 providing coverage for long term care or creating a health care spending account. There is also
21 debate over whether beneficiaries should bear the full cost of a health plan more expensive than
22 the voucher to encourage enrollees to select more economical health plans. Although there is
23 concern that such an incentive might drive beneficiaries to select plans of lesser quality or that
24 don't cover the full range of benefits, this is less of a problem if all plans offer the full range of
25 Medicare-covered services.
26

27 9. Reasonable cost sharing under voucher plans -- both fee for service and
28 managed care -- should be imposed to assure consumer cost consciousness in
29 utilization of services. Lower cost sharing should be imposed on clinically-proven
30 preventive services so that people are not unduly discouraged from obtaining
31 beneficial care. Preventive services should be subject only to copayments, not
32 deductibles. Copayments for preventive services should be set lower than those
33 for other services.
34

35 To avoid unjustified restrictions on choice of physician, POS voucher plans should
36 not impose unreasonable coinsurance on services provided by out-of-network
37 physicians. To prevent beneficiaries who seek out-of-network care from being
38 subject to unexpected out-of-pocket costs, POS plans and physicians should be
39 required to establish their own conversion factors to be used against an improved
40 resource based relative value scale (RBRVS). This would determine the rates the
41 POS plan would pay and the fees the physicians would charge for their services.
42 Plans and physicians would be required to supply enrollees in the POS plan with
43 information based on these conversion factors to enable enrollees to determine in
44 advance how much they would pay in going out of the plan's network of
45 physicians.
46

47 As an incentive to promote greater price consciousness in the traditional Medicare
48 program and to encourage the movement of beneficiaries into the voucher system,
49 those who choose to stay in the traditional Medicare program should be subject to

1 reasonable and non-punitive increases in cost-sharing. As with POS plans, in
2 order to buffer beneficiaries from unexpected costs, a requirement could be
3 imposed under traditional Medicare that physicians must establish their conversion
4 factor for their services each year concomitant with the announcement of
5 Medicare's conversion factor. Enrollees in traditional Medicare would be supplied
6 annually with information comparing the charges of physicians in their area to
7 Medicare's fees based on their respective conversion factors. In this fashion,
8 beneficiaries would know in advance whether or not they would have to pay out-
9 of-pocket for services charged under traditional Medicare.

10
11 Beneficiaries should not be subject to charges in excess of Medicare's payment
12 amounts under the following circumstances: in the case of low income
13 beneficiaries; emergency situations; when the beneficiary has little voice in the
14 selection of a physician or in areas of the country where there is no competition for
15 a particular medical specialty.

16
17 If true reform is to be instituted in the Medicare system, enrollees must understand the nature of
18 the costs of their care under that program. At the same time, policymakers should not lose sight
19 of the fact that 83 percent of Medicare expenditures go to beneficiaries with incomes at or below
20 \$25,000 and thus their exposure to additional costs should be limited.

21
22 ASIM believes it is especially important that cost sharing on preventive services be reduced and
23 deductibles on these services be eliminated entirely to avoid discouraging patients from obtaining
24 necessary care. By erecting barriers to cost-effective preventive care—for example, imposition of
25 cost sharing on mammograms—patients may avoid those services and wind up with more serious,
26 and expensive, illnesses in the future.

27
28 In addition, ASIM supports limits on the degree to which additional cost sharing can be imposed
29 on those enrolled in managed care plans who use a plan's point-of-service (POS) option to seek
30 care outside the plan's network of physicians. The intent behind POS is to allow beneficiaries
31 greater choice in physician and provider. If the cost sharing imposed on a beneficiary for going
32 outside a health plan's physician network is excessively burdensome, then the promise of greater
33 choice is a hollow one.

34
35 Obviously, if beneficiaries are to be encouraged to enter the voucher program, those who opt to
36 stay in traditional Medicare must bear a greater share of the cost of remaining in the more
37 expensive program. Nevertheless, any additional cost sharing should follow the principles stated
38 above so that primary care and preventive services are sheltered from deductibles and are
39 subject to cost sharing at a rate lower than that imposed on other services. Because high
40 deductibles can act as a disincentive for patients to receive needed primary care and preventive
41 services, ASIM does not support replacing the current coinsurance requirements under traditional
42 Medicare with a single high deductible.

43
44 ASIM believes that its Competitive Pricing, Informed Choices proposal—issued in 1992—offers a
45 means to instill price competition among physicians, enhance consumer cost consciousness and
46 prevent price gouging by unscrupulous providers. If health plans that pay according to a fee
47 schedule (POS plans, traditional Medicare, etc.) and physicians were required to set and publish
48 the conversion factors they would use each year to determine their charges and fees, this
49 information could be used by beneficiaries to determine what they would pay out-of-pocket, if

1 anything, if they joined a particular health plan or used a particular doctor. Beneficiaries would
2 then be able to decide if the value they derived from a health plan and/or physician in terms of
3 quality and service was worth the price of any additional costs.
4

5 For example, assume Mrs. Jones is a Medicare beneficiary who receives from HCFA a booklet
6 listing all the health plans and physicians in her area. Among the information contained in the
7 booklet might be the percentage difference between the conversion factors used by traditional
8 Medicare and POS plans and the physicians listed in the booklet. Mrs. Jones might see that Dr.
9 Smith has a conversion factor 10 percent higher than Medicare's conversion factor. If she went to
10 Dr. Smith for care under traditional Medicare, she would know that she would pay an additional
11 ten percent on Dr. Smith's charges beyond the payment traditional Medicare would make. Or,
12 Mrs. Jones might see that health plan ABC has a conversion factor for its POS option 20 percent
13 lower than Dr. Smith's conversion factor. She would then know that Plan ABC would pay 20
14 percent less for the services of Dr. Smith--who does not participate in her health plan physician
15 network--and she would be responsible for the 20 percent difference between the health plan's
16 payments and Dr. Smith's fees, in addition to any additional cost sharing required by Plan ABC for
17 enrollees going out of the network.
18

19 While ASIM generally supports cost sharing by patients in order to enhance cost consciousness in
20 the utilization of scarce health care resources, there are situations in which billing beyond
21 Medicare's payment rates or additional cost sharing should not be imposed. These situations
22 arise where beneficiaries' income is simply too low to sustain any additional out-of-pocket
23 financial burden, where they have no opportunity to "shop around" for a physician (e.g.
24 emergency situations), where beneficiaries have but one choice of physician (such as typically
25 occurs during hospitalizations when patients are essentially assigned certain hospital-based
26 doctors to deliver designated services) or where there are so few physicians in a particular
27 specialty within a community that there is no chance for competition among physicians to operate.
28

29 10. To qualify as a voucher plan under Medicare, health plans should have to:
30 offer a standard minimum Medicare benefits package that includes preventive
31 services; meet certain utilization review and quality assurance standards; involve
32 participating physicians in development of the plan's utilization review (UR) and
33 quality assurance (QA) and provider selection policies and procedures; disclose
34 their utilization review and quality assurance policies, restrictions on choice, risk
35 arrangements and provider selection criteria; establish due process mechanisms in
36 selection of plan providers; meet certain solvency standards; report certain
37 information -- such as premium costs, out-of-pocket liability, consumer satisfaction
38 and the percentage of premium dollars devoted to administration versus benefits --
39 to a central data collection entity so that this information can be distributed to
40 beneficiaries and use uniform claims forms and standard billing and claims
41 processing procedures.
42

43 Health plans that selectively contract with physicians should be required to offer
44 enrollees the opportunity to buy a rider that provides point-of-service access to
45 non-network physicians, in addition to meeting the foregoing standards.
46

47 Health plans should play by the same rules if competition is truly to be effective in controlling
48 costs. Given that the idea behind many Medicare voucher proposals is to enhance competition
49 within the program so as to bring down costs, it would seem equally advisable that health plans

1 should be required to meet certain rules if they wish to participate in the voucher program and
2 market themselves to beneficiaries as Medicare voucher plans.

3
4 A uniform minimum benefit policy would assure a basic level of care for all beneficiaries. In
5 addition, it would facilitate beneficiaries' comparison of health plans. If beneficiaries are to have
6 sufficient information to make informed choices with their vouchers, they will need data on a
7 plan's costs, patient out-of-pocket liability, provider panels, and quality. Furthermore, disclosure
8 of UR and selection standards benefits not only the providers involved with a health plan but
9 helps beneficiaries as well by giving them another piece of information on which to compare
10 health plans.

11
12 In addition, it is important that physicians have a role in developing and implementing health plan
13 policies and procedures that directly affect clinical decision-making--e.g. benefits coverage
14 criteria, determination of medical necessity, preauthorization of services, quality assurance
15 standards, protocols and processes for selection and deselection of physicians. To leave
16 decisions affecting patient care solely in the hands of health plan administrators whose concerns
17 center largely on cost containment may jeopardize the quality of care given to enrollees and deny
18 patients access to medically necessary services. Furthermore, health plans that involve
19 physicians in development of these policies are far more likely to obtain the cooperation of their
20 network physicians in proper implementation of those policies.

21
22 Finally, it is important that voucher plans be required to operate under similar billing and claims
23 processing procedures to avoid unnecessary red tape. All plans that currently operate within the
24 Medicare system must abide by the uniform claims form and billing rules and it would be logical
25 to expect that voucher plans should use a standard format and follow standard claims processing
26 procedures for this new variation of the Medicare program.

27
28 The type of standards to which ASIM refers--involvement of physicians in clinical policymaking,
29 providing information to enrollees and prospective enrollees sufficient to enable them to make
30 informed decisions about the plan--are, in fact, those that are being adopted by many well-run
31 health plans in today's marketplace. In a competitive environment, those plans that pursue
32 "patient-friendly" policies such as these are more likely to succeed than others.

33
34 11. Because Medicare is a federally funded program, the federal government must
35 continue to ensure that health plans are accountable for the care they give to
36 beneficiaries and that they abide by standards set out for Medicare plans. HCFA
37 or another federal agency should be responsible for contracting with health plans;
38 reviewing marketing materials; disseminating to beneficiaries objective data about
39 each plan in a region in a standard format; ensuring health plan compliance with
40 certain standards governing their rules and operations; and ensuring that health
41 plans meet certain quality standards. However, private accreditation agencies
42 should be able to achieve "deemed" status to fulfill the role played by HHS in
43 approving voucher plans. Mechanisms should be available for patients and
44 physicians to pursue grievances against health plans for denial of medically
45 necessary care. Patients and physicians should retain access to fair hearing and
46 judicial review processes at least comparable to those now available under
47 traditional Medicare.
48

1 Because vouchers would require more thought and decisionmaking by Medicare recipients, some
2 analysts question whether beneficiaries would find the voucher program truly appealing. Other
3 policymakers argue that the basic premise of the voucher program is simple and that most
4 beneficiaries, given the right kind of information, will be able to make proper decisions about a
5 health plan. While this may indeed be the case for healthy beneficiaries who are mentally alert,
6 the frail and disabled elderly, those who do not speak English very well or those with little
7 education may find the task of sorting through health plan information daunting. To respond to
8 some of these concerns, the voucher program should have an entity with which voucher plans
9 would contract and which would ensure voucher plan adherence to any standards adopted
10 governing such plans.

11
12 Given the characteristics of the Medicare population, an ombudsman's office should be created
13 to receive, investigate and resolve complaints against voucher plans as well as to offer guidance
14 to beneficiaries with questions about the voucher program. Finally, beneficiaries and physicians
15 should retain access to the current Medicare appeals process.

16
17 ASIM would prefer that the health care industry voluntarily abide by the standards established for
18 a voucher program and, indeed, supports the idea of a private accreditation body responsible for
19 ensuring health plan adherence to voucher program standards. However, the voucher program
20 will be funded by federal dollars and the federal government should not relinquish its
21 responsibility for ensuring that health plans are accountable for the care they deliver to
22 beneficiaries and for seeing that corrective actions are taken when deficiencies are found if a plan
23 wishes to remain in the voucher program. Health plans that accept the government contributions
24 should understand that, if they are going to compete for the business of the federal government
25 through the voucher program, they must accept certain standards and certain reasonable
26 oversight.

27
28 **12. Self-referral restrictions affecting shared laboratory facilities and group**
29 **practices should be removed and antitrust reforms enacted to enable physicians**
30 **and providers to negotiate on an equal footing with health plans and purchasers.**
31

32 Antitrust reforms and other modifications to statutory restrictions on physicians could improve the
33 functioning of health plans offered under a voucher system and the ability of physicians to deliver
34 services within their context. For example, self-referral restrictions on group practice
35 compensation arrangements not only interfere in the internal affairs of private businesses but lead
36 to confusion over how such practices may distribute revenue from ancillary services without
37 indirectly taking into account the referrals made by physicians. Furthermore, subspecialists--such
38 as oncologists and infectious disease specialists--in many group practices are barred from
39 providing drugs and other services to their patients because of the self-referral laws.

40
41 Limitations on the ability of physicians to share information in order to form integrated service
42 networks may impede the goals of voucher advocates who wish to foster competition that reduces
43 the cost of care and increases benefits to attract voucher recipients. Indeed, antitrust laws
44 developed at a time when most physicians and other providers practiced independently of one
45 another now prevent these caregivers from organizing preferred provider organizations, health
46 plans and other delivery networks that would enable physician-directed health care organizations
47 to compete in the marketplace and offer beneficiaries a wider choice of health care options.
48
49

1 **Conclusion**

2
3 ASIM is under no illusion that reforming Medicare will be simple, easy, or quick. Changes of the
4 magnitude required to place the program on sound financial footing and to guarantee that
5 beneficiaries continue to receive the high quality health care to which they have become
6 accustomed and to which they are entitled will require a great deal of thought and debate. For
7 ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared
8 responsibility.
9

10 Physicians have a responsibility to deliver care to greater numbers of Medicare patients under
11 health care delivery systems that will increasingly require them to accept financial risk and to be
12 accountable for the cost and quality of their clinical decisions--and to compete within this new
13 system on the basis of cost and quality.
14

15 Medicare patients have a responsibility to consider the costs of alternative sources of health care
16 coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive
17 coverage and--for those who can afford to--to contribute more to the financial support of Medicare
18 so that those of lesser means can afford coverage.
19

20 Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and
21 introduce positive incentives into the health care system including a limit on the tax deductibility of
22 employer paid insurance and increased taxes on tobacco.
23

24 The insurance industry has a responsibility to compete in the new system--not solely on price or
25 risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect
26 beneficiaries who choose private insurance coverage.
27

28 And the federal government has a responsibility to assure that the government's contribution
29 remains adequate to guarantee that all beneficiaries can obtain high quality coverage through
30 traditional Medicare and private sector alternatives--and to provide sufficient oversight over the
31 market to protect patients' interests.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: Klein

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: CAB 10/23

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

Designee to attend: AJ

Remarks: He is someone who attended
Portland Economic Conf.
Julie: Tucker

THE WHITE HOUSE

WASHINGTON

October 31, 1995

Charles R. Maples, R.Ph.
President
2725 N.E. Columbia Boulevard
Portland, Oregon 97211

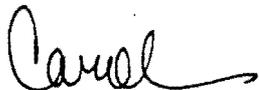
Mr. Maples:

Thank you for your letter about the Republican Medicare and Medicaid proposals. The Clinton Administration strongly opposes both the magnitude of the proposed cuts and the conversion of Medicaid into a block grant, eliminating guaranteed coverage to millions of Americans.

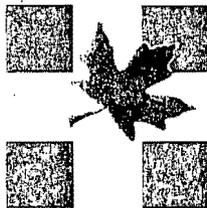
We also share your concerns about the lack of federal standards in the proposed block grant. In addition to the elimination of the protections you mentioned in your letter, the block grant would repeal quality standards for nursing homes that were enacted with bipartisan support, provisions that prevent spouses of nursing home residents from losing their incomes and homes, and protection for low-income Medicare beneficiaries under Medicaid.

We will continue to fight against these extreme proposals and very much appreciate your support.

Sincerely,



Carol Rasco
Assistant to the President
for Domestic Policy



I P A C
PHARMACY
A DIVISION OF MAPLES CORPORATION

CHARLES R. MAPLES, R. Ph.
President

2725 N.E. Columbia Boulevard
Portland, Oregon 97211
503-281-4722
FAX 503-281-9990
1-800-444-7574



OCT 13 1995

October 6, 1995

Carol H. Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC

Dear Carol,

I would like to share with you some of the programs and benefits we are providing at IPAC Pharmacy in line with our commitment to the health, education and welfare of our staff, their families and communities. I've enclosed three of our corporate newsletters outlining these programs.

I am extremely concerned, as are my colleagues here in Oregon and across the nation, with the House and Senate Republicans' approach to Medicaid and Medicare reform - more specifically, the move to enact Medicaid Block Grants. The "MediGrants" would eliminate OBRA '87 mandated protections for our nation's frail elderly. Among these federally mandated protections, there would no longer be the requirement for drug regimen review by the Consultant Pharmacist. It has been estimated that drug regimen review saves the country \$668 million per year in reduced hospitalizations, \$300 million per year in decreased drug handling time by nurses and \$250 million per year in decreased prescription costs.

Block Grants will negate the tremendous strides we have made in the protection of residents of the nations nursing homes and will be disastrous to our clients. I am asking for your administration's help in preventing the enactment of block grants. If I may be of any assistance in this end, I may be reached at 1-800-444-7574 any time.

Thank you for your kind attention to this matter. The quality of life for this country's nursing home residents depends on our preventing the enactment of block grants.

Best regards,

Charles R. Maples, R.Ph., FASCP
CEO, IPAC Pharmacy Services

THE WHITE HOUSE

WASHINGTON

November 1, 1995

George T. Chang, Ph.D.
Director of Laboratories
United Medical Laboratories, Inc.
6720 Old McLean Village
McLean, VA 22101

Dear Dr. Chang:

Thank you for writing about the impact of managed care laws on small medical laboratories. I understand your concerns.

As you know, the current laws governing commercial HMO's and Medicare HMO contracts do not regulate the market forces that affect medical laboratories. Prepaid medical plans can choose among any providers who meet certain criteria and standards defined by the Health Care Financing Administration.

If you would like to discuss this issue further, Chris Jennings, Special Assistant to the President for Health Policy Development, would be happy to meet with you. Please feel free to contact him at (202) 456-5585.

Sincerely,



Carol H. Rasco
Assistant to the President
for Domestic Policy



UNITED MEDICAL LABORATORIES, INC.®

6720 Old McLean Village Drive • McLean, Virginia 22101

Telephone: (703) 356-4422

July 24, 1995

Hon. Leon Panetta
Chief of Staff
White House
By Hand

Dear Mr. Panetta:

me I am very disturbed by managed health care systems that are restricting medical laboratory work to a few large laboratories for all testing needs. Such practices eliminate the competitive benefits offered by the inclusion of smaller, independent laboratories. These types of restrictions are devastating the thousands of community-based laboratories that employ many hundreds of thousands Americans. I am enclosing two copies of Virginia House Bill 840. I would like to see if the President can execute an executive order in which this law, or a similar law, can be enforced on a national level, specifically protecting the rights of small, independent, community-based medical laboratories.

Very truly yours,

George T. Chang, Ph.D.
Director of Laboratories

GTC:tes
Enclosure

OFFICE OF MANAGED CARE

FACSIMILE TRANSMISSION REQUEST

TO: Sarah Bianchi
DPC

FAX NO. 202/456-7431

C + 1

Please call _____ at for pickup

FROM: John Gorman
6069

REMARKS
Response to United Medical Labs, per request.

Please call _____ on _____ to confirm receipt

Why Co

MC is about acc & comp
→ business lgs need make
agreement.

IF ACFA tried micro man
market place provid
other
unsustainable



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Memorandum
Office of Managed Care

October 17, 1995

TO: Sarah Bianchi, Domestic Policy Council Staff, The White House

FR: Bruce Merlin *BMS*, Director-Designate

RE: Response to Inquiry from United Medical Laboratories on Managed Care

We are responding to your inquiry, faxed to us October 10, 1995, which was accompanied by supporting correspondence from George T. Chang, Ph.D. of United Medical Laboratories in McLean, VA, relative to managed care and medical laboratories.

your letter / As you know

① We understand and sympathize with the concerns expressed in the correspondence. However, under current federal law governing commercial HMOs and Medicare HMO contracts, we do not regulate the market forces which are affecting these laboratories, nor do we feel that it would be prudent to do so. Prepaid medical plans can choose the various providers with which they do business subject only to certain constraints as to the nature and quality of the services they provide their members. They are allowed to use sole source providers, competitive bidding or other contracting methods.

why wouldn't it be prudent to do so?

nature & quality of services & other contract members

② The current emphasis of managed care law and regulations is reflected in the thrust of our efforts at HCFA to assure:

- equal and convenient access of care to all managed care enrollees;
- quality of care that is consistently improving for these enrollees; and
- that both access to and quality of care are provided at a reasonable, affordable cost to the managed care members.

We hope that these comments will be helpful to you. Thank you for giving us the opportunity to assist, and please do not hesitate to contact us if we can be of further help.

→ we do require that services be required

regulating contractors

entering on behalf of providers managed care

only in specific circumstances others

→ then you have to regulate

→ As you know, regulation of insurance laws are historically done at the state level. In this environment of ~~the~~ cong int to move ~~to~~ state devaluated ~~fed~~ away ^{away} from federal regulation this would be difficult for. It may be difficult.

It is unclear whether executive order would indeed be helpful in this regard.

AMA. If you want
MARK MILL. to discuss
in further
w/ Chris Jennings

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

COMMONWEALTH OF VIRGINIA



BOX 115
RICHMOND, VIRGINIA 23204
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
October 17, 1994

ADMINISTRATIVE LETTER 1994-8

TO: All Insurers, Health Services Plans, and Health Maintenance Organizations licensed to write Accident and Sickness Insurance in Virginia

RE: Freedom of choice requirements - Pharmacies and Ancillary Service Providers

Chapter No. 963 of the 1994 Acts of the General Assembly of Virginia (1994 House Bill 840), took effect on July 1, 1994. The bill created six (6) new statutes, designated by the Virginia Code Commission as Sections 38.2-3407.7, 38.2-3407.8, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1, and 38.2-4312.2 of the Code of Virginia, as amended. These new requirements, which are imposed upon insurers issuing "preferred provider" policies or contracts and upon health maintenance organizations, relate to coverage for services rendered and products furnished by out-of-network pharmacies and ancillary service providers.

It has come to my attention that several issues have arisen regarding the interpretation of certain provisions of this legislation. The following is an explanation of how the Bureau of Insurance intends to administer certain requirements found in the new statutes listed above.

intend

Administrative Letter 1994-6

October 17, 1994

Page 2

DEFINITION OF "ANCILLARY SERVICES"

The term "ancillary services" is defined in §§ 38.2-3407.8, 38.2-4209.2, and 38.2-4312.2 as: *"those services required to support, facilitate or otherwise enhance medical care and treatment."* These statutes also provide that: *"the furnishing of durable medical equipment required for therapeutic purposes or life support" is an example of ancillary services.* It is the Bureau's position that the statutory definition of ancillary services is an extremely broad one, and cannot reasonably be construed as limited to the provision of durable medical equipment. Unless and until the statutory definition is made more restrictive, then, it is our position that any person or class of persons that provides services that *"support, facilitate or otherwise enhance medical care and treatment"* meets the definition of an "ancillary service provider."

Each of the statutes cited above contains the following language:

The [State Corporation] Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Therefore, the Bureau does not have the authority to intervene in disagreements among parties affected by these new requirements. Questions of interpretation concerning whether or not a provider is providing "ancillary services" will have to be resolved in forums other than the State Corporation Commission.

CONTRACT PROVISIONS

All six statutes cited above contain specific language prohibiting the imposition of:

any copayment, fee, or condition that is not equally imposed upon all individuals in the same benefit category, class, or copayment level, whether or not such benefits are furnished by [pharmacists or ancillary service providers] who are [non preferred or nonparticipating] providers. (emphasis added)

Administrative Letter 1994-8
October 17, 1994
Page 3

It is our position that each of these provisions prohibits an insurer or health maintenance organization from amending its contracts to provide that claimants obtaining services from out-of-network pharmacies or ancillary service providers must pay for the services and then seek reimbursement from the insurer or health maintenance organization, unless this same condition is imposed upon claimants utilizing the services of in-network pharmacists or ancillary service providers. Additionally, if information regarding coverage is available to in-network providers, such information must also be made available to out-of-network providers in the same or substantially similar manner.

All six statutes cited above also contain the following provision:

This right of selection extends to and includes [pharmacies or ancillary service providers] that are [non preferred or nonparticipating] providers and that agree to accept reimbursement for their services at rates applicable to [pharmacies or ancillary service providers] that are [preferred or participating] providers. (emphasis added)

written agreement
It is our position that affected insurers and health maintenance organizations must maintain records of written agreements with out-of-network pharmacies and ancillary service providers that have agreed to accept the rates applicable to preferred or participating providers. Any reference by the insurer or health maintenance organization to the possibility of a pharmacy or ancillary service provider billing the insured for the difference between the network rates and those charged must clearly state that the insured can verify in advance of a purchase that the provider in question has entered into an agreement to accept the network rate as payment in full to avoid additional charges. This verification must be provided by the insurer or health maintenance organization providing coverage.

This letter serves as notice of our intention to withdraw approval, pursuant to § 38.2-316 of the Code of Virginia, as amended, of any forms of which we become aware that do not comply in all respects with the provisions of §§ 38.2-3407.7, 38.2-3407.8, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1, and 38.2-4312.2 of the Code of Virginia, as amended. Insurers and health maintenance organizations are instructed to review their forms immediately and file amendments, within 45 days of the date of this letter, for the purpose of bringing any non-complying forms into compliance with the statutes discussed herein. Subsequently, any forms brought to our attention that do not comply will have their approval withdrawn, and the Bureau will consider initiation of any other disciplinary proceedings deemed

Administrative Letter 1994-8
October 17, 1994
Page 4

appropriate in the circumstances. It should be noted that the wording of each of the statutes listed above is sufficiently broad so as to apply to in force contracts as well as newly issued contracts.

Insurers and health maintenance organizations are also hereby instructed to take appropriate steps to expedite communication and agreement with non-network providers wishing to enter into agreements to accept reimbursement at network rates.

Any questions regarding the administration of these requirements should be directed to the attention of Althelia P. Battle, Senior Insurance Market Examiner, or Robert R. Knapp, Senior Insurance Market Examiner, Life and Health Forms and Rates Section, at the above address. The telephone number for the Forms and Rates Section is (804) 371-9110.

Sincerely yours,



Steven T. Foster
Commissioner of Insurance

STF/me

VIRGINIA ACTS OF ASSEMBLY -- 1994 RECONVENED SESSION

CHAPTER 963

An Act to amend the Code of Virginia by adding sections numbered 38.2-3407.2, 38.2-3407.3, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1 and 38.2-4312.2, relating to accident and sickness insurance; pharmacies and ancillary service providers; preferred provider networks and health maintenance organizations.

[H 840]

Approved May 20, 1994

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding sections numbered 38.2-3407.2, 38.2-3407.3, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1 and 38.2-4312.2 as follows:

§ 38.2-3407.2. *Pharmacies; freedom of choice.*

A. Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer proposing to issue preferred provider policies or contracts shall prohibit any person receiving pharmacy benefits furnished thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to pharmacies that are preferred providers.

B. No such insurer shall impose upon any person receiving pharmaceutical benefits furnished under any such policy or contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.

C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-3407.3. *Ancillary service providers; freedom of choice.*

A. Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer proposing to issue preferred provider policies or contracts shall prohibit any person receiving ancillary service benefits furnished thereunder from selecting, without limitation, the ancillary service provider of his choice to furnish such benefits. This right of selection extends to and includes ancillary service providers that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to ancillary service providers that are preferred providers.

B. No such insurer shall impose upon any person receiving ancillary service benefits furnished under any such policy or contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by ancillary service providers who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of ancillary service provider; or

3. Any reduction in allowable reimbursement for ancillary services related to utilization of ancillary service providers who are nonpreferred providers.

C. For the purposes of this section:

1. "Ancillary services" means those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support;

2. "Ancillary service provider" and "ancillary service providers" mean a person or persons providing ancillary services.

D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4209.1. *Pharmacies; freedom of choice.*

A. Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts shall prohibit any person receiving pharmaceutical benefits thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to

pharmacies that are preferred providers.

B. No such corporation shall impose upon any person receiving pharmaceutical benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.

C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4209.2. Ancillary service providers; freedom of choice.

A. Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts shall prohibit any person receiving ancillary service benefits thereunder from selecting, without limitation, the ancillary service provider of his choice to furnish such benefits. This right of selection extends to and includes ancillary service providers that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to ancillary service providers that are preferred providers.

B. No such corporation shall impose upon any person receiving ancillary service benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by ancillary service providers who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of ancillary service provider; or

3. Any reduction in allowable reimbursement for ancillary services related to utilization of ancillary service providers who are nonpreferred providers.

C. For the purposes of this section:

1. "Ancillary services" means those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support;

2. "Ancillary service provider" and "ancillary service providers" mean a person or persons providing ancillary services.

D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4312.1. Pharmacies; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans shall prohibit any person receiving pharmaceutical benefits thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are not participating providers under any such health care plan and that agree to accept reimbursement for their services at rates applicable to pharmacies that are participating providers.

B. No such health maintenance organization shall impose upon any person receiving pharmaceutical benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are not participating providers.

C. The provisions of this section are not applicable to any health care plan whose terms require exclusive utilization of pharmacies wholly owned and operated by the health maintenance organization providing the health care plan.

D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4312.2. Ancillary service providers; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans shall prohibit any person receiving ancillary service benefits thereunder from selecting, without limitation, the ancillary service provider of his choice to furnish such benefits. This right of selection extends to and includes

ancillary service providers that are not participating providers under any such health care plan and that agree to accept reimbursement for their services at rates applicable to ancillary service providers that are participating providers.

B. No such health maintenance organization shall impose upon any person receiving ancillary services benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by ancillary service providers who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of ancillary service provider; or

3. Any reduction in allowable reimbursement for ancillary services related to utilization of ancillary service providers who are not participating providers.

C. For the purposes of this section:

1. "Ancillary services" means those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support;

2. "Ancillary service provider" and "ancillary service providers" mean a person or persons providing ancillary services.

D. The provisions of this section are not applicable to any health care plan whose terms require exclusive utilization of ancillary service providers wholly owned and operated by the health maintenance organization providing the health care plan.

E. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Major HMO Operator Denied Accreditation

Mid Atlantic Medical Services Fails Rating

By David S. Hilzenrath
Washington Post Staff Writer

Mid Atlantic Medical Services Inc., the Washington area's largest operator of health maintenance organizations, has been denied accreditation by the nation's leading monitor of quality control in HMOs, an executive at the company said yesterday.

The decision, to be announced today, will not affect the operations of Mid Atlantic's HMOs, Optimum Choice and MD-Individual Practice Association, which have about 550,000 members in the Washington area. But some corporate benefits managers said they would reconsider their ties to Mid Atlantic if it doesn't obtain accreditation.

Only a small minority of companies have received a failing grade after being evaluated by the National Committee for Quality Assurance (NCQA), although many HMOs have not been reviewed.

"I can't say point-blank that employers shouldn't offer a plan that's been denied accreditation, but it certainly raises a big red flag," said consultant Barbara Lohr of Towers Perrin, a consulting firm that advises companies on employee benefits.

Many corporations refuse to do business with HMOs that do not submit to a review by the NCQA, and

some corporate benefits managers said yesterday that they would stop enrolling workers in Mid Atlantic HMO if the company failed to meet NCQA standards within a year of two. Mid Atlantic, which unsuccessfully appealed NCQA's decision over the past few months, may be reviewed again in a year.

"You should be concerned about it," said James N. Astuto, who oversees managed health care for workers in GTE Corp.'s southeast region. "If they can't eventually jump the hurdle, we're going to have to freeze them and eventually terminate the relationship."

"This was a valuable education to us," said Paul E. Dillon, senior vice president and treasurer of Mid Atlantic. "We will now work harder to try and meet more of the NCQA standards."

Dillon would not say what reasons NCQA cited for its decision and NCQA officials would not comment on the matter in advance of its announcement today. As a matter of policy, NCQA does not disclose the detailed findings of its evaluations, although it plans to begin issuing summaries in July.

One possible reason for denial is that a shortcoming at an HMO "poses a potentially significant risk to quality of care," according to an

See HMO, B12, Col. 3

NCQA manual, but Dillon said, "They didn't put it to us in that manner."
"We think that MAMSI is providing the best quality of care that's available in the marketplace today," he said.
Dillon cited one example of the shortcomings the NCQA identified: The company did not independently verify doctors' medical degrees and medical internships. Instead, Mid Atlantic assumed that hospitals had verified those credentials when they extended admitting privileges to the doctors, Dillon said.
The NCQA, a not-for-profit group based in the District, examines the way HMOs perform several functions: providing preventive health services, checking health care providers' credentials, protecting members' rights, keeping medical records, monitoring quality and managing the delivery of medical services to ensure that members receive necessary care and do not get unnecessary care. HMO companies pay \$30,000 to \$100,000 to be reviewed, depending on their size, NCQA spokeswoman Ann Greiner said.

"This was a valuable education to us. We will now work harder to try and meet more of the NCQA standards."

— Paul E. Dillon,
Mid Atlantic treasurer
and senior vice president

been denied accreditation, while 33 percent received full accreditation, 40 percent received one-year accreditation, and 14 percent received provisional accreditation, she said. Another 1 percent were under review.
In this region, Prudential Mid-Atlantic Group Operations and Prudential Health Care System of Rich-

mond had received full accreditation; Kaiser Foundation Health Plan—Mid-Atlantic, George Washington University Health Plan, Care First/Free State/Potomac Health Plan, Columbia Medical Plan Inc., CIGNA HealthCare of Virginia Inc. and Southern Health Services Inc. had received one-year accreditation; and HealthPlus Inc. had received provisional accreditation.
HMOs try to control the cost and quality of their members' health care by directing them to a network of doctors and hospitals that accept their payment terms and meet their practice standards. They typically require members to get approval from a primary care "gatekeeper" doctor before seeing a specialist or being hospitalized.
Mid Atlantic, which has been one of the nation's most rapidly growing HMO companies, earned a profit of \$54.5 million last year, up from \$24.8 million the year before. Chief executive George T. Jochum received salary, bonuses and other compensation of \$2,171,606 last year, not including stock options, according to a corporate report.
The company's MD-IPA health plan is one of several offered to Washington Post employees.

HMO Operator Denied Accreditation
The Washington Post June 15, 1995

HMO, From B10

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: KLEIN

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: X 10/16

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

Designee to attend: _____

Remarks: JULIE: TICKNER 10/16 ✓

SEP 2 9 1995

THE WHITE HOUSE
WASHINGTON

To:
Jen Klein

August 2, 1995

George T. Chang, Ph.D.
Chairman and CEO
United Medical Laboratories, Inc.
6720 Old McLean Village Drive
McLean, Virginia 22101

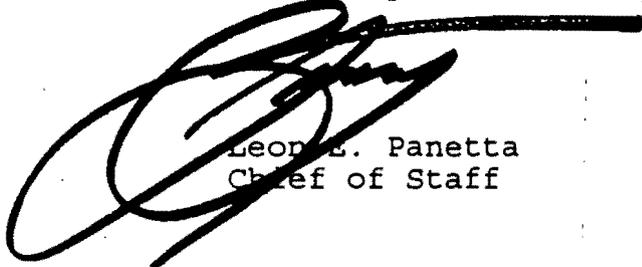
Dear Dr. Chang:

Thank you for your letter regarding your concerns about managed health care systems. I appreciate you contacting me concerning this important issue.

In order to give your concerns the appropriate attention, I have forwarded your letter and enclosures to Ms. Carol Rasco, Assistant to the President for Domestic Policy, and asked that she respond to you directly. You can be sure that your concerns will receive proper consideration.

Once again, thank you for writing.

Sincerely,



Leon E. Panetta
Chief of Staff

cc: The Honorable Carol Rasco

LEP/tab



UNITED MEDICAL LABORATORIES, INC.®

6720 Old McLean Village Drive • McLean, Virginia 22101

Telephone: (703) 356-4422

July 24, 1995

Hon. Leon Panetta
Chief of Staff
White House
By Hand

Dear Mr. Panetta:

I am very disturbed by managed health care systems that are restricting medical laboratory work to a few large laboratories for all testing needs. Such practices eliminate the competitive benefits offered by the inclusion of smaller, independent laboratories. These types of restrictions are devastating the thousands of community-based laboratories that employ many hundreds of thousands Americans. I am enclosing two copies of Virginia House Bill 840. I would like to see if the President can execute an executive order in which this law, or a similar law, can be enforced on a national level, specifically protecting the rights of small, independent, community-based medical laboratories.

Very truly yours,

George T. Chang, Ph.D.
Director of Laboratories

GTC:tes
Enclosure

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE



BOX 1157
RICHMOND, VIRGINIA 23209
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

SENT VIA FAX

October 17, 1994

Dr. George T. Chang
Director of Laboratories
United Medical Laboratories, Inc.
6720 Old McLean Village Drive
McLean, Virginia 22101

Re: House Bill S40
Your Letter of June 30, 1994 and Subsequent Telephone Conversations

Dear Dr. Chang:

Enclosed is a copy of a Administrative Letter 1994-8 that was mailed to Virginia licensed insurers today regarding the above-captioned subject. We hope that this administrative letter clarifies our position on the issues you have raised.

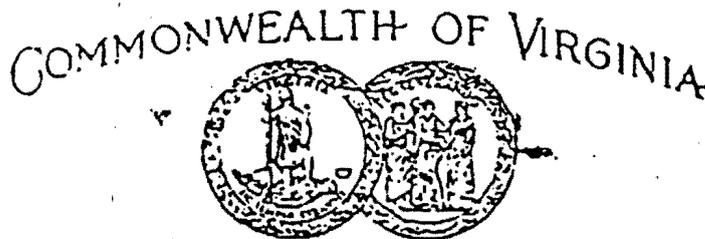
Sincerely,

A handwritten signature in black ink, appearing to read "J. Hil Richardson, Jr.".

J. Hil Richardson, Jr.
Senior Insurance Analyst
Life and Health Research
Telephone No.: 804/371-9388
FAX No.: 804/371-9944

Enclosure

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE



BOX 115
RICHMOND, VIRGINIA 23209
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-0306

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
October 17, 1994

ADMINISTRATIVE LETTER 1994-8

- TO:** All Insurers, Health Services Plans, and Health Maintenance Organizations licensed to write Accident and Sickness Insurance in Virginia
- RE:** Freedom of choice requirements - Pharmacies and Ancillary Service Providers

Chapter No. 963 of the 1994 Acts of the General Assembly of Virginia (1994 House Bill 840), took effect on July 1, 1994. The bill created six (6) new statutes, designated by the Virginia Code Commission as Sections 38.2-3407.7, 38.2-3407.8, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1, and 38.2-4312.2 of the Code of Virginia, as amended. These new requirements, which are imposed upon insurers issuing "preferred provider" policies or contracts and upon health maintenance organizations, relate to coverage for services rendered and products furnished by out-of-network pharmacies and ancillary service providers.

It has come to my attention that several issues have arisen regarding the interpretation of certain provisions of this legislation. The following is an explanation of how the Bureau of Insurance intends to administer certain requirements found in the new statutes listed above.

Administrative Letter 1994-8

October 17, 1994

Page 2

DEFINITION OF ANCILLARY SERVICES

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Each of the statutes cited above contains the following language:

The [State Corporation] Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Therefore, the Bureau does not have the authority to intervene in disagreements among parties affected by these new requirements. Questions of interpretation concerning whether or not a provider is providing "ancillary services" will have to be resolved in forums other than the State Corporation Commission.

CONTRACT PROVISIONS

All six statutes cited above contain specific language prohibiting the imposition of:

...any copayment, fee, or condition that is not equally imposed upon all individuals in the same benefit category, class, or copayment level, whether or not such benefits are furnished by [pharmacists or ancillary service providers] who are [non preferred or nonparticipating] providers. (emphasis added)

Administrative Letter 1994-8

October 17, 1994

Page 3

It is our position that each of these provisions prohibits an insurer or health maintenance organization from amending its contracts to provide that claimants obtaining services from out-of-network pharmacies or ancillary service providers must pay for the services and then seek reimbursement from the insurer or health maintenance organization, unless this same condition is imposed upon claimants utilizing the services of in-network pharmacists or ancillary service providers. Additionally, if information regarding coverage is available to in-network providers, such information must also be made available to out-of-network providers in the same or substantially similar manner.

All six statutes cited above also contain the following provision:

This right of selection extends to and includes [pharmacies or ancillary service providers] that are [non preferred or nonparticipating] providers and that agree to accept reimbursement for their services at rates applicable to [pharmacies or ancillary service providers] that are [preferred or participating] providers. (emphasis added)

It is our position that affected insurers and health maintenance organizations must maintain records of written agreements with out-of-network pharmacies and ancillary service providers that have agreed to accept the rates applicable to preferred or participating providers. Any reference by the insurer or health maintenance organization to the possibility of a pharmacy or ancillary service provider billing the insured for the difference between the network rates and those charged must clearly state that the insured can verify in advance of a purchase that the provider in question has entered into an agreement to accept the network rate as payment in full to avoid additional charges. This verification must be provided by the insurer or health maintenance organization providing coverage.

This letter serves as notice of our intention to withdraw approval, pursuant to § 38.2-316 of the Code of Virginia, as amended, of any forms of which we become aware that do not comply in all respects with the provisions of §§ 38.2-3407.7, 38.2-3407.8, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1, and 38.2-4312.2 of the Code of Virginia, as amended. Insurers and health maintenance organizations are instructed to review their forms immediately and file amendments, within 45 days of the date of this letter, for the purpose of bringing any non-complying forms into compliance with the statutes discussed herein. Subsequently, any forms brought to our attention that do not comply will have their approval withdrawn, and the Bureau will consider initiation of any other disciplinary proceedings deemed

Administrative Letter 1994-8
October 17, 1994
Page 4

appropriate in the circumstances. It should be noted that the wording of each of the statutes listed above is sufficiently broad so as to apply to in force contracts as well as newly issued contracts.

Insurers and health maintenance organizations are also hereby instructed to take appropriate steps to expedite communication and agreement with non-network providers wishing to enter into agreements to accept reimbursement at network rates.

Any questions regarding the administration of these requirements should be directed to the attention of Althelia P. Battle, Senior Insurance Market Examiner, or Robert R. Knapp, Senior Insurance Market Examiner, Life and Health Forms and Rates Section, at the above address. The telephone number for the Forms and Rates Section is (804) 371-9110.

Sincerely yours,



Steven T. Foster
Commissioner of Insurance

STF/me

VIRGINIA ACTS OF ASSEMBLY -- 1994 RECONVENED SESSION

CHAPTER 963

An Act to amend the Code of Virginia by adding sections numbered 38.2-3407.2, 38.2-3407.3, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1 and 38.2-4312.2, relating to accident and sickness insurance; pharmacies and ancillary service providers; preferred provider networks and health maintenance organizations.

[H 840]

Approved May 20, 1994

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding sections numbered 38.2-3407.2, 38.2-3407.3, 38.2-4209.1, 38.2-4209.2, 38.2-4312.1 and 38.2-4312.2 as follows:

§ 38.2-3407.2. *Pharmacies; freedom of choice.*

A. *Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer proposing to issue preferred provider policies or contracts shall prohibit any person receiving pharmacy benefits furnished thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to pharmacies that are preferred providers.*

B. *No such insurer shall impose upon any person receiving pharmaceutical benefits furnished under any such policy or contract:*

1. *Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;*

2. *Any monetary penalty that would affect or influence any such person's choice of pharmacy; or*

3. *Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.*

C. *The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.*

§ 38.2-3407.3. *Ancillary service providers; freedom of choice.*

A. *Notwithstanding any provision of § 38.2-3407 to the contrary, no insurer proposing to issue preferred provider policies or contracts shall prohibit any person receiving ancillary service benefits furnished thereunder from selecting, without limitation, the ancillary service provider of his choice to furnish such benefits. This right of selection extends to and includes ancillary service providers that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to ancillary service providers that are preferred providers.*

B. *No such insurer shall impose upon any person receiving ancillary service benefits furnished under any such policy or contract:*

1. *Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by ancillary service providers who are nonpreferred providers;*

2. *Any monetary penalty that would affect or influence any such person's choice of ancillary service provider; or*

3. *Any reduction in allowable reimbursement for ancillary services related to utilization of ancillary service providers who are nonpreferred providers.*

C. *For the purposes of this section:*

1. *"Ancillary services" means those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support;*

2. *"Ancillary service provider" and "ancillary service providers" mean a person or persons providing ancillary services.*

D. *The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.*

§ 38.2-4209.1. *Pharmacies; freedom of choice.*

A. *Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts shall prohibit any person receiving pharmaceutical benefits thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to*

pharmacies that are preferred providers.

B. No such corporation shall impose upon any person receiving pharmaceutical benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are nonpreferred providers.

C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4209.2. Ancillary service providers; freedom of choice.

A. Notwithstanding any provision of § 38.2-4209, no corporation providing preferred provider subscription contracts shall prohibit any person receiving ancillary service benefits thereunder from selecting, without limitation, the ancillary service provider of his choice to furnish such benefits. This right of selection extends to and includes ancillary service providers that are nonpreferred providers and that agree to accept reimbursement for their services at rates applicable to ancillary service providers that are preferred providers.

B. No such corporation shall impose upon any person receiving ancillary service benefits furnished under any such contract:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by ancillary service providers who are nonpreferred providers;

2. Any monetary penalty that would affect or influence any such person's choice of ancillary service provider; or

3. Any reduction in allowable reimbursement for ancillary services related to utilization of ancillary service providers who are nonpreferred providers.

C. For the purposes of this section:

1. "Ancillary services" means those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support;

2. "Ancillary service provider" and "ancillary service providers" mean a person or persons providing ancillary services.

D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4312.1. Pharmacies; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans shall prohibit any person receiving pharmaceutical benefits thereunder from selecting, without limitation, the pharmacy of his choice to furnish such benefits. This right of selection extends to and includes pharmacies that are not participating providers under any such health care plan and that agree to accept reimbursement for their services at rates applicable to pharmacies that are participating providers.

B. No such health maintenance organization shall impose upon any person receiving pharmaceutical benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of pharmacy; or

3. Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are not participating providers.

C. The provisions of this section are not applicable to any health care plan whose terms require exclusive utilization of pharmacies wholly owned and operated by the health maintenance organization providing the health care plan.

D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-4312.2. Ancillary service providers; freedom of choice.

A. Notwithstanding any other provision in this chapter, no health maintenance organization providing health care plans shall prohibit any person receiving ancillary service benefits thereunder from selecting, without limitation, the ancillary service provider of his choice to furnish such benefits. This right of selection extends to and includes

ancillary service providers that are not participating providers under any such health care plan and that agree to accept reimbursement for their services at rates applicable to ancillary service providers that are participating providers.

B. No such health maintenance organization shall impose upon any person receiving ancillary services benefits furnished under any such health care plan:

1. Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by ancillary service providers who are not participating providers;

2. Any monetary penalty that would affect or influence any such person's choice of ancillary service provider; or

3. Any reduction in allowable reimbursement for ancillary services related to utilization of ancillary service providers who are not participating providers.

C. For the purposes of this section:

1. "Ancillary services" means those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support; .

2. "Ancillary service provider" and "ancillary service providers" mean a person or persons providing ancillary services.

D. The provisions of this section are not applicable to any health care plan whose terms require exclusive utilization of ancillary service providers wholly owned and operated by the health maintenance organization providing the health care plan.

E. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

Major HMO Operator Denied Accreditation

Mid Atlantic Medical Services Fails Rating

By David S. Hilzenrath
Washington Post Staff Writer

Mid Atlantic Medical Services Inc., the Washington area's largest operator of health maintenance organizations, has been denied accreditation by the nation's leading monitor of quality control in HMOs, an executive at the company said yesterday.

The decision, to be announced today, will not affect the operations of Mid Atlantic's HMOs, Optimum Choice and MD-Individual Practice Association, which have about 550,000 members in the Washington area. But some corporate benefits managers said they would reconsider their ties to Mid Atlantic if it doesn't obtain accreditation.

Only a small minority of companies have received a failing grade after being evaluated by the National Committee for Quality Assurance (NCQA), although many HMOs have not been reviewed.

"I can't say point-blank that employers shouldn't offer a plan that's been denied accreditation, but it certainly raises a big red flag," said consultant Barbara Lohr of Towers Perrin, a consulting firm that advises companies on employee benefits.

Many corporations refuse to do business with HMOs that do not submit to a review by the NCQA, and

some corporate benefits managers said yesterday that they would stop enrolling workers in Mid Atlantic HMO if the company failed to meet NCQA standards within a year or two. Mid Atlantic, which unsuccessfully appealed NCQA's decision over the past few months, may be reviewed again in a year.

"You should be concerned about it," said James N. Astuto, who oversees managed health care for workers in GTE Corp.'s southeast region. "If they can't eventually jump the hurdle, we're going to have to freeze them and eventually terminate the relationship."

"This was a valuable education to us," said Paul E. Dillon, senior vice president and treasurer of Mid Atlantic. "We will now work harder to try and meet more of the NCQA standards."

Dillon would not say what reasons NCQA cited for its decision and NCQA officials would not comment on the matter in advance of its announcement today. As a matter of policy, NCQA does not disclose the detailed findings of its evaluations, although it plans to begin issuing summaries in July.

One possible reason for denial is that a shortcoming at an HMO "poses a potentially significant risk to quality of care," according to an

See HMO, B12, Col. 3

HMO, From B10

NCQA manual, but Dillon said, "They didn't put it to us in that manner."

"We think that MAMSI is providing the best quality of care that's available in the marketplace today," he said.

Dillon cited one example of the shortcomings the NCQA identified: The company did not independently verify doctors' medical degrees and medical internships. Instead, Mid Atlantic assumed that hospitals had verified those credentials when they extended admitting privileges to the doctors, Dillon said.

The NCQA, a not-for-profit group based in the District, examines the way HMOs perform several functions: providing preventive health services, checking health care providers' credentials, protecting members' rights, keeping medical records, monitoring quality and managing the delivery of medical services to ensure that members receive necessary care and do not get unnecessary care. HMO companies pay \$30,000 to \$100,000 to be reviewed, depending on their size, NCQA spokeswoman Ann Greiner said.

As of April 28, when the NCQA prepared its last public report, the group had reviewed 168 of the nation's 574 HMO companies. Greiner said 12 percent of those had

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— Paul E. Dillon,
Mid Atlantic treasurer
and senior vice president

been denied accreditation, while 33 percent received full accreditation, 40 percent received one-year accreditation, and 14 percent received provisional accreditation, she said. Another 1 percent were under review.

In this region, Prudential Mid-Atlantic Group Operations and Prudential Health Care System of Rich-

mond had received full accreditation; Kaiser Foundation Health Plan—Mid-Atlantic, George Washington University Health Plan, Care First/Free State/Potomac Health Plan, Columbia Medical Plan Inc., CIGNA HealthCare of Virginia Inc. and Southern Health Services Inc. had received one-year accreditation; and HealthPlus Inc. had received provisional accreditation.

HMOs try to control the cost and quality of their members' health care by directing them to a network of doctors and hospitals that accept their payment terms and meet their practice standards. They typically require members to get approval from a primary care "gatekeeper" doctor before seeing a specialist or being hospitalized.

Mid Atlantic, which has been one of the nation's most rapidly growing HMO companies, earned a profit of \$54.5 million last year, up from \$24.8 million the year before. Chief executive George T. Jochum received salary, bonuses and other compensation of \$2,171,606 last year, not including stock options, according to a corporate report.

The company's MD-IPA health plan is one of several offered to Washington Post employees.

HMO Operator Denied Accreditation
The Washington Post June 15, 1995

Babies and HMOs

TO SQUEEZE real money out of the health care system, as everybody wants to do, involves making painful decisions about the limits of medical care, sometimes with the kind of grim results that nobody wants. Since the costs won't come down without some serious cutting, it's all the more imperative that the people making those life-and-death calls do it in a conscientious and morally serious fashion and not create a situation in which the attending doctor's opinion counts for nothing at all. The apparent lack of such caution is what's shocking about reports that large numbers of health maintenance organizations, in order to save costs on hospital stays, have imposed a de facto ironclad requirement that hospitals discharge newborn babies and their mothers within 24 hours of delivery, regardless of the doctor's opinion as to whether the discharge is safe.

The point here isn't that all mothers should stay 48 hours or more in the hospital after giving birth without complications, any more than they should be obliged to stay—or insurers to cover—the four to eight days that were standard for childbirth a generation ago. The point is, rather, that in this case insurers looking for a place where a change of practice would bring significant savings—and childbirth is the most common of all reasons for hospitalization, one that a large number of people on any general health plan can be expected to make use of—sought to impose such a change even in cases where individual doctors had serious safety concerns.

The American College of Obstetrics and Gynecology

recommends 48 hours' stay after a normal birth to monitor babies' health and teach first-time mothers the basics. Over the past few years, since the 24-hour discharge became widespread, accounts have multiplied of such mothers who failed to realize their babies were not breast feeding properly and were actually starving. In a small but worrisome number of cases, doctors whose medical judgment told them it was risky to send a baby and mother home after 24 hours were obliged to do so anyway or face being kicked out of their insurance group, which would mean losing most or all of their patients.

Since this is in the purest sense a motherhood issue for politicians, capable of stoking strong emotions, it has led in short order to action by the state legislatures of New Jersey and Maryland and perhaps soon by others to soften this practice or to mandate that insurance companies cover a second day of hospitalization after birth if a doctor rules it necessary. No one could call this the most efficient way to make decisions about health care, nor is it likely to prove practical for medical care across the board, since most such arguments over proper practice lack the immediacy and simplicity of this one, not to mention its political appeal. Still, it's a reminder that overzealousness in cost-cutting is a danger and that the tug-of-war between what's financially feasible and what's medically necessary can't be left to the decision of only one of the parties to the transaction.

p A20 Tuesday, July 4, 1995



TAIWANESE AMERICAN POLITICAL EDUCATION COMMITTEE
6720 Old McLean Village Drive
McLean, Virginia 22101
Tel: 703-356-4787

July 24, 1995

Hon. Bill Clinton
President of the United States
c/o Hon. Leon Panetta
Chief of Staff
The White House
Washington, D.C. 20500

Dear Mr. President:

Peace and stability in East Asia serve the national interest of the United States of America. Recent events, including the military exercises by China, increase the tension that already exists in that region. Missile tests by China are intended to put Taiwan in a state of panic that is not justifiable.

Taiwanese Americans believe it is time for negotiation, rather than confrontation. Animosity is not the interest of peace-loving nations.

In order to maintain continued economic growth and peace in the Asian Pacific regions, specifically the interests of China, Taiwan, and the United States, I urge President Clinton to initiate an invitation to the Presidents of China and Taiwan to come to the White House to have a talk with President Clinton. The sole purpose of the visit would be to settle the long rivalry between Taiwan and China. The Marshall Plan of post World War Two may be a model for economic assistance to China from Taiwan as an incentive for the Chinese Leader to sit down with the leader of Taiwan. It is time to ease the strained relations between China and the United States.

Thank you very much for your assistance in this matter.

Very truly yours,

George T. Chang, Ph.D.
Chairman

GTC:tes

cc: Hon. Leon Panetta



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Chairman

GTC:tes

cc: Hon. Leon Panetta

CHARLES S. ROBB

SENATOR

W. ROBB
 Russell Senate Office Building
 First and Constitution Avenues, NE, Rm. 193
 Washington, DC 20510
 (202) 224-4024

United States Senate

WASHINGTON, DC 20510-4603

COMMITTEES:
 ARMED SERVICES
 COMMERCE, SCIENCE,
 AND TRANSPORTATION
 FOREIGN RELATIONS
 Chairman, East Asian and
 Pacific Affairs Subcommittee
 JOINT ECONOMIC COMMITTEE
 Vice Chairman,
 Democratic Policy Committee

December 2, 1974

The Honorable Leon Panetta
 Chief of Staff
 The White House
 Washington, D.C. 20500

Dear Leon:

Dr. George Chang is a constituent and supporter of mine, and would like to have a few minutes of your time to discuss the impact of HMOs and insurance companies on the health care industry. I have attached a copy of his letter to me for your consideration.

I think Dr. Chang and the members of his group could provide some valuable input to you on this subject, and I hope you'll have a chance to visit with them. Short of a meeting with you, I know Dr. Chang and his colleagues would appreciate a meeting with a member of the White House domestic policy staff.

Thank you in advance for your help with this request.

Sincerely,



Charles S. Robb

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 1001 East Broad Street
 Richmond, VA 23219
 (804) 771-2221

Regional Offices:

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 (804) 441-3124

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 Harrisonburg, VA 22801
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 Clintwood, VA 24222
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 530 Main Street
 Danville, VA 24541
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Greater Bank Building
 310 First Street SW, Suite
 Roanoke, VA 24011
 (703) 985-0103



UNITED MEDICAL LABORATORIES, INC.®

6720 Old McLean Village Drive • McLean, Virginia 22101

Telephone: (703) 356-4422

August 2, 1995

The Honorable Mr. Bill Clinton
The President
Washington, D.C. 20500

Dear Mr. President:

Happy Birthday!

In the past year, several attempts have been made by groups representing the interests of small business owners to raise the issue of unfair competitive business practices with regard to managed care.

Passage in Virginia of the Any Willing Provider Law, House Bill 840, seemed to achieve the purpose of allowing small laboratories an opportunity to compete with the larger labs for managed care contracts. Further clarification of the term 'ancillary service' in the language of the bill resulted in a narrow definition of the term to apply only to a particular pharmacy in the state of Virginia. For all intents and purposes, the law is now dead in Virginia.

In the state of Maryland, which is third in the nation in per capita of the population being enrolled in some type of HMO or managed care program, a version of the Any Willing Provider Law was rejected after a special presentation by a small, independent laboratory in the early spring in Annapolis.

The independent clinical laboratories would like to be able to compete equally with the larger laboratories at least on a local or regional basis. The smaller laboratories with annual sales of 10 million or less, many of which have been in business for over 20 years, have enjoyed long standing relationships with physicians which have been built on high levels of quality and personalized service. Meanwhile, the larger, billion dollar labs that have been formed through acquisitions and mergers of other smaller labs, depend strictly on mega volume to achieve profit, sometimes even at the expense of quality and service.

Quality and Personalized Service



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One method the large labs use to exclude smaller laboratories from the competitive bidding process is pricing lab tests by capitation. In this manner, lab tests are priced in the range of \$.45 -- \$.75 per member per month, especially to HMO's who award lab contracts to a primary vendor, with renewals on an annual basis. We feel that this is an unfair method of pricing, that shuts out the smaller labs from the bidding process. The preferred way of pricing is a discounted fee for service plan, or a set rate of fees much like Medicare and other insurance agencies reimburse for tests.

Very truly yours,

George T. Chang, Ph.D.
Chairman and CEO

GTC:tes

cc: Senator Chuck Robb
Lieutenant Governor Don Beyer, Jr.

Quality and Personalized Service

The White House
Office of Presidential Letters and Messages



Facsimile from Seth Masker
Voice: (202) 456-5514; FAX: (202) 456-2806

No. of Pages (including cover): 7 Date: 10/5/95

To: JEN KLEIN

Voice: 6-2599 Fax: 6-2878

Comments: FATE & TIMING HAVE CONSPIRED TO KEEP US
FROM TALKING. COULD I ASK YOU TO LOOK OVER THESE
2 LETTERS & CALL ME WITH ANY SUGGESTIONS YOU
HAVE? THANKS.

9/17
file
log



JACKSON HOLE GROUP

Paul M. Ellwood, M.D.
President

2057664

September 6, 1995

President William Clinton
Office of the President
White House
1600 Pennsylvania Ave.
Washington, DC 20500

2057664

Dear President Clinton,

Medicare

We have just concluded another valuable meeting of the Jackson Hole Group, much of which focused on Medicare. We did not take the politics of the situation into consideration because we think that Medicare should be dealt with in a bipartisan fashion. Furthermore, we are only useful if we emphasize what is viewed as practical by those who actually deliver and purchase health care for millions of people (both on and off of Medicare). I have outlined the conclusions that we reached about what can realistically be done. Many of these recommendations are dealt with in greater detail in my testimony to Senate Finance Committee on July 25. If you would like a copy, call Ellen Wilson at 307-733-8781.

Even if you are contemplating a delay of only two months in enacting Medicare reforms, Congress should immediately disconnect Medicare HMO reimbursement from the formula which keeps federal capitation payments rising in parallel with traditional Medicare. This is not a controversial move, and HMOs with the most Medicare experience could operate and grow with a predictable national aggregate rate of increase of 5% per year. Eventually, in say five years, the traditional Medicare defined contribution rate should be brought in line with the Medicare managed care rate. At that time, the federal contribution should be linked to the level of competitive premiums in each market.

The HMOs should be required to provide more extensive benefits than traditional Medicare. It should be a uniform set of benefits that is sufficiently comprehensive to include prescription drugs and eliminate the need for Medigap insurance. HMOs can charge an additional premium, but in doing so, they run the risk of being unattractive competitors.

While it may seem logical in a competitive environment to offer greater flexibility through a choice of benefit combinations, the overwhelming experience with health insurance is that this leads to risk selection and undermines objective plan comparison by consumers. Although much has been made of FEHBP's flexible benefits package, in reality, FEHBP controls benefit variations to avoid risk selection.

Mailing Address: P.O. Box 350 Teton Village, WY 83025
Fed-Ex/UPS: 6700 North Ellen Creek Road Jackson, WY 83001
307-739-1176 Fax: 307-739-1177

We recommend three benefit options: HMOs using selected providers; HMOs with an out of plan choice of providers (POS); and traditional Medicare with the existing choice of providers. For the health plans offering a full range of provider choices, the traditional Medicare benefit package remains the least disruptive benefit option. This program will inevitably be more expensive when combined with the cost of a Medigap policy. Further raising deductibles and coinsurance will not significantly lower utilization, and thus costs, unless Medigap policies are disallowed or seniors are put in a position where they wait too long to seek necessary medical care (which will inevitably drive up program costs). HMOs limit provider choice because they select physicians and hospitals on the basis of their ability to provide cost-effective medical care. However, if Congress elects to allow organizations, other than HCFA, to compete to offer the traditional Medicare benefits, they could be permitted to use a variety of cost containment techniques but, like traditional Medicare, would be expected to offer virtually all of the providers in the community.

Medicare's per capita reimbursement rate, adjusted for factor prices, should be gradually equalized across geographic locations. Eventually, market forces could work toward this objective as they have in the FEHBP program. However, the need to define in advance what the government intends to pay health plans, which is a necessary consequence of the CBO scoring process, does not allow a complete shift to market based government capitation rates until we know more about what HMOs propose to charge across the country and have a better understanding of how seniors respond to price differences between health plans. At our meeting, there were substantial differences of opinion among HMOs about the desirability of progressively moving towards a nationally equalized capitation rate. The evidence that I have been able to uncover is that the big differences in cost from one place to another are not justified clinically or by regional factor price variations. Most of the cost differences between areas are attributable to wide variations in the quantity of services provided that are unrelated to health status. Alain Enthoven and I recommend that low cost areas be given as much as a 7% annual rate of increase, while the higher cost areas have a 3% rate of per capita increase per year. It is our opinion that this will not inhibit the growth of HMOs in the more expensive Medicare markets and will accelerate it in those communities where seniors have had little access to managed care.

Failure by HCFA to ever promote HMOs over traditional Medicare account, in part, for the relatively low HMO enrollment by seniors, despite HMOs offering far more comprehensive benefits than traditional Medicare at lower cost to beneficiaries. For this reason, the agency within Health & Human Services offering HMO choices needs to be separated from HCFA. Naturally, it is difficult for anyone whose major responsibility is making traditional Medicare more attractive and cost-effective to encourage their beneficiaries to join another plan. This behavior is not unique to the HCFA administrator. We've observed the same kind of reticence on the part of traditional insurance company executives and employee benefits managers faced with the prospect of making the

transition to HMOs. It is only when their purchasers or competitors start taking customers away that they take on the task of building an entirely new kind of organization that both insures for and delivers managed care. In the case of the HCFA administrators, they have not had even enough discretionary authority to build an in-house HMO or PPO.

There continues to be sharp controversy over whether the traditional Medicare program can be operated more cost-effectively. The current HCFA administrator believes that he can slow the rate of inflation in the program, if given the opportunity to use the techniques of managed care firms. Many of his predecessors are dubious, in part because it is so difficult in government contracting to alter physician behavior and compensation. This is especially tough because public programs find it difficult to limit the number of licensed physicians who can participate. Is Congress ready to take on 100,000 or more surplus physicians who have been excluded by HCFA and who are attempting to persuade their patients that Congress is forcing them to go to an "inferior" doctor?

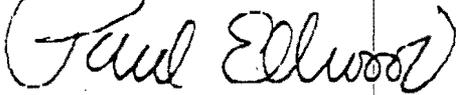
MSAs for Medicare are not a sensible option for seniors, whose genes and prior lifestyle are the major determinant of their need for medical care. The hardest task for Congress in introducing market mechanisms, such as health plan choice and defined contribution rates, is going to be avoiding any benefit arrangement, like MSAs, that divide seniors into healthy and unhealthy groups. Medicare's greatest strength is its universal pooling of risk. Don't fall into the trap of assuming that the excess utilization of health care is the patient's fault. Alain Enthoven's *New York Times* op-ed piece (8/16) elaborates on the possible adverse consequences of MSAs for this age group. MSAs, however, done the way that John Goodman and Mark Pauly have designed them for younger age groups are less likely to disrupt the risk pool.

As to dismantling HCFA and giving multiple contractors the opportunity to operate in an indemnity based insurance program, this should only be done IF CONGRESS QUILTS MICRO-MANAGING THE MEDICARE PROGRAM AND ALLOWS IT TO OPERATE UNFETTERED like it does with FEHBP. Given the history of 30 years of tinkering with Medicare by congressional committees and with so much at stake politically, this seems inconceivable. If you want to become educated on how FEHBP has served millions of government employees and lowered its premiums this last year, do as we did and have Lucretia Myers, who runs the program, tell you how it's done.

Just to give you an idea of the knowledgeable people who discussed these approaches to solve the Medicare problem, I have enclosed an attendee list of the most recent meeting in my living room—with one caveat, we never have votes or elicit unanimous opinions. I, of course, have a special interest in your pursuing a defined contribution, competitive choice approach to Medicare, having successfully applied it for 25 years and having seen it implemented by the private sector.

If you want to discuss these thoughts further, my number is 307-739-1176, or Alain Enthoven may be reached at 415-723-0641.

Sincerely,

A handwritten signature in cursive script that reads "Paul Ellwood". The signature is written in black ink and is positioned above the typed name.

Paul M. Ellwood, M.D.
President & CEO

cc: Alain Enthoven, PhD

Mark Miller

L.T.

Investment
CEA White Paper on Research

T.P. on

→ T.P.

Medicaid DSH lit

→ op-ed piece.

→ stronger

→ Stimulus → research & training
& we do.

202-224-0291

Jen -
Should there
be 2 responses?

The White House
Office of Presidential Letters and Messages



Facsimile from Seth Masket
Voice: (202) 456-5514; FAX: (202) 456-2806

No. of Pages (including cover): 4 Date: 10/27/95

To: CHRIS JENNINGS

Voice: 6-5560 Fax: 6-7028

Comments: JEN SUGGESTED THAT YOU AND CAROL RASCO
HAD RECEIVED THIS SAME LETTER AND THAT YOU HAD
ALREADY RESPONDED. IS THIS SO? COULD I GET A COPY?
THANKS.
AND AGAIN, CONGRATS!



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8720 Old McLean Village Drive • McLean, Virginia 22101

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August 2, 1995

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The President
Washington, D.C. 20500

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6720 Old McLean Village Drive • McLean, Virginia 22101

Telephone: (703) 356-4422

One method the large labs use to exclude smaller laboratories from the competitive bidding process is pricing lab tests by capitation. In this manner, lab tests are priced in the range of \$.45 -- \$.75 per member per month, especially to HMO's who award lab contracts to a primary vendor, with renewals on an annual basis. We feel that this is an unfair method of pricing, that shuts out the smaller labs from the bidding process. The preferred way of pricing is a discounted fee for service plan, or a set rate of fees much like Medicare and other insurance agencies reimburse for tests.

Very truly yours,

George T. Chang, Ph.D.
Chairman and CEO

GTC:tes

cc: Senator Chuck Robb
Lieutenant Governor Don Beyer, Jr.



UNITED MEDICAL LABORATORIES, INC.®

6720 Old McLean Village Drive • McLean, Virginia 22101

Telephone: (703) 356-4422

**TO: The Honorable Bill Clinton
The President
In Person**

**FROM: Independent Clinical Laboratory Owners
Metropolitan Washington, D.C.**

RE: Meeting, August 2, 1995

ISSUES

1. Equal Competition

That Congress pass legislation to level the playing field so that all clinical laboratories may compete evenly under managed care.

2. Preservation of Small Business

Failure to allow small, independent clinical laboratories to continue to survive and grow in the changing healthcare marketplace will lead to the loss of tens of thousands of skilled jobs regionally and nationwide.

3. Medicare Exclusion

That Congress pass legislation that excludes Medicare payments from being reimbursed under HMO-type capitation schedules.

Quality and Personalized Service

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO

Assistant to the President for Domestic Policy

To: _____ KLEIN
_____ (D'Nei report

Draft response for POTUS
and forward to CHR by: _____ the dir. of
participation

Draft response for CHR by: X 11/27 _____ attached

Please reply directly to the writer
(copy to CHR) by: _____ CD

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

Designee to attend: _____

Remarks: _____

Jim Tucker 11/27

THE WHITE HOUSE
WASHINGTON

file

December 5, 1995

James R. Teeter
President
Arkansas Hospital Association
419 Natural Resources Drive
Little Rock, AR 72205

Dear Jim:

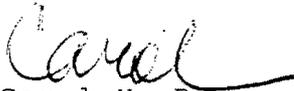
Thank you for writing about the Republican cuts in hospital spending and about provider-sponsored organizations. As you may know, we have been working closely with the American Hospital Association on both of these issues.

We continue to believe as you do that the Republican Medicare cuts are far too high, particularly their cuts in hospital reimbursement. The President's balanced budget proposal calls for at least \$25 billion less in Medicare spending reductions for hospitals. In addition, hospitals will be hard hit by the Republican's dramatic Medicaid cuts -- which are over three times greater than the President's cuts in Medicaid spending.

We are also developing language on provider-sponsored organizations that will allow local hospitals and physicians to set up federally certified networks with appropriate standards, including solvency standards.

As always, I very much appreciate your sound advice and expertise. I look forward to keeping in close touch with you about these and other issues as the budget debate continues.

Sincerely,



Carol H. Rasco
Assistant to the President
for Domestic Policy

Arkansas Hospital Association



November 7, 1995

JAMES R. TEETER
President

Carol Rasco
Assistant to the President/Domestic Policy
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Carol:

I am enclosing a letter to the President which I hope you will call to his attention when you deem it appropriate to do so.

In the meantime, I'd like to provide you with some background information supporting our plea that the President do what he can, when negotiating with the Republican leadership, to lower proposed Medicare payment reductions to hospitals, and to support the House language for provider-sponsored organizations.

We believe, Carol, that the *hospital* Medicare spending reductions proposed by the Congress (and the President) are too high. As you may know, a new study by Lewin-VHI, a respected research firm, finds that Medicare reductions to hospitals of more than \$75 billion over the next seven years will not allow them to keep pace with inflation and will result in a *real cut* in hospital spending per Medicare beneficiary.

The proposed hospital reductions (Senate \$91 billion, House \$80.3 billion according to the most recent CBO estimates) would mean that hospitals would have to do more with less while at the same time absorbing the impact of Medicaid spending reductions. Because these plans would take more than \$800,000,000 from Arkansas hospitals, we are concerned that the quality and availability of care to Arkansas Medicare beneficiaries and to all others who need hospital care will suffer.

The House Medicare reduction is preferable to the Senate's proposal because, nationally, it reduces "traditional" Medicare payments to hospitals by \$11 billion less than the Senate. These "traditional" hospital reductions include lowering the hospital market basket, payments for bad debt, graduate medical education, disproportionate share, capital and other changes in the way hospitals are reimbursed for providing care to Medicare beneficiaries.

Page two
Carol Rasco
November 7, 1995

Carol, you are probably familiar with provider-sponsored networks (called provider-sponsored organizations [PSOs] in the House bill), but we thought it might be helpful, nevertheless, to provide some information about them. PSOs are formal *local* affiliations of hospitals, physicians, and other healthcare providers that would provide a full range of healthcare services at the local level. Both the House and Senate proposals would let Medicare contract directly with PSOs on a full risk, capitated basis.

We believe that Medicare beneficiaries are more likely to opt out of the old fee-for-service program if they can sign up for PSO coordinated care which lets them keep the relationship they have with their hometown physician and hospital. We believe they will feel more comfortable dealing with a local PSO than they would having to work with large insurance companies where medical decisions are made, not by physicians and nurses, but by accountants and actuaries.

While local PSOs would be required to deliver most of the services themselves, the American Hospital Association's proposed standards require that a PSO be certified as financially sound, have an adequate net worth, and have sufficient funds to pay for whatever services might have to be provided *outside* its network. PSOs would be required to meet the same strict consumer protection standards called for under Medicare, but would also meet state-of-the-art quality standards that are higher than those currently required by Medicare or most HMO laws.

While the Senate proposal does allow PSOs, there are some serious problems with the language in the bill. Under the Senate provision, PSOs would first be required to apply to the state for certification and could apply at the federal level only if the state doesn't act within 90 days or if the state denies the application and HHS finds the state's standards were an unreasonable barrier to market entry. Also, the Senate provision would provide only for one three-year federal certificate with authority to license PSOs reverting thereafter to the state. PSOs must be assured that they will not lose their ability to contract directly with Medicare patients after three years, and Medicare beneficiaries should not have to fear that they will be required to change plans and providers at the end of an arbitrary three-year period. It is for these reasons that the House provision, which allows PSOs to enter the marketplace quickly through federal certification, is preferable.

As you may know, many of the large insurance companies, including Aetna, Cigna, The Prudential, and United Healthcare, prefer the Senate language. They want PSOs to be controlled by the states and to be regulated as insurance companies are regulated. They claim that PSOs are actually selling insurance, and should be required to have reserves for claims just as the insurance companies. Our position is that PSOs are providing medical services, not selling insurance and paying claims. The assets of PSOs are (and should be)

Page three
Carol Rasco
November 7, 1995

invested in the technology and human resources needed to provide medical services, not in reserves to pay claims.

Having to wait at *least* 90 days for state certification, as required by the Senate, would result in a marketing advantage for the large insurance companies, and a real disadvantage for PSOs because it would delay PSO entry into the marketplace. This would be unfair to providers, Medicare beneficiaries, and the government which, after all, is footing the bill which would include the "middleman fees" imposed by the insurance companies — "fees" that would not exist if PSOs contract *directly* with Medicare!

If you'd like more information about anything contained in this letter, Carol, please let me know. Phil and I will come to Washington to visit with you, or we will dispatch somebody from the Washington office of the American Hospital Association.

I hope that all is going well with you, Mary Margaret and Hamp. We'd love to have dinner and a visit anytime that you are home or when we're in DC.

Sincerely,



James R. Teeter

JRT:sd

Enclosures

P.S. Carol, I'm also enclosing American Hospital Association projections of how the Senate and House Medicare provisions would affect each Arkansas hospital. Of course, things would be even worse if the latest CBO estimates prove to be accurate.

Arkansas Hospital Association



November 6, 1995

JAMES R. TEETER
President

President Bill Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

The hospital community in Arkansas and throughout the United States breathes a collective sigh of relief each time you say you will veto the Republican budget bill and force the Congress to negotiate a more responsible plan.

While all of us believe that a balanced budget and tax cuts are desirable, we agree with you that what the Congress proposes is too much, too soon. According to the latest CBO estimates, the Senate bill would reduce hospital Medicare spending over seven years by \$91 billion; the House would impose reductions of at least \$80.3 billion; and, Mr. President, we believe that even your own budget would reduce hospital Medicare payments by \$78 billion.

Spending reductions of this magnitude would cause steep reductions in hospital services and the closure of many hospitals, seriously impacting beneficiary access to healthcare. These problems would be exacerbated by Medicaid block grants which would force hospitals to treat far more uninsured citizens with far fewer dollars.

When the time comes, Mr. President, that Bob Dole, Newt Gingrich and you sit down to negotiate what will eventually become the new budget, we ask only two things of you:

- 1) Please insist that seven-year hospital Medicare reductions not exceed the midway point between the Senate Democrats' recommendation of \$43 billion and the House Democrats' recommendation of \$63 billion.
- 2) Please demand that the House language for provider-sponsored organizations (PSO) be adopted. The House would allow PSOs to directly contract more expeditiously with Medicare through direct federal certification giving beneficiaries an opportunity to move sooner into coordinated care while letting them keep their doctor-patient-hometown hospital relationship. We are providing Carol Rasco with details of why the House PSO language is so important to Medicare beneficiaries and the hospitals and physicians who care for them.

Your consideration of our positions will be deeply appreciated by your hospitals back home and all across America.

Sincerely,

A handwritten signature in black ink, appearing to be 'J. Teeter', written over a white background.

James R. Teeter

JRT:sd

Expected Impact of Medicare Spending Reductions on Arkansas Hospitals

The Senate Finance Committee and the House Ways and Means and Commerce committees have each proposed plans to reduce the rate of growth in Medicare spending over the next seven years by \$270 billion. Details of the proposals differ to some degree, but both rely heavily on reducing the amounts that would be spent on hospital services. Under the Senate bill, hospital payments would be \$86 billion less than budgeted today. The House version of Medicare reform reins in hospital payments \$75 billion, but includes a "lookback" provision directing the Secretary of Health and Human Services to further reduce provider payments in the future, if they are on track to exceed targeted amounts. This "lookback" mechanism could place hospitals at risk for an additional \$40 billion. The list below shows the losses expected to accrue to Arkansas hospitals if the Senate Finance Committee bill is eventually approved.

**Medicare Revenues 1996 - 2002
Expressed In Thousands Of Dollars**

Hospital	Revenue Under Current Law	Revenue Under Senate Bill	Estimated Revenue Decrease	Hospital	Revenue Under Current Law	Revenue Under Senate Bill	Estimated Revenue Decrease
Arkansas Methodist Hospital	76,334	68,902	(7,432)	Lawrence Memorial Hospital (Walnut Ridge)	19,392	17,588	(1,804)
Ashley Memorial Hospital (Crossett)	21,188	19,293	(1,895)	Little River Memorial Hospital (Ashdown)	12,277	11,260	(1,017)
Baptist Medical Center, Arkadelphia	47,158	41,958	(5,200)	Magnolia Hospital	34,968	31,488	(3,480)
Baptist Medical Center (LR)	694,901	628,321	(66,580)	McGehee-Deshia County Hospital	13,195	12,022	(1,173)
Baptist Memorial Hospital (Blytheville)	42,131	37,886	(4,245)	Medical Center of Calico Rock	12,130	11,084	(1,046)
Baptist Memorial Hospital (Forrest City)	40,266	38,002	(2,264)	Medical Center of South Arkansas (El Dorado)	166,842	148,390	(18,452)
Baptist Memorial Hospital (Osceola)	29,229	28,500	(729)	Medical Park Hospital (Hope)	50,227	45,241	(4,986)
Baptist Memorial Medical Center (NLR)	206,958	187,106	(19,852)	Mena Medical Center	29,911	27,078	(2,833)
Bates Medical Center (Bentonville)	54,521	49,024	(5,497)	Mercy Hospital of Scott County (Waldron)	14,739	13,263	(1,476)
Baxter County Regional Hospital (Mtn. Home)	194,812	175,655	(19,157)	Mercy Hospital-Turner Memorial (Ozark)	20,112	18,264	(1,848)
Booneville Community Hospital	11,482	10,431	(1,051)	Methodist Hospital of Jonesboro	74,639	66,884	(7,755)
Bradley County Memorial Hospital (Warren)	27,144	24,735	(2,409)	National Park Medical Center (Hot Springs)	141,902	127,157	(14,745)
Carroll Regional Medical Center (Berryville)	26,918	24,204	(2,712)	Newport Hospital & Clinic	35,885	32,370	(3,515)
Central Arkansas Hospital (Searcy)	132,244	120,476	(11,768)	North Arkansas Medical Center (Harrison)	108,812	97,896	(10,916)
Chambers Memorial Hospital (Danville)	15,005	13,595	(1,410)	North Logan Mercy Hospital (Paris)	11,998	10,842	(1,156)
Chicot Memorial Hospital (Lake Village)	32,560	29,560	(3,000)	Northwest Medical Center (Springdale)	182,330	165,911	(16,419)
Cleburne Memorial Hospital (Heber Springs)	21,765	19,507	(2,258)	Ouachita County Medical Center (Camden)	60,345	53,818	(6,527)
Columbia Doctors Hospital (LR)	104,699	92,547	(12,152)	Piggott Community Hospital	26,267	23,729	(2,538)
Conway County Hospital (Morrilton)	34,065	30,910	(3,155)	Pike County Hospital (Murfreesboro)	8,926	8,170	(756)
Conway Regional Medical Center	83,233	74,362	(8,871)	Randolph County Medical Center (Pocahontas)	21,629	19,521	(2,108)
Crawford County Mem. Hospital (Van Buren)	88,593	79,400	(9,193)	Rebsamen Regional Med. Center (Jacksonville)	79,974	72,578	(7,396)
Crittenden Memorial Hospital (West Memphis)	107,697	98,607	(9,090)	Saline Memorial Hospital (Benton)	89,481	80,683	(8,798)
Cross County Hospital (Wynne)	21,815	19,927	(1,888)	Siloam Springs Memorial Hospital	39,387	35,712	(3,675)
Dallas County Hospital (Fordyce)	19,078	17,130	(1,948)	Southwest Hospital (LR)	58,925	51,054	(7,871)
Dardanelle Hospital	12,673	11,452	(1,221)	Sparka Regional Medical Center (Ft. Smith)	402,092	359,613	(42,479)
Delta Memorial Hospital (Dumas)	12,289	11,178	(1,111)	Stone County Medical Center (Mtn. View)	14,223	12,827	(1,396)
DeQueen Regional Medical Center	40,664	36,449	(4,215)	Stuttgart Regional Medical Center	64,341	57,447	(6,894)
DeWitt City Hospital	12,546	11,331	(1,215)	St. Bernard's Reg. Med. Center (Jonesboro)	397,399	361,437	(35,962)
Drew Memorial Hospital (Monticello)	27,408	24,876	(2,532)	St. Edward Mercy Medical Center (Ft. Smith)	324,939	293,488	(31,451)
East Ozarka Reg. Med. Cntr. (Cherokee Village)	21,533	19,526	(2,007)	St. Joseph's Reg. Health Center (Hot Spgs)	418,357	378,401	(39,956)
Eureka Springs Hospital	8,788	7,938	(850)	St. Mary's Regional Medical Center (Russellville)	107,617	97,780	(9,837)
Fayetteville City Hospital	1,262	1,155	(107)	St. Mary-Rogers Memorial Hospital	101,517	91,812	(9,705)
Fulton County Hospital (Salem)	16,321	14,863	(1,458)	St. Michael Hospital (Texarkana)	276,333	247,220	(29,113)
Gravette Medical Center	27,585	25,197	(2,388)	St. Vincent Infirmary Med. Center (LR)	817,959	738,939	(79,020)
Harris Hospital (Newport)	38,802	35,186	(3,616)	The University Hospital of Arkansas (LR)	291,010	239,879	(51,131)
Helena Regional Medical Center	88,200	81,220	(6,980)	Van Buren County Memorial Hospital (Clinton)	12,802	11,641	(1,161)
Hot Spring County Memorial Hospital (Malvern)	51,725	47,307	(4,418)	Washington Reg. Medical Center (Fayetteville)	195,808	173,938	(21,870)
Howard Memorial Hospital (Nashville)	27,996	25,435	(2,561)	White County Memorial Hospital (Searcy)	71,375	64,989	(6,386)
Jefferson Regional Medical Center (Pine Bluff)	308,573	273,552	(35,021)	White River Medical Center (Batesville)	131,180	118,791	(12,389)
Johnson County Regional Hospital (Clarksville)	39,898	38,151	(1,747)				
				ARKANSAS TOTAL			(792,053)

Source: American Hospital Association

Expected Impact of Medicare Spending Reductions on Arkansas Hospitals

The House Ways and Means and Commerce committees and the Senate Finance Committee have each proposed plans to reduce the rate of growth in Medicare's spending over the next seven years by \$270 billion. Details of the proposals differ to some degree, but both rely heavily on reducing the amounts that would be spent on hospital services. Under the House bill, hospital payments would be \$75 billion less than budgeted today. The Senate version of Medicare reform reins in hospital payments \$86 billion. Remember, however, that the House bill includes a "lookback" provision directing the Secretary of Health and Human Services to further reduce provider payments in the future, if they are on track to exceed targeted amounts. The "lookback" mechanism could place hospitals at risk for an additional \$40 billion. The list below shows the losses expected to accrue to Arkansas hospitals if the House bill is eventually passed.

Medicare Revenue 1998 - 2002
Expressed in Thousands Of Dollars

Hospital	Revenue Under Current Law	Revenue Under House Bill	Revenue At Stake Under "Lookback"	Estimated Revenue Decrease	Hospital	Revenue Under Current Law	Revenue Under House Bill	Revenue At Stake Under "Lookback"	Estimated Revenue Decrease
Arkansas Methodist Hospital	78,334	68,507	1,887	(8,484)	Lawrence Memorial Hospital	19,382	17,791	422	(2,023)
Ashley Memorial Hospital	21,188	19,531	458	(2,118)	Little River Memorial Hospital	12,277	11,414	268	(1,128)
Baptist Medical Center, Arkadelphia	47,158	42,282	1,038	(8,908)	Magnolia Hospital	34,988	31,650	756	(4,074)
Baptist Medical Center	694,901	634,804	19,032	(75,029)	McGehee - DeSha County Hospital	13,198	12,173	285	(1,307)
Baptist Memorial Hospital	42,131	38,133	914	(4,912)	Medical Center of Calico Rock	12,130	11,228	262	(1,184)
Baptist Memorial Hospital	40,288	38,288	880	(4,881)	Medical Center of South Arkansas	168,842	148,627	3,813	(20,828)
Baptist Memorial Hospital	29,228	28,732	631	(3,108)	Medical Park Hospital	50,227	48,707	1,088	(8,818)
Baptist Memorial Hospital Center	208,968	188,888	4,488	(22,881)	Mena Medical Center	29,911	27,383	681	(3,179)
Bates Medical Center	54,521	49,503	1,197	(8,215)	Mercy Hospital of Scott County	14,738	13,388	323	(1,688)
Bauder County Regional Hospital	184,812	177,507	4,248	(21,584)	Mercy Hospital - Turner Memorial	20,112	18,481	437	(2,068)
Booneville Community Hospital	11,482	10,558	280	(1,177)	Methodist Hospital of Jonesboro	74,638	67,408	1,821	(8,852)
Bradley County Memorial Hospital	27,144	25,048	587	(2,888)	National Park Medical Center	141,902	128,018	3,078	(16,983)
Carroll Regional Medical Center	28,918	24,444	580	(3,082)	Newport Hospital & Clinic	38,888	32,653	778	(4,010)
Central Arkansas Hospital	132,244	121,980	2,888	(13,113)	North Arkansas Medical Center	108,812	98,870	2,388	(12,328)
Chambers Memorial Hospital	15,008	13,748	328	(1,588)	North Logan Mercy Hospital	11,988	10,988	282	(1,301)
Chicot Memorial Hospital	32,980	29,848	704	(3,418)	Northwest Medical Center	182,330	167,878	3,948	(18,388)
Cleburne Memorial Hospital	21,788	19,888	478	(2,588)	Ouachita County Medical Center	60,348	54,017	1,318	(7,847)
Columbia Doctors Hospital	104,888	92,484	2,274	(14,518)	Piggott Community Hospital	26,287	23,983	574	(2,878)
Conway County Hospital	34,088	31,288	742	(3,538)	Pike County Hospital	8,928	8,278	193	(840)
Conway Regional Medical Center	83,233	74,758	1,808	(10,282)	Randolph County Medical Center	21,928	19,732	471	(2,388)
Crawford County Mem. Hospital	88,983	79,887	1,913	(10,838)	Rebsamen Regional Med. Center	79,974	73,427	1,738	(8,283)
Crittenden Memorial Hospital	107,887	98,837	2,327	(13,187)	Saline Memorial Hospital	89,481	81,548	1,943	(9,878)
Cross County Hospital	21,818	20,187	471	(2,088)	Steam Springs Memorial Hospital	38,387	36,128	858	(4,118)
Dallas County Hospital	19,078	17,234	413	(2,287)	Southwest Hospital	58,928	51,428	1,234	(8,730)
Dardanelle Hospital	12,873	11,877	278	(1,372)	Sparta Regional Medical Center	402,082	362,638	8,712	(48,168)
Delta Memorial Hospital	12,288	11,288	288	(1,288)	Stone County Medical Center	14,223	12,884	307	(1,538)
DeQueen Regional Medical Center	40,884	38,811	681	(4,884)	Stuttgart Regional Medical Center	64,341	57,888	1,400	(8,048)
DeWitt City Hospital	12,848	11,484	273	(1,388)	St. Bernard's Reg. Med. Center	387,388	368,504	8,580	(38,458)
Drew Memorial Hospital	27,408	25,118	582	(2,884)	St. Edward Mercy Medical Center	324,838	298,888	7,040	(38,113)
East Ozarks Reg. Med. Ctr.	21,533	19,783	467	(2,247)	St. Joseph's Reg. Health Center	418,387	382,813	9,108	(44,880)
Eureka Springs Hospital	8,788	8,023	182	(867)	St. Mary's Regional Medical Center	107,817	98,983	2,328	(10,983)
Fayetteville City Hospital	1,282	1,171	27	(118)	St. Mary - Rogers Memorial Hospital	101,517	92,824	2,212	(10,908)
Fulton County Hospital	18,321	15,048	388	(1,631)	St. Michael Hospital	278,383	248,838	8,018	(33,538)
Gravette Medical Center	27,588	25,528	584	(2,683)	St. Vincent Infirmary Med. Center	817,988	748,808	17,701	(88,851)
Harris Hospital	38,802	36,823	637	(4,118)	The University Hospital of Arkansas	291,010	248,808	8,288	(51,884)
Helena Regional Medical Center	68,200	61,518	1,478	(8,184)	Van Buren County Memorial Hospital	12,802	11,781	278	(1,298)
Hot Spring County Memorial Hospital	51,728	47,838	1,118	(4,808)	Washington Reg. Medical Center	198,808	178,977	4,258	(24,087)
Howard Memorial Hospital	27,888	25,738	608	(2,888)	White County Memorial Hospital	71,378	64,988		(8,388)
Jefferson Regional Medical Center	308,873	274,033	8,877	(41,217)	White River Medical Center	131,180	120,151	2,848	(13,878)
Johnson County Regional Hospital	38,888	38,888	888	(4,188)					
					ARKANSAS TOTAL	7,789,310	7,064,218	167,404	(882,498)

THE WHITE HOUSE
WASHINGTON

FAX COVER SHEET

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-3392 PHONE
(202)456-2878 FAX

TO: James Teeter
FAX #: 501-224-0519
FROM: JULIE DEMEO
NUMBER OF PAGES (including cover sheet): 2
COMMENTS: The hard copy of this letter is in the mail.

If you have any problems with the fax transmission, please call Julie Demeo at (202)456-3392.

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THE WHITE HOUSE
WASHINGTON

FAX COVER SHEET

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-5392 PHONE
(202)456-2878 FAX

TO: James Teeter

FAX #: 501-224-0519

FROM: JULIE DEMEO

NUMBER OF PAGES (including cover sheet): 2

COMMENTS: The hard copy of this letter is in the mail.

If you have any problems with the fax transmission, please call Julie Demeo at (202)456-5392.

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File: Medicare

American Hospital Association

50 F Street NW, Suite 1100
Washington D.C. 20001
(202) 638-1100

"FAX" COVER SHEET

TO: Carol Rasco

FROM: Rick Pollack

DATE: 4/25/94

PAGES TO FOLLOW 2

COMMENTS: _____

AMERICAN HOSPITAL ASSOCIATION

DATE: April 25, 1994
TO: Carol Rasco
FROM: Rick Pollack
SUBJECT: Television Ads on Medicare Reductions

Just wanted to follow-up on a telephone call I've placed to alert you to a television ad we're running on CNN as part of our continuing effort to raise concerns about Medicare reductions.

I've attached a script for your information. It continues the pattern of not singling out the Administration and suggesting alternatives.

CAPITAL COMMUNICATION STRATEGIES

1000 Wilson Blvd., Suite 101 • Arlington, VA 22209 • Phone (703)-612-3910 • Fax (703)-612-3249

AHA

Squeeze '01 - REVISED

:30 (TV)

(CRUNCH)

Congress is squeezing Medicare -- again.

(CRUNCH)

And Americans who rely on Medicare are feeling the pinch.

Soon, Medicare may pay only 71% of the real cost of hospital care or surgery -- care that senior citizens can't afford to lose or have delayed.

Meanwhile, Congress pays 100% of the cost of lots of things we don't need -- like the tobacco support program.

Seventy-one percent for health care but 100% for wasteful programs?

Call your member of Congress. Congress ought to cut waste -- not health care.

Verbal
to Jolinda
4/28/93

April 28, 1993

MEMORANDUM

To: Carol

Fr: Sara

Re: Secretary Shalala's memorandum regarding the 1994 Medicare physician fee update

I agree with the Secretary. It is true that the Medicare volume reduction incentive worked better than anyone might have anticipated and that, as a result, physicians are getting a bigger increase than expected. As the Secretary notes, the methodology needs an overhaul, although I would note that volume reductions of this magnitude cannot go on (nor should they be statutorily encouraged) indefinitely. Whether or not the statute needs revising, however, this is not the time to change our minds about rewarding doctors who have held down their volume of services. Since the target is consistent with the overall NHI theme of cost control through volume reduction, any attempt to reduce payments below the President's original budget request would be seen as punishing physicians when they do what is sought.

Please give me a call if you have questions.

file

file

THE WHITE HOUSE
WASHINGTON

December 13, 1995

Rita Hurst
Superior Senior Care
ABT Towers
Suite 200
P.O. Box 505
Hot Springs, Arkansas 71902

Dear Ms. Hurst:

Thank you for writing about your concerns about existing Medicare home care provider rules. The Clinton Administration is working to reduce the costs of home health services in Medicare while ensuring that beneficiaries get the care they need.

I very much appreciated learning more about the Private Care Association and the use of home care referral agencies. The Health Care Financing Administration (HCFA) has convened a working group to look at the Medicare home health benefit and has been considering using case management in home care. I have forwarded your letter to HCFA Administrator Bruce Vladeck for his further review of your proposal to begin a demonstration project.

Sincerely,

Carol H. Rasco
Carol H. Rasco
Assistant to the President
for Domestic Policy

cc: Russell A. Hollrah, Esq.
Nancy N. Delogu, Esq.

*Julie - 384-6
20201
Signed copy needs
to go to Bruce Vladeck.
I have discussed
response w/ HCFA. Jan*

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: J Klein

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: upon return to office

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

Designee to attend: _____

Remarks: _____

Julie: Fickler

ged CM
11/28

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: Jennings

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: COB 11/29

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

Designee to attend: _____

Remarks: _____

Julie: Feckler

Superior
SENIOR CARE

NOV 14 1995

ABT TOWERS • SUITE 200 • P. O. BOX 505 • HOT SPRINGS, ARKANSAS 71902
(501) 623-7767 • 1-800-951-9792

November 9, 1995

Ms. Carol H. Rasco
Assistant to the President
for Domestic Policy
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, D. C. 20500

Dear Ms. Rasco:

Last Friday, my husband, Byrum, and I met with the President in the oval office and discussed our concerns with the existing Medicare home care provider rules, which prohibit home care referral agencies like ours from participating under Medicare. I am the owner and operator of Superior Senior Care, which is a home care referral agency. We refer home care providers who work as independent contractors to patients in need of home care services.

The President suggested that I contact you for assistance in this matter. Our trade association, the Private Care Association ("PCA"), has been seeking a modification of the Medicare laws that would open the Medicare market for home care. Statistics show that home care costs have escalated under the current system to a point where home care costs under Medicare are much higher than in the private sector.

The PCA seeks a study by the Department of Health and Human Services which would evaluate a Medicare home care delivery system under which home care services are provided through a case manager, on a competitive bid basis. Enclosed is a copy of a letter that I provided the President during our visit which describes the PCA study proposal in more detail.

I have asked PCA's Washington counsel to follow up with you regarding this proposal. We would very much appreciate any assistance you could provide us in our effort to obtain a study of the PCA proposal. If you have any questions or would like additional information, please let me know.

Sincerely,



Rita Hurst
Owner, Superior Senior Care

Enclosure

Superior
SENIOR CARE

ABT TOWERS • SUITE 200 • P. O. BOX 505 • HOT SPRINGS, ARKANSAS 71902
(501) 623-7767 • 1-800-951-9792

November 3, 1995

President Bill Clinton
The White House

Dear President Clinton:

My business is Superior Senior Care, a home care referral agency that refers independent contractor care providers to provide home care for clients. Home care referral agencies are currently "locked out" of the Medicare market for home care.

The Private Care Association ("PCA") — a trade association representing businesses like Superior Senior Care — has been seeking a modification of the Medicare laws that would open the Medicare market for home care, so that businesses like Superior Senior Care can compete.

According to data provided by the Prospective Payment Assessment Commission, during the period 1991 through 1993, while overall Medicare costs grew by 11.8 percent, the home health care component of Medicare grew by 38.1 percent. Principal reasons for the dramatic escalation of home care costs, relative to Medicare costs overall, are that home health agencies — who are the only businesses allowed to perform such services under Medicare —

- (1) perform the *conflicting tasks* (which results in overutilization of services) of:
 - (a) determining the amount of care needed by a beneficiary, and also
 - (b) providing the care, and
- (2) are compensated for providing the care at rates significantly higher than private sector rates.

PCA seeks a study by the Department of Health and Human Services (like the study for Christian Science providers of home health services that is contained in the Medicare bill passed by the House — copy attached) of a Medicare home care delivery system under which home care services are provided *through a case manager — on a competitive bid basis* — by home health agencies or home care referral agencies (like Superior Senior Care) that meet applicable state licensing requirements. A case manager would be prohibited from having any economic interest in an entity involved in providing home care services.

The proposed delivery system would both (1) split the *conflicting tasks*, currently performed by home health agencies, into separate and unrelated entities — thereby eliminating the overutilization of services, and (2) allow Medicare to begin paying the significantly lower private sector rate for services provided.

We would be pleased to provide you with additional information concerning the proposal. Thank you for your consideration.

Best regards,

Rita Hurst
Owner — Superior Senior Care

Enclosure

Study of coverage of services of Christian Science providers. The bill requires the Secretary to conduct a study of the feasibility and desirability of providing Medicare coverage for home health services furnished by Christian Science providers which meet applicable requirements of the First Church of Christ, Scientist, Boston.

94

The Secretary would be required to submit a report on the study by July 1, 1996, and to include recommendations on criteria for certifying providers and an appropriate payment methodology for reimbursing covered services.

PART 2—MEDICARE SECONDARY PAYER (MSP) IMPROVEMENTS

S-41

A PROFESSIONAL CORPORATION
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HOUSTON, TEXAS

LONG BEACH

SANTA MARIA

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SANTA ROSA

MENLO PARK

STOCKTON

WALNUT CREEK

November 14, 1995

BY HAND DELIVERY

Ms. Carol H. Rasco
Assistant to the President
for Domestic Policy
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Ms. Rasco:

We are writing at the request of Rita Hurst and on behalf of the Private Care Association ("PCA") concerning a demonstration project that the PCA is seeking which would study a modified system for delivering home care services under Medicare. Ms. Hurst recently met with President Clinton concerning the proposal, and the President requested that more detailed information be forwarded to you.

The PCA is a national association of home care referral agencies, that is, agencies that refer self-employed providers of home care to clients in need of care.

The PCA proposal is modeled after a Florida Medicaid waiver, which awards contracts to provide home care services on a competitive bid basis. The Florida Medicaid waiver utilizes a case manager to determine an individual's home care needs and allows home care referral agencies to participate in the Medicaid program. As a result of that waiver, the Florida Medicaid program has realized a cost savings in excess of 20 percent. The PCA proposal, if adopted, would establish a trial study of a similar program under the Medicare laws. Enclosed is additional information concerning the PCA proposal.

A very similar study — that would open the Medicare market for home care to Christian Scientist home health care providers — is included in the Medicare reform bill passed by the House of Representatives. The inclusion of that study makes us believe that the PCA study would be politically feasible. Enclosed is a copy of the staff description of the Christian Science study.

The PCA attempted to have its home care reform proposal included in the Medicare reform legislation, but was unsuccessful. The PCA believes that a study of the proposal — in a trial state or region — will *prove* that home care can be provided at a much lower cost, without compromising the quality of health care services provided.

LITTLER, MENDELSON, FASTIFF, TICHY & MATHIASON

Ms. Carol H. Rasco
November 14, 1995
Page 2

Home health care represents the fastest growing component of Medicare costs. During the period 1991 through 1993, while overall Medicare costs grew by 11.8 percent, the cost of providing home care grew by 38.1 percent, according to data from the Prospective Payment Assessment Commission. In real terms, the Department of Health and Human Services reported that Medicare home health expenditures increased from \$3.3 billion in 1990 to \$14.4 billion (estimated) in 1995. While demand for home care has increased over that period of time, the increase in costs has far exceeded the increase in demand.

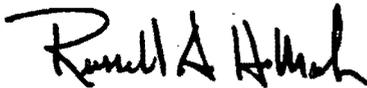
It is submitted that the primary reason that home health care costs have escalated so dramatically is that the *only* type of provider that is permitted to compete in the Medicare market for home care services is the "home health agency." Home health agencies drive up costs through (1) overutilization of services and (2) charging excessive prices for care provided.

The overutilization of services occurs because home health agencies influence the determination of what home care services are needed, and then perform those services themselves. The involvement in both those functions by a single entity creates an incentive to provide additional, perhaps unnecessary services.

The price for care provided that home health agencies is excessive because it is based on a reimbursement system under which the amount of costs incurred during one year will determine an agency's "reimbursement rate" for services performed in a subsequent year. Such a system encourages home health agencies to consistently increase the amount of costs so as to ensure a continuous annual escalation in the Medicare reimbursement rate.

Ms. Hurst and PCA respectfully request that the Administration consider supporting PCA's efforts by endorsing the inclusion of the PCA study proposal in the Medicare reform legislation. If you have any questions or comments concerning this proposal, please let us know. Thank you for your consideration.

Very truly yours,



Russell A. Hollrah



Nancy N. Delogu

Enclosure

cc: Ms. Rita Hurst

LITTLER, MENDELSON, FASTIFF, TICHY & MATHIASON

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WALNUT CREEK

Private Care Association Proposal for Reform of the Medicare Home Health Care Market

Executive Summary

Home health care represents the fastest growing component of Medicare costs. During the period 1991 through 1993, while overall Medicare costs grew by 11.8 percent, the cost of providing home care grew by 38.1 percent, according to data from the Prospective Payment Assessment Commission. In real terms, the Department of Health and Human Services reported that Medicare home health expenditures increased from \$3.3 billion in 1990 to \$14.4 billion (estimated) in 1995. While demand for home care has increased over that period of time, the increase in costs far exceeded the increase in demand. The dramatic escalation of home health costs is attributable to the following.

- The only type of provider that is permitted to compete in the Medicare market for home care services is the "home health agency." All other private sector competitors are locked out of the Medicare market for home care.
- Home health agencies operate under a financial conflict of interest. A home health agency both (1) significantly influences the determination of the amount of home care a beneficiary needs, and (2) performs the care that it determined is needed. The incentive created under this model is apparent, that is, for the home health agency to maximize the amount of care that can be justified under the Medicare guidelines, thereby maximizing the amount of revenue for itself through the performance of services. The resulting "overutilization" of services is a significant contribution to the excessive cost for home care under Medicare.
- Unlike most businesses, home health agencies are not paid a fixed fee for services performed. Rather, such agencies are compensated based on a reimbursement system under which the amount of costs incurred during one year will determine a "reimbursement rate" for the services performed in the subsequent year. The incentive created under this system is for a home health agency to consistently increase the amount of costs it incurs each year so as to ensure a continuous annual escalation in the Medicare reimbursement rate for the services it provides. Attached is a graph that illustrates the disparity in cost

for similar services provided by a home health agency in the Medicare market and provided through a home care referral agency in the private sector.

It is submitted that all of the foregoing taken together results in an extraordinary amount of excessive and needless expenditures of taxpayer money under the Medicare home health program.

The Private Care Association Inc. ("PCA"), a national association representing home care referral agencies, that is, agencies that refer self-employed providers of home care to clients in need of care, suggests the following proposal to eliminate the excessive cost escalation experienced by the Medicare market for home care.

- Modify the home health agency concept by stripping from such agencies the function of providing care, so that a home health agency is permitted only to operate as a case manager. The home health agency could be renamed the "case management agency" ("CMA"). A CMA would be prohibited from performing any home care services and from owning any financial interest in an entity that directly or indirectly is involved in the providing of home care. This would eliminate the conflict of interest that currently contributes to an overutilization of home care services. The CMA's role would be limited to determining the amount of care needed by a Medicare beneficiary and contracting out the performance of the needed services.
- Repeal the cost reimbursement system and require providers of home care services to perform such services on a competitive bid, fixed fee or hourly fee basis. This would eliminate the existing incentives for home health agencies to incur unnecessary costs in order to increase their next-year's reimbursement rate, and would permit market forces to bring the cost of home care down to the private sector cost (see attached graph).
- Open the Medicare market for home care to all private sector providers of care -- including home care referral agencies -- that satisfy applicable state licensing requirements. This would bring added market competition to the Medicare market for home care, thereby resulting in the services being priced at a true market value.

It is submitted that the foregoing changes would generate a material amount of cost savings -- without any reduction in benefits, without any increase in beneficiary co-payments and without requiring providers of care to accept below-market rates for services performed.

The foregoing represents a variant of the "prospective payment" concept, with the primary variation being that the price for services would be set by true market forces rather than by the government. The proposal might be combined with an increase in the beneficiary co-payment, in order to reduce the amount of the planned co-payment increase.

A more detailed explanation of the proposal is attached.

If you have any questions or comments concerning the proposal, or if we could provide you with any additional information concerning the proposal, please call Russ Hollrah at (202) 842-3400.

LITTLER, MENDELSON, FASTIFF, TICHY & MATHIASON

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WALNUT CREEK

Proposal for Reform of the Medicare Model for Delivery of Home Care

Prepared On Behalf of

PRIVATE CARE ASSOCIATION, INC.

July 1995

I. Introduction

The Medicare model for the delivery of home care services is highly cost-inefficient. It is submitted that the aspects of the Medicare model that drive up costs could be modified to produce a new model capable of delivering the same *quantity and quality* of services at a substantially lower cost.

II. Overview

This proposal would split apart the functions — currently performed by a home health agency under the Medicare model — that, when performed by a single entity, create a disincentive to contain costs. Currently, a home health agency both (1) influences the determination of the type and amount of home care services to be provided to a Medicare beneficiary, and (2) *performs* the services that *it* determined are needed.

Under the proposal, one entity — a Case Management Agency ("CMA") — would determine the amount and type of home care needed by a Medicare beneficiary, while entities not related to the CMA would perform the services. The CMA would be prohibited from performing any home care services. This division of duties would eliminate the financial incentives — that exist under current law — to overestimate the amount of home care needed by an individual.

The proposal would require that all home care services under Medicare be awarded to service providers on a competitive bid basis. What is more, the Medicare market would be opened to allow market access to all providers that compete in the private sector. The competitive bid concept is modeled after the private sector market for home care, which, as discussed below, is far more cost effective than the Medicare program.

Graphs A and B, attached hereto, demonstrate the disparity in the cost of home care services between the private sector market and the Medicare market. Graph A compares fees charged *Medicare* by home health agencies, with fees charged *private sector* clients by home care referral agencies. Graph B compares the fees charged *private sector* clients by home health agencies, with the fees charged by home care referral agencies. Especially interesting is the comparison provided by Graphs A and B, taken together, of the fees that a home health agency charges in the Medicare market versus what it charges when competing in the private sector.

It is submitted that the difference between what a home health agency charges Medicare and what it charges a private sector client provides compelling evidence that the exclusive access to the Medicare market that a home health agency has been statutorily provided is a major contributing factor to the explosive escalation of Medicare expenditures for home care that the Medicare program is currently experiencing.

III. The Medicare Model For Delivery of Home Care

The Medicare model creates an artificial market for home care services that includes only one type of service provider, the "home health agency." The Medicare statute requires a home health agency to provide at least one line of services with its own employees. The line of services that a home health agency most commonly provides with its employees is nursing and other types of home care services. Alternative sources for home care services, such as nurse registries and home care referral agencies — that refer independent contractors to perform the services — are *banned* from the Medicare market. Consequently, the home health agency is provided monopoly power to set prices for home care services in the artificial market established under Medicare.

So long as a home health agency provides one line of services with its own employees, it can contract-out other types of services. Such agencies do, in fact, typically contract-out physical therapy, occupational therapy and other similar types of services. In addition, when durable medical equipment and pharmaceutical products are required for a patient, such items typically will be purchased by the home health agency from third-party vendors.

Home health agencies also operate as *de-facto* case managers with respect to Medicare beneficiaries. While, technically, a physician is responsible for approving a program specifying the type and quantity of home care services that is appropriate for a particular Medicare beneficiary ("plan of care"), customary practices have evolved to where the physician's approval is given perfunctorily, and the home health agency is able to significantly influence the formulation of a plan of care. Moreover, home health agencies are responsible for documenting the care provided and the patients' response to such care. Since that information is highly relevant for purposes of determining the type and quantity of *additional* care that will be required, the entries provide yet another opportunity for a home health agency to influence that determination.

In the Medicare market, the fact that a home health agency significantly influences the *determination* of the type and quantity of care that is appropriate for an individual does not preclude that same agency from also being the *provider* of the services that it determined are needed. Indeed, the same home health agency commonly assumes both roles with respect to an individual.

The hourly rate that Medicare will pay for care provided by a home health agency is determined based on the home health agency's prior years' cost reports. For example, if for "year one," a home health agency provided 1,000 units of home care and incurred total costs attributable to that care for the year of \$5,000, the reimbursement rate for "year two" would be \$5 per unit of home care ($\$5,000 / 1,000$). If the total costs for the year had been \$6,000 instead, the reimbursement rate for "year two" would be \$6 per unit of home care. The incentives created under such a system are manifest. Profligate spending practices under such a system are *rewarded* under the Medicare model by creating higher reimbursement rates for the future.

IV. Cost Inefficiencies Created by the Medicare Model for Delivery of Home Care

It is submitted that the cost to Medicare for providing home care is substantially inflated by virtue of a home health agency:

- being given a monopoly market position for the delivery of home care services;
- effectively determining the type and quantity of services that a patient will be provided

by designing the plan of care, and

by documenting the care given and the patient's response to such care (which necessarily will influence the determination as to the type and amount of additional care that might be needed);

- being a provider of the care that it determined is necessary and appropriate; and
- being paid at a rate determined based on the home health agency's prior years' expense reports.

There is nothing sacrosanct about the Medicare model. It is just one possible model for providing the services that are needed. It is submitted that a different model which, from a structural perspective, is a mere variation on the Medicare model, would produce a radical change in the delivery of home care services and produce very material cost savings.

V. Suggested Modifications to the Medicare Model for Delivery of Home Care

The proposed new model would involve a central agency, similar to a home health agency, except that it would perform the case management function only. The agency could be called the Case Management Agency ("CMA"). The CMA would determine the plan of care for a patient, but would be prohibited from providing any services under Medicare. A CMA also would be prohibited from owning any economic interest in, or receiving any gift or payment from, a business that provides services under the Medicare program. Such prohibitions are needed to ensure that a CMA has no economic incentive to overstate the amount of services an individual needs.

Once the CMA determines the plan of care for a patient, the plan would need to be approved by a physician. After the physician's approval, the CMA would select one or more referral agencies to engage service providers to perform each type of service the individual needs. The CMA would issue to the referral agency a Medicare "authorization number." An authorization number would be required in order for the service provider to obtain payment from Medicare for providing the services indicated thereon. Authorization numbers would be nontransferable. Thus, the service provider could not subcontract the services to another. Furthermore, an authorization number would authorize payment for a specific type of services being performed a stated number of times or for a stated number of hours.

Authorization numbers always would be awarded based on a competitive bid basis to provide the care at a rate per hour or per visit, or under other terms specified by the CMA. Once the prescribed services are performed, the referral agency would so advise the CMA. If the CMA were to determine that additional care is needed, it would issue the referral agency another authorization number.

As noted, the referral agency, upon receiving an authorization number, would refer the matter to a service provider. Under the proposal, independent contractors would be eligible to compete as service providers. Employee-based providers would be permitted to compete both (1) with referral agencies for assignments from a CMA, and (2) with independent contractor service providers for assignments from a referral agency.

The service provider would perform the services assigned, document the care given and the patient's response to the care, and file reports with the referral agency. The referral agency would serve as the central repository for all such records. The referral agency would be responsible for providing such records to an inquiring government agency, to the CMA and to the physician involved in designing and monitoring the plan of care.

A referral agency would be authorized to refer services to any provider that meets applicable state licensing requirements. A provider would not be eligible for an assignment unless it satisfied applicable state licensing requirements for performing all types of services called for in the assignment.

If pharmaceutical products and/or durable medical equipment were needed, the CMA would issue a supplementary authorization number. For example, an authorization number with a suffix "A" could signify home care services, whereas an authorization number with a suffix "B" could signify pharmaceutical products or durable medical equipment.

In cases where services only were required, an authorization number with no prefix would be issued. For cases requiring both services and additional items, an "A" authorization would be issued for the services component, and a "B" authorization would be issued for the pharmaceutical products and/or medical equipment. If a "B" authorization were involved, the CMA would contract directly with a vendor, or the referral agency would do so. In either event, the vendor would be provided the "B" authorization and would bill Medicare directly for the items it provided.

A schematic presentation of the proposed *modified* Medicare model is attached.

VI. Anticipated Cost Savings

The anticipated cost savings from the suggested reform are many. The *per-unit-of-care cost of home care* services provided by an individual referred by a referral agency is substantially lower than the cost of comparable care provided by a home health agency.

Separating the case management function from the service provider function should reduce the *level of service utilization*. With both functions combined within one entity, as the Medicare model does, the case manager has a financial incentive to overstate the need for

services. By separating the two functions, the financial incentive to overstate the need for services would be eliminated.

The *market competition* that would be introduced to the Medicare market should result in reduced costs across-the-board. Under the current system, vendors and contractors who sell their goods and services to home health agencies have no incentive to lower costs. This is because the home health agency has no incentive to curtail costs, inasmuch as its reimbursement rate for the following year would vary directly with the amount of costs it incurs. If its costs increase, its Medicare reimbursement rate for the following year will increase, and vice versa.

VII. Quality of Care

The quality of care would be expected to improve under the modified model. Under the modified model, the client would be able to choose his or her own provider from a list of carefully pre-selected individuals that is prepared by the referral agency or referral agency. If the client decides to replace a provider with another individual, the client need only so advise the referral agency. Under the Medicare model, a client's choice in provider is limited to the home health agency's employees that happen to be available at the times needed by the client.

Under the modified model, care providers would need to compete for the opportunity to be selected and retained by a client, whereas under the Medicare model, a home health agency's employees at any given time represent the entire pool of talent available for a particular assignment.

Under the modified model, the client and the care provider would negotiate among themselves the specific terms and conditions of the arrangement, whereas under the Medicare model, such negotiations are between the client and the home health agency, and the service provider receives instructions from the home health agency, not the client. This disconnect can lead to miscommunications and a less flexible care environment. [This factor would be most applicable to long-term care arrangements.]

VIII. Conclusion

The suggested modification of the Medicare model for delivery of home care would not be extensive, from a structural perspective, but the consequences would be radical. The design defects of the Medicare model are manifest. The Medicare model creates unavoidable conflicts of interest by requiring the home health agency to both determine a client's plan of care, and also provide the services to fulfill that plan of care. What is more, the Medicare model discourages cost containment by basing a home health agency's reimbursement rate for a year on the amount of costs it incurred in previous years.

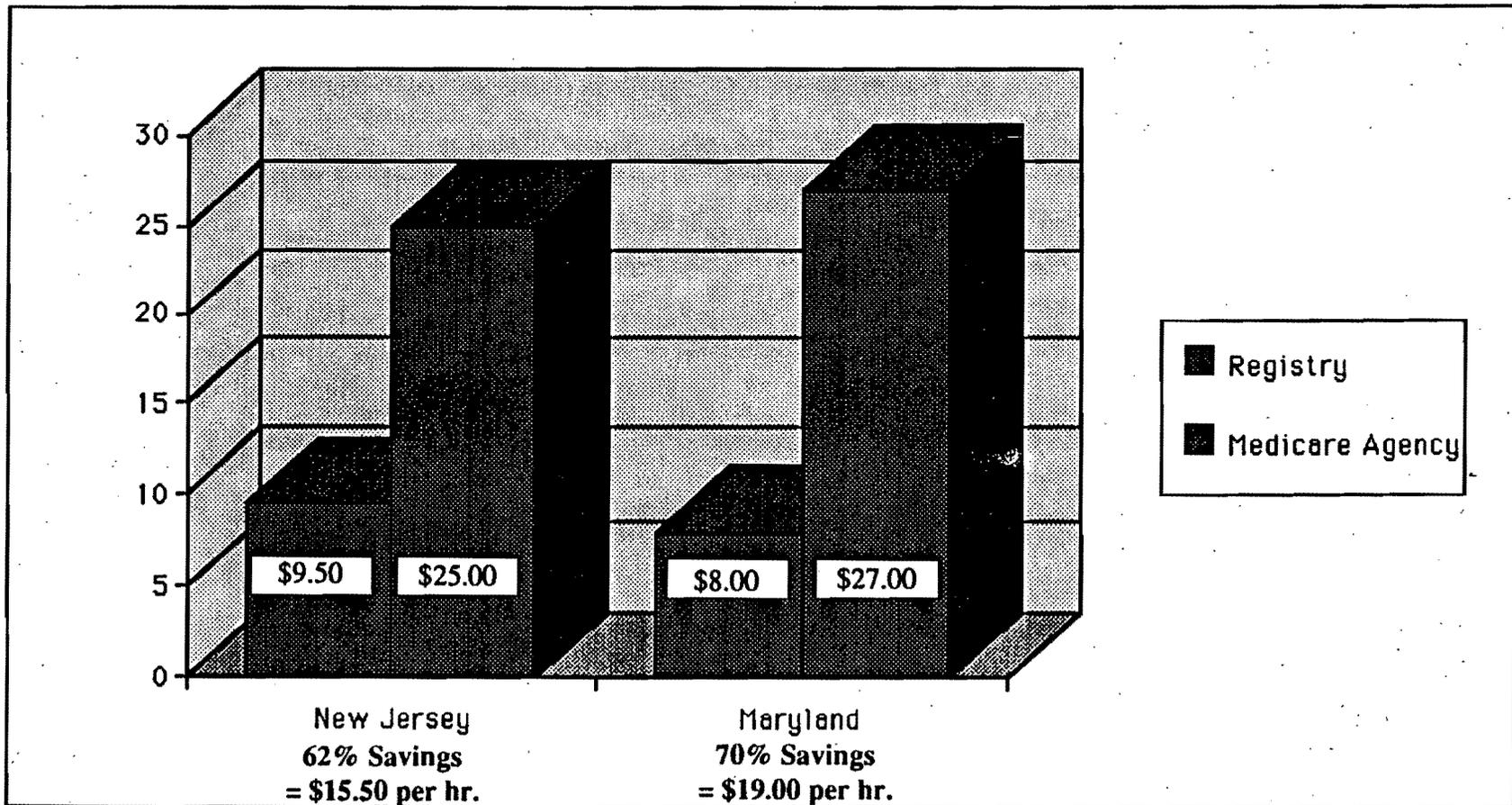
The Medicare model excludes from the Medicare market for home care the private sector competitors that, as illustrated in the attached graphs, have kept the private sector cost of services far below the Medicare cost.

Under the suggested model, the negative features of the Medicare model would be removed to produce a much more cost-efficient delivery of services without any decline in the quality of care.

If you have any questions about this proposal, please call Marc Catalano, RN, at (305) 821-4329, or Russell Hollrah, Esq. at (202) 842-3400. Thank you for your consideration.

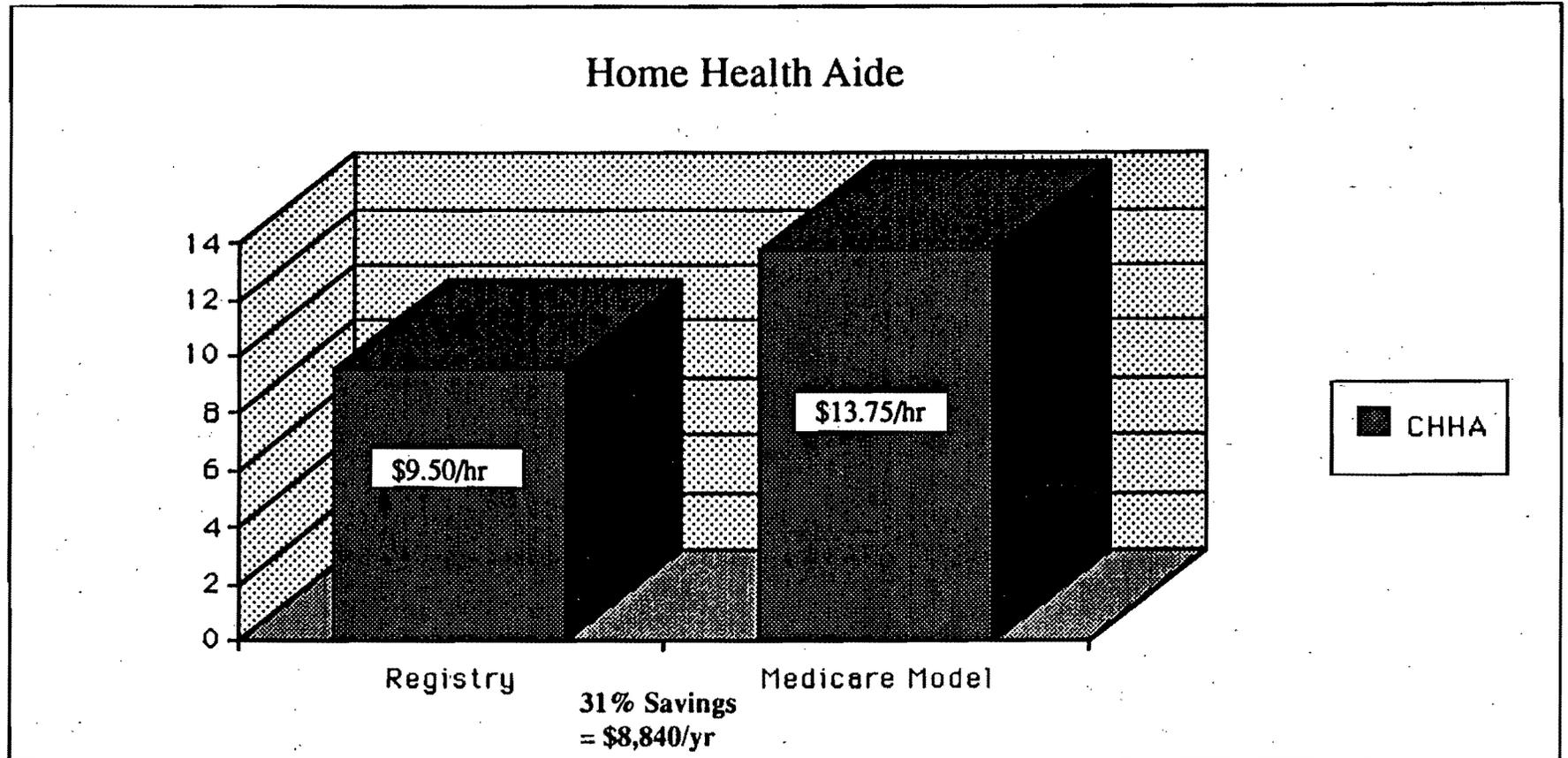
A

Registry Vs. Medicare Home Health Aide Visit

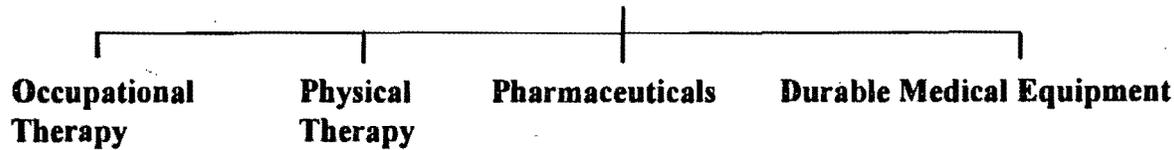


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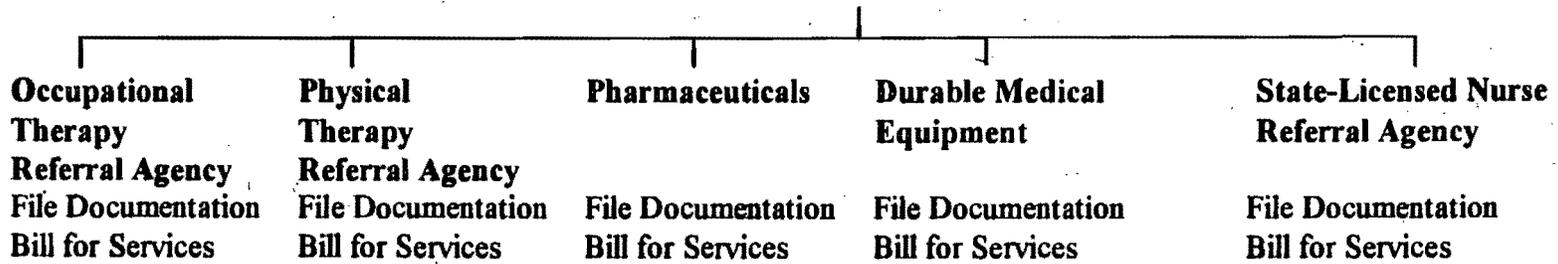
Cost For Home Care in New Jersey



Home Health Agency
 Case Management
 File Documentation
 Employees to Perform Skilled Nursing and Aide Services
 Contract-out Other Care
 Bill For All Services
 Monitor Patient Progress



Case Management Agency
 Case Management
 Contract-out All Care
 Monitor Patient Progress
 Issue Authorization Number to Registry For Billing Purposes
Prohibited From Providing Any Care and
Prohibited From Having Any Economic Interest In any Care Provider
 Cannot Bill for Any Services



----- *Prohibited from Subcontracting Any Services* -----

Study of coverage of services of Christian Science providers. The bill requires the Secretary to conduct a study of the feasibility and desirability of providing Medicare coverage for home health services furnished by Christian Science providers which meet applicable requirements of the First Church of Christ, Scientist, Boston.