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IMPROVING MEDICARE CHOICES

HEARINGS

BEFORE THE

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UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MARCH 19 AND 20, 1997

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IMPROVING MEDICARE CHOICES

WEDNESDAY, MARCH 19, 1997

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

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, D'Amato, Moynihan, Baucus, Rockefeller, Breaux, Graham, Bryan, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order. Today we begin a hearing on improving choice in the Medicare program. Because of the broad array of issues to be addressed at this hearing, it will extend over 2 days, today and tomorrow morning.

The issues related to providing choice in Medicare include expanding the type of choices available to beneficiaries, providing information to beneficiaries to help them make informed decisions, assuring quality and adequate consumer protections, and establishing equitable payment rates for private Medicare health plan options.

The witnesses that will appear before us over the next 2 days will each testify on many, if not all, of these issues. To begin our consideration of improving choice for Medicare, we will hear the President's proposal for improving choice.

Following the administration will be a panel focused on consumer protections and issues regarding Medicare supplemental insurance. Tomorrow, we will complete the hearing with a panel focused on provider sponsored organizations and Medicare managed care payment rates.

The Medicare program still looks very much like it did when it was enacted some 30 years ago. During this time, the health care delivery system in the United States has changed dramatically.

Medicare has been slow to adapt to this change, and, whatever we decide to do to solve the financial problems with Medicare, surely reforms must move in the direction of providing seniors with greater choice.

Allowing seniors to pick the type of health plan that best suits their needs and preferences will create competition that should result in improved quality and restrained costs.

Now, as Federal employees, we benefit from a program that provides a wide degree of choice among high-quality health plans and it is time to provide similar choices to our seniors through Medicare.

Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Thank you, Mr. Chairman. Welcome, again, to Dr. Vladeck. I very much endorse what you have said, that the world of health care in this country has begun undergoing an extraordinary transformation.

Yet, the Federal Government's principal health care program remains much as it was when established in 1966, which is to say at a time when individual fee-for-service arrangements between doctor and patient were the norms.

What we learned, if I can say yet again, in our hearings on the Administration's health care proposal in the 103d Congress, it was just one of those illuminating moments when Professor Fahey from Fordham said, what you are seeing is the commodification of medicine, the economic rationalization of medicine, which was bound to come and it is all about us.

The head of the UCLA hospital in California said, might I give you an example. In southern California, we now have a spot market for bone marrow transplants. Bone marrow transplants did not exist when Medicare began, and the advance of medical science has given options that both greatly decrease costs and make opportunities involving procedures that did not exist and are expensive, so they increase costs. The administration is going to solve all that for us, Mr. Chairman, and I look forward to Dr. Vladeck's explanation.

The CHAIRMAN. Thank you, Senator Moynihan.

I, too, would like to welcome you back, Dr. Vladeck. You testified before our committee last week on the issue of graduate medical education. Before you begin your testimony, I do wonder if you could tell us when we could expect to receive the details of the President's plan in the form of legislative language.

It would, to be honest, make these hearings more efficient if we did not need to question you so extensively on the details and could focus, instead, on the rationale behind the proposal. But, in any event, please begin. Your full statement, as always, will be included as part of the record.

STATEMENT OF HON. BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. VLADECK. Thank you very, very much, Mr. Chairman and Members of the committee. I am pleased to be back here.

Let me begin by responding, Mr. Chairman, with a less precise answer than I would like to be able to give you. But I believe that the specific legislative language, at least insofar as it affects the Medicare program, will be made publicly available in the very near future. Can I be more precise about that? I am afraid I cannot. But it is sooner rather than later.

The CHAIRMAN. A week, 2 weeks?

Dr. VLADECK. We would hope by the end of this month, or certainly by the conclusion of the impending recess, that it would be available. I hope sooner than that, but I just do not know to tell you any more precisely.

Senator GRASSLEY. Mr. Chairman, is there any doubt that one will be coming up here?

Dr. VLADECK. As I understand it, sir, the process of drafting and reviewing is largely completed, at least for the Medicare provisions. I cannot speak for the rest of the statutory language having to do with the President's budget proposal. It will be made available in the very near future, but more precise than that, I wish I could be for you, but I am afraid I cannot.

The CHAIRMAN. Well, we are, of course, talking about health and Medicare. But it is important that we obtain that at the earliest possible date.

Dr. VLADECK. I will do everything I can to try to expedite it. If I may, even with Senator Graham not yet here, make one other statement not immediately relevant to today's subject, but in follow-up on last week's hearing.

There was some confusion, as you will recall, about the availability of the administration's 10-year budget projections associated with our Medicare proposals. We had some confusion on our end. I was confused. Senator Graham has since received those 10-year numbers, and they are available to other Members of the committee and committee staff.

I need to, and wish to, note for the record that I believe last week I said that it was the Office of Management and Budget that was responsible for the unavailability of those numbers. That was not the case. We were confused in other ways, and I want to just correct the record, that OMB, in fact, encouraged us to make them available to all the Members of this committee at the earliest time.

The CHAIRMAN. And they have already been made available to the committee?

Dr. VLADECK. And they have been made available, yes.

The CHAIRMAN. All right. Please proceed.

Dr. VLADECK. So, having said that, you have my written statement. It is rather extensive. Let me proceed with the extensive topics before us this morning in very, very summary fashion and try to condense this as much as I can.

We are pleased to be here to talk about our efforts to ensure that Medicare beneficiaries receive high-quality care and that the range of choices available to them are substantially expanded.

It is important that we clearly define and support measures to promote choice and quality, not only for Medicare beneficiaries but for all Americans in all types of health plans.

Managed care is attractive to increasing numbers of Medicare beneficiaries because they can often receive the same financial protection afforded by Medicare supplemental or Medigap policies without additional premiums.

In addition, most plans are providing benefits not covered under the basic Medicare program, such as routine vision care, dental care, expanded preventive benefits, and some prescription drug coverage at relatively limited cost to beneficiaries.

As of January 1, almost five million beneficiaries were enrolled in 350 Medicare managed care plans, two-thirds of which have risk contracts with us. In 1996, risk enrollment grew fully by a third, and we expect this trend to continue.

Under current law, beneficiaries enrolling in Medicare managed care plans have a wide variety of consumer protections. They are entitled to enrollment without health screening or limitations on preexisting conditions. They are entitled by law to access to all medically necessary and appropriate care.

They are entitled to procedures to resolve grievances and have access to a neutral, independent third party for appeals of decisions made by the plan. Plans are required to maintain internal quality assurance processes and, in addition, they are all subject to external quality review.

There are protections associated with minimizing the risk to beneficiaries that might arise from financial instability of plans and there are limitations on the total potential out-of-pocket financial liability of beneficiaries who enroll in Medicare managed care.

We are working to improve the appeals and grievance process, particularly for urgent or time-sensitive conditions. We have recently clarified the importance of unrestricted communications between physicians and their patients and the illegality under the Medicare law of so-called "gag rules." We have published regulations regulating and making available public information about incentive compensation arrangements for managed care physicians. We have clarified the eligibility for emergency room services in a way similar to that which Senator Graham has been working on very actively for the last couple of years.

We are about to release, after extensive consultation with the managed care industry and consumer groups, national marketing guidelines for Medicare managed care, and we are investing a lot of time and effort in developing better comparative information for consumers.

We are also in the process of strengthening our quality monitoring and enforcement activities, recognizing that in the universe of 350 plans not all can always be counted on to meet our demanding standards. We are redesigning our data systems. We are working with the States to coordinate our regulatory activities.

We are testing a range of new techniques to measure and report on the quality of services provided by managed care plans, including, quite critically, the implementation this year of the first national survey of Medicare beneficiaries enrolled in managed care plans for purposes of addressing satisfaction with access to, and quality of care, as well as other aspects of managed care service.

This is all the background on which the President's 1998 budget proposals are built. Those proposals will contribute to our stated goal of preserving the solvency of the hospital insurance trust fund and enhancing beneficiary protections while significantly expanding choice. Many of them will sound familiar to you, Chairman Roth, in terms of legislation in which you and other Members of this committee have previously been actively involved.

In a very summary form, we propose to expand the types of plans with which Medicare contracts to include preferred provider organizations, or PPOs, which are the largest providers of managed care

services in the private insurance market, as well as provider sponsored organizations, or PSOs, which will be able to contract directly with the Medicare program.

We have established mechanisms in the bill for contracting with independent, neutral third parties in every market for a much-expanded program of consumer information and counseling, including: around-the-clock counseling, 800 numbers, and consumer information. We have put in place a financing vehicle to support those activities.

Now, the President's budget calls for an annual open enrollment season, similar to that which is used in the Federal Employees Health Benefits plan or that which is used by many of the more progressive employers, in which beneficiaries have the opportunity to pick not only from the range of managed care options, but among Medigap plans as well.

The President's proposal would extend the underwriting, open enrollment, and community rating requirements that now apply to Medicare capitated plans to Medigap so that people could move freely back and forth between the capitated and fee-for-service sectors.

And, while we will have an annual open enrollment season, the ability of Medicare beneficiaries to disenroll from a managed care plan on 30 days' notice will not be constrained or restricted by the President's proposals.

We seek to replace a lot of the sort of outmoded bureaucratic kind of requirements in the existing Medicare law with an entirely new quality management and quality measurement system for capitated plans. This system will also be extended over a period of years to the fee-for-service sector so that we will be applying the same quality standards and the same measures to the fee-for-service medicine in the Medicare program as we do to managed care plans.

If there are a set of measures that characterize optimal care of a diabetic patient or a patient who has had a heart attack, it should not matter whether that patient is enrolled in an HMO, or a provider-sponsored network, or in the fee-for-service community, good quality medical care is good quality medical care. We should employ the same measures and measurement techniques, and we will propose to do so.

At the same time, we are proposing a set of very, very significant changes in the way in which we pay Medicare managed care plans. There are a number of flaws in the existing system about which there is considerable consensus among the experts who have looked at this and our advisors on the Prospective Payment Assessment Commission, the Physician Payment Review Commission, the General Accounting Office, and others.

The first, is that there is significant geographic inequity between the lowest-cost county in the United States for which the current Medicare monthly capitation rate is $221 a month, and the highest-cost county where the capitation rate is approximately $770 a month.

Under the President's proposal, we would significantly reduce these inequities through two mechanisms. First, by putting a floor of $350 per beneficiary per month in the lower cost counties, and

second, by building on the proposal that first appeared in the Balanced Budget Act in 1995, and blending local and national rates.

The first chart here shows the extent to which, over the 5 years of the budget plan, the disparity across counties in the Medicare capitation rates would be shrunk by the President's proposal. There is a copy of this chart in the written testimony, where it may be somewhat easier to see. But the short answer is, you see much more concentration of the rates around the average after full implementation of the President's proposal than is now the case.

The CHAIRMAN. Can you illustrate by dollar figures what the difference will be at the end of 5 and 10 years?

Dr. VLADECK. If I could perhaps go to one of the subsequent charts, which actually uses several counties as examples, that might be helpful in that regard.

The CHAIRMAN. What is the difference currently?

Dr. VLADECK. As I say, the current extremes range from $221 a month to about $770 a month.

The CHAIRMAN. Two hundred and twenty-one dollars and seven hundred and seventy dollars.

Senator GRASSLEY. Is $221 a state-wide average?

Dr. VLADECK. No, these are each county rates. That is the lowest cost county in the United States. The range now is about 3½ to 1 from the highest cost county to the lowest cost county.

In the year 2002 under the President's proposal, the rate in the highest cost county would be roughly twice as great. It would be about a 100 percent difference as the rate in the lowest cost county.

The CHAIRMAN. What would those figures be?

Dr. VLADECK. Well, we would have to get to all the adjustments. In the lowest cost county in 2002 under the President's proposal, it will have gone from the $221 a month I identified to just under $400 a month. Its rates will roughly have doubled. That high-cost county will have gone from about $770 a month only up to $800 a month.

So we have a 2 to 1 swing as opposed to an almost 3½ to 1 swing under current law. We have provided, I believe, to committee staff the county by country breakdowns of the net effects of all of these changes on every county over the 5 years in the budget proposal.

I can go through these in somewhat greater detail if you want, but these are some other illustrative counties that show how it works because this reduction in the geographic disparity is only one part of the package. You have to look at the whole set of proposals together to evaluate their impact in any community. I will just go ahead, very quickly, and describe those as well.

The next thing we are doing is taking the money that is now included in HMO payment rates attributable to the cost of graduate medical education and disproportionate share out of the HMO rates and paying that money directly to the hospitals. This has been identified as the most important agenda item by the academic medical community for us in terms of the future of the Medicare program.

It does not result in any net budget savings to the Medicare program, we are simply taking the money out of the HMO rates and paying it to the hospitals. Nor does it move money from one county

to the next since, again, it takes money out of the HMO rates in those counties and pays it to the hospitals in those counties.

But it is a more appropriate targeting and use, we believe, of money the Congress has set aside to support graduate medical education and disproportionate share providers in hospitals.

There are two other major adjustments we are making in the payment proposals in the President's budget, or there are two other sets of adjustments. The first is that since we continued to tie the HMO payment levels to the level of outlays on the fee-for-service side, as we take savings in the budget package in fee-for-service payments for hospitals, physicians, or clinical laboratories, those savings flow through into the HMO payment rates to produce 5-year savings of approximately $18 billion.

If you are setting HMO payment rates at X percent of fee-for-service costs, as you bring down fee-for-service costs that brings down HMO prices exactly in proportion. We are also proposing a favorable selection adjustment to be implemented in the year 2000 which will produce 5-year savings of approximately $6 billion and will bring the average level of Medicare payments from 95 percent of fee-for-service costs to 90 percent of fee-for-service costs.

We have made this proposal because of the growing body of evidence that the patients enrolled in Medicare HMOs are systematically less expensive to care for and less subject to a variety of health care problems than those in the fee-for-service sector. The data has been confirmed not only by our own research, but again by the work of the independent commissions and the General Accounting Office as well.

In order to smooth the impact and mitigate the impact of all of these intersecting changes on any particular country, we also have as part of the budget proposal a so-called "hold harmless" provision so that, except in the year 2000 when we take this 5 percent across the board reduction, the rates in no county go down from 1 year to the next.

In the year 2000, the most that rates in any particular county can go down is equivalent to part of that 95 to 90 percent reduction, or a maximum reduction in the rates of about 3⅓ percent.

Finally, relative to payment, we recognize that all of these changes represent efforts to fix a payment methodology that over time is fundamentally flawed. As we get more experience with managed care and as managed care market penetration in Medicare grows, it becomes necessary to essentially have a managed care payment system that is not so tied to the fee for service sector.

To that effect, we require in the budget proposal that the Secretary report back to Congress by 1999 a plan for an entirely new payment system. That may be a system somewhat analogous to the kind of pricing system we use in hospitals, where we have a national price adjusted for the clinical characteristics of patients and input price differences from one community to another, or it may be an even more radical change in our approach.

We are testing, beginning with rates effective this coming January 1, a true market-based competitive bidding model in metropolitan Denver for the rate year 1998. We will be doing other competitive bidding demonstrations in the coming months and years. By

1999, the Secretary will have information from which to recommend an entirely new payment system to the Congress.

Again, Mr. Chairman, this is an awful lot of material about an awful lot of issues in a very, very compressed timeframe. I apologize for doing this so quickly. Let me just say a couple of words by way of conclusion.

The first, is that our actuaries have projected that the net impact of all of these changes will be not to decelerate the growth of managed care in the Medicare program, but actually to accelerate it relative to the current baseline.

That is to say, under current law our actuaries project that, in the year 2002, approximately 19 percent of Medicare beneficiaries would be enrolled in managed care. They project that, under the President's budget, that number would grow to about 22.5 percent.

CBO disagrees with us on this. They believe that the net effect of the President's budget proposal on the rate of increase in Medicare managed care enrollment will be roughly a wash, that it will neither significantly accelerate or decelerate that trend.

But their baseline is higher, so CBO is also projecting that in the year 2002 somewhere just under a quarter of Medicare beneficiaries will be enrolled in managed care plans, under the President's budget proposal.

The second thing to say relative to that point, is that we are often asked the question of what the right proportion is or what the right rate of growth is in Medicare enrollments in capitated plans.

Our response is consistent, and I think an appropriate way to conclude my presentation this morning; we do not believe it is up to the administration, or up to the Federal Government at all, to determine what the right distribution of Medicare beneficiaries across different kinds of health care plans should be.

We believe that that decision should be made by beneficiaries themselves, making free choices with good information in the absence of any economic coercion or pressures from the Government or anyone else to make one choice as opposed to another kind of choice. We believe that it is our obligation to provide a level playing field, a really fair marketplace, and really fair choice with good information.

And then over time the beneficiaries themselves, in response to the ways in which plans compete in the marketplace, will determine what the final number is in terms of the proportion in various kinds of plans.

Again, I appreciate the opportunity to be here again today, and I am happy to respond to any questions Members may have.

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

The CHAIRMAN. Well, thank you, Dr. Vladeck. Let me say to the panel, we have, I think, two votes at 11:30, which is going to cut seriously into our time. So, we will apply the time limits very strictly today to try to get as broad an opportunity to all of the members as possible.

Yesterday, Dr. Vladeck, there was a story in the *New York Times* about Medicare HMOs limiting beneficiary appeals. The IG said that many beneficiaries are really never informed of their appeal

rights. It goes on to talk about an Arizona case, where the Federal District Judge ordered certain compliance standards for appeals.

Now, you have indicated that you will be announcing new regulations. How do they compare with what the court requires? Let me also ask you this. There has been criticism as to the enforcement of these rights, that theoretically they have certain appeal rights but no real action is taken to put any substance to them. What is your comment?

Dr. VLADECK. Well, let me answer those in order, sir. First, our lawyers participated in the discussions leading up to the settlement order in that litigation in Arizona. We are very comfortable with all of the specifics in that settlement order and, indeed, our new regulations to be issued in the very, very near future will be entirely consistent with the conclusion of the court in that instance.

Second, what the Inspector General found, and we would certainly agree with, is that a considerable part of the problem with beneficiaries agreements and appeals within managed care plans was beneficiaries' ignorance of what their rights were. We, in conjunction with the Inspector General, have already taken some steps in that regard.

We worked with the Inspector General on development and publication of a new booklet to be made available both to beneficiaries and to advocates very explicitly clarifying what beneficiaries' rights relative to grievances and appeals are, both in managed care and fee-for-service.

I believe we have already distributed close to a million copies of that booklet and additional printings are being run. We have talked to the managed care community about additional kinds of patient information. Some of these issues will be addressed in our marketing guidelines.

Again, we will take a series of regulatory steps to substantially improve all aspects of the grievance and appeals process, but with some particular focus on making sure that beneficiaries, at the time they enroll and periodically thereafter, have a very explicit, very clear description of what the processes are that are available to them.

The CHAIRMAN. Have any sanctions ever been applied for failure to follow through on that?

Dr. VLADECK. We have applied sanctions to some plans, but I do not believe that any have been specific to management of the appeals and grievance process.

The CHAIRMAN. Now, the chairmen of the PPRC and ProPAC told this committee that they believed that reducing the Medicare managed care payment rates from 95 to 90 percent is a rather crude way to address the problem of risk selection and that it could exacerbate the problem because plans would have even more reason to try to avoid sicker enrollees. Do you agree or disagree with that analysis?

Dr. VLADECK. Well, I agree in part and disagree in part, I guess. I think the incentive that plans have to select healthier patients is the same regardless of the specific payment level, although I must say that most of the favorable selection we see in Medicare managed care is not the result of some dire conspiracy on the part of the plans. It is a natural effect of the fact that younger, healthier

beneficiaries are more likely to either relocate to communities in which they do not have established relationships with physicians or to be willing to change their patterns of medical care in exchange for increased benefits as opposed to older and sicker beneficiaries who are much more likely to be in a web of well-established physician relationships that they are reluctant to abandon. So, one will get favorable selection even if the plans play it entirely straight.

Having said that, we would like a more sophisticated individual risk adjustment as the basis for the payment system. We anticipate that part of the report to Congress, we contemplate, roughly 24 months from now would be based on such a system.

We have never empirically tested such a system. While we have a growing body of research literature, we think it is a little bit early to go to more radical approaches to this favorable selection problem.

The CHAIRMAN. Are you familiar with a suggestion from GAO that recommended a method of improving Medicare payment rates by including HMO enrollees' estimated costs in computing county rates?

Dr. VLADECK. We have. We have a couple of very significant concerns about the GAO proposal. I am not sure that we fully understand it yet or that it has been entirely specified. But one concern that we have is that if you had two adjacent counties under the GAO proposal that were identical in every respect except that one county had a higher rate of Medicare managed care enrollment than the other, the GAO methodology would produce a significantly lower rate in the high enrollment county, which seems to us, at a minimum, as sort of a counter-intuitive kind of proposal. One suggests that, while there are some intriguing ideas here, we are not sure any of these is quite ready for prime time this coming January.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman.

I would like to just ask Dr. Vladeck if he could step back just a moment to recognize what is going on here. I had mentioned earlier the concept of the commodification of medicine and you, with hesitation, spoke about plans competing in the marketplace, and which are the lowest cost, and highest cost, and so forth.

In a pattern of American Government, once you get a big market going it usually is followed by a measure of Government regulation. You are increasingly becoming a regulatory agency, for good or ill. But note that and watch the patterns of over-regulation which can come so readily in that setting.

But one of the central aspects of markets is that they do not provide for public goods. They do everything else very well, but they do not provide for public goods. What Senator D'Amato and I have been talking about, and this committee has been talking about, is what are you going to do about the medical schools and the teaching hospitals in this market environment?

They are public goods and they need a specific provision. You have come up here with a familiar, incomprehensible—not you, sir—IME/GME/DHS/DSH carve-out. Huh? We have been talking about a medical education trust fund financed by a direct tax on

health care premiums. Very direct, very open, very clear. Why can we not get this through to the administration? The Secretary, I know, is sympathetic. But is it just too much of a new idea as against IME/GME/DHS/DSH carve-out?

Dr. VLADECK. Senator, it is not in that regard an especially new idea. We spoke about it in our testimony.

Senator MOYNIHAN. We think it is a new idea. It appeared in this committee 3 years ago. All right.

Dr. VLADECK. We understand that. I guess our continuing concern is not with the concept of a trust fund at all, it is that there are two issues that need to be addressed in the construction of a trust fund.

No. 1, is some sense of what the allocation rules are going to be, then what the process is going to be for making those allocations. Frankly, we do not think any part of the Federal Government is necessarily the appropriate place to do that.

No. 2, if one is talking about a tax on premiums, I must say that one is talking in the context of general discussions of a whole variety of revenue-related issues as part of a broader budget reconciliation process.

Senator MOYNIHAN. Dr. Vladeck, do you understand or do you not agree that medical schools and teaching hospitals, as a consequence the State of American medicine, are endangered in the consequence of an otherwise welcome introduction of market forces into health care?

Dr. VLADECK. No, there is no question that that is the case and that we need to address it.

Senator MOYNIHAN. All right. Good. I will stop right there.

The CHAIRMAN. Senator Kerrey.

Senator KERREY. Dr. Vladeck, do you support minimum quality standards for these risk contracts?

Dr. VLADECK. Yes, we do. I do not know if that is a term of art or just a generic term, but we certainly believe very strongly in strong quality standards.

Senator KERREY. In your testimony you are implying that you are developing some technical expertise to be able to evaluate quality, is that correct? I mean, this is a new field and that new research is being done to enable us to provide consumers with more information about quality.

Dr. VLADECK. Well, there are two pieces to that. Let me, first, Senator, emphasize that we are hardly alone or doing this by ourselves. We are working in very close collaboration with major private sector purchasers with the plans and with the academic community in the development of these measures. There is a lot going on.

There is an issue, a very important issue, of making information available to the public that overlaps considerably but is not identical to the issue of professional measures that professional experts would seek to apply to patterns of care. We need to move ahead aggressively on both.

Senator KERREY. I am told by the Peer Review Organization in Nebraska that encounter data is not required to be provided to them. How do you monitor quality without encounter data?

Dr. VLADECK. Well, over time we will need encounter data. Everyone agrees that we have been explicit about the need for encounter data. The issue is defining precisely what encounter data is. We are testing——

Senator KERREY. Can I interrupt you and ask you what you mean by over time, speaking of a term of art.

Dr. VLADECK. Fair enough. We are engaged in a set of experimental tests of various, somewhat different encounter data sets in a number of sites around the country. Those tests are going on now.

We are obligated under the Kennedy-Kassebaum legislation, under the administrative simplifications of that, to promulgate a series of uniform national data standards. By 1998, we would expect managed care encounter data to be one of the data sets that we would be seeking to standardize under those provisions. So we are talking about moving toward a standardized managed care encounter data set sometime next year.

Senator KERREY. Sometime in 1998.

Dr. VLADECK. Yes, sir.

Senator KERREY. And tell me, is it important to get a specific set of data standards that you have established, is that what you are saying, that that is why it would not work to require this encounter data today? If we required the encounter data today, what would be the negative consequence of that?

Dr. VLADECK. The major objections we would hear at the moment are twofold. First of all, some of the managed care plans with the most sophisticated and highest quality data systems and information systems would tell us that the standard coding techniques, the standard nomenclature that is used, the standard information that is applied, is very misleading and not terribly useful for the management of high-quality primary care, in particular, and that we need to add some additional codes or define some of the things differently in order to have data that is useable for really evaluating primary care or really measuring how they are performing.

Senator KERREY. Do you anticipate being able to minimize the regulatory costs so that there is no substantive argument coming in the other direction that would say you have got to factor in all costs of this and you are basically doing something that is going to drive up the cost of providing care by requiring plans to provide this contact data? Are you arguing that standardization will reduce regulatory costs?

Dr. VLADECK. Well, I think our obligations toward data standardization are in statutory language under a title described as administrative simplification, but it is our very strong belief, based on our experience, that the quality of data we receive from providers is directly related to the extent to which that data is useful to the providers themselves. That is to say, if the data means something in the management of a managed care plan, it will be of higher quality than if it is purely an external bureaucratic——

Senator KERREY. Well, I have an intense interest in this issue. I do think that the reporting of encounter data, and I understand the need to standardize it, but I think as soon as we can start to provide that, that there is apt to be some reduction in cost on the

taxpayer side as a result of reduced re-enrollment back into fee-for-service.

I mean, there are apt to be a lot of benefits that come from this. It is difficult for me to understand how markets are going to develop effectively if we do not have a sufficient amount of qualitative information upon which beneficiaries can make a decision about which plan they are going to select.

Senator KERREY. Thank you, sir.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Before I ask a question, I would make a point about the AAPCC. It would be, first of all, to thank the administration for seeing this problem and having a plan for reducing the inequity.

The second thing, would be to ask you and my colleagues to consider some other ideas about it that are floating around. One would be, rather than to have a flat-dollar threshold, to have a percent of the national average—I suggest 80 percent—to be the threshold.

I think, even with raising the threshold, still in some of the really low counties of the midwest and west you still may not have it high enough to get the choice in managed care plans in there. The whole idea is to give Medicare people some sort of choice.

And the second thing I would ask you to consider, and I am convinced that on my first point, that a percent of the national average is better than a flat dollar amount. On the second one, I am not sure, but I want to raise a point for your consideration.

That is, whether you use 80 percent of the national average or whether you use a dollar threshold, in some parts of the country we are going to still be on the margin of whether or not these managed care programs are available.

Now, if we reduce the 95 percent that is presently applied for reimbursing HMOs, we may also further make that more marginal. If you apply the 90 percent to very low-cost managed care plans, then you are making it even more marginal, whether you can get things started.

So I am also asking you to consider that maybe—until we get these plans started, that somewhere along the line for the lowest counties, whether you use the 80 percent average or a dollar threshold—you cannot apply the reduction to those. If you have an answer to that, that that is right or wrong, I would like to hear it. But if you do not have, I am just asking you to think about it.

Dr. VLADECK. If I may respond, Senator, and I will try to do it very quickly. There is a certain irony in that, in the President's Medicare proposals. In his health reform legislation in 1993 and 1994 we did propose a floor as a percent of the national average for the payment rates and were criticized for not addressing the problems in rural areas. Then the consensus developed around the dollar floor proposal, which we have now come around to supporting. But we are certainly willing to look at a percent of the average as an alternative.

Second, we also need to understand, I think, the extent to which the barriers to the development of managed care, particularly in rural or less densely populated communities, are not solely a function of the payment rate. They have to do with other obstacles that arise from the mere fact that they are less populated communities,

including our so-called 50/50 rule about the proportion of commercial enrollment, our minimum enrollment rules, that we will not do business with a plan that has fewer than 5,000 members, and some of the obstacles that now exist to starting up provider-sponsored networks.

In addition, the fact that a plan going into an area on a very small population base would have to be at full financial risk. We have specific proposals to reduce the obstacles to development of managed care in rural communities in each of those four areas as well. So, we would be happy to work further with you on those.

Senator GRASSLEY. All right. So in regard to your last point, your admonition to us is to consider that these supplemental things are going to help make up for the shortcomings of maybe HMOs not being able to get into some rural areas?

Dr. VLADECK. Well, what I am saying is, we have found in our conversations with HMOs and with rural health care providers that, while obviously the level of rates is a concern, it is not the only barrier to entry and we have to address those other barriers as well.

Senator GRASSLEY. Yes. I believe I agree with you on that point. If my ideas were accepted, I still would say we would have to do what you just suggested.

My question to you, and the only question I will have, is in regard to the fact that consumers are finding it very difficult to get information about Medicare HMOs. They do not have a lot of straightforward information about the plans' methods of treatment and out-of-pocket costs. Measurement of quality is kind of difficult and, in some instances, unavailable, and certainly not accessible for most lay people. We eventually want to get to a point where the consumer considers this as they choose alternatives for managed care.

I have heard concerns raised that some managed care plans are attracting healthy seniors. How are beneficiaries currently choosing plans? In conjunction with the lack of information I have already referred to, is it because of aggressive marketing campaigns, and what does HCFA do to monitor this? And should HCFA do anything to reduce adverse risk selection and, if so, what?

Dr. VLADECK. Most of the information beneficiaries now receive about Medicare managed care plans is marketing material from the plans themselves.

We do review every item of marketing material that is used by the plans, but our review historically has not been very stringent. We have had no guidelines. We will be, within the next few months, issuing uniform national guidelines for marketing material for Medicare managed care plans.

Nonetheless, it is still critical that we develop and build on some of the activities of independent, third party organizations to provide unbiased information and counseling to Medicare beneficiaries about their choices. I think in your next panel you will hear about some early efforts.

Even if we do all of those things, however, the problem of risk selection will continue and needs, over time, to be addressed, not through regulatory mechanisms, but through appropriate pricing adjustments.

The CHAIRMAN. Senator Bryan.

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

Dr. Vladeck, as a follow-on to the Chairman's first question with respect to the issue of appeal. My understanding is that HCFA is in the process of developing some regulations, if I am correctly informed.

My question is twofold. No. 1, when will the regulations be out, and second, will the regulations, when promulgated, include a finite time period for resolution of issues raised on appeal?

Dr. VLADECK. I can answer the second question much more precisely than the first. The answer to the second question is, yes, absolutely. The major thrust of the first part of the new regulations we will be issuing is to provide for an expedited appeal process, with very short timeframes when there is some question of medical or clinical urgency associated with the issue being appealed.

Precisely when those regulations will be published, I wish I could answer as exactly. I would say within the next few weeks, but I cannot, because I do not know, answer more precisely than that.

Senator BRYAN. I presume that the sky will burn and the earth will cleave at some point then in the next 30 days. Would that be a reasonable time period?

Dr. VLADECK. If it does not, I will be terribly disappointed and surprised.

Senator BRYAN. I thank you.

Now, changing the focus to the provider sponsored organizations, and the issue of solvency standards. We had some experience in Nevada in the late 1980's with physicians organizing HMOs that became insolvent in a very short period of time. My question is, No. 1, what kind of solvency standards should be required; should they be comparable to solvency standards of HMOs?

No. 2, in terms of any kind of regulatory regime, what are your own thoughts, should it be done at the Federal level, should it be done at the State level, should we have some kind of Federal standards where that enforcement is delegated to the State level? Could you share your thoughts with me, please?

Dr. VLADECK. Yes. Perhaps in not quite the order of your questions, sir.

Senator BRYAN. Any order. That is fine.

Dr. VLADECK. First, we believe that there ought to be a set of very strong Federal standards, but that, by and large, in the great majority of instances in which States have comparable or stronger standards, the administration and enforcement relative to specific plan performance standards and plan characteristic standards should be administered by the States.

This is, in fact, the model we now use, by and large. It is the model that we have used very successfully with Medigap regulation. For a variety of reasons, the capability of the States to regulate health insurance and health insurance plans has increased very considerably in the last decade or so, and we are very comfortable with that general model.

Senator BRYAN. So you would have a Federal minimum, but the States could have a higher standard if they chose to do so?

Dr. VLADECK. That is correct. And if the State standard were identical to the Federal standard, we would defer to them as well

if we were satisfied they were actually enforcing their standards. That is the scheme that is laid out in the President's budget proposal.

In terms of solvency let me just say three things. First, the National Association of Insurance Commissioners has had a major committee working on new standards for so-called risk-based capital for all health plans, which expects to issue its final report in the next number of months. Our thinking about the precise definition of standards for all managed care plans, solvency standards, will be very much affected by the results of that. They are doing some very sophisticated work.

Second, it is probably true that our solvency standards, in general, are not high enough. That is one reason we are waiting for the NAIC standards.

Third, there has been a considerable——

Senator BRYAN. May I stop you there, Doctor, just to follow up on a point, if you will just hold your thought. The standards that NAIC is promulgating may, indeed, be very good, but they are not self-executing. NAIC, as you know, is an umbrella group, but does not have the power to require States to, in fact, enact anything by legislation or regulation at the State level.

Dr. VLADECK. That is true. But, again, we have the authority. It would be somewhat clarified under the President's budget proposal to adopt an NAIC standard as the Federal standard, and then States which adopted the same standard, we would basically defer to them in their administration of the standard.

Senator BRYAN. I see. All right.

Dr. VLADECK. The hospitals and other provider groups have expressed concern that, in the evaluation of solvency, certain assets, particularly hospital assets that are available for the provision of medical care, may not be fairly evaluated when compared to financial assets of insurance companies and so forth, and that there does need to be some way of equating those two. We have considerable sympathy with that argument and would propose to permit alternative measures of solvency for provider sponsored networks.

I must say, however, that based on where most State solvency standards are at the moment and where the financial positions of most hospitals are at the moment, that any provider sponsored network, of which a hospital was an integral part, we do not believe will have significant difficulty meeting existing across the board standards. But we are prepared to look at specialized standards for PSNs which have major nonfinancial assets involved in the delivery of medical care.

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

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Thank you very much, Mr. Chairman.

Dr. Vladeck, first of all, let me say that the Governor's office informed me that yesterday New York State received its approval of section 1915 waivers.

Senator MOYNIHAN. No.

Senator D'AMATO. Yes. Well, that is the little one. That is the little one. But that is something. So, that is good. I guess they knew you were going to be here today.

Dr. VLADECK. I do not believe the Governor's office did, sir.

Senator D'AMATO. Well, the Governor's office informed me, but I guess your people knew you were going to be here again today. But that brings me to the important one. Now, tomorrow—and that is when another panel is going to be testifying on this issue—marks the anniversary of the application. Do you know what anniversary?

Dr. VLADECK. I believe it is the second, sir.

Senator D'AMATO. Second what?

Dr. VLADECK. Second year.

Senator D'AMATO. Second year, not second month. Two years. Now, look. I think you have done an extraordinary job in a very difficult area on many occasions, answering the call, taking on criticism. Criticisms, I do not think, were justified. People just did not know. I think when people do not know they raise questions, but they should not be critical right off the bat.

I am talking about, I think, the ground-breaking effort, pilot program, which is quite a significant program as it relates to the hospitals and teaching hospitals in New York. I think when people look at it, it is a win-win.

The government saves money, it is not going to cost them money, and it is going to set the stage for even further reductions, both on the Federal and State side, and it will deal with the problem of whether or not it exists, but at least people seem to say that we are educating too many doctors. So I think you should be applauded. If I came from another State, maybe I would not say that.

But the fact of the matter is, I do come from New York, where this plan is going to be implemented. I really do think, if most people look at it logically, you can see it is a win-win and other States will probably pursue similar applications.

I do not know why they have to be dissimilar. I just throw that out. If it is good in one area and will apply and make sense and it is in Texas or California, why not give them that opportunity? It seems to me it is well-grounded in logic and the formulas are there to protect the taxpayer from any abuses. So, I applaud you for that.

But, by gosh, tomorrow is going to be 2 years. We are talking about managed care waivers. This is wrong. Now, Secretary Shalala was here last year. Oh, something is going to be done. Something is going to be done.

Senator Bryan talked to you about, when do we think we are going to get these new rules as it relates to letting people know about the appeal process within 30 days. Well, let us hope that is the case. But we are talking billions of dollars. I do not like hearing it bantered around, and New York has become the butt of criticism, attacked, some of it almost venal, by Members of the Congress as it relates to a bloated bureaucracy, system, et cetera, and the high cost.

Now, maybe some of that is fair. But it is certainly unfair if we are not given the tools to begin to reduce those costs. This is one of the most significant ways in which we can do it. Now, when are we going to get the waiver?

Dr. VLADECK. Well, Senator——

Senator D'AMATO. I am not going to stop, you know.

Dr. VLADECK. Senator Bryan used analogies about the sky turning color and the earth cleaving within the next 30 days. My un-

derstanding is, because, as you know, I have not been directly involved in that, that is a very reasonable timeframe for the New York 1115 waiver as well.

Senator D'AMATO. Within the next 30 days?

Dr. VLADECK. I believe so. Yes, sir.

Senator D'AMATO. Well, on that note, I will rest.

[Laughter.]

Dr. VLADECK. And if, 29 days from now, it has not yet happened, I will be on the phone to you, sir.

Senator D'AMATO. Thank you very much.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. Vladeck, I echo a lot of what Senator D'Amato has said about your job, which I think is one of the hardest in Washington. I think you have done very well and you have fought and you have tried to make reforms within HCFA. All of that I respect very much, and you know that because I have told you that directly.

Because you are not going to be here tomorrow on PSOs and you will not be testifying on that, I wanted to ask a couple of questions, because the Administration has included a PSO proposal in the President's budget. Dr. Frist and I have introduced a PSO bill which we think is better. We include in ours more specific quality and solvency standards.

I believe in your proposal that you deferred State licensure for the preliminary period, which is 2 years in your case and 4 years in our case, and that the Secretary would issue regulations during that time. Our bill is more specific.

Now, there have been a lot of concerns raised, and I share them, that Federal legislation allowing HCFA to directly contract with PSOs will exempt those same PSOs from a variety of consumer protection standards. The legislation that Senator Frist and I have authored would not exempt.

So my question to you is the following: Would the administration bill exempt PSOs from consumer protection in the following areas, and does Medicare currently require HMOs to meet specific standards in these same areas: marketing and enrollment—we can do it one by one, if you want.

Dr. VLADECK. I believe, if I understand correctly, that Medicare HMOs now must meet requirements in that regard and PSOs and PSNs, under our bill, would be required to meet the same standards from day one.

Senator ROCKEFELLER. All right. Access and benefits.

Dr. VLADECK. The same situation.

Senator ROCKEFELLER. Quality of care.

Dr. VLADECK. We are proposing in our bill, again, an across the board change in the nature of the Medicare HMO quality standards. The same quality standards would be applied in the President's bill to HMOs and PSOs.

Senator ROCKEFELLER. Grievances and bills. That has been referred to.

Dr. VLADECK. The same. It would be the same standards.

Senator ROCKEFELLER. Yes. Information to enrollees.

Dr. VLADECK. It would be the same system. In our proposal, which addresses issues that just are not addressed in your bill, sir,

there is more provision for third party information and counseling activity.

Senator ROCKEFELLER. All right. Business operations that is separate from solvency.

Dr. VLADECK. I do not know that we have a separate category to that effect. I think there would be some differences in standards during a phase-in, but I am not entirely clear what would come under that rubric.

Senator ROCKEFELLER. All right. Data collection and penalties.

Dr. VLADECK. That would be the same.

Senator ROCKEFELLER. All right. Blue Cross/Blue Shield issued a report, interestingly, yesterday that said, "Medicare is not the place to road test unlicensed PSOs." Their report targets rural PSOs as being especially risky for the Medicare program.

Now, a few weeks ago CBO, quite to the contrary, said that PSOs held a great promise for rural areas as a way for managed care, which is not spreading rapidly, to be able to spread somewhat more rapidly. You are the administrator of HCFA. What can you say about how PSOs would be approved by HCFA if PSO legislation was enacted that created a temporary Federal certification process?

Dr. VLADECK. Well, Senator, let me say several things, if I may. First, we are road testing PSOs right now as part of our Medicare Choices demonstration. We have, I believe, three or four up and running. We will eventually have 11. So, prior to the enactment of any legislation, we will have had real experience with direct contracting with PSOs in the Medicare program.

Second, we have provided in our proposal for a 2-year period in which we could directly evaluate the qualifications of PSOs for Medicare participation and directly enforce standards presumably during a time when there is considerable change going on and a lot of movement in the same direction in the State regulatory processes.

As an administrative issue, it would be a formidable one for us, but I think we could find a way to meet it. We think, not only in rural areas, but in metropolitan areas where we are moving toward the market with just two or three HMO-based competitors, this would also be a way of opening up competition even further, expanding choices, and maybe creating some of the other benefits of competition.

So we would hope, by the time we are done with the legislative process this year, that we will have had some real experience contracting with PSOs, have had the better part of a year's worth of experience in watching them operate, and be ready to go on implementing new provisions.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to ask two sets of questions. First, is on the method of compensation of HMOs. Am I correct in assuming that you would intend to apply the same compensation processes to the PSROs that you are now doing to the HMOs?

Dr. VLADECK. Yes, except that we are making available to HMOs the ability to offer beneficiaries so-called "point of service" options

or additional parts of their plan that permit them to get some insurance coverage when they go to out-of-plan providers.

We think, and we have some disagreements with the provider community on this, that to do that in a PSO kind of setting would be kind of dangerous because it is just too manipulable by a PSO. So we would not offer the same kind of arrangement with out-of-network supplemental point of service packages. Apart from that, the payment methods would be the same.

Senator GRAHAM. As you and I have discussed over a period of time, I have had some serious concerns about the rationale of using a percentage of fee-for-service within a catchment area, generally a county, as the basis of HMO reimbursement. What other large-scale users of HMOs, such as local governments, State governments, private employers, use the percentage of fee for service as the basis of compensating their managed care provider?

Dr. VLADECK. Well, I believe, Senator, that historically most purchasers, when they first begin contracting with HMOs, tend to set prices relative to what has been the prevailing market price for indemnity style or fee-for-service insurance and that, as best we can tell, the major method of pricing HMOs in the private sector and increasingly in State Medicaid programs is really just prior year plus a negotiated rate of increase. That is where most of the action is occurring these days.

Of course, over time that base becomes less and less connected to the historical fee-for-service rates. So there are some somewhat more technically sophisticated approaches. Some State Medicaid programs are actually using very detailed actuarial analyses of actual HMO costs. But, by and large, the prevailing pricing system in most of the country for larger purchases is last year, plus or minus a percentage.

Senator GRAHAM. Why has Medicare not explored more aggressively some of the other alternative means of compensation, such as, I understand California directly negotiates for its State employees' HMO plans, their examples of competitive bidding for HMO plans?

It seems to me as if we are sort of stuck with this one methodology that, on its face, does not appear to be very rational and does not capture to the Federal Government's reduction in costs some of the benefits of managed care.

Dr. VLADECK. I think that is a good question. I cannot speak for why the executive branch did so little work on alternative payment systems prior to this administration, but we have been moving very aggressively in a number of ways.

We are going to be testing competitive bidding in the Denver market over the next number of months. We have done a lot of research with other pricing methods, other risk adjustment methods, and have talked throughout the managed care community.

On a number of occasions since 1993, we have made an offer to the HMO community that we would test any alternative payment system they would propose to us, as long as it had a reasonable shot at being budget neutral.

Senator GRAHAM. But it seems to me, if I were the HMO community, I would not be advocating any changes. It would seem to me the system they have got now is ideal. They get 95 percent of fee-

for-service, and then are able to use effective marketing techniques to essentially skim off the least expensive component of the Medicare population. So I do not see that they would have any incentives to advocate anything other than the status quo.

Dr. VLADECK. That appears to be the case. That is why we are not only moving ahead with a competitive bidding demonstration that the industry is not supporting particularly enthusiastically and with research on risk adjustment, but we also have in the President's proposal authority to use negotiated rate-setting, alternative pricing mechanisms, and so forth.

Senator GRAHAM. Why do we have to, for instance for competitive bidding, set up our own demonstration? Why do we not take advantage of the experience that other large employers have already gained in competitive bidding and move more aggressively to alternative compensations?

I understand the President's proposal is to basically keep the current system with some adjustments, deleting some items from the 95 percent base, reducing the percentage gradually to 90 percent, putting in a minimum floor, but essentially the architecture is the same, we are just readjusting the furniture in a few rooms. I do not think the architecture has served us well, and I would not be happy to think that we are going to be living in this same home 5 years from now.

Dr. VLADECK. Well, again, Senator, I understand exactly what you are saying. At the current time, the only way we can do competitive bidding is under our demonstration authority.

We are seeking more general authority to do it, and we do lay out a plan in the President's budget that is not a 5-year plan, it is a 3-year plan, to come up with a whole new system. Frankly, I do not think we are ready to do it much more quickly than that.

Senator GRAHAM. Well, that is a distressing concluding comment.

Senator MOYNIHAN. Mr. Chairman, could I just make one comment to Dr. Vladeck, and thank you for fine testimony. I would hope you might have in mind that the nature of the work of HCFA—sounds like something you could get a diagnosis for—that you are turning from an administrative role, providing health care payments to a designated portion of the population, and you are turning into a regulatory agency that is regulating a sector of the economy, the medical sector.

This is a great transformation. If it goes unheeded at a conceptual level, you are going to have an awful lot of trouble. You have heard it from Senators here. In New York, just the example Senator D'Amato raised, 2 years ago the State asked to extend the use of alternative pricing mechanisms, or whatever they are called, HMOs. It has taken 2 years.

That is about where the Interstate Commerce Commission was on a railroad merger after about 50 years. It would easily take 2, 3, 4 years, or take a generation to get a decision. In the end, they abolished the ICC.

Over-regulation. There are patterns to Government activities of this kind. I would just urge you to think of that. Go off for a weekend with the American Academy of Public Administration and say, tell us the difference between a regulatory agency and an administrative agency.

Dr. VLADECK. Mr. Moynihan, if I may, we have given this a lot of thought. We are a regulatory agency already. We have always been one. But we have a somewhat different obligation, because not only are the 70 million beneficiaries in the health care market for whom our programs provide insurance in need of a fair market, but we have a special obligation on their behalf.

And we are not merely regulators, we are purchasers on their behalf. We are not only, like the Interstate Commerce Committee, saying the rules of the road, we have a 30 percent market share as purchasers in this market. It makes the role a little bit more complicated. It means that the purchasing function is related to the regulatory function. We have given it a lot of thought, and we would be happy to talk to you further about it because there are some very important questions involving that.

Senator MOYNIHAN. That is a very encouraging response. You might want to divide those functions. Think about it. You are thinking about them in that way, and that is very much to your credit and is not surprising at all to me.

Dr. VLADECK. Thank you. We would be happy to talk about it further. We have some further ideas we would like to talk to you about.

Senator MOYNIHAN. Thank you.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thanks for having the hearings. Dr. Vladeck, welcome back.

I would suggest to my good colleague, Senator Graham, who made the very astute observation that it is very frustrating to see what we cannot do with this system, and I think it goes back to what the Chairman said in his opening comments.

It is because we are trying to make fit into 1997 a system that is a 1965 variety. It was good in 1965, it worked in 1965, and it made some terrific, enormous contributions to the health and security of this country. But it simply does not fit in 1997.

I, for one, have become so frustrated with the current Medicare system that I am absolutely convinced that we cannot tinker around the edges any longer. We can no longer use the Band-Aid approach to fix it, we can no longer use what I would call a nip and tuck type of process of trying to get costs in line to save the system. It just will not work.

What we are doing in this proposal essentially is to say we are going to do the same nip and tuck we have done before. We are going to nip the doctors, we are going to tuck the hospitals, and hope to heck we can get past the next few years. That is not fundamental reform.

I would just suggest that you are hamstrung. You cannot do things that you ought to be doing because the law was written in a way that does not allow you to do it. It only allows you to regulate, regulate, and regulate.

And I am really concerned that with more reductions in provider fees we are going to be fast reaching the point where professional medical care people and providers will no longer want to deal with Medicare patients because they do not get reimbursed a sufficient price in order to take care of their services. Instead of helping seniors, we are going to be penalizing them by simply creating a sys-

tem where there are no longer any doctors willing to perform the services.

So I am absolutely tired of meeting with providers, telling me that I have to make a decision on what type of colon cancer screening should be done, whether it should be a barium enema or whether it should be a colonoscopy. I do not know. Yet, I have got people coming to me to try and talk to you to get you to pay for it. That is micromanaging to the nth degree.

Then coming just recently saying, why does HCFA not pay for the oral administration of this drug which is more efficient, cheaper, better for the patient, but they pay for it if it is IV-administered? We are not capable in Congress of making that type of decision.

So I am convinced that we just cannot make this round peg fit in the square hole the way it is currently structured. We are headed for a disaster and it is going to be absolutely critical for those of us in Congress to stand up and say to seniors, that we are going to have to give you a better plan, a better structure, a 1997 model instead of a 1965 model.

My thoughts are that we have, as Members of Congress, as Members of the Senate, which everyone here is, a very good plan, it is very efficient and the cost increases are substantially less each year than we have in Medicare. So I think that the Federal Employees Health Benefit plan is one that we should look at, trying to incorporate in for Medicare patients instead of HCFA—how many people work in HCFA?

Dr. VLADECK. About 4,000, sir.

Senator BREAUX. How many work in OPM doing the Federal Employees Benefit package?

Dr. VLADECK. A very small number.

Senator BREAUX. Maybe 100?

Dr. VLADECK. I do not know what the number is.

Senator BREAUX. Two hundred or less. I think that we have got a range of policies, we have got options. There are minimum standards. OPM gives us information. Our families can help us with the information. We can do other things that will avoid the problems with adverse selection and what have you. What are your thoughts about saying, look, let's wipe the slate clean and, for 37 million seniors, consider something—the whole statement, there is a lot to it.

When I go back home I say to my seniors, look, I would like you to have the same health care package that I have. They just think I have got to have the best in the world, because I wrote it, or I generically wrote it. What is the problem with trying to move in that direction and giving people like yourself some flexibility to do some things that make sense?

Dr. VLADECK. Well, let me just say a couple of things, if I may, Senator. We think there are large parts of the FEHBP model that are, in fact, contained in the present proposal. The structured annual open enrollment——

Senator BREAUX. With all due respect, you have to get a microscope to find them.

Dr. VLADECK. Some of that is a function of the question that was acknowledged before of when the statutory language was going to be there.

Senator BREAUX. That is right.

Dr. VLADECK. But I think that is laid out pretty clearly. Some of the ways in which that choice process works, the availability of consumers of information——

Senator BREAUX. I appreciate that. But I am talking about a fundamental change here.

Dr. VLADECK. Well, but let me just, if I could, sir, say a couple of things. One, is one of the reasons OPM has so few people administering the programs is because, by law, they use our rates. OPM plans——

Senator BREAUX. OPM does not set rates.

Dr. VLADECK. OPM negotiates prices with plans. Those plans, on the indemnity plan or on the network plans, are permitted by law to use Medicare fee schedules and Medicare hospital prices as payment to providers, and the providers must accept them as payment in full. The Medicare program does a lot of lifting for the private insurance plans in the FEHBP system in terms of establishing the parameters for the rates they pay providers.

Senator BREAUX. My time is out. But I just think we are strangling to death in a system, and there is no way out by tinkering around the edges. As bold as we were in 1965, we should be in 1997.

Dr. VLADECK. If I may just say one other thing. The issue of what procedures are covered, what technologies are covered, who decides whether a new drug or a new procedure is covered, is a problem that we are in constant conversation with the managed care plans on, because moving to a very different kind of model, like FEHBP or something like that, does not solve the problem, as some of the current controversies over treatment of breast cancer or management of other sorts of diseases suggest. We need a mechanism to take out of the hands of both Congress and the executive branch some of this decisionmaking about what ought to be covered, but the problem does not go away.

The CHAIRMAN. I would say to the distinguished Senator, you are singing my song. I have been a longtime believer that the Federal health plan provides precedent that is needed for reform.

Our time is running out, so I am going to ask that any additional questions be submitted in writing. We will keep the record open until 5 p.m.

Dr. VLADECK. We will respond as quickly as we can.

The CHAIRMAN. We appreciate your being here today.

Dr. VLADECK. Thank you very much, Mr. Chairman.

[The questions appear in the appendix.]

The CHAIRMAN. We have an additional panel. I understand votes are going to start in 5 to 8 minutes. But I thought if we could call the panel forward and get started on their statements, that would be progress.

On our new panel, our first witness is Diane Archer, executive director of the Medicare Rights Center in New York. Our second witness is Mary Lou Martin, general manager, senior services, Blue Cross of California. Ms. Martin is testifying on behalf of the

Health Insurance Association of America and the Blue Cross/Blue Shield Association. Finally, we will hear from Michael Thompson, managing director, Employee Benefits Services, Price Waterhouse, testifying on behalf of the American Academy of Actuaries.

It is a pleasure to welcome each and every one of you. I would ask that you keep your statements to 5 minutes, and your full statement, of course, will be included in the record.

We will start off with Diane Archer. Ms. Archer.

STATEMENT OF DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE RIGHTS CENTER, NEW YORK, NY

Ms. ARCHER. Thank you. I thank the Senate Finance Committee for this opportunity to testify on consumer protections in Medicare managed care. As you mentioned, I am the executive director of the Medicare Rights Center, a national not-for-profit based in New York City.

Medicare Rights Center assists seniors and people with disabilities on Medicare through telephone counseling and public education. I also serve as a member of the Medicare subcommittee of the National Committee for Quality Assurance.

People enrolled in Medicare HMOs have far too few protections and too little information to ensure that they will receive the care they need and the coverage to which they are entitled. Our Medicare counseling hot-line is deluged with calls from people who cannot distinguish among Medicare HMOs. They cannot make a meaningful choice in HMO enrollment.

HMOs have great potential to serve patient interests, but without regulation, oversight, and disclosure of useful information Medicare HMOs have strong financial incentives to avoid delivering costly care.

Of the many cases I could report, let me give you this one to illustrate key issues in Medicare managed care. Mrs. H, one of our clients, was hospitalized for a brain injury. Her doctor advised her to get further treatment at a rehabilitation facility. The facility approved her admission, but the HMO denied the service. It claimed it was unnecessary. The HMO failed to issue a denial notice. On advice of her doctors, Mrs. H disenrolled from the HMO and she secured the necessary services through traditional Medicare.

Let me add that she had enrolled after an HMO breakfast that persuaded her husband that she could get all Medicare benefits at less cost through this HMO.

There is mounting evidence that some of the sickest Medicare HMO enrollees who need quality care the most have worse health outcomes than people with similar illnesses in traditional Medicare. Patients with complex and costly conditions particularly need safeguards in Medicare HMOs.

Hundreds of our clients have asked for help in contesting improper denials of Medicare-covered services, wrongful refusals to refer for necessary specialty care, and illegal failures to notify enrollees of their appeal rights.

My testimony focuses on three areas. HMOs, first, must compete on quality, not simply on cost. HMOs must disclose intelligible, reliable, and standardized performance data and HMO enrollees must have effective appeal and disenrollment rights.

As to competing on quality, Medicare HMOs today compete only on cost and coverage. There is no information available to people on Medicare which can help them distinguish among HMOs by quality. Even the professional insurance counselors on my staff are unable to identify quality differences among plans based on the data available today.

In an attempt to help consumers distinguish among plans, Medicare Rights Center obtained from New York HMOs answers to a 90-question survey. Unfortunately, the information was not useful in helping to choose among HMOs by quality. Some of the information is appended.

HMOs uniformly refused to provide key information. In order to protect present and future Medicare HMO enrollees, HMOs must have a financial incentive to attract and retain enrollees with complex and costly health care needs.

As you have heard earlier, and you know, HMOs have an incentive to cherry pick only the healthy or less expensive enrollees, causing the Medicare program to lose, not save, money on HMOs. HMOs must be compelled to disclose reliable information on their medical treatment guidelines, appeals, and disenrollment, and HMOs must be more closely monitored and penalized for failing to deliver the care that they promise.

Second, HMOs must collect and report plan information in a standardized form. Medicare HMOs neither collect nor report data on quality, benefits, and out-of-pocket costs in a form which is useful for consumers choosing among them.

Different HMOs use different methods for collecting and reporting data. Consequently, many comparisons are impossible to make. Some HMOs collect very little data at all. Efforts of the National Committee for Quality Assurance to collect information should be commended. However, NCQA's performance data is largely self-reported by HMOs, unaudited by outside reviewers, and inconsistent because HMOs use different methods of collecting data. HMO information must be standardized, audited, and disseminated in forms that Medicare consumers can easily use.

HMOs should be required to collect and report utilization, outcome, and patient encounter data, appeal and grievance data, disenrollment rates, and consumer satisfaction data, among other data.

This information should be made easily available, and for greater comparability among HMOs it seems reasonable to standardize HMO benefits, just as Congress standardized Medigap benefits several years ago.

Finally, Medicare HMO enrollees require effective appeal and disenrollment rights. At Medicare Rights Center we find that few clients who are enrolled in HMOs know how or when to appeal, that HMOs frequently do not issue appeal notices when they should, and that the appeal process can be too protracted for patients in urgent need of health care services.

People on Medicare today must have effective rights to appeal or opt out of poor quality care. They need the right to leave a Medicare HMO on a monthly basis. Further, they need notification of their appeal rights with each patient encounter, just as bene-

ficiaries in traditional Medicare receive this notification through the explanation of Medicare benefits.

In addition, they need expedited appeals in cases where care is urgently needed. Finally, they need to be able to purchase a Medicare supplemental policy at a reasonable cost if they choose to return to traditional Medicare. Thank you for your time and interest. I would be happy to answer your questions.

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

The CHAIRMAN. Thank you, Ms. Archer.

Ms. Martin.

STATEMENT OF MARY LOU MARTIN, GENERAL MANAGER, SENIOR SERVICES, BLUE CROSS OF CALIFORNIA, LONG BEACH, CA, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND THE BLUE CROSS/BLUE SHIELD ASSOCIATION

Ms. MARTIN. Good morning, Mr. Chairman and Members of the committee. I am Mary Lou Martin from Blue Cross of California, representing both Blue Cross and Blue Shield Association, and the Health Insurance Association of America. We thank you for the opportunity to testify before the committee on Medigap and other Medicare issues.

Blue Cross of California is the largest provider of Medigap Medicare-select coverage in California, covering almost half a million seniors who have either purchased their coverage individually or have employer retiree health benefits.

The Blue Cross and Blue Shield Association and the Health Insurance Association of America are pleased that the committee is considering ways to expand Medicare to make available the same kind of health plan choices provided to working Americans that have enabled real cost savings in the private sector.

The administration and some Members of Congress are proposing changes to the Federal laws that regulate Medigap. These proposals will increase premiums and transform a well-functioning Medigap marketplace to one characterized by serious problems and the rush of some to create a revolving door for the few Medicare beneficiaries who want to switch back and forth between HMOs and fee for service. We must ask whether we are placing at risk the private Medigap market that provides easily accessible and reasonably priced products.

Before discussing our specific concerns, it may be helpful to review some important facts. First of all, the Medigap marketplace is working well today. Access is extremely high, with 90 percent of all Medicare beneficiaries in the fee-for-service program protected by supplemental coverage according to the PPRC. Ninety-seven percent of all beneficiaries say they are satisfied with the Medigap policies according to a recent HCFA report. Insurance commissioners report few complaints.

All seniors, regardless of their health, have a 6-month opportunity to choose the plan of their choice from any company when they first enroll and, if seniors want to switch coverage after a 6-month period, a recent GAO report found that they can, since all seniors in the country have access to one or more Medigap plans.

Medigap policies are required to meet stringent consumer protection requirements. Benefit policies must conform to 10 standard packages. Marketing standards prohibit insurers from selling Medigap policies to people who already have one.

All policies are guaranteed renewable, meaning they cannot be canceled even if the person moves out of State. Preexisting condition waiting periods are limited to 6 months and cannot be imposed if a continuously insured subscriber switches plans. Congress needs to be cautious in legislating new provisions.

I must emphasize that older Americans are very sensitive to price increases. They usually live on fixed incomes, and many cannot afford large premium increases. The administration's Medigap proposals will, without a doubt, significantly increase Medigap premiums and Medicare spending.

The key problems are, No. 1, community rating. Requiring insurers to charge the same price to everyone will mean that most Medigap insurers will immediately send to bill younger Medicare beneficiaries for larger premium increases. This premium shock is likely to cause these younger beneficiaries to drop or postpone coverage, leaving the oldest beneficiaries with ever-increasing and unaffordable premiums.

No. 2, annual guarantee requirements will fuel adverse selection by providing incentives to Medicare beneficiaries to postpone purchasing or switch plans based on their own health care needs. This will most certainly increase not only Medigap costs, but Federal spending on Medicare.

Recent announcements by the PPRC show that individuals who rapidly disenroll from HMOs cost 60 percent more than average. Moreover, CBO testified before Congress, saying the Administration's proposal will encourage disenrollment of sicker individuals, causing Medigap premiums to increase.

No. 3, mandatory enrollment of high-cost end-stage renal and disabled individuals will also result in higher premiums for seniors. ESRD beneficiaries are particularly expensive, costing nine times as much as seniors.

These high costs are the reason that this is the only illness that triggers Medicare eligibility. Combining these proposals will increase premiums, disproportionately impact rural areas, reduce choice for beneficiaries, and destable the entire Medigap market. The bottom line, Mr. Chairman and Members of the committee, is that all experts will agree that these proposals will make Medigap policies more expensive.

People may disagree on the magnitude of these price increases and they may vary by insurer and by State, and will depend on the dynamics of a given marketplace. However, there most certainly will be premium impacts. Because of these premium increases, some Medicare beneficiaries will be forced to drop their Medigap coverage.

We, therefore, urge you to proceed cautiously. While we have expressed serious concerns here today, our organizations want to work closely with the committee as you consider these proposals to ensure that the Medigap market continues to provide wide access at affordable prices.

As mentioned earlier, I would like to conclude by mentioning that the Blue Cross and Blue Shield Association has commissioned a series of studies looking at PSO issues. Just today, the association had released a new report conducted by the Barents Group, concluding that unregulated PSOs are extremely risky for rural America.

Thank you for your time.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Mr. Thompson.

STATEMENT OF MICHAEL J. THOMPSON, MANAGING DIRECTOR, EMPLOYEE BENEFITS SERVICES, PRICE WATERHOUSE, L.L.P., NEW YORK, NY, ON BEHALF OF THE AMERICAN ACADEMY OF ACTUARIES

Mr. THOMPSON. Yes. I am speaking today on behalf of the American Academy of Actuaries. The academy is a nonpartisan group that assists the public policy process through the presentation of clear, objective analyses.

We are very glad to provide comments on the administration's proposal to reform Medicare and provide additional choice. We have been specifically asked to comment on three areas: adding Medigap access provisions, including provider sponsored health plans in the Medicare program, and changing the managed care reimbursements.

The academy recognizes that, in the current situation, there is a significant degree of access to coverage in the Medigap area. The 6-month enrollment period when first eligible does permit people to get into the system today. At the same time, there are preexisting condition exclusions which do limit some access.

There is concern, however, that if the open enrollment requirements are liberalized, that this can lead to higher premiums for Medicare supplement plans, reduced market availability of the richer Medicare supplement plans, those with drug coverages, for example, and increased cost of the Medicare fee-for-service plans. Increased cost in the Medicare fee-for-service plans will come as individuals in the Medicare risk managed care plans migrate back to the Medicare plan.

The recent study by the Physician Payment Review Commission showed that individuals enrolling in Medicare risk in the 6 months prior to enrollment had costs about 63 percent of average, but individuals disenrolling from the Medicare plan had costs 160 percent of the average individual enrolled in Medicare. So, I think the issue of anti-selection is an issue that needs to be addressed head on.

Some of the ways that that could be minimized as we look to modify the open enrollment provisions, is to apply provisions that limit the time period and frequency of those open enrollments, limit the open enrollments to comparable or lesser benefits, limit the open enrollments to previously insured individuals, and apply those provisions universally across all carriers.

In the issue related to provider organizations, there are two key areas that we think need to be considered. First, is the issue of anti-selection. In offering additional multiple choices, you are opening the door for additional anti-selection.

But probably a more specific concern that we would raise is the issue of provider organizations who have intimate knowledge of the health status of the individuals that they take care of, and the ability of those providers somehow to influence the decisions they may make in the choices that they take. That could potentially add to the anti-selection issue.

Beyond that, from a solvency perspective, the academy has worked very closely with the NAIC to develop solvency standards that apply universally across all health care organization entities. The academy feels very strongly that the solvency standards should not vary by the nature of the legal entity, but rather by the risk that those entities are assuming.

The academy has also recently published a paper that was shared with the NAIC on the liquidity issue as it relates to health care assets. Again, I think that is a very complicated issue that I think was brought up earlier by Mr. Vladeck.

Finally, in terms of managed care reimbursements, the academy feels that the changes that are proposed will not address the underlying inequities in the system, and supports looking into modifying the length for fee-for-service payments and modifying the existing risk assessment methodology. The actuarial profession has done research in this area.

The academy would be glad to provide additional comments to help in the valuation of any proposals as you consider the issues of Medicare reform.

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

The CHAIRMAN. Thank you, Mr. Thompson.

Senator MOYNIHAN. That was a record for concision.

Mr. THOMPSON. We try to be, yes.

Senator MOYNIHAN. Mr. Chairman, our vote is now in its final stage. What do you wish to do, sir?

The CHAIRMAN. I think, in view of that, we had better recess. I would ask everybody to please return for the question period. The committee is in recess.

[Whereupon, at 11:45 a.m., the hearing was recessed.]

AFTER RECESS

The CHAIRMAN. I apologize for the delay. But I, in the interest of conserving time, will proceed with my questions.

Ms. Archer, you call for enrollees who disenroll from an HMO to have access to a Medigap policy at a reasonable cost. Does this mean you support the President's proposal for annual open enrollment and community rating of Medigap?

Ms. ARCHER. I certainly believe that community rating of Medigap policies is critical. Particularly, people with chronic and disabling conditions today cannot access Medigap policies after the initial open enrollment period. Sometimes they move and they need to switch plans, and they cannot. It is very important that they have the choice to join traditional Medicare and have access to a Medigap plan.

The CHAIRMAN. Are you concerned about the impact of open enrollment and community rating on premium price?

Ms. ARCHER. Obviously, any increase in premium price is something that has to be considered. But what I would say is that, in New York, we have community rating and it works quite well. We have a choice of 15 companies. All 10 plans are available in New York State. People who are sick can purchase a Medigap plan after the open enrollment period.

About 20 percent of the people who call our hot-line are from out of State, and generally the people who call are the ones who are in poor health, and often they are calling because they cannot purchase a Medigap plan out of State. They want to stay in traditional Medicare, they want to continue on with their doctors. For whatever reason, they cannot do so in an HMO. They cannot buy Medigap, either because it is not available or the price is so high that it is unaffordable.

I think that we should not continue to segment the Medigap marketplace. I think that it is better that seniors join together and pay a community-rated price so that everybody has access to this policy. Seniors who are healthy today may be sick tomorrow.

The CHAIRMAN. Let me ask you one further question. In your testimony you discuss the need for an effective appeals process for enrollees in Medicare HMOs. But it is also true that an effective appeals record is needed for fee-for-service Medicare, as well as Medicare managed care. I believe your organization outlined a number of problems with the fee-for-service Medicare appeals process in a report issued last October, is that correct?

Ms. ARCHER. That is correct. You are absolutely right, there are problems with the Medicare appeal process, both in traditional Medicare and in HMOs, but the critical difference is that, under fee-for-service, you generally get the care you need and then it can be difficult or time consuming to appeal a denial of coverage.

In an HMO, you generally do not get the care you need. You forego necessary care while you await a decision on appeal, and that can be a very protracted process. So that is the real critical difference. People's health can deteriorate significantly awaiting the outcome of an appeal in an HMO.

Let me just go back also to make one final point about the Medigap plans and community rating. I am not sure if you are aware of a 1995 GAO report that looked at Medigap premiums.

What that report showed was that 38 percent of Medigap plans were not in compliance with legal requirements that no more than 40 percent of premium dollars go to administrative costs and profits.

If the government, the Health Care Financing Administration, did a better job of ensuring that premiums were in compliance with legal loss ratios, then premiums might come down as well.

The CHAIRMAN. Thank you.

Ms. Martin, the President has proposed to provide information on beneficiaries annually that includes Medigap options as well as Medicare managed care options. The proposal also calls for HCFA to contract for the actual enrollment in the plans. Do the organizations you represent support this approach?

Ms. MARTIN. When it talks about an annual open enrollment period, and I will also point out the academy's study that changes

such as an open enrollment period on an annual basis will affect the cost of Medigap premiums and will affect, thus, Medicare itself.

Studies have shown that people disenroll from HMOs. They are 60 percent more costly than people who remain in the HMO program. So you will have people leaving the HMOs to go into fee-for-service, thus increasing the cost of premiums and increasing the cost for Medicare itself.

In addition to that, I think that from a Federal program perspective and looking at what we do on a group basis or commercial basis, if you will, people that are used to having an employer-employee relationship and can go through with getting information and being able to make decisions on their own, or talk to their employer or human resources department to help them with decisions are different than the senior population.

The idea that they get information in their home, that we as an industry, that HCFA, has the ability to have the manpower available for a 30-day period to answer 37 million people on Medicare's questions is a difficult one. I think it would be a very difficult one and a costly one to be able to handle and to implement.

If I could go back to your other question, though, if I could make just one comment about the HMO industry. The HMO, though it is a capitated plan and we talk about 95 percent of the AAPCC, the reality is, that is community rated.

I mean, that is not community rated, it is a fully adjusted plan. It is adjusted on age. It is through attained age. It is adjusted by disabled and end-stage renal disease, it is adjusted by gender, it is adjusted by working aged. So, there are many things that go into the AAPCC that we, as a health plan, get different money for different people regarding a variety of issues that they have.

The CHAIRMAN. All right.

Mr. Thompson, do you agree that the first dollar coverage which results from Medicare supplemental coverage results in increased Medicare costs, and does the academy have any ideas on how to change Medigap policies to address this?

Mr. THOMPSON. I think the academy would agree that, in the absence of having Medigap coverage, the cost of Medicare would be lower. There have been many studies that have shown that higher co-insurance does impede people getting access to health care, and I think the Medigap coverage does fill in those gaps.

Having said that, I do not think the academy has a position one way or the other in terms of whether that is good or bad. I think we tried to put ourselves in the position of explaining the implications of one policy decision versus another.

The CHAIRMAN. I would like to ask you a question about solvency regulation. Does the academy believe that solvency requirements should be different for providers who assume risk and provide services directly?

Mr. THOMPSON. No, they do not. The academy's position is that solvency requirements should vary based on the nature of the risk that a health organization assumes. There are a lot of factors that enter into that, including the nature of their provider arrangements and how they establish those arrangements.

Legal entity, in and of itself, is not a valid characteristic for determining whether or not a solvency requirement should be dif-

ferent. So many provider sponsored organizations today look very much like an HMO and have essentially the same risks as another HMO. I think the academy's position is, where that exists, they ought to be treated the same.

The CHAIRMAN. The same.

Senator Moynihan.

Senator MOYNIHAN. I want to thank our panel for their absorbing comments, and particularly thank the academy. It is all pro bono, but you could charge higher fees. Could I just get a general response from you. I have been absorbed with this question of the emergence of medical care as an economic sector, business products. All the terminology increasingly is that of many other economic sectors; this is our company, and we sell this product.

And, as I remarked earlier in the hearings on the Administration's health care bill in 1994, we were introduced to this idea by an ethicist, actually, from Fordham University, who said, what you are seeing is the commodification of medicine.

A wonderful term. And there is great history to that. The great, raging argument for the late 19th century that labor was not a commodity, and the Clayton Antitrust Act of 1914 so states. Whether it changed the reality or not, I do not know, but that is what the law says. Medicine is a commodity.

As I say, that great dean telling us about the spot market for bone marrow transplants in Southern California, the important point being that the bone marrow transplants—I do not know. I should not more than speculate. I think, as a procedure, it would not be more than 20 years old. Yet, now there is a spot market for them. This is characteristic of free markets in a period of great innovation.

But have you thought, Ms. Martin, Ms. Archer, Mr. Thompson, about this matter of, how do we provide for those institutions of health care that will not survive in a marketplace.

We have worked this out over two centuries of economic theory and thinking, the concept of a public good. A public good is something you do not have to pay for, you get it for free. But it is not for free, the society has to allocate resources to provide it.

Do you run into this discussion of what is going to happen to our medical schools and what is going to happen to our teaching hospitals? Yes, Mr. Thompson.

Mr. THOMPSON. Yes. That has certainly been a major issue.

Senator MOYNIHAN. Good. Good. Someone is thinking about it. All right.

Mr. THOMPSON. That is why you brought it up, I am sure. I think the market economy is not going to be concerned about a public issue such as that, it is really something that needs to be looked at.

Senator MOYNIHAN. A public good.

Mr. THOMPSON. A public good. Issues such as that.

Senator MOYNIHAN. Yes. Yes.

Mr. THOMPSON. And, for that reason, it is appropriately, in my opinion, anyway, looked to be regulated outside of, or financed, for that——

Senator MOYNIHAN. Provided for.

Mr. THOMPSON. Provided for outside of the market economy, if that makes sense. I think I would agree with the fact that the changes in the health care system have brought health care market economics to the health care system, and I think, overall, that has had some positive impacts. But I think that there are some ancillary issues that may better be served in the public good frame of reference, if you will.

Senator MOYNIHAN. In the public good frame of reference. A market economy will not provide for orphanages, and you go right down that list.

Ms. Archer, Ms. Martin, what do you think about that?

Ms. ARCHER. You are absolutely right. I mean, how are we going to fund graduate medical education, how are we going to care for the uninsured? How are we going to make this market economy want to treat people who are sick, people who are costly? I mean, as you know, 75 percent of Medicare program spending is on that 10 percent of the Medicare population, only four million people. That is 75 percent of Medicare program spending.

The HMOs would be crazy to want to attract these people today. We need to create, if we are going to have a market that works for people who are sick as well as people who are healthy, some kind of incentive for these HMOs to want to attract and care for people who are sick.

Senator MOYNIHAN. A nice thought. Ms. Martin. Nice thought.

Ms. MARTIN. I think, from an industry's perspective——

Senator MOYNIHAN. Industry.

Ms. MARTIN. Right. But I will get to the public comment.

Senator MOYNIHAN. She just said industry. All right. That is fine. I do not mind that. Spot markets.

Ms. MARTIN. But we need to keep the largest amount of people in a risk pool so that the sick are offset by the healthy. So when we look at regulations and legislation, that pool needs to be the largest possible pool in order to offset it.

I will also tell you that problems of the disabled, end-stage renal disease, which are included in current legislation proposals, look at only the seniors, the 65-plus population, sharing in the possible negative impacts of adding them into just their risk pool. So I think, as a society, we need to look at end-stage renal disease and disabled as society's problem versus just as a senior problem or a Medicare problem.

Senator MOYNIHAN. Right. And also, I hope, not too abstract, to see it as an aspect of the impact of technology on society. Again, I do not know and I wish I had someone around. Is there anybody in the audience who can tell me when end-stage renal disease treatment became available? We provided for it in 1972, so I suppose it would be a treatment of the 1950's. Is that about right?

Yes.

Ms. MARTIN. Yes.

Senator MOYNIHAN. Yes. I can recall, actually—and I will not go on forever, Mr. Chairman—but in the 1950's I was an aide to Governor Harriman in New York, and this procedure had reached New York. It probably began in New York, for all I know. Most likely it did. The State was beginning to provide for this. This was before Medicaid and Medicare.

You found persons in our division of the budget, budget examiners, as I recall, having almost personal crises. They were being asked how much money to allocate to end-stage renal disease, which was something they could do just fine. They need highways, name it. High schools, you name it. But this was asking how many people you are going to have live and how many you want to die. They had no professional formation for deciding how many people should die. Previously no one had asked them because they were going to die anyway, and there was nothing I can do about it. But now, if you spent a certain amount of money, you would get people to live, and all sorts of ethical questions and professional questions arise as technology in the form of science makes these things available.

I think we will do better if we approach them, at least in part, from that perspective. I thank each of you for your care and concern. Ms. Archer, steady on on Broadway.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Moynihan.

Ms. Martin, I have one final question for you. As you know, all the 10 packages cover the Part B co-insurance, giving seniors first dollar coverage. This is said to result in increased costs to Medicare because there is no financial incentive to restrain the use of services. Has your organization given any thought to changes in the Medigap packages to move away from first dollar coverage?

Ms. MARTIN. Yes, we have, to a certain extent. In looking at studies and talking to our seniors, I will be honest with you, they are concerned about not having a budgeted amount of money.

I mean, the thing that is good to them about Medigap policies is they know, I am going to spend X amount of dollars in January, February and March, because they are on a fixed income.

The idea of having a one-time, first dollar payment that is a reasonably sized big bill is of concern to them because it does not allow them to budget throughout the year.

The CHAIRMAN. Any comments, Ms. Archer?

Ms. ARCHER. We have not given thought to that issue. I know it is an issue. We have given more thought to the fact that Medigap does not provide unlimited prescription drug coverage, which many people need.

The CHAIRMAN. All right. Mr. Thompson, any further comments?

Mr. THOMPSON. No further comment.

The CHAIRMAN. Well, thank you very much.

Senator MOYNIHAN. A very good panel.

The CHAIRMAN. An excellent panel. We appreciate their patience. The committee is in recess.

[Whereupon, at 12:34 p.m., the hearing was recessed, to reconvene at 10 a.m., on Thursday, March 20, 1997.]

IMPROVING MEDICARE CHOICES

THURSDAY, MARCH 20, 1997

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

The hearing was convened, pursuant to recess, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, D'Amato, Gramm, Mack, Moynihan, Rockefeller, Conrad, Graham, and Moseley-Braun.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order. Today we will complete our 2 days of hearings on improving choice in the Medicare program. As we have heard from the Administration and our other witnesses yesterday, there is consensus about improving choice for our seniors. But, as with most major changes in policy, the devil is in the details.

Today we will hear more about reactions to the administration's proposals to improve Medicare choices. We are particularly pleased to have today our distinguished colleague, a doctor, a man of great talent, to begin our hearing. Dr. Bill Frist, together with Senator Rockefeller, has introduced legislation on provider-sponsored organizations.

We are very pleased to have you here today, Bill, and look forward to your testimony. Please proceed.

STATEMENT OF HON. BILL FRIST, M.D., A U.S. SENATOR FROM TENNESSEE

Senator FRIST. Thank you, Mr. Chairman, Members of the committee. In 1995, my first year in the U.S. Senate, the Medicare trustees told Congress that unless it took "prompt, effective, and decisive action, . . . Medicare will be dead in 7 years." Two years later, we are even worse off. We still face exactly the same tough choices. We must balance the budget. We must restore integrity to the Medicare trust fund. We need to update the Medicare system and provide consumers with more choice. More choice. A cornerstone, structural change that addresses the long term viability of the Medicare program.

In the 104th Congress, this committee, the Finance Committee and the U.S. Congress, realized that the fundamental way to capture the dynamics of change in the health care system requires us

to modernize Medicare by opening it up to a broader array of health care plans that could compete on quality and not just cost.

President Clinton recently has embraced this ideal as well by initiating Medicare Choices demonstration and by including provisions to expand choice, although I feel they are limited, in his budget submission to the U.S. Congress last month.

Two months ago, Senator Rockefeller and I introduced S. 146, the Provider Sponsored Organization Act of 1997. S. 146 expands the current Medicare risk contracting program to include PSOs, Provider Sponsored Organizations.

A PSO, very simply, is a private or public provider, or a group of affiliated providers, organized specifically to deliver a spectrum of health care services under contract to purchasers.

Our bill specifies detailed requirements for certification, quality assurance, and solvency to ensure that PSOs contracting with Medicare meet standards that are comparable or higher than those for health maintenance organizations today.

Specifically, the bill provides Federal leadership for States to fashion a streamlined PSO approval process that is consistent with Federal standards protecting Medicare beneficiaries.

Second, by providing incentives for PSOs and HMOs to evaluate patterns of care, the bill promotes state of the art, continuous quality improvement.

Third, the bill creates a mechanism by which the Secretary of HHS is allowed to enter into partial risk payment arrangements with PSOs or HMOs.

Fourth, it outlines specific solvency standards for PSOs which reflect the peculiarities of their operating environment.

Now, why are PSOs, to my mind, a good place to start in opening up and modernizing Medicare? First, and something very close to me as a physician and as one who has spent over 50,000 hours working in hospitals, PSOs will improve quality of health care. The creation of PSOs in the Medicare environment, I am absolutely convinced, will improve quality.

It really goes back to personal experience, in part. But the fundamental reason is that PSOs are the care-givers. PSOs are the physicians, the hospitals, the facilities.

It is those physicians, those care-givers who are on the front line of health care every day. Thus, they are in the best position to monitor quality, to deliver quality, and to demand quality for that individual patient who walks in through the door.

It is my feeling that in a competitive managed care environment PSOs will be at the table competing with insurance companies, competing with HMOs. But it is they, because they are the care-givers, that can bring to the table that concern for the individual patient, and demand quality, which will have a spill-over effect in the negotiations in the managed care environment. There is an inherent PSO emphasis on quality of care because the people at the table are the people who are taking care of the individual patient.

The second issue around quality, is that S. 146 requires collective accountability, where quality and cost are measured by overall practice patterns across the entire PSO rather than just case-by-case utilization review.

It used to be that we did not know how to do that. In 1997, we do know how to do that, where we look at system-wide measures of quality. The advantage of that, instead of case-by-case utilization, is better use of resources, less intrusiveness in the doctor/patient relationship, and it is state of the art today. It is built into our bill.

S. 146 requires PSOs to meet new, higher quality standards and they must, as spelled out in our bill, have experience in the coordination of care. Thus, we will not see the creation of inexperienced groups coming forward.

That is important because of the so-called 50/50 rule, a standard which is inappropriately used as a surrogate measure for quality, requiring that plans participate in the commercial marketplace.

Well, today, because of the outline of higher quality standards, and because of the requirement for experience with the coordination of care, the 50/50 rule does not apply and would be waived for PSOs.

I should also say that non-PSO Medicare risk contractors, under our bill, would be eligible for waiving of this quasi-quality measurement as long as they met the enhanced quality standards spelled out in our bill. Thus, S. 146 sets a new standard for quality assurance, a standard that I feel will set the pace for the rest of the industry.

Our bill returns to a basic concept that applies a lot to what we are doing in the U.S. Congress today. This bill will empower providers to become, once again, true partners in the clinical decisionmaking process. The PSO really does allow physicians, care-givers, and facilities to once again regain some control over what goes on at that doctor/patient relationship level.

In the U.S. Congress over the last year we have seen bills, like a 48-hour maternity stay bill post-birth, and a proposal for a 48-hour stay after mastectomy. I have had proposals come forward to me for 5-day bills after heart surgery. Well, obviously the U.S. Congress can go in and try to micro-manage, but I do not think that is the direction to go.

By bringing care-givers to the table, by re-enfranchising them, by allowing them to once again regain participation in the clinical decisionmaking process, we get out of that business.

Why? Because at the negotiating table in the managed care environment you have physicians and care-givers there speaking for the patient, not allowing just cost to drive what goes on in the managed care environment.

In addition, the PSO option will bring coordinated care to more communities. Again, this is terribly important because we see so much of managed care in urban areas and not in rural areas and not in under-served areas.

This bill very specifically has incentives built in it to encourage participation in those under-served and rural areas. It will very clearly, to my mind, bring managed care, coordinated care, networking of care, all that we know is important, to those communities where it is not available today.

As you know, managed care has had great difficulty in attracting seniors. We know that about three-quarters of the employed popu-

lation are enrolled in coordinated care/managed care today. But in Medicare, only 13 percent are enrolled.

Two reasons. Right now, the rigidity of our Medicare system does not allow any other entities besides a very narrowly defined HMO. We can agree or disagree whether to open that system up to a broad array of plans. Indeed I think this first step of a PSO is the most reasonable way to go to begin to expand that choice.

In the State of Tennessee, the majority of Medicare beneficiaries have no choice. There is no HMO, except right in middle Tennessee. There are no other plans. Senior citizens have no choice whatsoever in Tennessee, except right in Nashville, where they can choose one plan today.

The second reason, is that our seniors are scared their care is going to be taken away. They are scared to join managed care because they are scared that their local physician will be dropped from the network. Many fear that an HMO or managed care plan might drop their physician once they join it, and that frightens them a great deal.

It only makes sense that Medicare beneficiaries will feel much more secure about coordinated care knowing that they have the choice of a health care plan run by care-givers, run by physicians, nurses, and hospitals who are in their own local community. The Rockefeller-Frist bill will give them that security.

PSOs, as I mentioned, do apply particularly well to rural communities. Because the doctors and hospitals are already in the rural areas, it is easier for them, rather than some outside insurance company maybe located 200 miles away, to network, to come together, and to provide coordinated care in what have been traditionally underserved rural areas.

Finally, given the fact that Medicare's own trustees have reported that the trust fund soon be bankrupt, Medicare's rate of growth clearly must be slowed. The introduction of PSOs will advance market-based competition within Medicare, which I believe is absolutely essential to the long-term integrity of the entire Medicare program, both Part A and Part B.

Now, just to paint a little bit of perspective, very quickly, of this particular bill versus what this committee has considered in the past and what was part of the Balanced Budget Act of 1995, let me make a couple of quick comparisons.

The Balanced Budget Act of 1995 created a legal definition of PSOs and developed a definition of affiliated provider. Our bill goes one step further. It defines a Medicare qualified PSO as a PSO that has the cability to contract to provide full benefit, capitated, coordinated care to beneficiaries.

Specific criteria for the direct provision of services by affiliated providers are spelled out in the bill. This ensures that all but a small fraction of contracted services are provided either under affiliation or by participating provider agreements.

All current Medicare provider contracting rules, especially those that protect beneficiaries or consumers from financial liability in the event of a plan failure, will also apply to PSOs.

Since Medicare qualified PSOs do not enter the commercial market as a health plan in order to contract with Medicare, S. 146 pro-

vides Federal certification for the first 4 years, after which transition to State licensure is carried out.

In addition, this bill requires that the Secretary contract with States during that 4-year period to provide local monitoring—that is the States which will provide the local monitoring—of ongoing PSO performance, as well as beneficiary access to services. At the end of that 4-year period, State licensure would be required as long as State standards are sufficiently similar to the Federal standards, and the solvency standards are identical.

This approach over these 4 years marries the benefits of national standards for a national program with the benefits of close monitoring at the State level by State agencies, an approach currently used by Medicare in certifying a variety of health care providers.

The issue of solvency. Last year's Balanced Budget Act mandated that the Secretary develop new solvency standards that are appropriate to this PSO, provider-sponsored, environment.

Similarly, S. 146, our bill, recognizes that PSOs are different. They are not insurance companies, nor should they pretend to be insurance companies. PSOs are the care-givers themselves.

Thus, it is not necessary, because they are care-givers—physicians, nurses, and facilities—for them to go out and contract out or pay claims for services that they have to go out and essentially buy, as insurance companies have to do. Very different. This bill establishes these new solvency standards to protect Medicare beneficiaries against the risk of PSO insolvency.

The test of fiscal soundness is based on net worth and reserve requirements drawn from current Medicare law and the current National Association of Insurance Commissioners' (NAIC) Model HMO Act. Adjustments are made to reflect the operational characteristics of PSOs, that is, that this group is the care-givers themselves. They do not require you to go out and purchase care from somebody.

For example, in determining net worth, it ensures that health delivery assets held by the PSOs, such as the hospital building, are recognized just as they are in the NAIC's Model HMO Act. Thus, fiscal soundness is assured.

Another issue on which the Rockefeller-First bill differs from the 1995 Balanced Budget Act is that it gives the Secretary authority to enter partial risk contracts, either with PSOs or with HMOs.

The Balanced Budget Act required that PSOs take full risk with respect to Medicare benefits. While both bills require PSOs to provide the full Medicare-defined package, S. 146 adds a partial risk payment method, that is, payment for all services based on a mix of capitation and cost. This is actually very important if we want to have coordinated care go to our rural communities.

Now, why is PSO legislation necessary? First, current Medicare statute does not allow managed care plans to serve only Medicare patients. Instead, currently it requires these types of plans to participate also in the commercial market.

The Balanced Budget Act established the premise, as this committee did last year, that PSOs should be allowed to offer Medicare-only plans. Therefore, the rule that I mentioned earlier, the so-called 50/50 rule, is inappropriate under our bill for Medicare-only type plans.

Second, plans today are required to go through the State licensure process. Again, this is the second point of why we need to look at this PSO legislation, and it has to be passed. The overwhelming majority of State licensure processes do not recognize the fact that PSOs are different from insurers. Rather, States today expect them to look and act like insurers. But they are not, they are care-givers.

Senator Rockefeller and I, in closing, did not introduce this legislation to eclipse the current Medicare risk contractors. Rather, the PSO Act compliments existing HMO options in the Medicare program and expands the choices available to seniors and individuals with disabilities.

This bill is narrow. It is focused. It really does not take on the broader issues of reform that you must address in Medicare. I would like to see much more choice than this bill, but this is the place to start.

Qualified PSOs will challenge all health care organizations participating in Medicare to meet the goal of an integrated, coordinated health care system where quality, and not just cost, is put forward, where relationships of care-givers and their patients is preserved, and where physicians, nurses and hospitals come to the table. PSOs will challenge the entire system and the result will be higher quality.

I thank the committee for the opportunity to present to you this bill.

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

The CHAIRMAN. Senator Rockefeller, as the co-sponsor of this legislation, would you like to make any comment?

Senator ROCKEFELLER. If I could, Mr. Chairman. You are very courteous in granting me that opportunity. If the good Senator from Tennessee could explain, I think the core of this whole thing, and the frustration, is that physicians are not allowed to do what they know needs to be done because, as the system is, they have to call up an insurance company to get permission. It would be helpful, I think, just for the record, to explain, briefly, from personal experience, the dimension of that frustration and why it is unnecessary.

Senator FRIST. As I mentioned, one of the huge advantages of this bill is that it returns what we are trying to micro-manage out of the U.S. Congress, and it is impossible to do. We tried to do it through the bills that I laid out, the 48-hour bills. It is impossible to do.

It returns that doctor/patient relationship back to the table to participate in the decisionmaking process. You talk to any physician, any hospital, any nurse, and they will tell you that their biggest problem with managed care is that the clinical decisionmaking is being taken out of their hands.

Just a very quick example. I do heart surgery, and I have had the opportunity to operate on thousands and thousands of hearts. Over the last 2 years, before I came to the U.S. Senate, it was to the point where I, as a heart surgeon, would have to get on the telephone, call an insurance company, maybe 200–300 miles away, and talk to a nurse—this is me, personally doing this—to explain that the hematocrit, which is a blood count level, of 26, even

though it falls out of certain guidelines, is appropriate after heart surgery, in order for me to get permission to discharge my patient.

If I discharged them with a lab value that was 26 percent instead of 30 percent, I would be audited and actually have to sit down and fill out two long sheets of paper and answer three more phone calls. Now, all of that is well-intended. All of us want high quality. We recognize there are certain standards to set.

But this idea of having somebody 300 miles away dictate how I take care of a patient, after about 10 years of training, doing thousands of operations, and taking care of these patients, is where we are today.

That frustration would be removed if, all of a sudden, I and my facility, working together, networking with others, which our bill requires, can become part of the clinical decisionmaking process once again.

That is why I think it is a beautiful bill, in that it really does re-enfranchise that relationship between the doctor and the patient. They are the ones closest to quality. They deliver the care. That is where quality is monitored. That is where you can best judge it, not from somebody 300 miles away.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Rockefeller.

We appreciate your being here today, Senator Frist. We will certainly be hearing a lot more about PSOs and will count on your personal experience in helping us develop legislation, and we will want to work very closely with you and Senator Rockefeller.

Are there any questions?

[No response]

The CHAIRMAN. If not, thank you again for being here today. Your testimony has been extremely helpful.

Senator FRIST. Thank you very much.

The CHAIRMAN. We will turn to Glenn Pomeroy, who is commissioner of insurance for the State of North Dakota. I think Senator Conrad would like to introduce Mr. Pomeroy.

Senator CONRAD. Thank you very much, Mr. Chairman. It is an honor for me to be able to introduce the insurance commissioner from the State of North Dakota to this committee and to my colleagues.

Glenn Pomeroy has been before this committee and other committees of the Congress before, not only in his role as the insurance commissioner of the State of North Dakota, but also in his role as vice president of the National Association of Insurance Commissioners, selected by his peers as their spokesperson. I think that shows the high regard that they have for him.

If I could just say, Mr. Chairman and Members of the committee, that Glenn was elected in 1992, replacing his brother, who was elected to the Congress. In North Dakota, our politics are up close and personal, as all of you know. But we have often thought that it was one of those rare circumstances where both offices were improved by that one change. [Laughter.]

So, I want to welcome Glenn to the committee.

STATEMENT OF GLENN A. POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, BISMARCK, ND, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. POMEROY. Thank you, Senator Conrad. Good morning, Mr. Chairman and committee Members. It is my very big pleasure to be here, and I am especially proud to be introduced to you by my good friend, Senator Conrad.

As the Senator mentioned, I am the insurance commissioner from the State of North Dakota and currently serve as the vice president of the National Association of Insurance Commissioners. I also, in addition to that, serve as the vice chair of NAIC's Special Committee on Health Insurance, which is comprised of 42 of our members, on whose behalf I testify today.

The NAIC established this committee several years ago as a forum to discuss Federal proposals related to health insurance reform and to provide technical assistance on a nonpartisan basis to all who sought our expertise.

I am pleased to have this opportunity to speak with you today about the regulation of provider sponsored organizations participating in the Medicare managed care program, and I will touch briefly on Medicare supplement insurance as well.

Based on the State's extensive experience in regulating the business of insurance, we strongly believe that the most appropriate approach to the regulation of health-insuring organizations is by function, not by acronym. We do not view health insurance organizations sponsored by providers as substantively different from other health-insuring organizations.

These entities, with varying forms of ownership and affiliations, are required to obtain a State insurance license because of the insurance function they perform. Organizations subject to State insurance regulation already include those sponsored by providers.

A key characteristic of health insurance arrangement is the spreading of the risk of financial loss among a group of individuals. State insurance regulation serves as the foundation for the current regulatory structure governing Medicare managed care, providing a foundation for fundamental consumer protections.

As long as pooling of financial risks and loss exists, insurance risk is present. Anyone who is engaged in the business of insurance is, and should remain, subject to the regulation by the States.

The protections we offer extend beyond financial solvency and other licensing standards to market conduct standards and financial examination activities. To provide these same protections, the Federal Government would need to replicate the State's insurance regulatory framework, resulting in significant and unnecessary costs to the Federal Government.

Provider organizations have argued that direct provision of services by providers transforms the financial risk of loss to a more general form of business risk, rather than insurance risk.

We believe that is simply not the case. Moreover, there are a wide range of necessary expenses in delivering health benefits. Most provider sponsored organizations currently operating in the marketplace are licensed as HMOs.

For example, in our State of North Dakota we have an HMO sponsored by a major clinic and hospital. Northern Plains HMO became licensed a couple of years ago and is regulated under North Dakota law, just as it should be. My predecessor, now Congressman Earl Pomeroy, had the unpleasant experience of having to place a different organization that was sponsored by providers into receivership.

Thanks to the State's regulatory authority, the commissioner of insurance was able to act promptly and obtain another source of coverage for the 30,000 people insured by that organization. North Dakota's net worth requirements have since been strengthened to avoid a reoccurrence of this unfortunate event.

Through the NAIC, States are addressing the changes which are taking place in the health insurance market. One of our committees has begun a review of NAIC model laws as part of an initiative we refer to as the "Consolidated Licensure of Entities Assuming Risk," or the CLEAR initiative.

Through this initiative, NAIC members are seeking to promote a more competitive marketplace by ensuring that entities that perform same or similar functions are subject to a level regulatory playing field.

CLEAR also serves to clarify that the wide array of organizations performing managed care functions which finance and deliver health care will continue to fall within the scope of State regulation.

CLEAR will include a review of financial standards and reporting requirements, as well as the incorporation of health plan accountability standards, such as network adequacy.

On behalf of the Nation's insurance commissioners and with the strong support of the National Governors' Association and the National Conference of State Legislatures, I would like to summarize our bottom line regarding the emergency of provider sponsored organizations servicing the Medicare population.

States must not be prohibited from maintaining and enforcing important consumer safeguards designed to make sure these organizations will, in fact, be around to deliver the services to your Medicare-eligible constituents who choose to enroll and rely upon them.

Turning, if I might, to the issue of Medicare supplement insurance. We believe important consumer protections are crucial. The NAIC's Senior Issues Task Force, which I chair, will meet soon specifically to discuss S. 302 and the Clinton administration proposal.

We must remain vigilant with regard to issues like open enrollment provisions to avoid the risk of adverse selection, the concept of standardization of benefit packages in managed care plans also merits further review.

The States and the NAIC appreciated our roles in helping design the 10 standard Medigap plans which preserve consumer choice, while minimizing consumer confusion. The issue of community rating, which has traditionally been reserved to the States, is one that will require close scrutiny as well.

Mr. Chairman, should you or your colleagues have State-specific questions, we have provided in our written testimony a list of State health contacts and how to get in touch with them.

We look forward to working with the 105th Congress on this and other issues of mutual concern, and I would like to thank you again for the privilege of appearing before you today.

The CHAIRMAN. Thank you very much for being here today, Mr. Pomeroy. What we are going to do is have the testimony of each of the witnesses, then we will have questions for the panel as a whole.

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

The CHAIRMAN. Next, we will hear from Karen Ignagni, who is president and chief executive officer of the American Association of Health Plans. It is a pleasure to have you here. Please proceed.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman, Members of the committee. On behalf of AAHP, I would like to make a point that our plans stand ready, willing, and able to work with you to deal with the very difficult matters that will be on your plate today with respect to Medicare reform.

We do believe that it is absolutely essential, as Senator Frist said, that Medicare beneficiaries be given the same opportunity to make choices that those who are under 65 do in the workplace, and fully support that principle. So, we do want to be part of the solution.

At the same time, we are concerned about the effects of the Administration's proposal and have shared our concerns, both with the Administration and Members of Congress, and would like to outline those for you today.

We do not believe that the goal of expanding options can be accomplished the way the proposal has currently been fashioned. We reached this conclusion based on an analysis conducted for us by the Barents Group, which shows that the proposal has a disproportionate impact on beneficiaries, many of whom are low to moderate income, who have chosen to enroll in managed care plans.

This proposal will have a similar effect on PSOs and PSNs, or other choices that might be added to the program, the second topic before the committee this morning.

Our analysis shows that 95 percent of beneficiaries live in a county where payments would decrease and, thus, affect benefits and choices available. Beneficiaries in our plans are being asked to shoulder a disproportionate amount of the cuts, thus providing an advantage to the traditional program.

If members of this committee have the view that government should be neutral with respect to the choices that beneficiaries make and they should be able to look at the full spectrum of choices and make their own decisions, then we believe that that goal and that principle is not fulfilled.

This proposal could reduce the extra benefits provided, increase out-of-pocket costs, and decrease the number of plans from which beneficiaries may choose. We know that Members of Congress are going to want to look at the impact of this proposal on their constituents and their beneficiaries, and we stand ready, Mr. Chair-

man and Members of the committee, to brief each and every one of you and have provided a summary of our data today as well.

On the matter of the second topic addressed by Dr. Frist, should the program be expanded to include PSOs, the succinct, clear answer by our association is yes. But the choice alone, in our view, is not enough to ensure the success of the program.

As a matter of principle, plans competing and offering similar products and processes to beneficiaries ought to be held to similar standards. I think Mr. Pomeroy made that point exceedingly well, and would like to associate myself with the comments that you have just heard.

Without endeavoring to repeat that, I will say that the growth in the numbers of entities—PSO, PSN—being licensed at the State level as health plans demonstrates the ability of quite a number of entities to compete in the delivery system today.

Indeed, about 20 percent of our membership now is in the form of integrated health systems, PSOs, PSNs, who are and have competed in delivery systems under current State licensure authority.

In addition to our testimony on these important issues, we have included in our testimony a summary of what the managed care industry is doing to respond to a number of consumer challenges, and frankly a number of provider challenges that have been put forth in the political arena, both at the State and Federal Government level. I hope you will take a look at that.

I would like to summarize our activities as follows. In an effort to be succinct, there have been a number of issues that have been raised with respect to whether beneficiaries are sufficiently aware of their rights in health plans, whether providers are sufficiently aware of processes, whether they are sufficiently aware of protocols, drugs in formularies, et cetera.

We have endeavored to do a number of things over the last few months that put our members on record and accountable to the beneficiaries they serve, as well as the provider partners that they have engaged with, both short and long term. These will be enforceable standards within our association and we look forward to summarizing them for you today.

So, Mr. Chairman, we have prepared and put before you a complete summary of our views on the matters before you. I would be delighted to answer any questions, when appropriate. Thank you.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Our next witness is Dr. Ted Lewers, a member of the board of trustees of the American Medical Association. It is a pleasure to welcome you, Dr. Lewers.

STATEMENT OF DONALD T. LEWERS, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, EASTON, MD

Dr. LEWERS. Thank you, Mr. Chairman and Members of the committee. I am Ted Lewers. I am a nephrologist and internist in the town of Easton, MD, on the Eastern Shore of Maryland. I am also a member of the American Medical Association and a member of its executive committee.

The AMA is pleased to offer our views and suggestions on improving the Medicare program. Today, however, we will focus our attention and comments on the need for physician sponsored organizations and health plan standards for our Medicare patients.

Mr. Chairman, we think the case for PSO is compelling, as presented by Dr. Frist. Last year, thanks to congressional pressure, the FTC and the DOJ issued new antitrust guidelines for physician networks that provided necessary antitrust relief. Today, we are here to seek your help in securing the remaining tools needed to promote the development of PSOs and PSNs.

Physicians are troubled by threats to patients in the form of third parties intruding into medical decisionmaking. We know that by using recently designed techniques we can reduce costs and lead medicine into a new era of improved quality.

Yet, fear of competition has caused the big insurance companies to vehemently oppose any PSO legislation. It is to their advantage to keep physicians, hospitals, and others out of the health plan market.

We note, positively, the introduction this year of the Provider Sponsored Organization Act of 1997, S. 146, by Senators Rockefeller and Frist. We believe PSO legislation, however, should have certain characteristics.

First, the legislation should allow as much flexibility as possible. Legislation should not favor one PSO model in terms of ownership and management structure. Second, PSO legislation should contain tough consumer protection standards that are strenuously enforced across the board.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain antifraud and abuse laws, and self-referral laws which were designed for non-risk sharing arrangements, a different thing entirely.

Fourth, since Medicare is a Federal program, PSOs should be subject to federally developed standards which will recognize their unique differences. Many State regulators fail to account for the distinctions between provider networks that deliver services directly and insurers that purchase health care services and resell them.

By developing a Federal framework, Congress will continue to encourage new ventures that stimulate competition and provide efficiencies, just as it did when it approved the HMO Act of 1973.

Finally, any legislation considered by the Senate should include the creation of PSNs, which could contract with PSOs to deliver health care services. A PSN is a network that does not have the capacity to deliver a substantial portion of Medicare benefits, but a PSN can contract with PSOs to deliver care in risk-sharing arrangements.

While choice should be the heart of the health care system, empowering patient protection should be its backbone. We are pleased that Congress is looking at the appropriateness of certain medical decisions being made by health plans across the country.

While we support anti-gag clauses, drive-through mastectomies, and emergency services measures, we believe more is needed. These issues are only the symptom of a more general problem. They represent a failure to integrate good medical science with in-

volvement of practicing physicians and their patients to meet the unique needs of individuals.

We are especially concerned about the grievance and appeals abuses recently reported in the *New York Times* regarding Medicare HMOs. We are willing to work with Congress and the managed care industry on more comprehensive patient protection legislation.

We urge all plans to be guided by the following principles, which enjoyed bipartisan support in the past Congress: (1) disclosure of patient plan information, rights, and responsibility; (2) allow for appropriate professional involvement in plan medical policy matters; (3) disclosure utilization review policies and procedures; (4) provide a reasonable chance for patient choice of plans and physicians; (5) reasonable access to physicians, both primary care and specialty care.

In conclusion, the AMA appreciates this opportunity to testify. We look forward to working with you, Mr. Chairman, and the Members of your committee, to address these important Medicare reforms. Thank you.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Our next witness is John Nielsen, who is director of government relations, Intermountain Health Care, Salt Lake City, UT. He is here on behalf of the Coalition for Fairness in Medicare.

Mr. Nielsen.

STATEMENT OF JOHN T. NIELSEN, DIRECTOR OF GOVERNMENT RELATIONS, INTERMOUNTAIN HEALTH CARE, SALT LAKE CITY, UT, ON BEHALF OF THE COALITION FOR FAIRNESS IN MEDICARE

Mr. NIELSEN. Thank you, Mr. Chairman and Members of the committee. I am delighted to be here this morning with you.

I am senior counsel and director of government affairs for Intermountain Health Care, which is a large, integrated health care delivery system operating in Utah, Idaho, and Wyoming. We have 23 hospitals, 33 clinics, 300 employed physicians, and a large health plan component which includes a Medicare risk HMO called Senior Care, and I will describe that and talk about that in greater detail in a moment.

I am appearing today on behalf of the Coalition for Fairness in Medicare, a group of hospital systems, HMOs, and State hospital associations who share a common goal, and that is fairness and equity in Medicare payments.

We were formed and founded in 1995 to address the gross payment disparities and inequities that exist in the Medicare HMO payment formula, and that is the subject that I wish to address today.

This subject is not new. I suspect many of you have heard it before. We have been active in addressing this issue before the Senate and the House over the past year. If we are to understand and be persuaded that the ability to enhance choice and to move the Medicare population into managed care will decrease costs and assist the program, we believe that we cannot do it without address-

ing the wide geographic disparities and inequities in these payments.

This is the theme of my testimony and the goal of our coalition. These disparities are historical in nature, and certainly were unintended as Congress designed the Medicare HMO product. The payment formula known as the Average Adjusted Per Capita Cost, or AAPCC, was developed from historical fee-for-service rates.

As a result, in markets where utilization was controlled and costs constrained, they were penalized in favor of high utilization markets where costs in medical delivery were unconstrained. The current calculations and adjustments in the AAPCC methodology simply perpetuate this disparity.

Let me illustrate. In 1997, Medicare HMO payments varied geographically from a low of $271 in Arthur, NE, to a high of $767 in New York City. A recent GAO report disclosed that four States account for over one-half of all Medicare HMOs, 19 States have none. The reason is simple: Medicare HMO enrollment is the highest where the AAPCC payment is the highest. We believe the result is grossly unfair.

Why should a senior living in Eugene, WA, or Salt Lake City, for instance, have to pay a premium, a co-pay, and supplemental premiums to receive prescription drug and eyeglass benefits with no dental benefit even being available, where seniors living in high payment areas enjoy all of those benefits with little or no out-of-pocket expense?

It just is not fair and is not right that most of the seniors in our country cannot share the advantages available to their high payment area counterparts. Even though they have paid the same amount in Medicare taxes, they will receive vastly different benefits depending upon where they live in this country.

Let me just give you a bit about our experience in Utah. In May 1996, we initiated our first Medicare risk HMO product. It is marketed in three large urban areas where managed care is already well established.

Our actuaries advised us that the product was financially marginal because of our low AAPCC payment, but, in accordance with our health care delivery mission, we decided to offer the product.

Currently, it covers about 5,000 enrollees. Each pay a premium, each pay a co-pay. There are additional premiums for high-option benefits such as outpatient drugs and eyeglass benefits. There is no dental benefit available.

Our experience is that the product is losing money rapidly. We cannot afford to offer it in rural Utah and rural areas, and all of the health plan executives in our company agree that the low AAPCC payment is impeding the success of the product. In the current environment, it is unlikely, in our judgment, that the product can survive.

Now, what are the solutions to this dilemma? As a coalition, we support the past Finance Committee approach which designed a blended rate formula, which blends each area-specific rate with the national average. We also support a specific payment floor which would immediately raise payments in most rural areas.

Such an approach would be substantially beneficial to us in Utah, and aid in our efforts to allow this product to expand. We

also believe the same would be true in many other jurisdictions and States in our country.

We were pleased that the administration proposal included a blend and a floor. However, the other payment reforms that are suggested in that proposal, we believe, would essentially nullify the benefit of the blend and the floor. And, while we have not had a chance to analyze this with great thoroughness, it suggests that, at least in Utah, we would increase only $11 in the first 3 years.

In conclusion, Members, Congress has an opportunity to modernize and restructure the program. We do not believe broad, across-the-board cuts are the answer. Rather, a balanced approach which solves this inequity would allow HMOs to exist, and with the commensurate saving of the program.

In the current environment, that is not going to happen. We want to create an environment where HMO products will flourish. We do not believe that will happen in the current environment. Thank you very much. I would be pleased to answer any questions.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Last, but not least, we will hear from Richard Reiner, who is president and chief executive officer of the Florida Hospital Health Care System in Orlando, FL.

Mr. Reiner.

STATEMENT OF RICHARD K. REINER, PRESIDENT, FLORIDA HOSPITAL HEALTHCARE SYSTEM, ORLANDO, FL

Mr. REINER. Good morning, Mr. Chairman and other Members of the committee. I am pleased to be here today. I do not come to Washington often, and it is kind of an awesome experience. But I would like to share a few things this morning about real life in a provider sponsored organization, and maybe some of that you might find helpful as we move along.

We are a major hospital system in Orlando, FL, who believed early on that the Medicare risk business was for us. We could not find the appropriate partner in the HMO world to do what we believed needed to be done, and that was put together a community-based organization made up of physicians and hospitals to be able to take care of our patients and to do what we knew our patients needed done through the years.

Our physicians have become very frustrated, as Dr. Frist and others have pointed out, with the fractionalization of—and you mentioned yesterday, Senator Moynihan, the commodification—of health care, to some degree. I call it the fractionalization of health care, with how payment mechanisms have been foisted on hospitals.

So we decided to stick our oar in the water and we took a very aggressive move in Orlando, FL: we applied for a Medicare demonstration project. For all of those people who say this is a Sunday afternoon walk in the park for provider sponsored organizations to measure up to HCFA standards, this is just the first application.

There were two or three more submittals of materials that we were able to provide for the good folks at HCFA who, by the way, I admire for sticking their neck out and working with a few of us

under the demonstrations to test the theory as to whether or not people would join a health plan that was owned by their local hospital, because in the end health care is local. It is a local business and doctors and hospitals know best. They know their patients best. We have all been frustrated with the processes of the last 10 years about how managed care works.

So I would suggest three premises that you think about on this provider sponsored organization. You think about the fact that, when all the pieces are left to be picked up, who sees the patients in the emergency department? The hospitals and the doctors do.

The health plans are not anywhere to be found when the patient crashes in the ER. Whether they have money or not we take care of them, even though health plans do not pay us because, 2 weeks later, they say that was not an emergency, so we are not going to pay you for that.

Our doctors are saying the paradigm needs to shift. They have voted with their feet for the last 3 years, giving hundreds and thousands of hours. In our organization, over 100 of them every month come together and monitor patient care, look at how our processes can be improved. I have seen them error, many more times than not, to spend more money for patient care because it is the best for the patient.

We will send a patient out of network, we will add the additional test or do the things that will cost us all, since we are economically integrated, because it is right for the patient.

The customer. Now, we call them Medicare beneficiaries and we call them patients, but all of us need to think of ourselves, to some degree, as providing services to customer. The customers in our market, defined in my talk as patients, have voted with their feet relative to our early success of our plan.

Now, I do not come here as any great expert about how this is all going to play out, because we are very early in the game. You have to put in context that we are a 3-year-old PSO doing Medicare for 3 months. But two or three significant examples about marketing, and then I am going to close and ask for questions.

The market has 30 percent penetration in Medicare. There is about 34,000 people that are already in a Medicare risk plan. They have had to leave their doctors to join those plans, because many of our doctors have not liked the rules that the health plans have given them. We have served them because we have seen these patients, but 85 percent of our hospital Medicare business is fee-for-service business, not managed care business.

When we started marketing we were overwhelmed with the response, with the phone calls, and the response to seminars. We had to add extra telephone operators, we had to add extra seminars for the people who were clamoring to enroll in our plan.

What they told us was, why they joined it is because the hospital's name is on the product and my doctor is in the plan. And you know what? I trust my hospital and my doctor. They have been here 80 years and they may be here another 80 years. Sometimes health plans get bought and sold, folks. Sometimes they leave. Sometimes they stiff providers and do not pay us. My belief is, the Medicare beneficiaries in many, many markets are going to have this very same experience.

Many PSOs are going to have this very same experience, by saying, that is my hospital, that is my doctor. When I have a problem, I can deal with it. The doctors are going to get together and say, you know, I have got to see this patient next week, next year, and we, as hospitals are going to say, we have got to see them next year as well.

So, about solvency. We have to be there in the morning to see those patients in the ER. We have a business need to stay in the community and be viable. We will not fail. We have the solvency to make this work. If you give us a chance, we will show that not only this demonstration is going to be successful, but dozens and hundreds of organizations like ours around the country will make you proud if you pass this legislation. Thank you.

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

The CHAIRMAN. No applause from the committee, please.

Senator GRAMM. It was great testimony.

The CHAIRMAN. Thank you, Mr. Reiner. You do, indeed, present a very good case for PSOs. I do not think there is much disagreement about whether PSOs should be allowed to compete in the Medicare market. The issue is whether they should have special rules and be allowed to bypass State regulation.

Now, from your description, I assume your organization could get a State license. Why did you decide to take the route of a demonstration and not just get a Florida HMO license?

Mr. REINER. A good question. I would really like the chance to respond to that. We have a good relationship with 19 of the 22 health plans in Orlando, FL, as we speak, or in our market. There are already 22 health plans there.

If we wanted to get in the Medicare risk business on our own, because of the threshold of entry, with the 50/50 and commercial lives, we would have to go get an HMO license, which would take, I know, 6 months to a year, if you are lucky, in our State.

Then we would have to go enroll a commercial life, get a mass of commercial lives, and then we could go apply to HCFA to be an approved competitive medical plan provider. It takes too long to get all of that done. Our Medicare patients and enrollees are saying, we do not want you to wait that long.

So it is the fact that there is, we feel, enough commercial competition in the market already, why add another plan. I think the State of Florida, by the way, is a reasonable agency to work with. We have had a good relationship with them, and I think they would probably grant us one. But we would still have the problem, if we did not get the PSO waivers on licensure, before being able to market. We have over 4,000 lives after 2 months.

Another health plan who uses our same delivery system started marketing the very same day. This was a very nationally well-known HMO, well-known in many, many communities, one of the largest in the country. They have 200 members, we have 4,000. We just did not want to wait, we just wanted to get going because we can do a good job.

The CHAIRMAN. Let me turn to you, Ms. Ignagni. I think it was Dr. Lewers who mentioned the article in the *New York Times* yesterday. This story dealt with the problem of Medicare HMOs limit-

ing beneficiary appeal rights. The Inspector General says that many Medicare beneficiaries are never informed of these rights.

Then the story refers to an Arizona case where "the Federal District Judge has ordered certain compliance standards for appeals for Medicare HMOs." Yesterday, we were told by Bruce Vladeck that the administration will soon be releasing new regulations that conform to the standards ordered by the judge. I would appreciate your comments on what is happening in this area and how you and your organization view the new standards to be proposed by the administration.

Ms. IGNAGNI. Thank you, Mr. Chairman. I appreciate the opportunity to respond. This is an issue that I know is on a number of your minds. Back in October, we sent a letter to Secretary Shalala prior to the court decision, prior to the activity being begun and started at HCFA, that we are ready, and, in fact, over this last summer, had done considerable work with our members about the issue of grievances and appeals.

What we found in consulting with not only our members but our physicians and consumers in our health plan was that a number of individuals—particularly in the Medicare area, as you know, the numbers are approximately 100,000 a month entering into Medicare HMOS—unlike the employed population, have not had experience in managed care. It became very, very clear to us that additional steps need to be taken to address the challenges of a population that is, perhaps, unfamiliar with this style of practice.

So in October we sent a letter to Secretary Shalala outlining various steps that our members had been recommending. We have been in discussions with the Secretary and her staff since then, and with Dr. Vladeck, and we are working very collaboratively, and hope to continue to work collaboratively, with the department.

I would say also, I have a copy of the Inspector General's report right here. The Inspector General makes the point that 86 percent of respondents stated that they knew they had the right to complain about their medical care or services. So there seems to be a broad, 86 percent of the population that is aware of it.

However, when it comes to individual cases, there seems to be some difference of opinion and lack of information. So, in addition to being on record and working with HCFA, we, in our own initiatives, as we spelled out in our testimony, have been working very diligently to lay out the appeals and grievance processes in our member plans, and that will be available for all members to take a look at for physicians and consumers.

So we think that if consumers feel there is a problem, it needs to be addressed and we are prepared to work on that in a variety of formats.

The CHAIRMAN. I have one final question. This question would be addressed to each member of the panel. As you well know, concerns have been expressed about allowing organizations such as PSOs who have no State license and, therefore, no experience accepting full risk, to experiment and learn on the Medicare population.

Now, the counter-argument is that providers already accept a lot of what is called downstream risk by contracting with managed care organizations and, therefore, they do, in fact, have experience.

I would appreciate your comments on accepting downstream risk versus full risk.

Mr. Pomeroy, shall we begin with you?

Mr. POMEROY. Thank you, Mr. Chairman. First of all, I would like to say that proponents of efforts to prohibit States from continuing to be able to protect individuals who enroll in these plans often say that States are barriers and restrict the develop of this sort of market.

I would just like to say that we have recently surveyed our 50-member States and have found that, in the 39 States who have responded to the survey, organizations that are provider sponsored exist in at least 27 States. Those 27 States were able to process those applications in an average of 90 days.

I do not know how long the Federal agency took to process that application, but I can tell you that we recently licensed a provider-based HMO in North Dakota and the packet was not nearly that thick. Yet, in the process, we were able to maintain our authority to protect the consumers who would ultimately enroll in it.

When you eliminate State regulation and the State's ability to protect consumers, not only do you transfer to some other place the authority to provide that up-front screening, but you take with it the State's ability to protect consumers on an ongoing basis through the market conduct activities that take place, and through the financial examination activities that States presently engage in, and for the ability of States to receive complaints and deal with complaints that consumers may have once they become enrolled in one of these plans.

The key question is, is the organization the ultimate one who assumes the risk? If the organization is the one who accepts the premium and says to the person who enrolls in it, we will be there for you to provide for your health care benefits, that is not a downstream risk, that is front-line.

It is so important to your constituents and the folks whom it is my job to protect, to make sure that organizations will remain financially strong to honor the commitments that they make when they enroll someone in the program.

The CHAIRMAN. Has any study been made of the timeframe it takes States to grant licenses?

Mr. POMEROY. Yes, Mr. Chairman. We recently completed a survey, and I think we have included the survey results in the prepared written testimony. It appears the average length of time for dealing with an application is about 90 days, once the application is properly completed.

Sometimes we will get an application that needs some work because it has not been properly completed. We do not think you should start counting the clock at that point in time, because the application really needs to be full and complete before the State can actually do its job of making sure that the protections are there. Once the application is complete, we have an average turnaround time across this Nation of approximately 90 days.

The CHAIRMAN. If you did not include that, I would appreciate it if it would be made part of the record.

Mr. POMEROY. Thank you. We will, Mr. Chairman.

The CHAIRMAN. Next, Ms. Ignagni.

Ms. IGNAGNI. Thank you, Mr. Chairman. I think Mr. Pomeroy stated it very well. In our view, it is wrong to treat entities that are offering similar products and performing similar functions in the market differently.

From the perspective of role of government, consumer protection, et cetera, there is a current major debate about whether the regulations for managed care are adequate currently, and we would hope that, as the Congress as a whole and this committee looks at that matter, you would not carve out particular delivery systems and set up a special corridor for those delivery systems. We do not think the case is made that you need to do that, based on what is going on in the market.

The CHAIRMAN. Dr. Lewers.

Dr. LEWERS. Thank you. I believe your statement regarding the physician providers having experience is certainly a true one, in providing care and taking risk. In the more recent years, risk has been great. There is a great variation in State-to-State handling of issues of this nature and the applications.

So, a uniform handling of something such that could occur in the Medicare program is appropriate. The Medicare program has been in the past a program in which we have been able to evaluate effective programs to see if we can get them to work. The biggest example of that is the RBRVS, which was initiated in the Medicare program and reformed and refined in that process, and then now has spread throughout the entire industry.

So there is precedent for this. The Medicare beneficiaries tell us, as their physicians, that they want choice. They want choice of their plan, they want choice of their physician. I think we should give them that opportunity, and do so. We do have a series of controls through the Medicare program that would allow us to evaluate this process and to show that it can be cost effective and that it can provide quality of care.

The CHAIRMAN. Thank you, Dr. Lewers. Mr. Nielsen.

Mr. NIELSEN. Thank you, Mr. Chairman. The coalition that I represent has not taken a position on these issues, but if I might just for a moment describe our entity, which is an integrated system, which I guess in the very purest sense is a PSO.

However, integrated systems like ours are a bit schizophrenic, I suggest, because you do have health plans who are sympathetic with the kinds of concerns Mr. Pomeroy and Ms. Ignagni suggest, as well as hospitals whom I think would be sympathetic with the American Hospital Association position and the other witnesses here.

Our company has not taken a definitive position, but I would think certainly it would be important that, in whatever form the regulatory oversight takes, that it pay careful attention to solvency requirements and quality requirements, which may only be able to be offered at the local level, at least with respect to quality. But those are concerns. They will remain concerns. Perhaps they will be overcome with respect to the kinds of things that Senator Frist has in his bill. Thank you.

The CHAIRMAN. Mr. Pomeroy, then I will go to you, Mr. Reiner. You mentioned that, on average, I think it was 90 days. Are there any States in which it takes substantially longer?

Mr. POMEROY. Mr. Chairman, I do not know the specific answer to that. I will get the survey for you. I am sure any time you have an average you are going to have some who are able to meet the mark sooner and some who are going to take longer. On average, though, the responding States, all totaled, was about 90 days.

The CHAIRMAN. But I would like to know the range.

Mr. POMEROY. All right.

The CHAIRMAN. Mr. Reiner.

Mr. REINER. The issue of downstream risk and some of the differences, I would appreciate the opportunity to circle back around on that. HMOs are warming to the idea of using PSOs to off-load the medical costs, and that physicians and hospitals, that is how we are learning to do some of the things that we do, is from lives the HMOs bring us.

As you all know, the struggles about the money, how much money do they keep for the sales, marketing, overhead, and profit, and how much actually gets to the providers who have to deliver the care, integrate the care, and be at risk for the care. It does end up being a struggle.

I think if you asked the industry, they would just as soon keep us in the position we are in, where they give us the money and they decide how much to give us, and we do not have much leverage to carry that out.

I would also submit that, if you are looking for some dollars—and I think you are; what I read in my Orlando paper and my trade journals say you are looking for some savings in some Medicare dollars—I am clear that provider sponsored organizations, well-developed provider sponsored organizations, criteria met, ones who have been around the track, know how to do this, can save a fair amount of Medicare money. The overhead and the extra money that is being kept could be saved by Medicare and the PSOs could do their job.

One quick, last example, if I may, Mr. Chairman. We are also testing with HCFA, as a part of our demonstration, not only the demonstration of a provider sponsored organization being a powerhouse in the market, but second, all the talk about the AAPCC—and I can elaborate on that, too, if you would like, in a minute—about being wrong and overpaying because of well people in health plans and sick people in fee-for-service, we are testing a risk adjustor which will retrospectively, based on data for the previous year, either have us reimburse HCFA or HCFA will reimburse us more, depending on the health status and the resources consumed of the patients that enroll in our plan.

Now, I think that is the end game. I think that is the fairest way, if this can be tested. I do not know whether health plans were asked or were willing to try that, because of some of the adverse consequences that may come out of that risk adjustor model experience that we are testing with HCFA. But we have nothing to lose. We have good data. We are a community hospital. If we are paid more than we should, we should give it back to the Government. So you need to keep that in mind, as well.

If you would like to ask me about AAPCC, I could opine on that as well.

The CHAIRMAN. I think the return of any money to the Federal Government would be a historic event.

[Laughter.]

Mr. REINER. Well, it may happen in Orlando, FL.

The CHAIRMAN. Please let us know.

Mr. REINER. I will, Mr. Chairman. I will write you a letter.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. May I say, Mr. Chairman, that I am not well-equipped to add much to this particular discussion. There are so many people on this committee who know so much more than I do. Senator Rockefeller has devoted much of his career to health issues.

Senator Conrad was tax commissioner in North Dakota and knows these things intimately from a hands-on basis. Senator Graham was Governor of Florida and knows all those hospitals you are talking about. He knows them specifically. Carol Moseley-Braun was a State official with great involvement. I have not had any of this.

The only thing that I think I might offer to this is some perception about what Mr. Reiner called a paradigm shift. You were kind enough to mention that I was, yesterday, going on about the idea of the commodification of medicine. That was offered to us in testimony by a Jesuit from Fordham University, ethicist, who said, "What you are seeing is the commodification of medicine." You enter a marketplace that determines outcomes in a way that was previously determined by other standards.

The American Medical Association, Dr. Lewers, and all of its counterparts around the world, was a guild, in every sense, a recognizable, medieval guild. It has its standards, admitted its members, it disciplined its members.

Morris Fishbein would be horrified to think that you, sir, would be testifying before the Senate Finance Committee. Everything that he stood for in life was to see that you never came near this place, where we regulate, tax, and finance. You regulated yourselves. It is like the bar association regulates itself. This is an old and very honorable arrangement, but it has changed by a combination of things that I do not know that I fully understand. But the idea of a paradigm shift is very important. A term comes from Thomas Kuhn's book, "The Structure of Scientific Revolution," which was published in the 1950's.

The classic situation, is Galileo came along and said, I think the earth moves around the sun. The pope told him to shut up and go home and stop talking such things; everybody knows the sun revolves around the earth. He went home, he shut up, and his last words were—and I cannot remember the Italian exactly—but it still moves, the earth is moving. We suddenly realized we had to rethink the whole universe over.

What we are seeing now, I just think of the comments that you have made, Mr. Reiner. You were speaking of sales, marketing, overhead, and profit. Mr. Pomeroy, you talked about health insurance market. You talked about more competitive marketplaces. Consumer safeguards. Ms. Ignagni talked about products, talked about the managed care industry. This is what we are talking about here.

What the Federal Government is doing, and I spoke with Dr. Vladeck yesterday, we are moving from the administering of a program by which the Government provides services to regulating a sector in the economy. As we do this we must take care, because over-regulation can be such a calamity. Look at that thing you have brought here.

I am glad that Senator Graham is not here to hear me say this, but the tendency to over-regulate is inherent in the process. It can be very destructive. I think the Interstate Commerce Commission almost over-regulated the railroads out of existence.

Can I ask, do you all share any of this perception? I do not want to go on, but if you could write me a note if you see something that encourages you in this regard, or am I getting it wrong? I do not know.

Ms. IGNAGNI. Are you asking rhetorically?

Senator MOYNIHAN. Yes, but I would take an answer.

Mr. REINER. Would you like a response?

Senator MOYNIHAN. Yes.

Mr. REINER. If you do not mind, I will take a shot at it. I have been around the industry for about 12 years and I have seen——

Senator MOYNIHAN. Industry.

Mr. REINER. I am sorry. Yes, I did use that word, did I not?

Senator MOYNIHAN. Yes. Sure. Dr. Fishbein would never ascribe it to industry.

Mr. REINER. Let me start over. I use a number of simple phraseologies. When I go home at night and my 14-year-old wants to know why I have not been there in 14 hours, she says, what have you been doing? I say, I have been talking to doctors about power and money. We are shifting the paradigm and we are reclaiming the ground.

The providers have lost ground. We feel like the power situation has moved away from patients and away from physicians. What PSOs will do is bring that back. I have heard talk about level playing fields. The playing field is not level today, it is at our significant disadvantage. This legislation will bring the playing field back to level, in my opinion.

Senator MOYNIHAN. Good. All I asked is that, if you think about it in those terms, you will get better answers than if you do not note that there has been this transformation from a guild arrangement to an economic arrangement.

Mr. REINER. A very commercial enterprise.

Senator MOYNIHAN. A commercial enterprise. There is nothing wrong with commercial enterprises, but be careful how government regulates them, and encourage what seems to me to be a very inspired notion of sort of half-way between the almost secretive—well, remember, doctors used to, and probably still do, write prescriptions in a handwriting that only pharmacists can read.

Mr. REINER. They still do.

Senator MOYNIHAN. That is just a very close, controlled relationship, and best not anybody should know. It is a sacred duty. Well, commerce does not allow that, unfortunately.

Ms. IGNAGNI. Senator, could I comment just very briefly?

Senator MOYNIHAN. I am taking too much time, but yes, please.

Ms. IGNAGNI. I think that you have put your finger on one of the vexing challenges for Members of this committee, and indeed, all Members of Congress. You are talking about the role of government in health care. We have not really had a forum to think about it in that way for quite some time. We have had a number of pieces of legislation over the last few years, particularly that got close to that. But, in the forum of committee discussion, it is very difficult to step back and adequately look at what is in the regulatory area today.

Mr. Reiner brought this book for you, which I think very much makes the case, I would say to you, that the important thing to remember is that plans, integrated systems, going through this new corridor have less regulation to meet than plans that are in the market today, so the book's are actually much higher. That is the first point.

The second point, is as you look at this issue of role of government throughout all delivery systems, we hope that we might be helpful in bringing a sense that we have learned, particularly over the last few months, which is that our consumers and our providers want to be far more engaged and hear more about health care delivery matters, about ethical standards of our health plans, what values we hold dear, and they want to be part of a discussion where they can be involved in that.

We have endeavored to put a number of things on the table to move toward that, but I think you are at a propitious time here as you are looking at Medicare, and looking, indeed, at the entire delivery system to talk about the matter of how you preserve consumer protection, but at the same time increase the activities in the market.

Senator MOYNIHAN. Fine. Thank you. My time is up. I am afraid, Mr. Pomeroy, I am going to be in the second round. But I just want to say that I think that Senator Rockefeller and Dr. Frist had a very ingenious way of finding a transition here between these two systems.

But also, may I just note that we are talking about providers. Dr. Fishbein used to talk about doctors.

Dr. LEWERS. Mr. Chairman, may I respond briefly to this? Briefly.

The CHAIRMAN. Sure. Go ahead.

Dr. LEWERS. The American Medical Association is 150 years old this year. The first thing that the AMA did when it was formed was develop a code of ethics. That code of ethics is to do one thing: protect patients. What we have forgotten, and what Senator Moynihan is bringing out, that we are here to deal with patients, and for patients. We have developed——

Senator MOYNIHAN. No, no, Doctor. Consumers.

Dr. LEWERS. No, no. I am sorry, Senator. I treat patients, not consumers. They are consuming and the environment has changed, but we need to get back to our basics. That is, providing health care through the patient/physician relationship which is sacred, and which is the development of quality, cost-effective health care because quality health care is cost-effective health care. So the Senator has hit on the point on which we need to work and really get back to the basics. Thank you very much, sir.

Senator MOYNIHAN. Thank you very much.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. Might I say, Mr. Chairman, I think you have brought before us one of the best panels I have heard. I just think each one of you should be commended for excellent testimony, clear, concise, interesting. I think I have learned things here this morning, and that does not always happen. So, I want to thank this panel, and each one of you has done just an excellent job.

The whole notion of PSOs, it seems to me, the attractive feature of them, is that it brings the treatment closer to the patient. That is, the treatment decisions.

I must say, my grandfather was a doctor. I have got lots of relatives that are doctors. I hear repeatedly things that are very troubling, needing to call 500–800 miles away to get approval for a procedure that is absolutely essential and being given the run-around.

I have one relative who is a doctor in Richmond who finally became so fed up, after months of delay, to get a procedure for one of his patients—not one that he was going to perform, not one that he was going to benefit from, one that the patient needed—and called the insurer in question and got the run-around, calling a 1–800 number.

Finally, after 45 minutes the representative of the insurer came on and said, well, doctor, what you need to do is call this 1–800 number. And he said, well, what number do you think I called? That is where he had started. So this is very troubling.

I think the notion of PSOs being closer to the community is very attractive. So I do not think the issue here, as the Chairman indicated, is the difference with respect to having PSOs participate. I think virtually all of us, if not all of us, agree with that proposition.

One of the questions is, where are they to be regulated? That is kind of interesting. We make the point that the PSO is closer to the community, and so they will have more of an interest in serving that community appropriately. And then we talk about regulation, and bringing the regulation back to Washington rather than have that done at the State level, where it is closer to the patients, closer to the community. It seems to me there is sort of a disconnect here.

On the one hand, we say it is advantageous to the patient to have a PSO that is closer to the community. Then we are saying, well, let us have regulation from Washington rather than at the State level closer to the community.

I would just ask Mr. Reiner, why is the case Mr. Pomeroy makes not the correct one, that the States have experience in this area, that they are closer to the entities involved, and that they should do the regulation?

Mr. REINER. If one of the regulatory hurdles is to get the traditional HMO license, this would really need to be done together, the Federal Government and the States together.

If one of the hurdles of the HMO license was not there and there were other means of being certified as a provider sponsored organization by a State that took into account some of the differences of a provider sponsored organization and an insurance company, then perhaps—and I say perhaps—that may be an option. But it seems

to me that the State insurance commissioners work at a fairly slow speed to bring about any change in regulation, and that some of these things need to get moving a little quicker.

Senator CONRAD. You think the Federal Government moves faster?

Mr. REINER. This project moved pretty fast.

Senator CONRAD. Let me just say, that is a breakthrough testimony.

[Laughter.]

Senator CONRAD. I have been here 10 years. Nobody has ever told me that the Federal Government moves faster than the States. But I am glad to hear it.

Mr. REINER. Senator D'Amato left. He has waited longer for his waiver than I took to get the demonstration project.

Senator CONRAD. Mr. Pomeroy, would you like to respond?

Mr. POMEROY. Thank you, Senator. There is a diversity that exists amongst the States, but it is a healthy diversity and it allows the regulatory framework to evolve over time and one State to benefit from the experience of another.

The world is far different, as we approach the year 2000, than it was a century ago. Magnificent discoveries have taken place in medical technology, producing wonderful results, but at tremendous costs.

One-seventh of our gross national product is now devoted to costs associated with health care. Clearly, there is an important public interest here, which is why you are conducting this hearing.

We believe that the States continue to be the appropriate place for organizations like this to evolve. We believe that the regulatory framework that exists in the individual States, as Senator Conrad mentioned, is closest to the community, is most able to put in place the kind of protections that consumers in those localities require.

Senator CONRAD. I thank the Chairman.

The CHAIRMAN. Thank you, Senator Conrad.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I would just like to make one, sort of, clarification. That is, what we are talking about here in the form of S. 146 has to do with Medicare, PSOs for Medicare. Medicare is a national program.

The concept that the Federal Government would say we want, in terms of quality, solvency, and some other things, a Federal standard nationwide for a Federal program for a period of 4 years not in order to allow the States just to change rules and regulations, but change, in some cases, laws, I think is a very sound one.

I have to say, having been a Governor for 8 years, that the concept of a State insurance agency/department, moving at a very slow level, is one which I am very familiar with. It was true in West Virginia, it has been true in many States that I know about. But I think that is the point we have to get. We are talking Medicare. We are talking national standards because we are talking about a national program. We are not talking about under 65.

Let me just ask Dr. Reiner a question. This is very important for me in a rural State like West Virginia, where HMOs are a concept which is still distant. Blue Cross/Blue Shield held a press conference yesterday, or this week, in which they said that "PSOs are

a very risky prospect for Medicare, particularly in rural areas." I would like to get your comments on that.

Mr. REINER. Giving some thought to that, and I can give you some practical experience as well. Now, Florida is not totally rural, but I think Senator Mack and Senator Graham would say part of it is. We have initiatives under way to support some of our smaller rural hospitals in Central Florida, Sebring, Avon Park area. We have a facility there.

We are going to provide all of our infrastructure and support services to them so that when the time comes for them to be a Medicare risk provider, hopefully as a PSO, they can buy that from us on an incremental basis and not incur the expense that we did to get the significant infrastructure and support services in place to do it.

So rural can be met two ways. No. 1, linking with larger facilities. I think there are enough big towns in West Virginia that would be able to support the infrastructure. Then lease that, or lease that out, to the rural areas to make sure that they do not make some of those mistakes. I guess, provide some of the technical insurance expertise necessary to do it. Another part of our organization has also put together another arrangement in North Georgia.

Part of our company owns some hospitals in North Georgia. Four hospitals have formed a coalition or a new business enterprise to purchase software, hire employees to be able to manage risk, and pool their economic resources and the other resources of their physicians by banding together to be a super PHO. In this way, they are going to share some of these start-up expenses and be able to facilitate that in rural markets. I think it is very doable in rural markets, with some creativity.

Senator ROCKEFELLER. Can I ask you why you think that PSOs, from your experience, are so attractive to Medicare beneficiaries?

Mr. REINER. I think, as I said in my earlier statement, they have connected much, much longer, if they have lived in the community very long, with the hospital and with the physicians. When we put our name on the product and our label, Florida Hospital Premiere Care is the name of our product, they connect with that. They trust it. They expect it to be there tomorrow. I referenced that earlier.

I think rural areas, with some adjustment in the AAPCC, deserve some of these extra benefits that come along with a managing care plan and finding a few more dollars to provide the extra health enhancement and health improvement benefits that, really, people ought to get.

Senator ROCKEFELLER. Why do you think that Blue Cross/Blue Shield and HMOs are as opposed to Federal PSO legislation, as they appear to be?

Mr. REINER. It is going to take away their power and clout. They right now have the money. You know the old golden rule, he who has the gold makes the rules. They do not want organizations that are going to compete with them.

I have to tell one other story, if I may. We tried for 4 years to find a national HMO partner to sign a long-term arrangement with us, because we knew Medicare and we knew our power in the Medicare market as a major Medicare hospital would be a great part-

ner. Let us jointly label. Let us do a 10-year deal here. Let us really think outside the box and get creative and do a Medicare project together. Could not interest them. Could not interest them. So, we were left to our own devices. We are going to find a better mousetrap and we are going to create a dynamic that is even better.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. LEWERS. May I respond briefly, Mr. Chairman?

The CHAIRMAN. Yes.

Dr. LEWERS. Sorry to keep getting in on the tail end of that. But the Senator has hit on a very important point. That is, we have problems providing rural health care. We have problems getting physicians into the rural area, as you well know. Part of the problem is, you are out there isolated alone if you get into an area. If you can become part of a network, a provider sponsored network, then I think we will expand rural health care.

There are examples of that. Look at some of the earlier groups that formed and then found that in a competitive environment they needed to put physicians into that rural area. We now have seen examples to where they have done it so well, that Blue Cross/Blue Shield has accused them of antitrust factors.

In Minnesota, a major suit which was an antitrust case which came about because a group of physicians moved into a rural area that needed care, then once they were established and providing that care, Blue Cross felt that there was an antitrust case and had a major problem. So, sir, we have got to look at all of these issues.

There are a lot of very important things you are looking at. The ERISA laws, being exempted on the State level. The fact that many of the State insurance departments only look at risk. We cannot stop at risk, we have got to go to quality of health care and the provision of health care. That is why you are programmed to put this in the Medicare program where the evolution into the State is so important, and I commend you for that, sir.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I want to associate myself with the remarks that have been made earlier about what an excellent panel this was. I told Mr. Reiner, as he came to the table, that I was not going to be able to stay for the hearing. I do not know what else I was supposed to do, but I will say, this was so compelling that I have missed it.

I would like to ask a couple of questions. One, is the question that Senator Conrad and Senator Rockefeller were just discussing, and that is this State/Federal relationship. I will express a bias. I start from the premise that the best regulation and the best control is as close to the people who are involved as possible, so the burden is on those who are going to advocate a nationalization to make the case.

It seems to me that, as relates to Medicare beneficiaries specifically, that we have the possibility here of a mixed relationship between the State and the Federal Government.

Let me suggest that, in terms of regulation, that the challenge to the States is to come up with a model of regulation that recognizes that the provider-based organization is not like a financially based HMO, and that those differences deserve to be dealt with by specially tailored regulations, possibly State legislation, and stand-

ards. I have been searching for an analogy and I have not come to one that is totally satisfactory.

I hate to be as commercial as Senator Moynihan has accused us of being, but this is going to be rankly commercial. In some ways, the provider-based organization is like the commodities market. If, in the final analysis, you cannot meet the obligations of your contract, then somebody dumps two tons of corn in your backyard.

In the case of this, if the provider-based organization for some reason is placed in jeopardy, they are the people who have the ability to provide the equivalent in terms of days of hospitalization or hours of access to a health care professional. That difference between a financial HMO which does not have those inherent resources and a provider-based organization ought to be recognized, ideally, at the State level.

So, with that long introduction, I would like to ask Mr. Pomeroy, to what degree are the States recognizing that difference and, therefore, reducing some of the barriers that Mr. Reiner and Dr. Lewers described to get a regulatory system at the State level to govern this new entity within the health care system.

Mr. POMEROY. Thank you, Senator Graham, and committee Members. I appreciate both observations about State insurance regulations and I am sorry that Senator Rockefeller had a bad experience back when you were Governor with some State insurance regulation. I can tell you that I sincerely believe the state of State insurance regulation is far better today than it was a decade ago.

A tremendous amount of effort has been placed in making State insurance regulation work better through this accreditation program, which I will not bore you with the details about today. But to a State, States are better now, more equipped now, have more tools now to service the market efficiently and effectively.

With respect to the question, Senator Graham, that you just posed, the challenge now to the States is to make sure that the regulation that will affect these provider sponsored organizations makes sense from the concept of this particular form of entity.

Over the last many months, the organization has been working on two projects which are covered in more detail in my prepared remarks, but this CLEAR initiative, the Consolidated Licensure for Entities Assuming Risk, we have made much progress in terms of designing standards which will be uniform from State to State concerning the regulation of entities such as this.

Senator GRAHAM. And are these regulations sensitive to the difference between a financial entity and a provider entity?

Mr. POMEROY. More in the initiative I am just now going to discuss, and that is something referred to the Health Organization Risk-Based Capital formula, which is under construction. A test for regulators to use, a tool for regulators to use, to ensure that entities that assume risk have the appropriate amount of capital to be around to pay the claims. It is in the development of that formula where sufficient flexibility needs to exist to recognize the distinct differences between these organizations.

This Health Organization Risk-Based Capital, or HORBC, as we refer to it, will be a product that will be completed this summer. It has been under development for some time with a great deal of input in a very public, open format, input from the provider groups

from all of the special interests who have special concerns concerning the regulation of these entities.

Ms. IGNAGNI. Senator Graham, may I just add a quick note. I think that one of the most depressing things is that once you have been around for a while in the health care industry, things start to recirculate. I would just make the observation that your colleagues who have come before you wrestled with this matter about 28 years ago under the Medicaid program, when the decision was made to set up a special corridor at the Federal level for so-called prepaid health plans that allegedly were going to be closer to the community, would not necessarily be able to meet the test of insurance commissioner regulation, et cetera.

I would just note for the committee that the literature is replete with failures and problems with respect to beneficiaries and providers associated with those. For us, we believe that the market ought to be open, that there ought to be more competition. We fully support that. But then the question is, should the Government be neutral with respect to competitive advantages given to one versus the other?

Senator GRAHAM. But I am saying something maybe that is consistent with what you said, but I do not think applying the same standard to different entities equals equality.

Ms. IGNAGNI. We agree with that. We agree with that.

Senator GRAHAM. To me there is a significant difference between a financial managed care organization and a provider managed care organization, and that difference needs to be recognized. Then if it is recognized, you can have a level playing field.

Ms. IGNAGNI. Yes, sir. Indeed, you may be pleased to know that our organization has been very much involved with the NAIC and their risk-based capital work group, and believes that, as a matter of principal, that you are right, that different organizations ought to be looked at differently. Then you need to pull back and look at comparability, and the NAIC is in the process of doing that now and presumably there will be public comment, et cetera.

Mr. REINER. Let me add just one other comment. If you do go the State regulation route and do not leave it as the bill says now, then please do something with that 50/50 requirement because if I can demonstrate my ability to manage care and I have got one commercial life or 10 commercial lives, but I can really do Medicare well, then I do not want to be penalized in any way.

The CHAIRMAN. I would just like to ask a follow-up question, because it is my understanding, Ms. Ignagni, that Congress did give special consideration to HMOs in the early days. So there is precedent for giving preferential treatment to PSOs to help them get off the ground.

Ms. IGNAGNI. Well, to the extent the Federal HMO Act preempted laws at the State level that were barriers to our plans getting into the market, that is true.

The CHAIRMAN. Is that not the concern here?

Ms. IGNAGNI. We had any willing provider legislation, as you know, Mr. Chairman, on the books in many States around the country in the late 1960's, early 1970's.

Indeed, the first court case was in the late 1930's here in the Washington, DC, market, where the medical society took one of our

health plans to court to try to prevent that health plan from moving forward in the Washington community.

I would suggest that that is a very different situation than the one you have today, where experience has demonstrated that integrated systems are, indeed, being licensed and growing quite rapidly.

Senator ROCKEFELLER. Mr. Chairman, can I just add to your point. I mean, I think that you have made a fundamental point, that back in 1973 the Congress made a decision to give, in fact, financial help in the startup of HMOs, because at that time the folks who were in the field did not want HMOs. Congress knew there had to be more competition, and so they helped HMOs get started.

Now you have the situation where you have another form of competition entering, and those same HMOs are resisting them coming into the market. People say, well, it ought to be State. Well, it will be State. It will be State in 4 years, or maybe it will be 3 years. It will be State. But, because it is Medicare, it starts off national because of certain requirements there, and then it goes to the State.

The CHAIRMAN. In other words, we want to make sure the door is open.

Ms. IGNAGNI. Mr. Chairman, I would just observe, as you all well know, that back in 1973, with the passage of the HMO Act, the requirement was that our plans had to be licensed at the State level before being qualified.

The CHAIRMAN. But certain laws, I think, were exempt as well.

Well, we have our distinguished Senator from Florida again, Senator Graham.

Senator MACK. Senator Mack.

The CHAIRMAN. Mack, I mean. Yes.

Senator MACK. Any comments you want to make, Senator Mack? [Laughter.]

The CHAIRMAN. I apologize, Senator Graham.

Senator MACK. No, no, no. You should not apologize. Well, thank you for the opportunity. I am going to follow on, I think, with part of this discussion.

But let me first say that, back in the 1970's, I found myself drawn into the health care business in the sense of chairing a hospital board for almost 4 years, and being on a hospital board for some 6 years. I find this panel to be extremely helpful, as all of us have indicated.

I mean, the change that has taken place in the health care field over those years is dramatic. When I was involved, I do not even remember what the term was. Was it cost plus reimbursement, something like that? Then we went to DRGs, and now we are talking about things that are just so totally different.

I want to focus still, for a moment, on this issue of the treatment of PSOs. My instincts are that, in fact, PSOs are different from insurers. I must say, I approach this from a fairly simplistic approach. I watch what they do. I observe what they are involved in and draw the conclusion that they are different.

I gather, though, from the discussion that has taken place here today that, while we may have begun the discussion with the assumption that Mr. Pomeroy, for example, implied that they are all

the same, then I heard others saying, well, what we are really doing is saying we are rewriting the way we are going to be looking at these institutions and implying that you recognize that there are differences.

Again, my feeling is that doctors and hospitals are different from someone who takes the risk as the insurer. I am concerned about the development of legislation that would make it more difficult for hospitals and providers to get into a more competitive position. I will just kind of throw that out. And if there is any further clarification people want to make, I would be delighted to hear it. Dr. Lewers.

Dr. LEWERS. Thank you. I think you have touched on another very important issue. I am a physician. I treat patients. I have to look at that patient in the eye when I treat that patient and when I have to tell them, your plan does not allow this. I know what they need. You put me into a competitive market, and I will provide the care to my patients. There has been recent evidence of this.

If you talk about Jamie Robinson's study from Berkeley which was in the *New England Journal of Medicine* demonstrating that this did work, that hospital days did decrease, that the cost did decrease in the system. So we have experience with this.

Quite frankly, it is a simple issue. It is because I have to live with these people that I treat. They are part of my community. They are part of my life. I am going to provide them quality of health care, and if I am in the competitive market I am going to do so in such a way that I do reduce costs. I have to do it.

So, I think there is the major difference. I said it earlier, and Senator Frist said it. The patient/physician relationship is a unique situation and one that you only experience when you partake of it. So, there is a difference.

Senator MACK. Mr. Pomeroy.

Mr. POMEROY. Thank you, Senator. The skills associated with being a brilliant legal mind and devoted to making people well is not necessarily the same set of skills that is required to be an expert manager of risk.

The business of insurance is a business, and it is a complicated one. It involves making actuarial projections, receiving enough from premiums from a group of people to take that risk up the entity itself, spreading that risk amongst the whole. That is an entire set of expertise that is different than one that is required to treat that person in the emergency room that we have been talking about.

There are those who say, these entities can be treated far differently because basically you have in them the sweat equity of the doctors. So, therefore, if the money is not sufficient to pay the claims, the doctors will just work for less, is what some proponents of getting States out of the way claim. We do not think that is an appropriate approach.

We think that there are all sorts of costs associated with these kinds of entities, clinical personnel, facility costs associated with running the organization, and associated costs such that it is not sufficient to just have beneficiaries or enrollees in this plan rely on their doctor working for less someday if somehow the projections made up front were insufficient. The business of insurance is com-

plicated. It does require expertise. And regulating, we think, also requires expertise which now resides in the States.

Senator MACK. I assume, Mr. Reiner, you want to respond.

Mr. REINER. She wanted to make a comment first.

Senator MACK. Before either one of you make a comment, the implication there, let us say, at least with respect to hospital-based organizations, that they somehow do not have the expertise.

I must tell you that the hospitals that I have come in contact with over the years, I am incredibly impressed with their expertise, way beyond the knowledge necessary to work with the patient. I mean, the expertise that is in these institutions is unbelievable, in my experience. So I, again, do not accept the basic premise that you have put out.

Mr. REINER. As a lead-in to that, I have maybe not made it totally clear before, but PSOs will only work if they are a real partnership of physicians and hospitals. Physicians bring the clinical capital and the clinical know-how to do what the doctor just said, hospital people bring the business expertise.

When we do not have it internally, we go buy it, and find it. We hire actuaries, accountants, claims people, information systems. These are people out there, and you need that infrastructure that I was talking to Senator Rockefeller about. That is the kind of thing you have to have in place in order to do this. So physicians may not have it, but in partnership they will find it.

Let me make one final point. As we think about the ultimate beneficiaries, I think I made a point earlier, 40 percent of the people who have joined our plan in the last 3 months have joined because they left another HMO. I think that is a pretty telling statistic as to their satisfaction level with what they have been in with what they are now planning on getting from us.

Senator ROCKEFELLER. Mr. Chairman, I totally apologize, but I have one sentence from CRS that I really would like to read. It says in a report, "Health Maintenance Organization Act signed into law by Nixon in 1973 which enabled HMOs meeting Federal requirements to be exempt from specific State laws, such as laws requiring physicians to constitute all, or a percentage, of an HMO's governing body and," I say significantly, "laws requiring the HMO to meet State solvency requirements." So, the Government was not neutral back in the early 1970's about competition.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Ms. Ignagni, on page 6 of your testimony you had some figures about the growth of HMOs. I get the impression, which I do not think is the impression you want to leave, that this growth can go on and on, that we should not do something about it. Particularly, you mentioned Dade County, that it would grow from $748 per month per beneficiary to $1,073. That is 9 percent growth, $14,000 per year.

You are legitimately making a plea with us that we have got to be careful not to ruin HMOs when we are balancing the budget. I think that is legitimate because I want to get HMOs into my State, and they are not there because it is a rural area.

But I have to ask, is it your position that in just a few more years we ought to be paying $14,000 per month or per year?

Ms. IGNAGNI. No, sir. I appreciate the question. What we have endeavored to do in our testimony is lay out the results of the Barents' report and how it compares to current law. Point No. 1, we have been on record, and indeed came before this committee 2 years ago, with a proposal on behalf of the entire industry to deal with the range in payment across the spectrum of the country from Florida, California, to Minneapolis, Seattle, and indeed in rural areas.

At that time, what we had proposed was a floor. We had proposed differential rates of growth to begin to deal with the very important issues that are before you today. We would be delighted to resubmit those proposals.

I think Mr. Nielsen made the point very effectively about what is happening in certain markets where we already have penetration, where there are not enough resources to continue and expand, and certainly in rural markets, in terms of entities going into the market.

At the same time, I think what you do not want to do is develop a policy that sets back the progress that we have made in areas that have been fairly highly penetrated, and that is the balance. But we want to participate in that.

Senator GRASSLEY. Would you say the end result of your proposals of past years was to narrow the discrepancy from the low to the high?

Ms. IGNAGNI. Yes, sir.

Senator GRASSLEY. So that we would be able to have thresholds and get plans in rural areas.

Ms. IGNAGNI. Yes, sir.

Senator GRASSLEY. All right. Thank you. I am very happy to have that clarified. But I obviously did not read your statement the way you had intended it.

Ms. IGNAGNI. No, I am sorry, sir. We had not provided it again this time, but we would be delighted to do so, if the Chair would care to have that material.

Senator GRASSLEY. Yes, we should have it.

The CHAIRMAN. Without objection.

[The information appears in the appendix.]

Senator GRASSLEY. So, Mr. Nielsen, then since you are also concerned about the AAPCC, I would ask you and refer to what we did in 1995. We were trying to have a $350 per month, per enrollee floor. Now, even though it is 2 years later, the President has proposed that floor.

In your testimony, you mention that the average in your market area was about $350, but you also said that your plan charges enrollees additional premiums, and that even so the plan still is losing money.

If an experienced HMO like yours serving a low-cost area cannot make programs like that work with a payment of $350, should that tell us that the $350 being proposed today by the administration is inadequate, and how would you recommend that we determine what level, what floor we have?

Mr. NIELSEN. Thank you, Senator. I have appreciated the passion here for PSOs and I am glad that we can share our passion for the issue that you have raised. We have found with the level of AAPCC payments in Utah, and I would also suggest to you the $350 level

is before the demographic adjustments, which bring it down to about $307, that is simply not adequate, in our experience, for us to have a product that appears to be able to survive.

The floor that is suggested is likely going to be too low no matter where you have it. We think it looks like, at least with our experience now after a year, for us to have a product that is going to survive in this market we have got to be somewhere near $400. There are plenty of markets in that range.

The solution, I suspect, is not only the floor, which would at least have the benefit of raising these levels up to some competitive advantage with high payment areas, but there has got to be more than that.

There has to be some mechanism by which the AAPCC can be adjusted or averaged so that these low-payment areas more greatly approach the national average. They do not do that right now. There is no way that that mechanism is going to have that effect. Until that occurs, areas like that that exist in your State and mine are simply not going to have the ability to have these HMO products available to citizens.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. At the outset, I want to add my congratulations to you for this panel. I was intending, and in fact had a schedule, to be at another committee, and decided to dust it off and stay and listen to this testimony this morning.

To Senator Moynihan, let me say that the gentleman doth protest too much about not understanding what is going on here. I think, Senator Moynihan, you understand precisely what is going on here.

There is, indeed, a paradigm shift. In fact, there was a joke in the circles some time ago for health care activists that said that organized medicine had spent so many years trying to avoid the embrace of socialized medicine, that they ran into the clutches of the venture capitalists.

The fact is, we do have a Federal role. We are spending over $200 billion, or close to it, annually, so that really does put a lot of Federal resources certainly at risk. I think that says that we ought to at least take a look at what roles are appropriate in the hope that we can strike some balance.

Looking at this proposal by Senator Rockefeller and Senator Frist, quite frankly, I think it does, in an interesting kind of way, marry the concerns that we have had regarding both cost containment, which is the risk management aspect, and quality of care, which is the provision of service aspect.

So, there is an interesting kind of marriage going on here between two, at least, of the dynamics that we have focused in on as part of our whole approach to this paradigm shift, this reformed health care delivery.

Having said that, I would like to ask a question that I do not know the answer to. That is something I guess they say a good lawyer never does, is ask a question you do not know the answer

to. But I am going to ask it because nobody else, I have found, at least in the last few minutes, can answer it either.

That is, taking the insurance issue, the other side of the insurance issue here, is the insurance pertaining to malpractice. You have the insurance of the delivery of services, and the back end of that is the whole question of the malpractice exposure for physicians and practitioners that may be involved.

My question is whether or not there is a difference in malpractice exposure for physicians based on the construct of the practice. That is, a physician practicing in an HMO versus a physician practicing in a PSO in which he or she may have an ownership or not. Is there a difference, or has anybody looked at whether or not the malpractice laws would mitigate differently in those situations? I do not know the answer to that question, and whatever guidance you can give us on that, I would appreciate.

Mr. REINER. Senator, I think I can give at least one real-time example. There is a PSO in South Florida that has negotiated for their physicians a 20–35 percent discount for malpractice rates because they are part of an integrated PSO and they are paying a lot more attention to quality of care, and the insurers, the ultimate people that have to go at risk for the actuarial expected loss, believe that physicians in that kind of an enterprise are a better risk and are going to do a better job for patients.

Senator MOSELEY-BRAUN. And so because of the quality of care improvements——

Mr. REINER. Because of the extra credentialing and the emphasis on quality in that integrated dynamic, it is a smaller group of doctors. The medical staff is out here, the integrated physicians are in here. In fact, when I get home I am going to start that process and I am going to find some discounts for my physicians as well.

Senator MOSELEY-BRAUN. Ms. Ignagni.

Ms. IGNAGNI. Senator, I think Mr. Reiner said it very well. It sounded as if you were speaking for a health plan because, as you know, the same provisions are held for plans that are providing quality assurance mechanisms, et cetera, distributing risk data, what have you.

Mr. POMEROY. Senator, I would like to touch on, briefly, the other point you raise and explain to you why States officials from across the country have cold feet about the marriage that you were saying is embodied in this bill, and that is this.

Senator MOSELEY-BRAUN. Cold feet about marriage. I have heard of that. Go ahead.

Mr. POMEROY. State officials do not appear before you today to say that we should regulate the Medicare program. What we are here to tell you is that we believe we have the expertise to provide consumer protections and regulate those entities that are going to be assuming the risk here.

That is, those entities who are saying to your constituents who will be enrolling in these programs that they will be there to provide the benefits that they claim when they enroll the individual in the program.

Financial solvency requirements, market conduct activities, financial examination activities on an ongoing basis, the ability of States to receive complaints when an individual has a bad experi-

ence, are all important things that we are doing now, and I think we ought to continue.

Senator MOSELEY-BRAUN. Mr. Pomeroy, you are not answering my question and I do not want to lose out on the opportunity for Dr. Lewers and Mr. Nielsen to answer my question specifically.

I mean, I do not want to cutoff your commercial, but I read your testimony and we have been talking about that issue. Just on this tiny little point about malpractice, just because it is such a concern, and we obviously have to look at those issues as part of what we do, the broader sense.

Mr. Nielsen.

Mr. NIELSEN. Let me just respond a bit to some of the things you said. I think people file malpractice actions, or do not file them, for a variety of reasons. Certainly one thing, in my experience at least, that inhibits some of that is if someone has a close relationship with a physician they are far less likely to engage in a malpractice action. As we have moved toward what I am going to characterize as—and Senator Moynihan will really not like this term—the corporate practice of medicine, as we have moved farther in that direction——

Senator MOYNIHAN. I think that is a wonderful term. I think that is what we are talking about.

Mr. NIELSEN. Accurate, perhaps. As we move in that direction, where you divorce the personal relationship and, in fact, the action is to be brought against an impersonal entity, it may, in fact, and it has been our experience, that that has made people perhaps more prone to consider malpractice actions against their physicians and other providers.

Dr. LEWERS. Senator, there has been a recent study which we will be happy to provide for you which has been published showing that there is a decrease in the liability suits and claims where there is a closer relationship between the patient and the physician, i.e., the patient/physician relationship we spoke of.

In my other life, I am the chairman of the board and chief executive officer of a liability insurance company, one of the physician-owned companies. We have been working with groups and with physician networks to develop risk management programs and to have them share the risk to reduce the risk and to reduce this.

We have been providing programs for them and have some very early suggestions that, indeed, we have been able to reduce the number of claims that have been filed. Unfortunately, on the other end some of the HMOs are now claiming that they do not have the liability and are trying to exclude themselves from the process, dropping it back on the physician in the provider community.

So the information is very early, but I think it is suggesting that where you have this relationship, where you have the provider definitely involved, there will be fewer suits.

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

The CHAIRMAN. The record will stay open until 5 p.m. so that written questions may be submitted.

Senator GRAHAM. Mr. Chairman, would it be possible if I could ask a couple of more questions? I had thought we were going to have a second round. I am sorry.

The CHAIRMAN. I would ask that they be as rapid as possible.

Senator GRAHAM. I will then try to make it rapid. Several of you have talked about changes in the current method of compensation, the 95 percent rule. My own bias is that that is fundamentally flawed, it is not just a matter of trimming around the edges to try to deal with the low fee-for-service areas.

What is your assessment of the fundamental validity of the current method of compensation, particularly as it would be applied to a provider-based organization, and what are some alternatives that we should look at to the 95 percent rule?

Mr. NIELSEN. I could just respond most generally. I think Ms. Ignagni could probably talk to it to a greater degree. The whole thing needs to be reworked. It is fundamentally flawed. As long as we are talking about the 95 percent rule, we may as well talk about the whole construct of the formula that develops the AAPCC. We have got to do something with it, and do it quickly in order to salvage this program if we believe that moving it into managed care is the answer, or is at least one of the answers.

Ms. IGNAGNI. I think Mr. Nielsen is right. Having said that there are issues with respect to flaws in the current methodology, I find that having looked at a range of alternatives that have been developed, Mr. Reiner, I think, made the very important point about the need for risk adjustment and further exploration in that regard. We very much believe that the payments ought to be as accurate as possible.

Having said that, I would be less than candid if I did not say, in a very straightforward way, that no one is really sure how to get to the next step. I think that will involve exploring a range of proposals through demonstrations, and we certainly support that.

One issue that you may have on your mind that is often raised is the competitive bidding issue. That is certainly one model to look at, but I would just ask somewhat rhetorically that, if we are going to move forward in demonstrating competitive bidding, that we simply cannot have health plan competing with health plan, we have got to look at the whole market and every entity in a market, whether it be PSO, PSN, fee-for-service, and then think about broadly looking at terms and conditions.

So I am afraid, Senator, I would like to be able to give you a very succinct answer that this is it, but the truth is that I am not sure that the PPRC, ProPAC, any one group has the best answer for reform. I think a number of people have agreed that there are steps that will go into reform that we ought to look at, and I think there is quite a consensus of opinion around those.

Mr. REINER. One quick comment. Paying on the health status of the person is ultimately, I think, where you want to get. It is easy to say, it is harder to get to. But there are formulas being developed that say we should pay for this person's disease and illness the costs that they have incurred, and no more.

I think, if you will let us stay around a little bit longer in business, we will be able to demonstrate some of those models in our risk adjustor experiment with HCFA as well.

Ms. IGNAGNI. I would say, just back to that, I think that that is absolutely right, except we all know that 80 percent of the variation in health care is still unexplained. So we have quite a lot of technical work to do in the future in getting that together.

Dr. LEWERS. There is no question it needs to be reworked. I have had the privilege of seeing the PPRC chapter for this year that will be coming to you very soon. I think you should pay particular attention to some of the recommendations there and the risk adjustment factor is one that has to be included in any reworking, and the mechanisms on how to do that are included there. So I think that the PPRC has at least made an attempt to answer your question, and that chapter is forthcoming very soon.

Senator GRAHAM. Given the steely looks I am getting from the Chairman and Ranking Member——

[Laughter.]

Senator GRAHAM [continuing]. I will not ask this question to be answered orally, but I would like a written response. What are the best examples today of financial relationships between managed care and their clients, whether it is the California State Employees plan, a plan with a private sector employer, or otherwise, that we ought to be learning from in terms of how Medicare can relate to its HMO providers. Thank you.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Just quickly to thank Senator Moseley-Braun for the best quip of the morning about fleeing from socialized medicine. I have a line here. Morris Fishbein was for about 30 years the editor of the *Journal of the American Medical Association*, a very responsible position.

In 1932, he had an editorial in which he pounced savagely on the advocacy of group practice. Group practice. One of his sentences began, this book says, "The rendering of all medical care by groups, or guilds are medical Soviets." These affairs sound like medical Soviets to me, but that is how far we have advanced.

Mr. Chairman, could I respectfully suggest that when we publish the transcript of this hearing is that it be called "On the Corporate Practice of Medicine," in honor of Mr. Nielsen? And thank you all. It has been wonderful. Thank you.

The CHAIRMAN. Yes, indeed. I do want to thank the panel for the excellence of their testimony. I think the Members have demonstrated the interest that you have sparked, and we look forward to continuing to work with you. Thank you very much.

[Whereupon, at 12:18 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF DIANE ARCHER

Thank you very much for the opportunity to testify today. I am the Executive Director of the Medicare Rights Center, a national not-for-profit organization based in New York. MRC assists seniors and people with disabilities on Medicare through counseling and public education. MRC operates an Insurance Counseling and Assistance telephone hotline with partial support from the New York State Office for the Aging.[1] Last year, we fielded more than 42,000 calls to our Medicare counseling hotline. (Appendix A)

The proportion of hotline callers with questions about Medicare Health Maintenance Organizations has exploded from one in twenty just two years ago to one in five this year. Clients call us with all sorts of questions that we are unable to answer. Which HMO is best? Which ones will take good care of me when I get ill? Can I go to St. Vincent's Hospital with this HMO? Is this HMO the Cadillac of health care or the Ford Pinto? While we provide a general overview of Medicare HMOs, we advise callers to research specifics by requesting information directly from the HMOs.

In an effort to help our clients with the legwork of shopping for HMOs, we performed our own survey of the HMOs in downstate New York. We asked each of them 90 questions on plan benefits, costs, rules, restrictions, structures and measurements of quality. (Appendix B) We found the process of shopping for HMOs to be tremendously time-consuming. Moreover, much of the information provided by the HMOs was not useful for making comparisons. (Appendix C)

- The survey took far more resources and time than most people on Medicare can devote. We made over 100 telephone calls and sent over 50 faxes and mailings to get answers from 11 Medicare HMOs. Even though we were able to bypass the customer service department, response times ranged from 2 weeks to 8½ months. A person on Medicare slogging through customer service voicemail would have had even more difficulty.
- Answers to the survey were often not useful for making comparisons. Data related to quality of care, such as the rate of appeals for denials of care, the rate at which HMO members left the plan, and member satisfaction were collected in different ways and thus not comparable. And benefits such as prescription drugs and point-of-service coverage for out-of-network care were hard to compare. Confusing terminology and confusing answers also made comparison difficult. (Appendix D)
- There were many questions that HMOs refused to answer. HMOs wouldn't reveal clinical guidelines or utilization review guidelines that could give people an idea of what care they would get if they became ill. The majority wouldn't reveal which drugs were covered in their formularies. Of those that did, only HIP volunteered the conditions under which the drugs would be covered. One HMO, CIGNA, even refused to provide a list of doctors in the network, stating it was only available to people on Medicare if a sales representative were allowed to visit them.
- The answers changed constantly. Throughout the project we had to constantly update our chart to incorporate changes in HMO benefits, costs, rules and restrictions. Doctors in the HMO networks and drugs in the HMO formularies also changed regularly.

So, even with the survey results, our counselors are hard-pressed to distinguish among HMOs. We still don't have useful information about quality, and the answers on the chart are too misleading to release without an accompanying explanation.

Consumers need comparison charts, but comparison charts alone are not enough. In order to help consumers to make meaningful choices among competing HMOs, they need:

1. Comparison charts that are based on standardized, audited, HMO data.
2. Up-to-date information on HMO network providers, formularies, and rules and restrictions on care.
3. Standardization of additional HMO benefits.
4. Easy availability of HMO data and comparison charts, and public education to help them use the comparative information.
5. Comparison charts must be compiled that are based on standardized, audited, HMO data.

The answers that HMOs gave for our survey questions on rates of appeals, grievances and disenrollment were not useful for comparison. HMOs had different methods of collecting and reporting data, and no outside agencies reviewed the accuracy of their information.[2] Other information that HMOs use to advertise quality, such as consumer satisfaction surveys and National Committee for Quality Assurance data on plan performance, is neither audited nor standardized and thus of limited value for comparing HMOs.

People on Medicare today get the majority of their HMO information from marketing materials and presentations.[3] They have very little objective information about HMOs and aren't educated about what they should look for beyond the glossy brochures. HCFA already collects or should collect much of the information that people on Medicare could use to choose among HMOs, such as disenrollment rates, benefits and costs, and it is developing standardized measures of consumer satisfaction.[4],[5] HCFA should release comparison charts based on this information as a needed first step towards informed choice for people on Medicare.

2. Up-to-date information on HMO network providers, formularies, and rules and restrictions on care should be made available to the public on a frequent and regular basis.

In order to make smart choices, consumers also need detailed information, such as the drugs covered in HMO formularies, that can't be included in a comparison chart. Much of this information is unavailable and constantly changing. While some consumers may be satisfied to compare copayments and caps on prescription drug benefits, others will need more specific and up-to-date information on which drugs the HMO will cover.[6],[7],[8] For example:

Mr. P of West Palm Beach joined Humana, a Florida Medicare HMO, for its prescription drug benefit. However, the drug used to control his prostate enlargement was taken off the HMO formulary, and he was left to pay for his medication out-of-pocket.

Many people pick HMOs based on the doctors or hospitals in the HMO network. They want to know before they enroll which doctors are in an HMO, whether they accept new HMO patients, and whether they have referral privileges to other doctors or hospitals that they want to see. Consumers need this information to make informed choices, just as they need information on how HMOs oversee the care that doctors give their patients. Such information includes clinical guidelines with recommendations on how doctors should care for different illnesses, and utilization review guidelines describing the conditions under which HMOs will approve particular treatments for different conditions. For example:

Mr. K of Bridgeport joined Keycare 65, a Pennsylvania Medicare HMO, after the HMO told him that his doctor would deliver exactly the same care in the HMO for his cardiac arrhythmia as he did in traditional Medicare. After he joined, his doctor told him that he could no longer obtain the tests that he needed for his heart condition twice a year, as he did under traditional Medicare, because the HMO would only authorize them once a year unless he became significantly ill. Mr. K returned to traditional Medicare to get the tests he needed.

Without access to up-to-date descriptions of what HMOs cover and their conditions for coverage, consumers are vulnerable to a bait-and-switch game.

HCFA should regularly make available to consumers current information on providers, formularies, clinical guidelines and treatment restrictions. HMO information for consumers should also include notification that benefits and provider networks may be subject to change.

3. Additional HMO benefits should be standardized to allow consumers to make more meaningful comparisons, just as Medicare supplemental insurance was standardized several years ago.

Our clients tell us that shopping for an HMO today is unnecessarily complicated. Our own experience compiling the comparison chart for New York City HMOs confirms their opinions:

- HMO benefits are difficult for our clients to compare by cost. How are they to weigh Elderplan's eyeglass benefit with a $10 copay against PHS's eyeglass benefit with a $100 maximum?
- HMO benefits are difficult for our clients to compare by coverage. How are they to know that the "point-of-service" benefit for out-of-network coverage can mean $100 every three months at NYLCare and 80% of the Medicare-approved amount for an extra $87.50 premium each month at USHealthcare?

The additional benefits of Medicare HMOs should be standardized in simple, easy-to-understand packages which still allow room for HMOs to offer new innovations and benefits. Standardized benefits, along with disclosure of information like drug formularies that is difficult to standardize, are needed in order to help people on Medicare make better comparisons among competing HMOs.

4. The HMO data and comparison charts should be made widely available, and funding should be committed for public education to help people on Medicare use the information.

While some comparison charts of Medicare HMOs have been created, the commitment to systematically create and disseminate them has not been made.[9] HCFA should collect and verify the necessary data to compile comparison charts, and make the charts and information on providers, formularies and treatment restrictions available on the Internet, in publications and through the media. People on Medicare should be able to find information on HMO benefits, costs and restrictions as easily as parents are able to find test scores for school districts in the newspaper.

Public education efforts must accompany the comparison charts as well. Most people on Medicare have little experience with managed care and do not understand the relevance of many HMO quality measures to their own health care. Preliminary results from our survey of low-income elderly reveals that most do not even fully understand that HMO members can only see HMO doctors and hospitals for their care. (Appendix E) Many people on Medicare need public education in order to understand what a Medicare HMO is before they can try to choose among HMOs. Information must be disseminated in a way that is meaningful to consumers, and appropriate resources for insurance counseling programs across the U.S. shou'd be secured.

Thank you for your time and interest. I would be happy to answer your questions.

ENDNOTES

[1]: A contract to provide Health Insurance Counseling and Assistance from the New York State Office for the Aging, with funding from the Health Care Financing Administration, covers 15% of the costs for our toll-free hotline. The rest is raised from public and private sources.

[2]: For example, Oxford Health Plans categorized disenrollments as voluntary or involuntary, while other HMOs did not make the distinction. In addition, none of the disenrollment data reported by HMOs agreed with statistics reported by HCFA for the same time period.

[3]: Kaiser Family Foundation/Agency for Health Care Policy and Research survey, October 1996.

[4]: General Accounting Office. "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance." October 1996.

[5]: The Consumer Assessment of Health Plan Satisfaction (CAHPS).

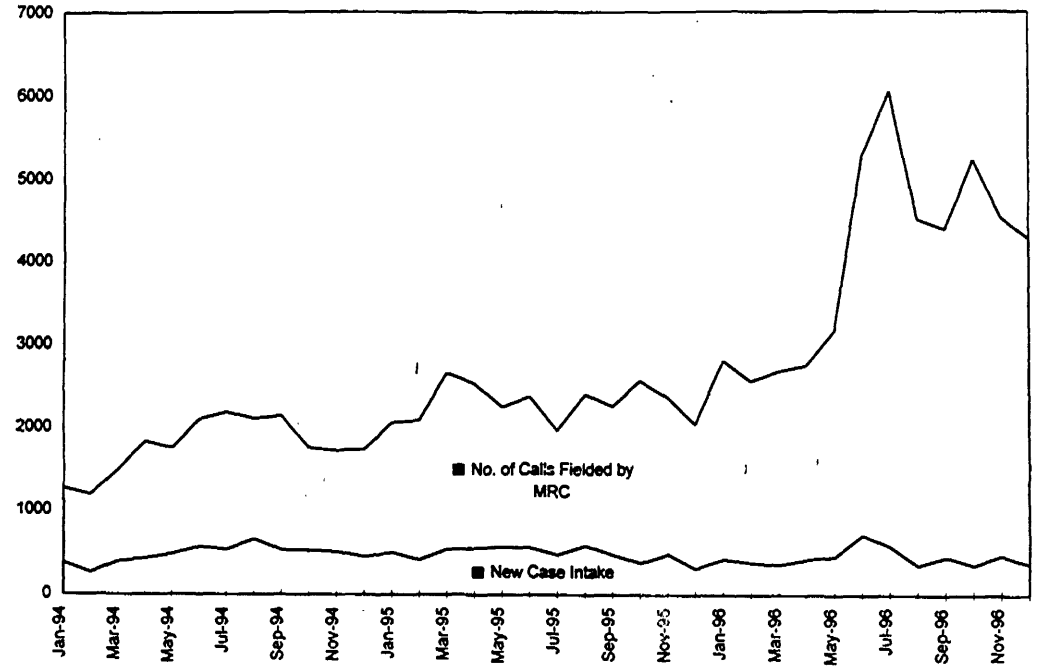
[6]: O'Malley, Sharon. "Report Cards: How Relevant Are They for Patients?" Quality Letter for Healthcare Leaders, 9:3:12 March 1996.

[7]: Hibbard, Judith et al. "Evaluating the Approaches for Supporting Informed Consumer Decisions." Unpublished paper presented before the American Public Health Association, October 1996.

[8]: Sofaer, Shoshanna et al. "Providing Consumers with Information to Support Health Plan Decisions: A Theory of Action." Unpublished paper presented before APHA, October 1996.

[9]: HCFA resources at the present time appear inadequate to compile and disseminate such a chart. While 13% of Medicare beneficiaries are enrolled in managed care organizations, only 5% of HCFA staff are allocated to oversee and administrate Medicare HMOs.

Appendix A
MRC's Telephone Counseling Hotline: 1994-1996



Medicare Rights Center

Appendix B
Sample Cases which Illustrate Problems in Medicare Managed Care

Medicare Rights Center is handling an increasing number of cases involving Medicare HMOs. These cases illustrate a number of systemic problems with Medicare HMOs which can have a devastating impact on the quality of health care for seniors and people with disabilities. Several typical cases are outlined below.

1. **Access to specialty care:** Mrs. C enrolled in an HMO in the New York City area. When she noticed that she had a skin lesion that was potentially cancerous, she went to see her primary care physician and asked for a referral to see one of the HMO's dermatologists. The primary care physician told Mrs. C that she would arrange for the referral. Mrs. C had to wait almost two weeks for an appointment with the dermatologist, only to find out once there that her primary care physician had not arranged for a referral, and so the dermatologist would not see her. Five weeks later, after several phone calls and two trips to the primary care physician's office, Mrs. C had still not been able to see the dermatologist. MRC staff advised her to file a complaint with the NYS Department of Insurance, and with the HMO. Mrs. C filed both complaints and, frustrated by inaction and a long wait, disenrolled from the HMO. She is now in another HMO and receiving the necessary care.

2. **Access to specialty care:** Mr. S, a member of a Medicare HMO, was referred to a urologist from the hospital where he had emergency hernia surgery. The urologist told Mr. S that he was in the HMO's network; however, it turned out the urologist was only affiliated with the HMO's non-Medicare product, not with the Medicare-contracting portion of the HMO. Mr. S was therefore billed for out-of-network visits to the urologist. Now Mr. S's HMO wants him to see a urologist whose office is an hour away from Mr. S's home. The HMO refuses to give Mr. S a referral to see the out-of-network urologist, even though that urologist is in the HMO's non-Medicare network. Mr. S is disenrolling from the HMO so he can continue with the non-network urologist and not have to travel so far from home for treatment.

3. **Access to rehabilitation services; failure to notify of appeal rights:** After being hospitalized for a traumatic brain injury, Mrs. H was told by her doctor that she needed to be admitted to a rehabilitation facility. The rehabilitation facility approved her admission, but the HMO denied the service, claiming it was unnecessary. The HMO also failed to issue a denial notice. Because of the protracted length of an appeal and on advice of her doctors, however, Mrs. H disenrolled from the HMO and secured covered rehabilitation services under traditional Medicare.

4. **Access to care: Denial of Medicare-covered service:** Mrs. F, a 92 year-old Medicare patient and a member of a Medicare HMO, entered the hospital for congenital heart failure and a number of other medical problems. She was discharged directly to a skilled nursing facility where she received physical and occupational therapy five days a week.

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Her unstable medical condition was also monitored by a skilled nurse. For these reasons, Mrs. F clearly met Medicare guidelines for coverage of a skilled nursing facility stay. However, Mrs. F's HMO denied Mrs. F coverage because it claimed that the services she received in the nursing facility did not fit Medicare's definition of "skilled services" and were therefore not covered.

MRC appealed the HMO's denial on Mrs. F's behalf, but Mrs. F never received a written denial from the HMO explaining her appeal rights. (A verbal denial may be appealed if no written denial is issued.) After several months of negotiations with the HMO, HCFA, and staff at the nursing facility, MRC received notification that the HMO would be required to cover the majority of Mrs. F's stay in the nursing facility.

5. **Access to care; failure to notify of appeal rights:** Mrs. L. is an insulin-dependent diabetic who has multiple sclerosis, arthritis, and is blind in one eye. She is a member of a Medicare HMO in the New York City area. Mrs. L began a home health care program after an inpatient hospital stay for congestive heart failure. She received physical therapy and home health aide services three times a week through a Medicare certified home health agency contracted by her HMO.

   At the end of a month, Mrs. L's primary care physician denied approval for continuation of Mrs. L's home health care program. However, the HMO failed to issue Mrs. L a written denial notice or to inform her of her appeal rights. MRC staff discovered that HMO representatives did not realize that the denial must be issued in writing. Mrs. L's physical therapist wrote a letter to the physician stating that while Mrs. L had shown improvement during the course of therapy, she continued to need physical therapy so that her maximum functional capabilities could be realized. MRC appealed the denial of continued therapy services on behalf of Mrs. L, and, after several months, the HMO agreed to continue Mrs. L on a physical therapy program.

6. **Access to care: Denial of Medicare-covered service; failure to notify of appeal rights:** Mr. D was a member of a Medicare HMO in New Jersey whose HMO primary care physician and HMO urologist prescribed biofeedback therapy for his urinary incontinence post prostate surgery. The HMO, disregarding the medical opinions of its own doctors, denied such care stating that it was not covered under the terms of its Medicare contract.

   MRC informed Mr. D that Medicare did indeed cover biofeedback therapy where, as in Mr. D's case, other more conservative treatments had been tried and had failed; the HMO also had not provided Mr. D. with a proper denial notice. MRC argued, on behalf of Mr. D, that because Medicare did cover the treatment the HMO, under the terms of its contract with HCFA, was also required to provide the treatment to its Medicare beneficiaries, regardless of whether or not they had a network supplier or provided the treatment to their non-Medicare HMO patients. After reviewing MRC's appeal letter for two months, the HMO decided to provide the care to Mr. D.

7. **Access to care: Denial of Medicare-covered service:** Mr. B, a member of the same HMO as Mr. D above, contacted MRC a few months after Mr. D with exactly the same case. With MRC assistance, Mr. B was also able to receive bio-feedback therapy through the HMO. MRC, however, also contacted the HCFA regional office in charge of this HMO's contract to complain that the HMO, previously informed that its denial of benefits in this type of case was erroneous, had not taken any systemic, remedial action.

8. **Access to care: Denial of Medicare-covered skilled nursing facility care:** Mrs. M, a Medicare HMO enrollee, underwent hip replacement surgery in early 1996 and entered a skilled nursing facility (SNF) shortly thereafter. The HMO notified Mrs. M that coverage for her SNF care would be limited to three weeks, terminating on 4/25/96. The HMO also advised the family that Mrs. M would derive maximum benefit from inpatient SNF care in three weeks and additional progress was unlikely after that time. Mrs. M's surgeon and the SNF medical staff disagreed with the HMO's assessment and recommended continuing SNF care beyond the three weeks, believing that significant improvement in Mrs. M's functioning could be achieved. Based on this opinion, Mrs. M's family decided to extend Mrs. M's stay in the SNF and privately paid for SNF care from 4/25/96-9/11/96. Mrs. M's family reports that the intensive rehabilitation program at the SNF greatly improved her condition.

   Mrs. M appealed the denial of coverage for SNF care beyond three weeks, claiming that additional inpatient rehabilitation was medically necessary to effect optimal recovery. The HMO affirmed its initial decision and forwarded the case to Network Design Group (NDG) for external review. NDG partially overturned the HMO's denial, awarding Mrs. M coverage for SNF care from 4/25/96 - 8/15/96; the family accepted this decision, which resulted in an estimated $20,000 - $30,000 in reimbursement. Mrs. M was notified that the HMO would consider appealing the NDG "partial overturn" in Federal District Court. The family contacted MRC seeking information about Mrs. M's rights. MRC briefed them on the statutory appeal process and offered to provide assistance if the HMO contested the NDG decision. Fortunately, the family was recently notified that the HMO intends to comply with the NDG decision.

9. **Access to coverage: Denial of Medicare-covered emergency services:** Mr. P, a member of a risk-contract HMO in New York, while visiting his daughter in Florida when, on Christmas Eve, began experiencing severe difficulty breathing. He was rushed to the hospital and, as instructed on the HMO card, a family member immediately called from the hospital to notify the HMO that Mr. P was having emergency treatment out of the HMO's service area. After Mr. P returned to New York, his HMO informed him that none of the treatment would be covered because the HMO had not been notified within 48 hours of the emergency. The HMO claimed to have no record of anyone calling.

   MRC informed Mr. P that, while non-Medicare-contracting HMO plans can require members to notify the HMO within a certain time period in order to obtain coverage for emergency treatment, Medicare HMOs cannot deny benefits because the HMO was not notified of the emergency treatment. Therefore, Mr. P was under no obligation to notify

the HMO and the HMO cannot refuse coverage for that reason. MRC assisted Mr. P in appealing the HMO's denial and he eventually received full coverage for his out-of-area emergency treatment.

10. **Access to care; confusion about HMOs; language barriers:** Mr. F, a native Spanish-speaker, was enrolled in a Medicare HMO but never received any literature in Spanish from the HMO explaining the rules of his contract. When the HMO failed to provide adequate care for Mr. F's severe knee pain, Mr. F went to an out-of-plan doctor for knee replacement surgery. He did not realize that he would be liable for the cost of the care. His HMO denied coverage, saying the procedure was elective and that he had not obtained prior authorization from the HMO. Mr. F, because of the language barrier, never understood the way his HMO worked until after he was hit with huge hospital and doctors' bills. MRC appealed the HMO's denial of coverage and requested retroactive disenrollment for Mr. F. The appeal was decided against Mr. F.

11. **Marketing abuses; confusion about HMOs:** Mr. P and his wife have both Medicare and a Medigap policy. While visiting relatives in Florida, Mr. P was visited at his relative's house by an HMO representative. Impressed by the low cost of the policy and swayed by the representative's sales tactics, Mr. P signed application papers that day. He and his wife were promptly enrolled in the Florida HMO. He did not drop his Medigap policy, nor did he understand that they were now members of a risk-contract HMO which required that they stay within the HMOs network of doctors. Thinking that he simply had a new Medigap policy, Mr. and Mrs. P saw doctors outside of the HMOs network for two months before Medicare began to send denials stating that they were enrolled in an HMO. Mr. and Mrs. P's case is a typical example of seniors subjected to an HMO's high pressure sales tactics who enroll without understanding how to receive care and coverage for that care from an HMO.

12. **Marketing abuses:** Mrs. G , an 88 year old Medicare beneficiary with an organic brain disorder manifesting itself by memory loss and extreme confusion, was solicited by an HMO sales agent in her home. The sales agent enrolled Mrs. M in the HMO, without making sure that Mrs. M. was able to understand the implications of her decision. Mrs. M. continued to pay her Medigap premiums and when admitted into a hospital three months later signed a statement saying she was not an HMO member. As a result of the HMO's abusive marketing practices, she incurred over $2,100 in medical expenses that both Medicare and the HMO refused to pay. MRC successfully requested retroactive HMO disenrollment for Mrs. M on the basis of impaired mental status at the time she enrolled in the HMO.

13. **Marketing abuses; confusion about HMOs:** Mrs. M of New York was persuaded by a door-to-door salesperson to join a Medicare HMO in May 1996 while she was visiting her children on vacation. She did not understand the HMO rules and restrictions and was simply told that "Medicare will take care of it." She received an HMO card with her enrollment stating the name of her primary care physician and was told that it was

"someone she could see if she needed care," and was never told of network restrictions. Not even her children knew that she had enrolled in a Medicare HMO.

While in Arizona, Mrs. M did visit a physician other than her primary care physician, and when she returned to New York she visited New York physicians and hospitals who were outside the HMO's network. None of her care was paid for. The day of her discharge from a hospital in September, the hospital discharge planner called Medicare Rights Center because the home health agency whose services she needed was refusing to visit her due to nonpayment of past charges. Medicare Rights Center advised that she disenroll right away and has helped Mrs. M's children to request that the Health Care Financing Administration retroactively disenroll her from the HMO so that the care which she received between May and September will be covered by fee-for-service Medicare. The family is also filing a complaint with HCFA regarding the HMO's marketing abuses.

14. **HMO administrative problems:** Mrs. Y belonged to an HMO through her Employer Group Health Plan. Knowing that she was going to retire at the end of January, she requested that the HMO transfer her to its Medicare HMO product on February 1. The HMO said that it would need verification of her retirement from her employer in order to process her enrollment. Her company promptly sent the letter and Mrs. Y assumed that her application had been cleared. During the same time, she also applied for Medicare coverage with Social Security and received a Medicare card which stated that her coverage became effective on February 1.

Mrs. Y continued to receive services from an HMO psychologist who she knew was in the Medicare HMO network. After 18 months of treatment, the psychologist informed her that the HMO was refusing to pay for services rendered between February and April of 1995 and Mrs. Y now owed him $574. Mrs. Y called up the HMO who informed her that her Medicare HMO coverage did not start until April 1. Mrs. Y had no way of knowing that the HMO had delayed the starting date of her Medicare HMO coverage. She had followed the correct procedure to ensure that her health coverage would be continuous.

Medicare Rights Center

APPENDIX C
Medicare Rights Center Survey
of Medicare Managed Care Plans

In 1996, the Medicare Rights Center (MRC) surveyed the Medicare managed care plans that serve Ohio and downstate New York. The purpose of these surveys was to identify distinctions among Medicare managed care plans and to publish the data for consumer use. We recognized that the data we would receive from the plans would not be audited. However, there is no other source for much of the data that we were seeking.

Research design. Medicare managed care plans were contacted and asked to respond to a 90-question survey that inquired about the following aspects of the plans' Medicare product: its providers and resources; services and benefits; practice guidelines and utilization reviews; enrollment/disenrollment rates; grievance and appeal rates; and marketing and enrollment procedures.

The plans' responses were inputted into a database and examined. In cases where we needed further clarification of a plan's response, we sent out follow-up questionnaires.

Results. After months of phone calls and much persuasion, we were successful in obtaining answers from 8 out-of-the 11 plans that serve Ohio and 10 out-of-the 11 plans that serve downstate New York. But obtaining the plans' cooperation was just the first of many obstacles in our attempt to provide information to consumers. Some of the other obstacles that we encountered are outlined below.

First, since plans are not required to collect and/or report data in a uniform manner, we had difficulty comparing the plans on several areas, such as physician credentials and the average waiting time to see a physician.

Second, since plans are not required to divulge their treatment protocols, drug formularies, disenrollment rates, grievance rates, and appeal rates, several of the plans failed to answer our questions on these topics. However, such information is indispensable to a beneficiary when he or she is deciding which plan to enroll in. Moreover, in an effort to verify answers that we *did* receive from plans on their disenrollment rates, we requested disenrollment rate reports from the Health Care Financing Administration (HCFA). Unfortunately, we soon discovered that HCFA's data collection methods are faulty. HCFA's data fails to distinguish the many reasons why beneficiaries are disenrolling from a plan. In addition, the method by which HCFA calculates disenrollment rates appears to be problematic. HCFA reported that a couple of the plans had disenrollment rates over 200%!

Last, without standardized, audited data from the plans and the government, it was difficult to interpret the data that we did receive, especially with regard to the grievance and appeal rates. For instance, we were unsure about how the plans distinguished a grievance from an appeal.

We have included on the following pages responses from New York State plans that demonstrate the above problems.

As a result of the above issues, we have decided to publish a booklet, in addition to comparability charts, that will explain the value and limitations of the data that we are reporting. Moreover, because the charts that we have developed are quite complex, we plan to disseminate them mainly to counselors. The counselors will be trained on how to use the charts and how to help beneficiaries find their way through this Medicare maze.

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Sample of New York Medicare Managed Care Plans' Responses to the Medicare Rights Center's Questions on Grievance and Appeal Rates

HMO *Medicare Product*	Total number of members as of 12/31/95	How many of your Medicare enrollees filed grievances in 1995?	How many of your Medicare enrollees filed appeals in 1995?	What was the nature of the appeals?
Elderplan	5,147	(The plan did not respond to this question.)	85 (1.65%)	Appeals are defined in accordance with HCFA regulations, re. a denial of service
HIP of Greater NY ***VIP***	48,202	124 (0.26%)	155 (0.32%)	The reasons for reconsiderations were not tracked in 1995
Managed Health ***Managed Health 65 Plus***	1,268	(The plan did not respond to this question.)	(The plan did not respond to this question.)	(The plan did not respond to this question.)
NYLCare Health Plan of NY ***NYLCare 65***	13,500	491 (3.64%)	228 (1.69%)	Mainly claims denied for no authorization of service.
Oxford Health Plan ***Medicare Advantage***	60,989	This information is not available at this time	This information is not available at this time.	This information is not available at this time
US Health Care ***US Health Care Medicare***	9,937	28 (0.28%)	19 (0.19%)	Most appeals were for lack of referrals for specialty services or denial of skilled nursing placement due to lack of skilled needs
VytraHealth ***VYTRA Medicare***	593	0 (0%)	3 (0.51%)	One for denial of continued services

Sample of New York Medicare Managed Care Plans' Responses to the Medicare Rights Center's Questions on 1995 Medicare Beneficiary Disenrollment Rates

HMO *Medicare Product*	What was the disenrollment rate from your Medicare product in 1995?	Why did Medicare beneficiaries disenroll from your plan last year?
Elderplan	1 3%	Involuntary disenrollment such as death or move out of area, change to another HMO.
HIP of Greater NY ***VIP***	Using HEDIS specifications, HIP's disenrollment rate for 1995 was 9%. This means that of those members enrolled as of December 31, 1994, 9% were not members as of December 31, 1995. This measure includes both voluntary and involuntary disenrollment.	HIP is in the process of conducting a member disenrollment survey which will include Medicare enrollees. This data will be available in the next few months.
Managed Health ***Managed Health 65 Plus***	(The plan did not respond to this question.)	(The plan did not respond to this question.)
NYLCare Health Plan of NY ***NYLCare 65***	1 97%	The two top reasons are primary care selection and in-office waiting time.
Oxford Health Plan ***Medicare Advantage***	6 5%	Most of the disenrollments from Oxford Medicare Advantage occur before the Member is ever effective on the plan. Thus, the plan itself has no influence on their decision to disenroll. Oxford tracks the Medicare enrollee's disenrollment by voluntary & involuntary reasons. The 1995 involuntary rate is 2% & the voluntary rate disenrollment rate is 4 5%. Please see the following charts for Medicare involuntary & voluntary disenrollment by reason. Medicare Advantage Involuntary Disenrollment by Reason: Reason — # of disenrollees — % of total enrollment moved — 378 — 0 6 ineligible (no A or B) — 42 — 0 1 death — 529 — 0 8 SS/HCFA — 332 — 0 5 Other — 54 — 0 1 Total — 1335 — 2 0 Medicare Advantage Voluntary Disenrollment by Reason Reason — # of disenrollees — % of total of enrollment No reason given — 2031 — 3 2 Dissatisfied with doctor — 92 — 0 1 Dissatisfied with service — 24 — <0 1 Dissatisfied with lock-in — 111 — 0 2 Joined other plan — 465 — 0 7 SS/HCFA — 332 — 0 5 Total — 3055 — 4 5
US Health Care ***US Health Care Medicare***	3 6%	To join another HMO. To see physicians not in the plan.
VytraHealth ***VYTRA Medicare***	2 1%	(The plan did not respond to this question.)

Sample of New York Medicare Managed Care Plans' Responses to the Medicare Rights Center's Questions on 1995 Physician Participation Withdrawal Rates

HMO *Medicare Product*	How many physicians withdrew their participation from your Medicare product last year?	Why did physicians withdraw their participation from your Medicare product last year?
Elderplan	(The plan did not respond to this question)	(The plan did not respond to this question)
HIP of Greater NY *VIP*	The overall turnover rate for HIP primary care physicians, including voluntary and involuntary reasons, was 12 9% for 1995 This rate is not available only for physicians who had Medicare members in their panel	Most terminations take place at retirement or within the first 2 years of a physician's probation within a medical group, a period of acclimation to HIP's group practice philosophy and HIP's assessment of the physician's abilities In 1995, many physicians were terminated because they failed to comply with HIP's enforcement of strict credentialing standards
Managed Health *Managed Health 65 Plus*	(The plan did not respond to this question)	(The plan did not respond to this question)
NYLCare Health Plan of NY *NYLCare 65*	5%	To pursue other career opportunities
Oxford Health Plan *Medicare Advantage*	Less than 1% of Oxford-contracted Medicare physicians disenrolled from Oxford	This information is not available at this time
US Health Care *US Health Care Medicare*	5%	Generally, physicians left due to limited capacity to accept new patients
VytraHealth *VYTRA Medicare*	The physician turnover rate as of January 1, 1996 is 5 7%. The portion of this turnover rate that applies to those providers terminated involuntarily is 1 8%	The following termination reasons are considered involuntary terminations fraud, failed recredentialing, excessive malpractice, failure to comply with Vytra's policies, conduct, loss of DEA certification, dissolution of practice, and insolvency

Medicare Rights Center

Appendix D

MEDICARE APPEALS AND GRIEVANCES: Strategies for System Simplification and Informed Consumer Decisionmaking

EXECUTIVE SUMMARY AND KEY FINDINGS

Medicare is a 30-year-old federal program designed to provide broad coverage for health care services to the nation's seniors and people with disabilities. Medicare currently insures 38 million Americans who paid taxes during their working years, and now pay premiums, to earn their entitlement. Approximately ninety percent (90%) of Medicare enrollees have fee-for-service coverage and ten percent (10%) have enrolled in Medicare managed care plans.[1] Medicare is a relatively efficient program, spending only 2% of its budget on administrative costs (commercial insurers spend on average 12%).[2] It pays for most medically necessary and reasonable health care services. Individuals enjoy substantial consumer rights and protections from Medicare, not the least of which is an appeal process which guarantees them the right to challenge almost any denial or reduction of benefits. The Medicare appeal mechanism is generally superior to the appeal procedures provided by commercial health insurers.

Statistics collected by the Health Care Financing Administration, the federal agency that oversees the Medicare program, indicate that a tremendous number of individuals may not be receiving the full Medicare benefits that they are entitled to. While fewer than 1% of Medicare Part B claims are appealed, approximately 75% of appealed claims result in increased payments after the first level of appeal, amounting to nearly $600 million in added benefits in 1995. Over 40% of claims appealed at the second level result in increased payments (nearly $30 million), and over 40% of those appealed to the third level also result in increased payments (nearly $300,000).[3] An even smaller percentage of Part A claims are appealed, and 40% of those result in increased payment after the first level.[4]

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[1] HCFA/Office of Managed Care (1996).
[2] 1994 HCIA HMO data; HCFA/Office of National Health Statistics (1993).
[3] HCFA/BPO/Division of Reports and Information Management; fiscal year 1995 data.
[4] HCFA/BPO/Division of Reports and Information Management; fiscal year 1994 data.

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Medicare managed care plans (HMOs) do not release statistics for the first level of appeal, but the independent contractor which reviews HMO appeals at the second level overturned the HMOs' denials of care or coverage 35% of the time in 1994-95, amounting to over $5 million in additional coverage. In another 6% of cases, the contractor determined that the claimants did not understand the restrictions that go along with enrolling in an HMO and recommended that they be retroactively disenrolled from their plans, thereby making them eligible for Medicare coverage for any out-of-network services they received.[5]

Based on these statistics and Medicare Rights Center's (MRC) own experience counseling thousands of individuals on Medicare, we believe that many people are paying for health care or forgoing care that Medicare should be paying for because they lack a strong understanding of the actions available to them when Medicare reduces or denies their benefits.[6] Those who do understand their appeal rights may not be up to the task of proving the medical necessity of a procedure or figuring out whether a coding error led to a denial. Without sufficient knowledge and the physical and mental ability to persevere, many individuals who should challenge a claim will not do so.

Based on accounts from individuals on Medicare and their advocates, MRC has concluded that this troubling situation exists for two main reasons. First, it is extremely difficult (and in some cases impossible) for consumers to access the information they need in order to obtain proper coverage for their health care. Finding out what Medicare covers, why it denies particular claims, and how to challenge claim determinations can be too burdensome for the average elderly or disabled person to manage. Unfortunately, Medicare all too often places the responsibility of securing coverage on the consumer, making access to this information crucial.

Second, the Medicare appeal system is effectively paralyzed by a backlog of unprocessed appeals and persistent delays at the latter stages of the appeal process. In MRC's experience, and confirmed by HCFA data, consumers commonly wait months and even years to obtain Medicare coverage for medically necessary health care. For example, in April 1996, 224 ALJ hearing requests were filed nationwide, while 10,528 requests were pending.[7] With some simple streamlining and restructuring, the appeal mechanism could work more efficiently and protect Medicare consumers, protecting them against wrongful denials of coverage and care.

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[5] Network Design Group, Inc., Special Report of HMO/CMP Reconsideration Results: National Summary of Final Decisions and Value of Contested Claims (February 16, 1996).
[6] Dept. of Health and Human Services/Office of Inspector General, Pub. No. OEI-01-93-00120, Understanding Medical Benefits: The Explanation of Medicare Part B Benefits 10 (April 1995).
[7] Supra note 3.

Issues of access to information, coverage, and quality health care are of especial concern for Medicare Health Maintenance Organization (HMO) enrollees. Managed care plans are penetrating the Medicare market significantly. From December 1994 through January 1996 Medicare risk HMO enrollment grew 41%, and more than 4 million beneficiaries (over 10% of the Medicare population) are currently enrolled in Medicare managed care plans.[8] Access to information is crucial for HMO enrollees because their plans may deny them not only coverage, but also necessary health care services without their knowledge. Finding out when a denial of service has occurred is difficult for HMO enrollees because the denial is often prospective—occurring prior to their receipt of services—and no one may have told them that a service was not authorized. Moreover, many enrollees do not know how to protest these denials.[9] The ability to effectively challenge denials of service is crucial to any health care delivery system where providers are financially rewarded or penalized based on the amount and cost of care delivered—both fee-for-service and HMO care. However, HMO financial incentives often prevent physicians from freely advocating for their patients in the appeal process as they could in the fee-for-service arena and therefore present a disturbing conflict of interest.

The lengthy delays in the HMO system are also particularly problematic, since delays in resolving HMO appeals can lead to consumers waiting months to receive necessary medical care.[10] As more individuals on Medicare enroll in HMOs, it is imperative that the Medicare HMO appeal mechanism be improved in order to preserve the health and safety of HMO enrollees.

This report aims to apprise policy makers and the public of limitations in the current Medicare appeal system and to recommend ways to improve the system. The first section of the report critiques existing grievance and appeal procedures in both of Medicare's payment systems: fee-for-service, where Medicare pays for individual services, and managed care, where Medicare usually pays a fixed sum per enrollee to a health care plan to provide all covered services. We present a detailed discussion of the informational problems with the Medicare appeal mechanisms, the lengthy delays in resolving appeals, and special issues surrounding appeals and grievances in the Medicare managed care program.

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[8] HCFA/Office of Managed Care; Group Health Association of America Patterns of Enrollment, 1995 Edition.
[9] Dept. of Health and Human Services/Office of Inspector General, Pub. No. OEI-06-91-00730, Beneficiary Perspectives of Medicare Risk HMOs ii (March 1995).
[10] U.S. Gen. Accounting Office, Pub. No. HEHS-95-155, Medicare: Increased HMO Oversight Could Improve Quality and Access to Care 14 (1995).

The report's second section proposes specific ways to improve the appeal and grievance mechanisms in both fee-for-service Medicare and Medicare HMOs. Some recommendations can be instituted at minimal cost and effort; others might require a commitment of substantial resources. All remain necessary for the protection of consumer rights in the Medicare program. We highlight below some key recommendations:

- HCFA must develop standardized written materials about HMO enrollee rights and require all HMO providers to give their Medicare patients these materials each time they receive treatment.
- HCFA must require each Medicare HMO to designate a Medicare ombudsman to assist enrollees with understanding their rights and to process all appeals and grievances.
- HCFA must require HMOs to track and release data on the number, type and nature of grievances and appeals that they receive.
- HCFA must streamline the appeal process by allowing claimants to bypass appeal levels where the outcome is pre-determined against them.
- HCFA must institute an expedited HMO appeal system for consumers who have been denied care and whose life and health are in jeopardy.
- HCFA must establish a Medicare fee-for-service and HMO ombudsman's office to receive feedback from regional offices about systemic coverage and procedural issues, including inconsistencies in fiscal intermediary (FI), carrier and HMO policies, examine these issues and recommend action.

Our final objective is to educate present and future Medicare consumers about their Medicare rights and ways to exercise them. We also seek to inform family members, social workers, and advocates who are often involved in medical decisions of special rules and procedures enabling individuals to obtain covered treatment. Toward these ends, we have added two appendices to the report which explain the basic workings of the Medicare program and the current appeal and grievance mechanisms. Appendix A provides background information explaining the Medicare fee-for-service and managed care programs. Appendix B describes Medicare consumers' rights and the current procedures for appealing denials of covered services We recommend that any readers who are unfamiliar with the Medicare program and/or the Medicare appeal system read both appendices before reading the main body of the report.

PREPARED STATEMENT OF HON. ALFONSE D'AMATO

Mr. Chairman, I commend you for holding this hearing today to continue the discussion of Medicare choices. I also wish to thank our esteemed colleague from Tennessee, Senator Frist, for testifying today, and for providing valuable information about the legislation that he and Senator Rockefeller of this Committee have introduced to make it easier for Medicare beneficiaries to enroll with qualified Provider Sponsored Organizations (PSOs). I would also like to thank the other distinguished panelists for sharing with us their insights and concerns.

Medicare provides affordable health care to 38 million older and disabled Americans. More than 4.9 million Medicare beneficiaries are now enrolled in managed care plans. As we explore different types of managed care options, it is critical that we recognize the need for providing protections for consumers.

Medicare beneficiaries must continue to have the flexibility of choosing the plan that best suits their needs, and they need to have appropriate information about competing plans in order to make wise decisions. Most importantly, we must guarantee certain minimum standards of quality for all health care plans.

It is essential for us to preserve Medicare for today's beneficiaries, and for every American who will need Medicare in the future. As we consider different plans to save Medicare, it is imperative that we do so in a fair manner. Any changes to the Medicare program must preserve the delivery of essential services to those who need them.

I look forward to the witnesses' comments and recommendations.

PREPARED STATEMENT OF HON. BILL FRIST

In 1995, my first year in the United States Senate, the Medicare Trustees told Congress that unless it took "prompt effective, and decisive action...Medicare will be dead in seven years." Two years later, we are even worse off. We still face the same tough choices. We must balance the budget, restore integrity to the Medicare trust fund, update the Medicare system and provide consumers with more choice -- a cornerstone structural change that addresses the long-term viability of the Medicare program.

In the 104th Congress, the Finance Committee and the United States Congress realized that the fundamental way to capture the dynamics of change in the health care system would be to modernize Medicare by opening it to a broader array of private health plans that would compete on the basis of quality in addition to cost. President Clinton has embraced this ideal as well by initiating a Medicare Choices demonstration and including provisions to expand choice, although limited, in his budget submission to Congress last month.

Therefore, two months ago, Senator Rockefeller and I introduced S.146, the "Provider-Sponsored Organization Act of 1997." S.146 expands the current Medicare risk contracting program to include Provider Sponsored Organizations (PSOs). A PSO is a public or private provider, or group of affiliated providers, organized to deliver a spectrum of health care services under contract to purchasers. Our bill specifies detailed requirements for certification, quality assurance and solvency to insure that PSOs contracting with Medicare meet standards that are comparable to or higher than those for Health Maintenance Organizations (HMOs). Specifically, it provides federal leadership for states to fashion a streamlined PSO approval process that is consistent with federal standards protecting Medicare beneficiaries. Second, by providing incentives for PSOs and HMOs to evaluate patterns of care, it promotes state-of-the-art continuous quality improvement. Third, it creates a mechanism by which the Secretary of HHS would be allowed, but not required, to enter into partial risk payment arrangements with PSOs or HMOs. Finally, it includes specific solvency standards for PSOs which reflect their ope.ating environment.

Why are PSOs a good place to start in the greater goal of offering Medicare beneficiaries more choice?

First, PSOs will improve quality of care in the following ways:

A. PSOs are comprised of physicians and hospitals. And it is physicians who are closest to the patient and who are in the best position to control, monitor, and demand quality for every patient. Thus in a competitive managed care environment, PSOs will demand that quality, not just price, be considered. This inherent PSO emphasis on quality will spill over to other types of insurance plans, which by their very nature are more distant from the doctor-patient relationship.

B. S.146 requires collective accountability, where quality and costs are measured by overall practice patterns across the entire PSO, not simply by case-by-case utilization review which can be intrusive and burdensome.

C. PSOs will impact the broader community because the physicians and hospitals that provide health services locally are concerned with the health of the whole community -- not just those enrolled in their plan. For example, a hospital must see anyone who shows up at its emergency room regardless of whether an individual is enrolled in a PSO, another plan, or is indigent. This broader responsibility provides the incentive for PSOs to think of the future and to make systemic quality improvements.

D. Because S.146 requires PSOs both to meet new, higher quality standards and to have experience in the coordination of care, the 50/50 rule, a standard which was merely a surrogate for true quality measures, is waived for PSOs. Similarly, non-PSO Medicare risk-contractors are eligible for waiving this quasi-quality measure in exchange for meeting the enhanced quality standards prescribed in the bill. Indeed, S.146 sets a new standard for quality assurance, a standard that likely will set the pace for the rest of the industry.

Second, by empowering providers to become true partners in the decision-making process, the PSO option will give them an opportunity to re-gain control over clinical decisions by accepting the responsibility for coordinating care.

Third, the PSO option will bring coordinated care to more communities, especially to rural and underserved areas. It will bring managed care to markets where managed care has been slow to develop.

As you know, Medicare has had much more difficulty attracting seniors to managed care plans than the private sector -- although enrollment is growing each year. While almost three-quarters of the employed population is enrolled in managed care, only about 13 percent of Medicare beneficiaries are in managed care. Our seniors simply are not given the choice of plans that non-seniors have today. Moreover, seniors frequently express the fear of being herded into a managed care plan that does not include the physicians, hospital and other caregivers with which they are familiar. Many fear the managed care plan will drop their providers from the network at a later time. And many say their fear of managed care stems from anxiety that their physician is no longer in control of their care. Medicare beneficiaries will likely feel more secure knowing that they have the choice of a health plan run directly by local, community based providers. The Rockefeller/Frist bill will give them that security.

Fourth, because the doctors and hospitals are already in communities, serving the local population, it is easier for them than for outside insurers to organize, network and provide a coordinated care option for seniors in traditionally underserved rural areas. This support of local providers can help strengthen rural communities that have suffered social and economic hardship over the past few decades. The building of integrated networks in all areas of the country is necessary if we hope to offer REAL choice to ALL Medicare beneficiaries.

Fifth, given that Medicare's own trustees have reported that the trust fund will soon be bankrupt, Medicare's rate of growth must be slowed. The introduction of PSOs will advance market-based competition within Medicare, which I believe is essential to the long-term integrity of Medicare.

The "Provider Sponsored Organization Act of 1997" builds on the PSO provision included in the Balanced Budget Act of 1995 (BBA). The BBA created a legal definition of PSOs and developed a definition of "affiliated provider." S.146 goes one step further. It defines a Medicare ***Qualified*** PSO as a PSO that has the capability to contract to provide full benefit, capitated, coordinated care to beneficiaries. Clear criteria for the direct provision of services by affiliated providers are also provided. This inclusion will ensure that all but a small fraction of contracted services are provided under either affiliation or participating provider agreements. It also ensures that current Medicare provider contracting rules, especially those that protect beneficiaries from financial liability in the event of a plan failure, will also apply to PSOs.

Since Medicare qualified PSOs do not enter the commercial market as a health plan in order to contract with Medicare, S.146 provides federal certification for the first four years and then transitions to state licensure. This contrasts with the BBA provision which allowed a PSO to seek federal licensure if an application had gone through the state process and had been denied or delayed for a lengthy period.

In addition, our bill requires that the Secretary contract with states during that four year period to provide local monitoring of ongoing PSO performance and beneficiary access to services. At the end of the four year period, state licensure would be required as long as state standards are sufficiently similar to the federal standards and the solvency standards are identical. This approach marries the benefit of national standards for a national program with the benefit of the closer monitoring eye of state agencies -- the approach currently used by Medicare in certifying a variety of health care providers.

Last year's BBA provision also mandated that the Secretary develop new solvency standards that are more appropriate to PSOs. Likewise, S.146 recognizes that PSOs are the caregivers themselves and thus it is not necessary for them to contract out or pay claims for health care services -- as insurers have to do. The bill establishes new solvency standards to protect Medicare beneficiaries against the risk of PSO insolvency. The test of fiscal soundness is based on net worth and reserve requirements drawn from current Medicare law and the current National Association of Insurance Commissioners (NAIC) "Model HMO Act." Adjustments are made to reflect the operational characteristics of PSOs. For example, in measuring net worth, it ensures that health delivery assets held by the PSOs, such as the hospital building, are recognized as they are in NAIC's Model HMO Act. Fiscal soundness is assured.

Also, the Rockefeller/Frist bill differs from the 1995 Balanced Budget Act by giving the Secretary authority to enter "partial risk" contracts with plans (PSOs or HMOs). The Balanced Budget Act required that PSOs take full risk with respect to Medicare benefits. While both bills would require that PSOs provide the full Medicare-defined benefit package, S.146 adds a partial risk payment method (that is, payment for all services based on a mix of capitation and costs). This approach expands the ability of health plans to provide capitated, coordinated care to smaller rural or chronic care populations.

In the 104th Congress, the Finance Committee accepted the challenges posed by the current Medicare statute by attempting to address these issues in a bipartisan manner. This process created a foundation for further action.

There are two reasons why PSO legislation continues to be necessary.

First, current Medicare statute does not allow managed care plans to serve only Medicare patients. Instead it requires plans to participate in the commercial market. It defines the range of benefits that a plan must offer in the commercial market, even though it includes benefits not covered by Medicare. The Balanced Budget Act established the premise, as this committee did last year, that PSOs should be allowed to offer Medicare-only plans. Therefore, the rules regarding minimum enrollment and public versus private payer enrollment (known as the "50-50 rule") are not appropriate for a Medicare-only plan.

Second, plans today are required to go through the state licensure process. The overwhelming majority of state licensure processes do not recognize the fact that PSOs differ from most insurers. Rather, states expect them to look and act like insurers, but they are not -- they are caregivers. The Rockefeller/Frist bill specifically requires that a "substantial proportion" of services are provided directly by the PSO's affiliated providers (those that are under common control or ownership or who share substantial financial risk). This requirement ensures that a plan is not simply contracting out for services, but is the caregiver.

Senator Rockefeller and I did not introduce this legislation to eclipse the current Medicare risk contractors. Rather, the Provider Sponsored Organization Act compliments the existing HMO options in the Medicare program and expands the choices available to seniors and individuals with disabilities.

The Rockefeller/Frist bill is constructed to be narrow, focusing only on PSOs. It does not take on the broad challenges this committee faces in overall Medicare reform. I do advocate much broader choice options for our seniors as part of fundamental structural reforms for Medicare. PSOs are a good place to start -- whether or not we implement broader structural reforms this year.

Qualified Provider-Sponsored Organizations will challenge all health care organizations participating in Medicare to meet the goal of an integrated health system: a system which provides an environment with lower costs, higher quality of health care, and preserved relationships between caregivers and their patients.

PREPARED STATEMENT OF KAREN IGNAGNI

Mr. Chairman, I am Karen Ignagni, President and Chief Executive Officer of the American Association of Health Plans (AAHP), the principal national trade association representing HMOs, PPOs, and other network-based health plans. The Association represents approximately 1000 member plans serving over 140 million Americans. AAHP appreciates the opportunity to testify today on two important issues affecting the future of the Medicare risk contracting program[1]: how Medicare establishes a payment policy that will sustain the trust fund and offer a range of choices to beneficiaries and whether the risk-contracting program should be expanded to include provider-sponsored organizations (PSOs).

We would like to reaffirm here today AAHP continues to support the principles we articulated during the debate over Medicare reform two years ago: Medicare should be restructured to give beneficiaries the full range of health plan options that are available to Americans in the private sector.[2]

When Medicare was enacted in 1965, it was modeled closely on the fee-for-service system that was then the principal way of delivering health care in the United States. Although the program has been expanded since that time to include HMOs, it has not kept pace with the

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[1] The risk-contracting program is a program established under section 1876 of the Social Security Act that authorizes Medicare to contract with health maintenance organizations (HMOs) and competitive medical plans (CMPs) to provide Medicare benefits to beneficiaries choosing to enroll with them. HMOs and CMPs with a Medicare risk contract (often called "risk contractors") are paid a fixed amount per member per month for providing all covered services. A CMP is an HMO that has not chosen to pursue designation as a "federally qualified HMO" under title XIII of the Public Health Service Act, but meets similar standards for Medicare. For the remainder of this testimony, we use the term "HMO" to refer to both HMOs and CMPs.

[2] Attached to this testimony is a Statement of Principles on Medicare Reform that was adopted by AAHP's Board of Directors. It reaffirms our commitment to modernizing Medicare and provides the basis for much of this statement.

rapid changes in the private market and still has a predominantly fee-for-service orientation. As Medicare restructuring is considered, it will be important to ensure that this fundamental fee-for-service orientation does not result in an allocation of funding that places the fee-for-service Medicare program at a competitive advantage over other options. If this occurs, Medicare beneficiaries will continue to have fewer health plan choices than other Americans. While enrollment in participating network-based plans has expanded rapidly in recent years, continued strong enrollment growth will be needed to reach levels comparable to those in the private sector.

AAHP believes that if Medicare is restructured to increase beneficiary choice and to provide comparative information about all available options, including the fee-for-service Medicare program, it will not only enhance choice for beneficiaries, but it will also strengthen the program. In the past 30 years, we've learned how to organize and deliver health care in ways that improve coverage and quality while controlling costs. Consumers in the private market have benefitted from these improvements in recent years, but their effect on Medicare has been smaller and less direct. A recent report on national health expenditures reveals that per capita health spending for Americans covered by private insurance increased at an average annual rate of 3.5 percent from 1993 through 1995, while per capita Medicare spending increased at an average annual rate of 9.7 percent for the same period.

We believe that restructuring Medicare will contribute to the program's long-term survival by providing greater access to the same cost-effective, affordable care as in the private sector. But we also believe that, unless it is done carefully, restructuring the program can hinder the cause of Medicare reform by making it less attractive to beneficiaries. In our view, this problem may arise for a least two reasons. First, if restructuring is done in a way that eliminates

those features of the current risk contract program that have proven attractive to beneficiaries, it may cause some of those who are now enrolled with a Medicare HMO to return to the traditional program and slow future enrollment growth. Second, if restructuring is done in a way that opens the Medicare market to organizations that do not meet consistent consumer protection standards and that do not have a proven track record of accepting full risk for the provision of the Medicare benefit package, lack of long term stability in the health plan options beneficiaries may choose and the failure of some organizations to deliver promised benefits because of inadequate resources or experience could undermine beneficiary confidence in the reliability of private coverage. For Medicare reform to succeed, it should build on the success of the risk contracting program.

Building on Recent Gains

Although Medicare enrollment in network-based plans needs continued strong growth to reach private sector levels, tremendous progress has been made toward closing the gap over the past few years.

- As of January 1997, nearly 4.9 million beneficiaries have voluntarily chosen to join HMOs, representing almost 13 percent of the Medicare population. Five years ago, only 6.4 percent of all beneficiaries were enrolled with HMOs.[3]

- According to the Health Care Financing Administration (HCFA), enrollment in the Medicare risk contract program is currently growing by 80,000 to 90,000 beneficiaries per month. The annual growth rate for enrollment in this program has increased from 10 percent in 1990-1991 to 32 percent in 1996-1997.

- Low levels of disenrollment also contribute to this rapid growth. A study released by the

[3] An October 1996 KPMG Peat Marwick study estimates that 74% of all workers with employment-based coverage were enrolled with a managed care plan in the Spring of 1996.

Physician Payment Review Commission (PPRC) in November 1996 shows that only 2.8 percent of the Medicare HMO enrollees who were surveyed returned to the traditional fee-for-service program. Of this group, over one quarter did so because of factors beyond their control (such as change of residence), leaving only 2.0 percent of the survey sample who voluntarily returned to traditional Medicare.

o Even beneficiaries with serious health conditions, such as cancer, have low disenrollment rates. For instance, a study released by Gerald Riley of HCFA earlier this year found that Medicare HMO enrollees with cancer were no more likely -- indeed were less likely -- to return to the traditional program than were their counterparts who were cancer-free.

Several factors account for the growing popularity of the risk contract program. First, the number of plans participating in the program has increased and is now at an all-time high. In January 1997, 248 HMOs had Medicare risk contracts, compared with 189 in January 1996. In addition, there are currently 67 pending applications for new risk contracts, as well as 20 pending applications by current plans for expansions of their service areas. This means that more beneficiaries have a greater choice of plans.

Cost is also an important factor in explaining why more beneficiaries -- many of whom live on modest, fixed incomes -- are choosing network-based plans. Many risk contractors offer, at little or no out-of-pocket cost to the beneficiary, extra benefits not covered by the fee-for-service program -- services such as routine physicals, immunizations, preventive health screenings (such as eye and ear exams), and outpatient prescription drugs. Approximately half of all plans charge no monthly premium, and the premiums for the remaining plans are generally lower than those beneficiaries would pay for comparable medigap coverage in the fee-for-service program.

While tremendous progress has been made in recent years, there is still room for improvement. As PPRC has noted in a December 1996 report, while the number of beneficiaries

having 5 or more risk plans from which to choose increased from 14 to 25 percent between June of 1995 and June of 1996, 37 percent of all beneficiaries still have no risk contractor serving their area. The unevenness of opportunity for beneficiaries to choose health plans is due, at least in part, to inappropriately low Medicare payment levels in some parts of the country. The challenge to Federal policy makers in crafting a Medicare reform initiative is to restructure the program in a way that increases access to private plan options in these underserved areas without undermining the gains that have been made in other parts of the country.

Regrettably, Mr. Chairman, the proposals included in the budget submitted by the Administration fail to strike that balance. Almost 95 percent of Medicare beneficiaries, and 96 percent of current Medicare HMO members, live in a county where HMO payments decreased under the Administration's proposal from what they would be under current law.

While I will comment on the specifics of the policy changes proposed by the Administration later in this testimony, I would first like to focus on their larger impact. Some have drawn the conclusion that the Administration's payment proposal will not harm the current risk contracting program or reduce the choices available to beneficiaries because, under the proposal, the average amount Medicare pays to network-based plans in 2002 will be higher than it is today. Others have claimed that this proposal will help those areas whose current payment rates are too low to sustain a viable health plan.

AAHP commissioned the Barents Group of KPMG to take an in-depth look at the President's plan. The results of this study reveal a far different picture and call into question whether there is any cause for optimism. In brief, the Barents study finds that under the Administration's proposal:

- Although only about 12 percent of beneficiaries are currently enrolled in HMOs, they account for more than one-third of the Administration's proposed payment cuts.

- Per capita payment rates for Medicare HMOs will grow at 2.4 percent per year from calendar year 1997 to 2002, while fee-for-service payments per capita will grow at two and a half times this rate, 6.1 percent per year, during the same period.

- The national average payment rate in 2002 will be 19.2 percent less than under current law.

- Low payment areas would not benefit under its proposal. 63.0 percent of all low payment areas (containing 69.2 percent of beneficiaries living in low payment areas) would actually have lower payments than under current law.

I know that statistics sometimes fail to convey the real impact of a proposed policy change, so I would like to give you a few concrete examples of the potential impact of the President's proposal on the payment rates for plans in counties of selected States represented on the Committee. Based on the information that is currently available about the Administration's proposal, Barents estimates the average monthly program payment made by Medicare on behalf of beneficiaries in these counties as follows:

County	1997 monthly rate	2002 monthly rate (current law)	2002 monthly rate (Clinton budget)	% Difference
Dade (FL)	$748.23	$1173.76	$757.95	-35.4%
Queens (NY)	$658.84	$845.32	$674.06	-20.3%
Polk (IA)	$402.14	$552.98	$482.83	-12.7%
Kanawha (WV)	$453.88	$704.48	$517.33	-26.6%

AAHP will share the Barents analysis with all of the members of the Committee so that you may assess the impact of the President's proposal on your constituents.

Mr. Chairman, the amount of money the President proposes to remove from the risk

contracting program is not only ill-advised -- it is disproportionate and will disadvantage private plan options in relation to the traditional, fee-for service program. Based on Congressional Budget Office projections, about 20% of Medicare beneficiaries will be enrolled, on average, in managed care during FYs 1998-2002, but they account for 39% of the Administration's proposed reductions in provider payments.

What will all of this mean for Medicare beneficiaries? In our view, it will jeopardize the extra benefits and plan choices enjoyed by those beneficiaries. The impact will be particularly serious, because many beneficiaries who have already joined an HMO have low or moderate incomes. In addition, it will do very little to assure that beneficiaries residing in areas whose current rates are inappropriately low have a choice among the same types of health plans available to beneficiaries in other areas. Instead of expanding choice, it will reinforce the program's prevailing fee-for-service orientation. Instead of building on the recent success of the risk contracting program, it will reduce benefits for beneficiaries who are currently enrolled.

I would like to comment now on the specific proposals included in the President's budget. Since payment rates for risk contractors are currently based on 95 percent of average per capita spending in fee-for-service Medicare (the "adjusted average per capita cost" or "AAPCC"), approximately half the savings from the risk contract program under the President's proposal would flow from the Administration's proposed reductions in payments to fee-for-service providers. While these reductions will obviously have their effect on the resources AAHP's member plans have available to serve their Medicare enrollees, far more troubling to the Association is the complex interaction of these reductions with those that flow from two other changes proposed by the Administration.

First, the Administration would remove from the AAPCC the costs associated with extra payments made to teaching hospitals and hospitals serving a disproportionate share of low-income patients under the fee-for-service program. The stated reason for this proposal is that HMOs do not contract with the facilities for which these payments are intended. We ask the Committee to consider evidence that network-based plans do, in fact, contract with, and refer patients to, teaching and disproportionate share hospitals.

A Medstat Group analysis of a nationwide database of inpatient hospital claims for individual covered by large employers, commissioned by AAHP, offers evidence on the use of teaching hospitals by capitated plans and the reimbursement of such facilities by capitated plans. First, the study found that the use of major teaching hospitals -- many of which also receive disproportionate share payments -- was not different among capitated plans versus fee-for-service plans.[4] Second, for the most part, capitated plans' severity-adjusted facility payments per admission were significantly higher for major teaching hospitals than for non-teaching hospitals while severity-adjusted lengths-of-stay for capitated plans were not significantly different between capitated and fee-for-service plans. By removing the medical education component of the AAPCC, the Administration's proposal would create disincentives for health plans to continue using teaching hospitals. By removing the medical education component of the AAPCC, the Administration's proposal would create disincentives for plans to contract with teaching hospitals.[5]

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[4]The study found that 27% of all admissions by capitated plans were in major teaching hospitals while 22% of all admissions by fee-for-service plans were in major teaching hospitals.

[5]AAHP notes that the AAPCC does not reflect costs incurred by beneficiaries using VA or DOD health care systems. In areas where risk enrollees do not use these systems as much as beneficiaries in the

Second, the President would reduce program payments from 95 percent to 90 percent of the AAPCC. This policy is based upon the Administration's judgment that risk contractors are enrolling beneficiaries who are healthier than average and, therefore, are being overpaid. Mr. Chairman, AAHP's view is that the studies on which the Administration relies are based on out-of-date information and therefore do not reflect important changes in the Medicare program. Any "favorable selection" that may have occurred in the early days of the risk contracting program has been overtaken by the rapid enrollment growth that is now taking place -- and that the so-called "correction" included in the Administration's proposal, while it may be a convenient way to achieve budgetary savings, will penalize plans for caring for beneficiaries who are seriously ill. In addition, the studies have not examined the actual utilization of services of HMO members during their enrollment in the plan. Instead, they have used estimates of the cost of caring for these enrollees in the fee-for-service program, where financial barriers to care may have prevented enrollees from receiving needed services.

While greater market penetration, in itself, should assure that Medicare HMO enrollees are representative of the program's population, other factors are contributing to the same result. The success of our member plans in retaining Medicare beneficiaries as enrollees once they leave the traditional program means that a growing number of current members are aging and that their need for health care services is, on average, increasing. This is produces a phenomenon known as "regression to the mean" -- which simply means that the costs incurred by a group of enrollees who initially may be healthier-than-average come to resemble those incurred by other enrollees over time. Likewise, the increasing number of Medicare plans from which

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fee-for-service system, risk payments are too low.

beneficiaries may choose increases the likelihood that beneficiaries will be able to continue with their chosen providers in at least one of these plans, and this may increase the attractiveness of membership in a network-based plan for some beneficiaries, particularly those linked to their current providers because of ongoing illness. In a 1996 study for PPRC, MPR reported that the proportion of Medicare HMO enrollees who are able to use the primary care provider they used before enrolling nearly doubled between 1990 and 1995. AAHP believes that the combined effect of these and other trends is to minimize the potential for favorable selection.

Preserving Beneficiary Confidence

For Medicare reform to succeed, Mr. Chairman, it must increase the choices available to beneficiaries. But enhanced choice, in itself, is not enough to assure the success of reform. Beneficiaries must also have the confidence that all of their health plan options are held to the same high standards, and that -- whatever option they choose -- it will be there for them over the long run. As suggested earlier in this testimony, rapid turnover in the plans available to serve them, or the failure of even a small number of plans to deliver promised benefits because of inadequate resources or lack of experience, could discredit the entire reform effort for years to come.[6]

AAHP believes that the best way to ensure this does not happen is to hold all Medicare health plan options to strong and comparable standards. Invoking the cause of greater beneficiary choice, some have urged Congress to create separate standards for health plan options

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[6] It could also increase the financial exposure of the Federal government, which would be responsible for assuring that affected beneficiaries receive the services to which they are entitled.

sponsored by providers. They have argued that, because providers have the facilities and professional services to generate services "directly", they do not bear the same risk as organizations that contract with others to provide them. They have also argued that State solvency and other requirements are inappropriate for them and that the States are not equipped to review their applications for licensure expeditiously. These assertions are contrary actual experience.

In our view, any organization that accepts full financial risk for the provision of all covered benefits to Medicare beneficiaries bears the same risk and should be required to meet minimum requirements regarding the resources it has available to meet its responsibilities to Medicare beneficiaries. Whether it functions as a "provider" or part of a Medicare health plan, a hospital needs an adequate funding base to pay its staff, operate its facilities, and provide its services. Provider-based plans should also be required to meet the same minimum enrollment requirements in order to ensure that they have a sufficient base over which to spread risk.

AAHP believes that the current, two-tiered regulatory framework for the risk contracting program is an appropriate basis for judging whether Medicare should entrust its beneficiaries to a health plan. Under it, plans must meet uniform Federal standards. They must also be State-licensed. This ensures that all plans have passed two levels -- one at the state level to ensure that the organization has the structure and financial resources to gain market entry and another at the federal level to ensure that it standards for participation in the Medicare program. Based on experience -- sometimes hard experience -- the current framework should not be compromised simply to promote "choice".

We would also point out that the health care market has changed a great deal in the two

years since Congress first considered Medicare reform and this issue of provider-sponsored organizations. In today's market, an increasing number of provider-owned entities are performing the same functions as health plans and are complying with the same regulatory requirements. They are meeting the same state licensure and other standards as other members of AAHP. More than 300 provider-owned, State regulated health plans now operate in 43 States.

In addition to rapid growth in the number of provider-owned HMOs and PPOs, enrollment in these plans is also growing rapidly. In its June 17, 1996, issue, Modern Healthcare reported that from 1994 to 1995 enrollment in the ten largest provider-owned HMOs increased 16.7 percent, from 2.1 million to 2.4 million.

This demonstrates that States are not imposing unreasonable barriers to market entry for provider-sponsored organizations -- and that they are capable of processing requests for licensure expeditiously. In doing so, states are carrying out their traditional role of ensuring the welfare of their citizens by overseeing the organizations that operate within their borders. This role makes an important contribution to the regulation of entities participating in federal programs, because the federal government would require significant additional resources in absence of state efforts.

Other Issues Affecting Beneficiary Choice

Before concluding my testimony, Mr. Chairman, we would like to highlight several other issues affecting beneficiaries and their choice of health plans. AAHP believes that health plans participating in Medicare should be held to standards that are strong and afford comparable protections for all beneficiaries, but we do not believe that regulation is the answer to every problem. Health plans are listening and actively responding to the needs and concerns identified

by patients and physicians, as well as those of employers and other purchasers, such as Medicare.

One example of our responsiveness to these needs and concerns is our recent statement on mastectomy length of stay. Because of the importance and sensitivity of the mastectomy stay issue and to reassure patients facing this difficult surgery, in November 1996, AAHP's Board of Director's formally adopted a policy that states the following:

> The decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient. Health plans do not and should not require outpatient care for removal of a breast. As a matter of practice, physicians should make all medical treatment decisions based on the best scientific information and the unique characteristics of each patient.

This policy statement on mastectomy represents an important first step in a broader effort. The next step in this process is implementation of *Putting Patients First*, an ongoing, comprehensive program established by AAHP to let affected parties know what they can expect from their health plans in a number of key areas. A task force of the Association's Board of Directors is charged with identifying and highlighting specific health plan policies and programs that can respond to the needs and concerns of patients and physicians. The components of this initiative that have been announced to date include:

- Information for Patients and Physicians.--In December 1996, AAHP announced its policy on patient information. It calls for a commitment by our member plans to ensuring that patients can obtain, upon request, clear information about how plan physicians are paid; how medical necessity decisions are made (including the basis for specific decisions); whether specific prescription drugs are included in a plan's formulary; and how a plan decides if a treatment is "experimental".

- Communications between patients and their physicians.--At the same time, the AAHP Board adopted a statement affirming that nothing in any plan policies or contracts between health plans and physician should be interpreted as prohibiting physicians from discussing treatment options or any other care-related matters with patients. It affirms that plans encourage full and open communications between physicians and patients

about patient care and will not prohibit factual, nonproprietary statements about the plan.

- Emergency Care.--In January 1997, AAHP announced its policy on emergency care, which is designed to facilitate a swift, medically appropriate, and coordinated approach to treating patients facing a medical emergency. It states that plans should cover emergency department screening and, if necessary, stabilization services for conditions that reasonably appear to constitute an emergency based on the patient's presenting symptoms. To promote optimal care, the emergency department should contact the patient's primary care physician as soon as possible.

- Appeals of Coverage Decisions.--Also in January 1997, AAHP announced its policy on appeals of coverage decisions. It states that plans should provide timely notice to patients when a plan determines that a particular treatment or procedure will not be covered or when there is a disagreement between physician and patient about the course of treatment. This notice should include an easily understood description of appeal rights and the time-frame for appeals. In addition, the policy calls for health plans to establish an expedited appeals process when the regular time-frames for an appeal would seriously jeopardize a patient's life or health.

- Compliance.--On February 24, 1997, AAHP's Board of Directors approved a process for ensuring compliance with the policies established by the *Putting Patients First* program. Plans joining AAHP or renewing their membership will be required to uphold these patient-centered policies. Procedures to be implemented as part of the new compliance process are designed to support and strengthen plan efforts to uphold these policies, and they allow the Association to exclude health plans that do not. We believe that this initiative can work in tandem with efforts by Medicare officials to assure that beneficiaries who choose AAHP member plans will be treated fairly and receive quality, cost-effective care.

Finally, Mr. Chairman, the Administration's budget includes a number of other proposals that would affect how beneficiaries choose their coverage option. Although the details on these aspects of the President's plan are somewhat sketchy, it appears to provide for: a single coordinated open enrollment period during which beneficiaries may choose from among all of the Medicare health plans serving their area; distribution by a third party of comparative information to facilitate beneficiary choice (funded by a fee imposed on plans); and standardization of the extra benefits that plans may offer to beneficiaries. It is unclear from the

available information whether the enrollment process would be administered by a third party; whether plans would be permitted to enroll beneficiaries at other times during the year; and whether beneficiaries would be permitted to disenroll at any time during the year as under current law.

AAHP favors policies that increase the choices available to beneficiaries and ensure that they have the opportunity to choose the option that best meets their needs. Removing the freedom of beneficiaries to disenroll from a network-based plan at any point during the year will discourage some beneficiaries from choosing a private plan option. Further, the Association believes that a single annual coordinated open enrollment period will not work for Medicare beneficiaries, who are not connected to the workplace and often need more time to choose their health plans. Such an approach also will cause abrupt changes in plan enrollment, which will make it more difficult for network-based plans to assure that their provider networks are appropriate for the number of enrollees who choose them. If Congress determines that a uniform open enrollment period is appropriate, it should permit plans to enroll Medicare beneficiaries at other times of the year as well.

While AAHP believes that comparative information will promote beneficiary choice and that standardizing the extra benefits a plan may offer is unnecessary to permit beneficiaries to readily compare plan offerings and will needlessly limit beneficiary choice. In addition, it believes that any involvement of a third party in beneficiary education efforts will be counterproductive if it includes acquainting beneficiaries with the unique features of each available plan, a function performed more effectively by plan representatives. AAHP also believes that third party involvement in enrollment will further complicate an already difficult

data transfer and eligibility verification process and will work to the detriment of beneficiaries rather than to their benefit.

Use of a third party enrollment contractor is one of a number of serious design problems that AAHP has identified with a competitive pricing demonstration project that the Health Care Financing Administration proposed to implement in the Baltimore area last year and is now proposing to implement in the Denver area. We strongly urge the Committee to carefully examine the practical implications of this and other features of this demonstration project which we believe, in its current form, is seriously flawed.

We appreciate the opportunity to testify and look forward to working closely with you and your staff as you examine these issues.

The American Association of Health Plans commissioned the Barents Groups of KPMG to analyze the Administration's Medicare managed care payment proposal contained in the President's Fiscal Year 1998 Budget. The key findings of this analysis are presented below.

Key Findings

- Almost 95% of Medicare beneficiaries, and 96% of current Medicare HMO members, live in a county where HMO payments decrease under the Administration's proposal from what they would be under current law.
- Almost 70% of Medicare beneficiaries living in "low payment" areas reside in a county where HMO payments decrease under the Administration's proposal from what they would be under current law. About 63% of these "low payment" areas will actually have lower payment rates under the Administration's proposal than under current law.
- More than 96% of Medicare beneficiaries living in "moderate payment" areas reside in a county where HMO payments decrease under the Administration's proposal from what they would be under current law. About 96% of these "moderate payment" counties will have lower payment rates under the Administration's proposal than under current law.
- Every Medicare beneficiary living in a "higher payment" area resides in a county where HMO payments decrease under the Administration's proposal from what they would be under current law. Every "higher payment" county will have lower payment rates under the Administration's proposal than under current law.
- Under the Administration's proposal, per capita payment rates for Medicare HMOs grow at 2.4% per year from 1997 to 2002, while fee-for-service payments per capita grow at 6.1% per year during the same time period, a difference of more than two and a half times.
- Close to 42% of Medicare beneficiaries reside in a county where HMO payments decrease 10 to 20% under the Administration's proposal from what they would be under current law. Almost 42% live in a county where HMO payments decrease more than 20% under the Administration's proposal from what they would be under current law.

Key Findings of the Barents Analysis

- As Table 1 shows, under the Administration's proposal, the national average payment rate in 2002 will be 19.2% less than under current law.

  The average annual growth in payment rates will be 2.4% from 1997 to 2002 under the Administration's proposal. Under current law, growth in payment rates is expected to be 6.9%.

Table 1: Impact of Administration's FY 1998 Proposal
Comparison of Growth Under Current Policy vs Administration's FY 1998 Proposal

	1997 AAPCC	2002			Compound Growth Rate 1997-2002	
		Current	Proposed	% Difference	Current	Proposed
U.S. Average (weighted by risk enrollment)	$526.09	$733.19	$592.43	-19.2%	6.9%	2.4%
Average for Top 100 Counties (weighted by risk enrollment)	$540.78	$748.97	$604.88	-19.2%	6.7%	2.3%
Average for All Other Counties (weighted by risk enrollment)	$464.48	$667.00	$540.24	-19.0%	7.5%	3.1%

Source: Barents Group

- Table 1 also shows that for the 100 counties with the highest number of Medicare risk enrollees, the average payment rate in 2002 will be 19.2% less than under current law.

  The average annual growth in payment rates for these 100 counties will be 2.3% from 1997 to 2002 under the Administration's proposal. Under current law, growth in payment rates for these 100 counties is projected to be 6.7%.

- As Table 2 shows, almost 95% of Medicare beneficiaries and 96% of current Medicare HMO members live in a county where HMO payment rates decrease under the Administration's proposal from what they would be under current law.

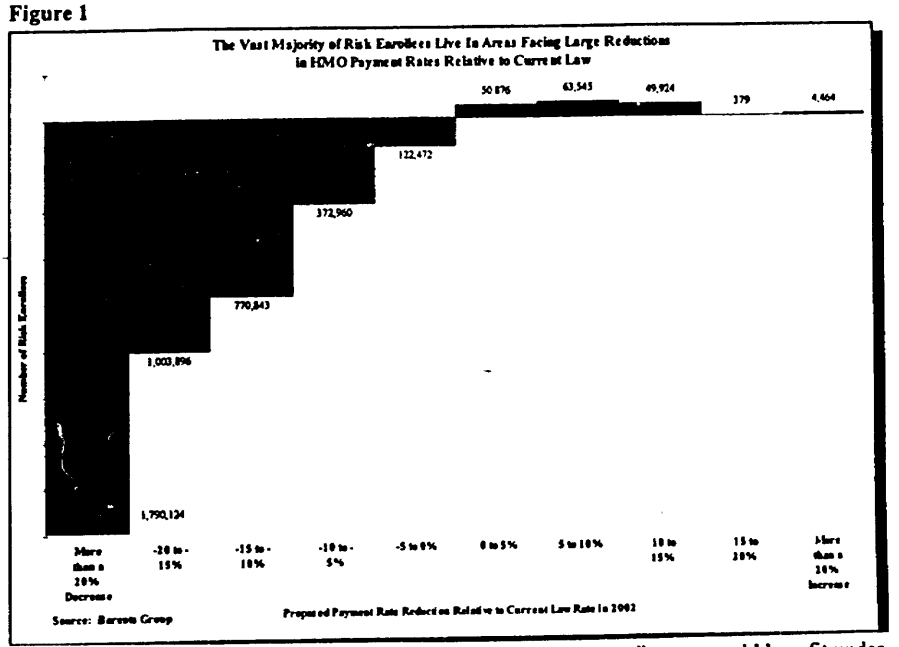
Table 2: Distributional Impact on Counties, Beneficiaries, and Risk Enrollees
Comparison of County Payment Rates in 2002
Current Policy vs Administration's FY 1998 Proposal

	Distributional Impact by:					
	Counties		Medicare Beneficiaries		Risk Enrollees	
Administration Payment Relative to Current Law Payment in 2002	Number	Share	Number	Share	Number	Share
Payment Increase	421	13.5%	2,169,633	5.6%	169,188	4.0%
Payment Decrease	2,704	86.5%	36,259,247	94.4%	4,060,295	96.0%
Total	3,125	100.0%	38,428,880	100.0%	4,229,483	100.0%
Payment Increase of More Than 10%	218	7.0%	725,579	1.9%	54,767	1.3%
Payment Decrease of More Than 10%	2,258	72.3%	31,267,552	81.4%	3,564,863	84.3%

Source: Barents Group

- As Figure 1 shows, the Barents analysis estimates that 1.8 million HMO enrollees (42.3% of all Medicare risk enrollees) live in counties where payment rates will decrease by more than 20%. An additional 1.8 million enrollees (41.9% of all risk enrollees) live in counties with payment rate reductions ranging from 10 to 20%.

Figure 1



- Although the Administration has indicated that "low-payment" areas would benefit under its proposal, 63.0% of "low-payment" areas (containing 69.2% of beneficiaries living in low-payment areas) will actually have lower payment rates under the proposal than under current law. See Table 3 below.

  On the other hand, the analysis estimates that by 2002 only 342 "low-payment" counties (out of a total of 3,125 counties in the US) will have higher payment rates under the proposal than under current law. About 1.3 million beneficiaries, 3.3% of the 38.4 million Medicare beneficiaries, live in these 342 counties.

Table 3: Distributional Impact in Low-payment Areas, by Counties, Beneficiaries, and Risk Enrollees
Comparison of County Payment Rates in 2002
Current Policy vs Administration's FY 1998 Proposal

	Counties with 1997 AAPCC below $350.00		Distributional Impact by: Medicare Beneficiaries in Low-payment Areas		Risk Enrollees in Low-payment Areas	
Administration Payment Relative to Current Law Payment in 2002	Number	Share	Number	Share	Number	Share
Payment Increase	342	37.0%	1,258,327	30.8%	32,396	61.6%
Payment Decrease	582	63.0%	2,823,582	69.2%	20,188	38.4%
Total	924	100.0%	4,081,909	100.0%	52,584	100.0%
Payment Increase of More Than 10%	199	21.5%	568,287	13.9%	9,946	18.9%
Payment Decrease of More Than 10%	341	36.9%	1,550,564	38.0%	3,718	7.1%

Source: Barents Group

- The proposal also markedly reduces payment rates in other areas. Almost 86.5% of all "moderate-payment" areas will face payment reductions of 10% or more in 2002 compared to current law. About 22.2 million beneficiaries (57.9% of all beneficiaries) live in these areas. (See Table 4 below.)

Table 4: Distributional Impact in Moderate-payment Areas, by Counties, Beneficiaries, and Risk Enrollees
Comparison of County Payment Rates in 2002
Current Policy vs Administration's FY 1998 Proposal

Administration Payment Relative to Current Law Payment in 2002	Counties with 1997 AAPCC between $350.00 and $549.99		Distributional Impact by: Medicare Beneficiaries in Moderate-payment Areas		Risk Enrollees in Moderate-payment Areas	
	Number	Share	Number	Share	Number	Share
Payment Increase	79	3.8%	911,306	3.4%	136,792	5.2%
Payment Decrease	2,012	96.2%	25,650,710	96.6%	2,498,387	94.8%
Total	2,091	100.0%	26,562,016	100.0%	2,635,179	100.0%
Payment Increase of More Than 10%	19	0.9%	157,292	0.6%	44,821	1.7%
Payment Decrease of More Than 10%	1,809	86.5%	22,243,986	83.7%	2,134,153	81.0%

Source: Barents Group

- About 98.2% of all "higher-payment" areas will face similar reductions. (See Table 5.)

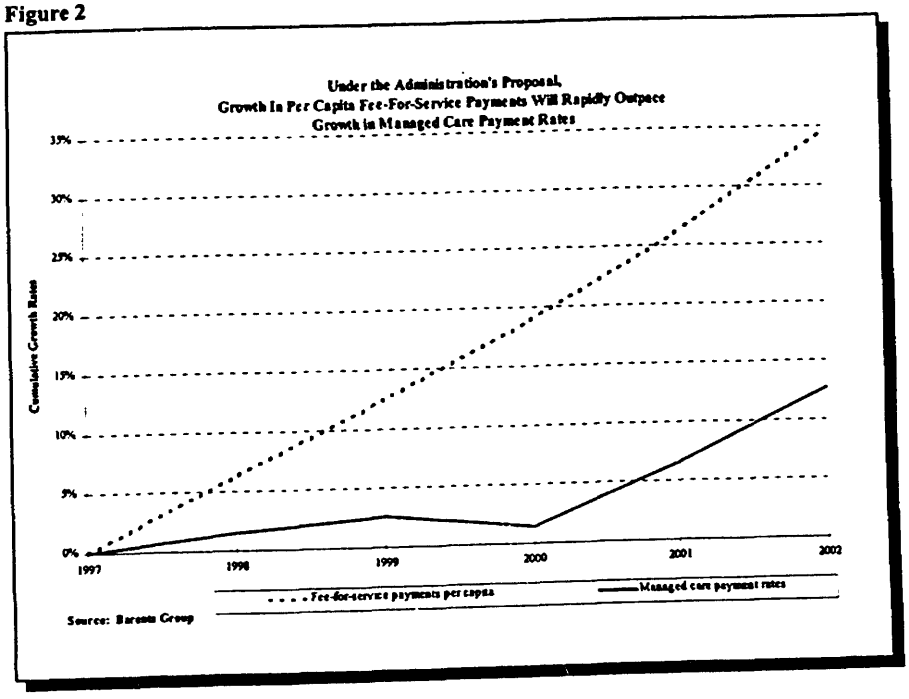
Table 5: Distributional Impact in Higher-payment Areas, by Counties, Beneficiaries, and Risk Enrollees
Comparison of County Payment Rates in 2002
Current Policy vs Administration's FY 1998 Proposal

Administration Payment Relative to Current Law Payment in 2002	Counties with 1997 AAPCC over $550.00		Distributional Impact by: Medicare Beneficiaries in Higher-payment Areas		Risk Enrollees in Higher-payment Areas	
	Number	Share	Number	Share	Number	Share
Payment Increase	0	0.0%	0	0.0%	0	0.0%
Payment Decrease	110	100.0%	7,784,955	100.0%	1,541,720	100.0%
Total	110	100.0%	7,784,955	100.0%	1,541,720	100.0%
Payment Increase of More Than 10%	0	0.0%	0	0.0%	0	0.0%
Payment Decrease of More Than 10%	108	98.2%	7,473,002	96.0%	1,426,992	92.6%

Source: Barents Group

- As shown in Figure 2, under the Administration's proposal, per-capita payment rates for seniors in Medicare managed care will grow at 2.4% per year from 1997 to 2002 while fee-for-service payments per capita will grow at 6.1% per year during the same time period.

Figure 2



Methodology Used In The Barents Analysis

Barents estimated county-level payment rates to Medicare risk contractors under current law using the January 1997 Congressional Budget Office (CBO) baseline of Medicare spending. Barents then compared its estimates of projected payment rates under current law to estimates of payment rates under the Administration's proposal. Estimates of payment rates under the Administration's proposal were based on CBO's estimate of the impact of the proposal (i.e., the proposal would save $29.9 billion from FY 1998 to 2002).

All data are from government sources such as the Health Care Financing Administration, the Congressional Budget Office, and the President's Fiscal Year 1998 Budget.

PREPARED STATEMENT OF TED LEWERS, MD

INTRODUCTION

Chairman Roth, Members of the Committee, my name is Donald Theodore "Ted" Lewers, MD. I am a nephrologist and internist from Easton, MD. I also serve as a member of the American Medical Association (AMA) Board of Trustees. Today, I am pleased to offer our views and suggestions on improving choice in the Medicare program by facilitating the formation of Physician Sponsored Organizations (PSOs) and by determining the appropriate standards to protect our Medicare patients. We commend you, Mr. Chairman, for holding this important and timely hearing.

TRANSFORMING MEDICARE

As we testified last week before the Senate Finance Subcommittee on Health Care, the AMA's proposal entitled Transforming Medicare, is our vision for fundamentally changing the Medicare program. The heart of the AMA's updated Transforming Medicare proposal, which we have delivered to every Member of Congress, is based on the following principles:

- Expansion of Choice;
- Movement to a "Defined Contribution" Approach;
- Individual Selection; and
- Structural Reforms to Offer and Make Choices, perhaps, modeled on the Federal Employee Health Benefit Program (FEHBP).

The AMA's plan for reform is a competitive market-driven system which offers more choice to senior citizens and the disabled without placing these vulnerable populations at risk. In short, these choices would range from remaining in a restructured Medicare program, to selecting from various competing health plans, including managed care plans, traditional insurance, Provider Sponsored Organizations (PSOs), or Medical Savings Accounts (MSAs) (which we were encouraged to see enacted as a pilot project for the non-Medicare population last year). The government would pay the same amount regardless of the patient's choice.

While the AMA will continue to work toward comprehensive and structural change in the Medicare program, we understand the necessity for incremental efforts as well. As a result, we would like to focus our comments on two important incremental components of Medicare reform: (1) approving essential health plan standards for protecting patients; and (2) creating the framework necessary to stimulate the formation of PSOs dedicated to the delivery of high quality, affordable patient care. We look forward to working with this Committee in promoting greater choice and enhanced quality of care for Medicare beneficiaries.

I. PSOS: FULFILLING THE PROMISE OF ANTITRUST RELIEF FOR PHYSICIAN NETWORKS

The market for health care finance and delivery is undergoing substantial change. It would be optimal if this transformation resulted in a greater choice of health plans for patients, including those formed by physicians, hospitals, or other health care providers to compete with insurance companies. However, regulatory obstacles block the way.

Last year, we came to Congress seeking relief from one of those obstacles—antitrust enforcement policies that chilled the development of physician-owned health care delivery networks and health plans. In response, House Judiciary Committee Chairman Henry Hyde introduced H.R. 2925, legislation that would have afforded physician networks the same antitrust treatment as joint ventures in other industries. The bill gained a formidable list of cosponsors—over 150 in all. Ultimately, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) agreed that changes were needed, and despite massive opposition from the insurance companies, issued new enforcement guidelines similar in application to Chairman Hyde's legislation. According to those agencies, the goal of the guidelines is to "ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."

Mr. Chairman, we are here today to seek your help in securing the remaining tools needed to promote the development of PSOs and Provider Service Networks (PSNs). In so doing, Congress can improve health care quality by putting physicians and other qualified health care providers back in charge of medical decision-making.

MAKING THE CASE FOR PSOS

Many physician networks have been successful in reducing health care costs while maintaining or enhancing quality. For example, a recent study in the New England

Journal of Medicine, by James C. Robinson and Lawrence P. Casalino, reported on the cost performance of six physician-owned medical groups in California that accepted global capitation arrangements (i.e., the physicians accepted the risk that patients would need hospital services as well as physician services). It found that hospital use by these groups in 1994 ranged from 120 to 149 days per 1,000 non-Medicare members, and from 643 to 936 days per 1,000 Medicare members. In contrast, the mean number of 1993 hospital days per 1,000 non-Medicare members for commercial health maintenance organizations in California was 232 days, and for Medicare members was 1,337. This is especially significant because hospital use accounts for by far the highest percentage of health care expenditures, and the primary source of savings achieved by managed care health plans has been reductions in hospital usage.

Underlying these developments, and making them possible, are changes in the way that physicians are approaching medical care. First, organized medicine is undergoing a period of comprehensive reassessment to determine what health care services are in fact beneficial to patients. Those found not to be effective are being discarded. Second, physicians are evaluating the best ways to coordinate the services of multiple providers used to treat an illness or injury. The object is to eliminate inefficient uses of resources and to improve the quality of the outcome of the treatment process.

This process of assessment and coordination is handled by groups of physicians who evaluate data about their performance, including cost and outcome, and then investigate the care giving sequence. They determine whether all services provided in the sequence were effective, and whether the services were provided in the most efficient way possible. Some have called this process "total quality improvement." We believe that this process is best handled by the physicians involved in providing the care. It is not possible for insurers or other intermediaries to engage in a similar process effectively, since they are not involved in the direct provision of medical care. They are too remote from actual health care delivery.

Insurance companies managed by non-physicians can, and have, reduced health care costs by placing restrictions on hospital stays by their beneficiaries. They enforce these limits with "preauthorization procedures," which require physicians to obtain approval for all hospitalizations from the insurance company. Insurers have done this by using non-physician personnel to enforce the limits during preauthorization procedures. These personnel usually communicate with physicians by telephone, fax or computer, and are often hundreds or thousands of miles away from where the care is being provided.

Improving such limits does little to improve the quality of care provided and, more importantly, there is a limit on the extent to which these restrictions can reduce costs without compromising quality. Once hospital stays are reduced to the levels contained in the limits, there is little more that the insurer can do.

To achieve additional savings while actually improving quality, it is necessary for physicians to gather data about the exact services provided to treat an illness or injury, how the services were provided, the cost, and the outcome. By engaging in a critical review of the details of the process, physicians can determine the best services to treat an illness or injury, thereby improving quality, and the most efficient provision of these services, thereby reducing costs. This is a much different process than placing arbitrary limits on hospital stays or denying coverage for various kinds of treatment.

That is why PSOs and PSNs are so important to the future of health care in our country. They are health care delivery systems owned by physicians and other health care providers that are designed to maximize cost savings and quality by engaging in this process. Their development is essential to reach the next level of cost savings while enhancing quality of care.

In general, PSOs are defined as health care delivery systems owned and operated by physicians and/or other health care providers with the ability to provide a substantial part of the Medicare benefit package pursuant to risk sharing arrangements. A PSN is a provider network that does not have the capacity to deliver a substantial portion of Medicare benefits, but which can contract with PSOs or other eligible organizations to deliver care pursuant to risk sharing arrangements

Physicians and other providers are eager to develop PSOs and PSNs. We are concerned about third-party intrusion into the patient-physician relationship and, ultimately, medical decision-making. We are troubled that judgments are made about the care of individual patients pursuant to restrictions imposed from remote sites by non-physicians. Physicians and other health care providers believe that we can not only reduce costs but lead medicine into a new era of improved quality if we can take back the reins.

The AMA is pleased that Congress acknowledged the importance of PSOs and PSNs by including provisions meant to facilitate their development in the "Balanced Budget Act of 1995," which was subsequently vetoed by President Clinton.

In addition, we note the introduction of the "Provider-Sponsored Organization Act of 1997" (S. 146) by Senators Rockefeller and Frist. This legislation would allow PSOs to provide benefits to Medicare beneficiaries without any unnecessary insurance middleman. The legislation would establish standards that qualified PSOs must meet in order to serve Medicare patients such as solvency requirements, licensing requirements, and enhanced quality standards and consumer protections. We commend the sponsors of this legislation for moving the PSO debate forward this year in the Senate. We look forward to working with Senators Rockefeller and Frist to ensure that the full potential of physician and other health care provider-led networks is realized.

THE AMA'S VISION OF PSOS

The AMA's plan to transform Medicare is based on expanding the choice of health plans available to Medicare beneficiaries, including PSOs and other eligible organizations that partner with PSNs. Congressional action is essential to fostering the formation of these entities. The AMA believes that PSO legislation should have certain specific characteristics.

First, the legislation should allow as much flexibility as possible to stimulate innovation in the delivery of patient care. Legislation should not favor any one PSO model type or any health care provider group over another in the ownership and management structure of a PSO. The market should determine what PSO models and ownership structures are the most successful.

With regard to flexibility, the AMA is concerned that S. 146 would favor the hospital-owned or physician/hospital organization (PHO) model to the exclusion of others. The AMA believes that physician networks and large group practices should also be able to lead the formation of PSOs. This is important to the public because it is ultimately physicians who must engage in the process of evaluating medical care to improve its quality and reduce its cost. Again, we believe these decisions should be left to the market to determine.

Indeed, the importance of physician leadership is borne out by research. A recent study led by Stephen M. Shortell, a Professor of Health Services Management at Northwestern University, found that health care delivery systems which had significant "physician-system integration" performed better than those that did not. The author defined physician system integration as the degree to which physicians use the system, including being involved in the planning, management, and governance of the system. The study also found that the higher the degree of physician-system integration, the greater the delivery system's inpatient productivity. The study noted that "(i)t is simply not possible to achieve any measurable level of clinical integration for patients without a close relationship of physicians with an organized delivery system."

Second, PSO legislation should contain tough consumer protection standards. Such standards should include requirements that PSOs use continuous quality improvement methods, evaluate continuity of care, monitor the over-or-under-provision of care, provide information to help beneficiaries choose plans and require coordination of utilization review with a PSO's quality program. The AMA has long been committed to the protection of the patient and has undertaken a number of unprecedented efforts in the area of quality assessment and physician performance which is described in greater detail below.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain anti-fraud and abuse laws and self-referral laws. These laws were designed to regulate the conduct of physicians in independent practice under traditional fee-for-service medicine, and they were intended to prevent the provision of unnecessary care. The laws make sense for the regulation of fee-for-service arrangements where the physician may have an incentive to provide unnecessary care. However, they have no purpose in the regulation of networks that are designed to reduce the provision of unnecessary care, especially when the networks are involved in risk sharing arrangements in which physicians have an incentive to reduce unnecessary care.

Another regulatory obstacle is pension regulations found in the Internal Revenue Code. These provisions could have a material adverse effect on the retirement plans set up by individual physicians and could discourage physicians from developing networks.

Fourth, solvency standards should reflect the unique characteristics of PSOs. In spite of the potential benefits of having physicians direct health plans, in 1994 only

6.4% of health maintenance organizations (HMOs) were owned by physicians, physician medical groups, physician hospital organizations (PHOs), and state medical societies combined. This is due, in part, to the chilling effect of state insurance and HMO regulations that fail to account for the distinctions between provider networks that deliver services directly and traditional HMOs and insurers that purchase health care services and resell them.

There are dramatic differences between provider organizations that assume risk and insurance companies. Provider organizations exist for the primary purpose of delivering health care services to patients. To the extent that they enter into risk sharing arrangements, they do so in order to deliver health care. The assets of providers that enter risk sharing arrangements are concentrated in health care delivery. A way to better understand this concept is to consider the analogy of repair warranties issued by car manufacturers. These warranties involve the assumption of risk, and are a significant financial commitment. However, car manufacturers offer them in order to sell cars, and the assets of car companies are concentrated in car manufacturing.

In contrast, the primary purpose of insurance companies is to profit by underwriting risk. Insurance companies do not deliver health care services. They buy them to the extent necessary to satisfy claims. Insurers seek to profit by investing the spread between premium income and claims in financial securities such as stocks, bonds, mortgages, and other investments. Their assets are concentrated in such liquid securities, not in health care delivery. However, the regulations of most states, including solvency standards, statutory accounting principles, and financial reporting requirements, are designed for insurance companies, not provider networks that assume risk. They typically require that insurers maintain a substantial amount of liquid assets and maintain a financial management system that identifies those liquid assets for insurance regulators. This suits the business of insurance well because insurers typically maintain a substantial number of liquid assets in the ordinary course of their business, and if they do not, then they are likely to be in danger of becoming insolvent.

State regulations do not fit the operations of health care providers. Health care providers normally do not maintain substantial liquid assets. However, that does not mean that they are in danger of becoming insolvent. Their assets are concentrated in health care delivery, and they have the capacity to deliver services for which they assume risk. That does not mean that provider networks can sustain substantial and unexpected catastrophic losses, but they can sustain themselves longer without liquid reserves because of their health care delivery assets.

Because of this, and because of the particular demands of the Medicare program for uniformity in administration and operation across the United States, PSOs should be subject to federally-developed solvency standards which recognize their unique differences. Solvency standards should recognize the value of assets used in health care delivery as well as ways of responsibly handling risk such as reinsurance, capitation, and fee withholds. PSOs are critical to the success of a reformed Medicare system based on free market competition; it is essential that they not be forced into inappropriate state regulatory structures that would compel them to become HMOs, thereby eliminating them as a separate option under Medicare.

By regulating PSOs at the federal level, Congress will follow its precedent of encouraging new ventures that stimulate competition and provide efficiencies. A notable example is the "Federal HMO Act of 1973" that was intended to, and did, facilitate the development of HMOs as a means of increasing access and lowering costs. At the time, HMOs faced legal barriers including state solvency requirements viewed as not recognizing their particular characteristics. To remedy the barriers, the Act created a federal regulatory scheme for HMOs that preempted state laws that interfered with their formation and operation. These provisions included grants and loan guarantees for the formation of new HMOs, solvency requirements different from those of other health plans, and a mandate that employers offer HMOs available in their geographic locations as a health benefit option to their employees. In comparison, the provisions to facilitate PSOs are modest in scope.

Finally, any legislative proposal considered by the Senate should also include the creation of PSNs. PSNs, owned and operated by physicians and other health care providers, could contract with PSOs to deliver health care services.

Physicians usually begin the process of managing care with a PSN, because the development of skills and capacity necessary to operate a PSO takes time and experience. These networks typically begin with simple arrangements that are easy to manage, such as discounted fee-for-service networks, and then enter into risk sharing arrangements that require greater managerial sophistication. If the network is successful and is able to manage greater and greater amounts of risk, meaning that larger amounts of services and patients are included in these arrangements, the net-

work could evolve into a provider-owned health plan such as a PSO. Therefore, PSN development is important to the creation of PSOs.

SETTING THE RECORD STRAIGHT

Fear of competition has caused the insurance industry to vehemently oppose any PSO legislation. Since most insurance companies are corporate profit-making entities, first and foremost, it is to their advantage to keep physicians, hospitals and others out of the market. Insurers argue that different solvency standards for provider networks will put patients at financial risk.

The reality is that insurance companies are making the same arguments against the pending PSO legislation in the Senate that they used in the 1970s to oppose HMO laws. HMOs argued successfully that they represented a different product and should be evaluated by different standards. Established insurers will maintain an unfair competitive advantage if provider networks are required to meet the same standards as insurance companies. Patients will ultimately bear the unnecessary cost of excessive capital requirements. Physician and hospital networks are different than insurance companies and commercial HMOs that operate as third party payers. PSOs must and should be required to meet high standards that guarantee consumer protection and quality assurance. But they should not be treated as something they are not: insurance companies.

The insurers argue that state insurance regulation will better protect consumers. The truth is that insurance companies have a checkered history on patient protection. Several plans have either suffered unfavorable court rulings or have been forced to refund millions of dollars bilked from beneficiaries. Tax-favored plans in certain states have overcharged patients by failing to pass on discounted rates and have collected excessive patient co-payments.

The insurers also argue that PSOs would lack consumer protections without state licensing. As we will discuss in more detail in a moment, the AMA supports applying to all health plans including those covering the Medicare population, consumer protections such as disclosure, grievance and appeals processes and enrollment and marketing standards. We also support enhanced quality standards including continuous quality improvement methods and evaluation of continuity of care.

The case for PSOs and PSNs is compelling. Yet, provider networks will be unable to present a meaningful alternative to insurance company plans, and, thereby, improve the competitive process, if they are not permitted to operate effectively. The encouragement of these networks subject to federal regulation will benefit both the Medicare Program and Medicare beneficiaries.

II. ESSENTIAL HEALTH PLAN STANDARDS

The AMA believes that while choice should be at the heart of the health care system, health plan standards and empowering patient protections should be its backbone. In other words, if patients are allowed a choice, whether it be in the Medicare program or in the private marketplace, they must also be given the appropriate information to make these choices in an informed manner. Plans must also be given the appropriate clinical information to improve quality and reduce costs. The AMA urges that all plans be guided by the following principles, which enjoyed bipartisan support in the previous Congress. In general, plans should:

- disclose to patients plan information, rights and responsibilities;
- provide for appropriate professional involvement in medical policy matters;
- disclose utilization review policies and procedures;
- provide reasonable opportunity for patient choice of plans and physicians; and
- provide reasonable access to physicians (primary care and non-primary care).

DISCLOSURE

More specifically, plans should disclose information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. In selecting plans, individuals need information to understand how the plan operates, what they get in benefits, what they must do to ensure that services are covered, and where and from whom they get services. Patients also need to know how plans compare on items such as quality indicators, patient satisfaction, cost control programs, disenrollment rates and grievance and appeals procedures.

Under no circumstances should "gag clauses" or "gag practices" be tolerated. As you know, physicians have an ethical and legal duty to provide patients with all the information they require. We believe that patients should no longer fear that third-party payors could interfere with crucial medical information. In this regard, the AMA strongly supports the "Patient Right To Know Act of 1997" (H.R. 586), and

looks forward to working with you, Mr. Chairman, toward quick passage and implementation of this necessary legislation in the Senate.

We were encouraged when the Health Care Financing Administration (HCFA), in conjunction with the Office of Inspector General (OIG-HHS), recently issued a Medicare Beneficiary Advisory Bulletin, entitled "What Medicare Beneficiaries Need To Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights." This advisory bulletin is an excellent example of the type of important information Medicare beneficiaries should have available to them. The AMA has strongly urged HCFA to require that every Medicare risk contract enrollee be provided with this booklet upon enrollment in an HMO and annually thereafter.

Furthermore, there are legitimate concerns regarding market segmentation and marketing practices designed to attract healthy enrollees. The AMA believes that there should be a minimum set of standards that plans must meet and enrollment procedures with which plans must comply with that are fair and avoid inappropriate market segmentation. To this end, the AMA recently commented on the proposed "Medicare National Marketing Guidelines for Managed Care Plans" issued by HCFA in November of 1996. The AMA believes that while HCFA is headed in the right direction, this effort should be strengthened to ensure that the Medicare risk program establishes appropriate safeguards.

REGULATION OF PLAN POLICIES AND PROCEDURES

In order to guarantee fairness and the provision of necessary medical services, procedures must be established that provide enrollees and physicians with a system to resolve disputes within the plan. In cases where the grievance or appeals cannot be resolved within the plan, participants should be able to seek independent means to address the problems. A recent report issued by the OIG cited a number of problems found in the Medicare risk program regarding the grievance and appeals process. Specifically, the OIG report cites problems with beneficiaries not receiving written determinations, including appeals rights, and the need for HMOs to emphasize standardized appeal and grievance language requirements in marketing, enrollment materials and operating procedures. The report also stated that most beneficiaries who were denied services or payment were not given initial determination notices. The AMA looks forward to working with HCFA and Congress on this important issue.

APPROPRIATE PROFESSIONAL INVOLVEMENT

We believe that physicians have a duty to ensure that their patients receive necessary and appropriate care regardless of the setting or method of payment in which that care is delivered. To enable physicians to meet this obligation, plans need to provide a process, based on the medical staff model, for meaningful physician involvement in the development of medical policies of the plan, including the determination of drug formularies. It is also necessary for plans to have procedures and methods that assure that high quality care is provided; yet, plans should also be given some degree of flexibility in order to achieve these standards and to encourage innovations in quality improvement and cost-effective care.

At the same time, we are pleased that Congress is considering the appropriateness of certain medical decisions being made by health plans across the country. We believe that the reports of "drive-through" deliveries, "drive-through" mastectomies and "drive-through" appendectomies are not the problem, but only the symptom of a more general concern. The problem is that health plans, in efforts to increase savings to premium payers, have ignored certain fundamental principles that must be followed to assure appropriate medical decision-making. We understand that health care plans cannot be considered a blank check and we endorse reasonable efforts to restrain costs. The "drive-through" bills represent a failure to integrate good medical science with appropriate involvement of practicing physicians and their patients to tailor general guidance to meet the unique needs of individual patients.

UTILIZATION REVIEW

Plan quality management systems and utilization review programs must operate to enhance patient care and be based on sound scientific and medical information. Cost alone cannot be allowed to drive quality. Those who are involved in final decisions should be knowledgeable and qualified in the area they are reviewing. Procedures need to be fair and prompt.

COMPREHENSIVE VERSUS INCREMENTAL PATIENT PROTECTIONS

While we are somewhat sympathetic to the voluntary efforts put forth by the industry, we believe "anti-gag clause" and length of stay for mastectomies legislation should be enacted to help allay the public's fear, among other reasons, and restore trust in the nation's health care system. We believe that enacting these patient protections is simply the right thing to do! We are willing, however, to work with the managed care industry to stem the tide of piecemeal legislation. Should the industry demonstrate a willingness to develop more comprehensive legislation based on restoring the primacy of the patient-physician relationship in the medical decision-making process, we would be interested taking the next step. In our view, Americans want to know that they are receiving all the care to which they are entitled. We all agree that the "bad apples" must not be tolerated.

QUALITY ASSESSMENT AND PERFORMANCE

The AMA has undertaken a number of unprecedented efforts in the area of quality assessment and physician performance. As you may be aware, the AMA last year approved the development of an accreditation program for physicians. Subsequently named the American Medical Accreditation Program (AMAP), the program is designed to establish national standards of physician performance.

Last week AMAP took its first step toward implementation and announced that it is now ready to approve self-assessment programs for inclusion in the AMAP program. As a result, AMAP has invited those entities with self-assessment programs to submit them for review. This week, we unveiled our perspective on a set of health plan characteristics that we believe to be essential to the operation of a quality managed health care plan. The document, entitled "Essential Characteristics of a Quality Health Plan" describes what makes for "good" managed care, including patient rights, continuous quality improvement, accreditation and respect for the patient-physician relationship.

CONCLUSION

The Medicare transformation we propose is a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. We do, however, strongly support the need for appropriate patient protections and quality assessment across all health plans even as we move to ensure that a competitive marketplace meets the program's goals and responsibilities.

The AMA appreciates the opportunity to testify before this Committee to express our views concerning the need for PSOs and appropriate patient protections for health plans. We look forward to working with you, Mr. Chairman, and the members of this Committee to address these important Medicare reforms.

PREPARED STATEMENT OF MARY LOU MARTIN

SUMMARY

The Medigap market is working well today:

- 90% of Medicare beneficiaries have supplemental coverage.
- All seniors have a 6-month opportunity to choose any plan when they first enroll.
- 97% of beneficiaries say they are satisfied, according to a recent HCFA report.
- Insurance Commissioners report very few complaints.
- Recent GAO report found that all seniors have access to one or more Medigap plans—regardless of health—if they want to switch coverage after the 6-month open enrollment period.

Medigap policies are required to meet stringent consumer protection rules:

- Benefit policies are required to conform to 10 standard packages.
- Insurers are required to accept all seniors—regardless of health status—during a 6-month open enrollment period when they first enroll in Medicare Part B.
- Marketing standards prohibit insurers from selling duplicative Medigap policies.
- All policies are required to be guaranteed renewable; they cannot be canceled even if a beneficiary moves.
- Preexisting condition waiting periods are limited to 6 months and may not be imposed if a continuously insured Medigap subscriber switches plans.

Congress needs to be cautious in legislating new provisions. Proposals under consideration will increase premiums, reduce access and destabilize the supplemental

market. Older adults generally live on fixed incomes, making them particularly sensitive to premium increases.

The Administration's Medigap proposals will significantly increase Medigap premiums and Medicare spending. Key problems:

- Community rating will result in large premium increases for younger beneficiaries, who will then drop coverage, leaving the oldest beneficiaries with ever-increasing unaffordable premiums.
- Annual guarantee issue requirements will fuel adverse selection by encouraging beneficiaries to postpone purchasing and/or switch plans based on their perceived health status. This will increase Medigap and Medicare costs.
- Mandatory enrollment of high cost under age 65 Medicare ESRD and disabled beneficiaries will result in increased premiums for seniors. ESRD beneficiaries are particularly expensive, costing nine times as much as seniors; these high costs are the reason that this is the only illness that triggers Medicare eligibility.

Two other key issues:

- **Provider Sponsored Organizations (PSOs):** Our organizations do not oppose PSOs. PSOs need to be regulated and state licensed like all other HMOs. PSOs that accept a per person monthly premium payment directly from a purchaser, such as Medicare, are unequivocally HMOs. Providing special exemptions for PSOs is extremely risky and will harm Medicare beneficiaries.
- **Medicare HMO Payment Reforms:** BCBSA and HIAA support payment reforms that assure access and competition in all parts of the country—including rural and underserved areas.

Good morning, Mr. Chairman and Members of the Committee. I am Mary Lou Martin, General Manager of Senior Services for Blue Cross of California, a subsidiary of WellPoint Health Networks, Inc. I am here today representing both the Blue Cross and Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA). These organizations thank you for the opportunity to testify before the Committee on Medigap and other Medicare issues.

Blue Cross of California has been involved in Medicare since its inception in 1966 in several different ways. Blue Cross of California (BCC) is the largest provider of Medicare supplemental/Medicare SELECT insurance in California, covering almost half a million seniors who have either purchased their coverage individually or have employer retiree health benefits. In addition, BCC is a Medicare risk HMO contractor and has been the Medicare intermediary for California for over 30 years, handling the day-to-day administration of Medicare Part A.

Our overall strategy at Blue Cross of California is to provide seniors a range of affordable health benefit options, just like employers demand in the under age 65 marketplace.

The BCBSA and HIAA are pleased that the Committee is considering ways to expand Medicare to make available the same kind of health plan choices provided to working Americans. We believe that by increasing reliance on private competitive markets, Medicare can deliver quality health care and achieve the kind of cost savings that have been realized in the private sector.

MEDIGAP

The Administration is proposing changes in the federal laws that regulate Medicare Supplemental Insurance—Medigap—as part of the President's 1998 Budget proposals. In addition, several Members of Congress are advocating revisions to Federal Medigap laws. These proposed Medigap changes will increase premiums, reduce access and destabilize the supplemental market.

In the rush by some to create a revolving door for the few who wish to switch easily between Medicare managed care and fee-for-service, it is important to ask whether we are placing at risk the vibrant private Medigap market. Currently, the Medigap market provides easily accessible and reasonably priced products.

Before discussing the specifics of these proposals, it may be helpful to review key aspects of the Medigap market.

The Medigap Market is Working Well

Medigap policies—more formally known as Medicare supplemental insurance—are private insurance policies that supplement Medicare benefits. Medigap covers Medicare copayments and deductibles and other services not covered by Medicare such as outpatient prescription drugs. The Medigap market is working well today:

- Access is extremely high: Over 90 percent of Medicare beneficiaries in the traditional fee-for-service program have supplemental coverage today, according to the Physician Payment Review Commission. About 78 percent of beneficiaries have private coverage, and another 12 percent are covered by Medicaid, which

pays for Medicare copayments and deductibles for dual Medicare and Medicaid eligible individuals and Qualified Medicare Beneficiaries. Of those with private coverage, about one-half receive these benefits from their employers under their retiree benefits and another one-half purchase individual Medigap policies.

- All seniors are guaranteed the opportunity to choose any plan, regardless of their health conditions. Current law requires that seniors are given a 6-month open enrollment period to purchase any Medigap policy they choose when they first enroll in Medicare Part B. During this period, Medigap insurers may not deny coverage to applicants or adjust premiums based on health status.
- Satisfaction is extremely high: Almost all—97 percent—Medicare beneficiaries reported that they were satisfied with their Medigap insurance, according to a recent HCFA-commissioned report, conducted by the Research Triangle Institute, as part of the Medicare SELECT evaluation.
- Insurance Commissioners report very few complaints: The National Association of Insurance Commissioners has indicated that the individual State Insurance Commissioners have received very few complaints about Medigap insurance policies from Medicare beneficiaries.
- GAO reports that all seniors can switch plans today: In 1995, Congress directed the General Accounting Office (GAO) to study the extent to which Medicare beneficiaries are able to switch Medigap policies without medical underwriting. This report, issued in September 1996, concluded that all beneficiaries, regardless of their health status, have access to one or more Medigap policies if they want to switch policies after the guaranteed 6-month open enrollment period. AARP policies are offered in every state and some Blue Cross and Blue Shield Plans offer Medigap policies without medical underwriting. Still, despite this availability, very few beneficiaries change their Medigap policies. The GAO study found that 99 percent of all beneficiaries kept the same policy between 1991-1994.

Medigap Policies Are Required to Meet Stringent Consumer Protection Rules Today

Medigap policies that are sold to individuals are required to meet stringent federal and state consumer protection requirements. States are responsible for assuring that Medigap policies comply with these rules. HHS has the authority to review state enforcement policies. Federal and state Medigap laws apply only to individually sold Medigap policies; employer-sponsored policies are not subject to these rules.

The major Federal rules that all Medigap policies must meet include:

- Standard Packages: Policies are required to conform to 10 standardized sets of benefits, referred to as A-J. Medigap insurers can offer some or all of these benefit packages, but are not allowed to vary the benefit configurations (except in 3 waivered states: Massachusetts, Minnesota, and Wisconsin).
- 6-Month Open Enrollment: As mentioned above, insurers are required to accept all seniors—regardless of their health status—during a 6-month open enrollment period when they first enroll in Medicare Part B. Marketing—duplication prohibited: Insurers cannot sell a Medigap policy to someone who already owns one.
- Guaranteed Renewable: All policies sold are required to be guaranteed renewable. If a beneficiary moves to another state, he or she simply takes the coverage with them—the policy is totally portable. Preexisting Conditions: Waiting periods are limited to 6 months; however, if a continuously insured Medigap subscriber switches policies, new preexisting periods may not be imposed.

Congress Should Be Cautious in Legislating New Requirements

The current Federal rules were carefully crafted to balance access to coverage with affordability. The requirements being proposed will have serious unintended consequences, including large premium "shock" to seniors. Older adults generally live on fixed incomes, making them particularly sensitive to premium increases. These proposed changes can transform a well-functioning Medigap marketplace to one characterized by serious problems.

The Administration's Proposals Will Increase Premiums, Reduce Access, and Destabilize the Supplemental Market

HIAA and BCBSA have major concerns with the Medigap changes proposed by the Administration. The Administration's Medigap proposal has 4 major components:

1. **Community Rating**—an insurance rating practice where an insurer charges everyone the same premium regardless of their age—would be required for all private Medigap plans.

This change will result in significant premium increases. Since younger Medicare beneficiaries use fewer services, most Medigap policies charge 65 year old subscribers less than 85 year olds. If this proposal were enacted, younger beneficiaries would receive large premium increases immediately. These young beneficiaries are then likely to drop their Medigap policies or not purchase them at all. When this happens (and experience confirms that this will), the older and sicker Medicare beneficiaries will be left. A cost spiral will begin, prices will increase, and fewer people will be covered. Federal policy should encourage just the opposite incentives—all individuals should have the incentives to purchase coverage when they are young and to remain in the insurance pool.

Proponents of this change indicate that these premium increases would be a "one-time" increase only. However, this is not the case. Blue Cross of California has just completed an analysis that demonstrates that using attained age rating—where premiums vary by a subscriber's age—actually results in a lower lifetime rate, than community rating. The reason: younger healthier individuals remain in the insurance pool under attained age rating. These younger, beneficiaries are needed to offset the costs of older, more expensive beneficiaries.

Some people have argued that since Medicare HMOs are required to community rate their premiums, Medigap insurers should have similar requirements. While this appears logical, this is misleading. Although HMOs are required to charge a community rated premium to beneficiaries, the Federal payment to HMOs (the AAPCC) is fully adjusted for the beneficiary's (attained) age. Since most HMOs do not charge any premiums, they are receiving 100 percent of their payment on an age-adjusted basis.

2. Guarantee Issue—where insurers offer coverage regardless of health status—would be required of all Medigap policies during an annual coordinated open enrollment period. This change would increase both Medicare spending and Medigap premiums significantly. Actuaries will attest that premiums will increase if individuals are permitted to postpone purchasing and/or switch health plans based on their perceived health needs.

The President's proposal would encourage individuals to switch back and forth from Medicare HMO plans to the traditional Medicare program supplemented by Medigap and/or postpone purchasing coverage altogether. While sounding attractive, this policy will increase adverse selection problems resulting in large increases in Medigap costs. The impact is not just on Medigap. Medicare program costs will increase as well. The healthiest seniors will tend to choose Medicare HMOs and return to traditional Medicare and purchase Medigap when they become ill. The Physician Payment Review Commission analyses show that individuals who rapidly disenroll from HMOs cost 60 percent more than average.

The result: Medicare beneficiaries during high-cost episodes would be concentrated in traditional Medicare (where the Federal government pays direct fee-for-service costs) and the supplemental market. The healthiest seniors would be concentrated in the private plans where the Government is paying a fixed premium. In fact, the Congressional Budget Office recently testified before Congress that the Administration's Medigap proposals raises "complex issues" and "would encourage the disenrollment of sicker beneficiaries from HMOs, compounding selection problems and causing Medigap premiums to increase."

Combined, community rating and guarantee issue would also have the following impacts:

- Disproportionately impact rural areas since Medicare beneficiaries in rural areas generally do not have access to HMO coverage. While HMOs are available on a county basis, Medigap plans are often available statewide. Consequently, individuals in rural areas will pay the cost of the HMO-opt out provision—through higher premiums—without the benefit.

Reduce choice for beneficiaries because long standing Medigap insurers may be forced to exit the market. Particularly disadvantaged will be Medigap insurers who enroll a higher percentage of older Medicare beneficiaries than their competitors. These insurers will immediately have a "higher" community rate, and will have great difficulty in attracting younger, less costly people to offset these higher costs. Destabilize the entire Medigap market because the concentration of higher cost Medicare beneficiaries in the traditional Medicare program with Medigap coverage will result in higher premiums, and thereby drive insurers out of the market.

3. Enrollment of High Cost, Under Age 65 Medicare ESRD and Disabled Beneficiaries would be required in all Medigap plans. This would increase premiums for all beneficiaries. In particular, ESRD beneficiaries are very expensive—costing Medicare an average $46,332 per person/year in 1997, 9 times as expensive as an older beneficiary ($5,604/year). Medicare has recognized that care for ESRD individuals is unusually costly by making this the only illness that triggers Medi-

care eligibility. In addition, because of the higher costs of ESRD and disabled individuals, Medicare has established separate Medicare Secondary Payer rules. Also, Medicare HMOs are not permitted to enroll ESRD beneficiaries. Coverage can be provided through other mechanisms. Most states now have high risk pools that provide Medigap-type protection to these individuals.

4. Annual Coordinated Open Enrollment periods would be required for all Medigap and Medicare managed care plans. While the details of the Administration's plan have not yet been released, the Health Care Financing Administration (HCFA) has expressed interest in hiring third-party administrators to provide information and actually enroll beneficiaries into Medicare private plans and Medigap policies. The President's FY 1998 budget plan proposes to develop comprehensive comparative information on all plan options, including Medigap, that would be financed through taxes on private plans. Many, if not most, states already have entities that prepare and distribute this type of information. We therefore question whether more federal regulation is needed which may unnecessarily tax seniors to pay the cost.

We are very concerned about the administrative feasibility of having a one-month annual open enrollment program for Medicare. This would be an enormous undertaking and have a high risk of failure. Plans would need significant resources, including trained staff, telephones, computers, etc.—to handle millions of questions and enrollment forms during a 30-day period. It would also be questionable whether HCFA could manage this coordinated open enrollment program without substantial new resources.

CONCERNS WITH S. 302

BCBSA and HIAA also have concerns with the bill (S. 302) introduced by 2 distinguished Members of this committee—Senators Chafee and Rockefeller. Many of the provisions of this bill are also included in the Administration's proposal. While S. 302 is much more targeted than the Administration's proposal, it also will result in premium increases.

First, this bill, like the Administration's proposal, requires enrollment of under age 65 Medicare ESRD and disabled beneficiaries in all Medigap plans. As explained earlier, this change will result in increased premiums for all beneficiaries.

Second, S. 302 would establish special open enrollment periods for certain individuals whereby Medigap insurers would be required to offer coverage with no preexisting condition limitations and no variation in price because of health status. Eligible individuals would include:

- Beneficiaries who move out of the service area;
- Individuals whose employer retiree plan ceased or benefits were "significantly" reduced;
- Beneficiaries choosing managed care for the first time and disenrolling within 12 months; and
- People in plans that have terminated or beneficiaries who have moved out of the service area.

These special enrollment periods would increase premiums for Medicare beneficiaries who have been continuously enrolled in Medigap. Of particular concern is the provision requiring Medigap plans to accept all Medicare HMO disenrollees at the same price as other Medigap subscribers. These individuals are generally expensive—PPRC analyses indicate that HMO disenrollees cost 60% more than an average Medicare beneficiary.

The provision dealing with individuals in employer retiree plans that reduce benefits has the same adverse selection problems and, in addition, has significant implementation problems. Employers frequently change their coverage options, potentially making a large number of people eligible for the guaranteed issue requirement. The term "significantly" will be difficult to define and could lead to large numbers of individuals qualifying for special treatment under this provision. For example, if an employer changes its retiree plan from PPO to HMO coverage, or increases the fee-for-service premium by 10 percent, would this qualify as "significantly reducing" benefits?

Medigap coverage, without medical underwriting, is already available to all of these individuals, as documented in the recent GAO report, cited earlier. Moreover, Medicare beneficiaries who move have several options today: they can join a Medicare HMO, purchase a new Medigap policy, or keep their existing Medigap plans (all Medigap plans are guaranteed renewable and cannot be canceled, even if a person moves).

Third, the bill would ban the one-time preexisting condition limitations that are now permitted during the 6-month open enrollment period. This would increase pre-

miums. Currently, Medigap plans are required to accept all Medicare beneficiaries age 65 and older when they first enroll in Medicare Part B, but are allowed to impose a one-time, 6 month preexisting condition limitations. Once an individual satisfies the 6-month Medigap requirement, new preexisting condition limits are prohibited.

While we have expressed serious concerns with these proposals, we intend to work closely with the Committee to assure that Medicare beneficiaries are protected and to carefully balance access with affordability of Medigap. As indicated earlier, the Medigap market is working well today. We want to make sure it continues to provide wide access at affordable prices.

PROVIDER SPONSORED ORGANIZATIONS

HIAA and BCBSA believe that Congress should encourage competition and consumer choice in the Medicare program by including the full range of managed care choices available in the private sector. The Medicare program already offers coverage through Provider Sponsored Organizations (PSOs) that contract as Medicare risk HMOs and are state licensed HMOs. In fact, 1 in 7 HMOs today are PSOs. However, it is extremely important that any new Medicare managed care entities play by the same rules, and be state licensed, as current regulations require.

Some proposals, including the Administration's, would provide special treatment for PSOs by exempting them from state licensure when they contract on a risk basis with Medicare. In their simplest forms, PSOs are companies formed by groups of doctors, hospitals or other health care providers to sell health care services to employer groups and individuals, as well as the federal government. These entities—once they accept a premium or capitation payment, in exchange for the risk of providing all covered benefits—are indistinguishable from HMOs. I want to emphasize that our organizations do not oppose PSOs. The concern is that some PSOs operate as HMOs, but are trying to avoid state HMO regulations that protect consumers. Again, when a PSO accepts a per person monthly premium payment directly from a purchaser, such as Medicare, the PSO is "de facto" an HMO.

Exempting PSOs from state licensure and oversight, would place Medicare beneficiaries at risk. PSOs claim they can be exempt from requirements to hold minimum net worth standards in cash because they have substantial assets in hospitals and real estate; and they employ the staff that provide care and this staff's "sweat equity" will provide a cushion if an unusual number of subscribers become ill.

These arguments fail to address the underlying reasons for the application of solvency standards to HMOs. Even if provider owners were willing to work for free when reserves were depleted, PSOs will need cash reserves to cover payments for the costs of nurses, physical therapists, pharmaceuticals, and other hospital supplies. Reserves are also needed to cover out-of-network emergency or specialty care. Buildings and real estate assets, while valuable, cannot be readily converted into the cash needed to pay unexpected claims or to pay for out-of-network care.

BCBSA has commissioned a series of studies looking at PSO issues:

- A January 1997 report from California consumer attorney Carol Jimenez found that "the lack of state licensing and operational standards for PSOs means a lack of consumer protections for those enrolled in them." "Without such quality and solvency protections, it is likely that consumers will experience more problems enrolled in PSOs than any of the historical problems some have experienced in HMO settings." There are more than 1,000 state laws designed to protect consumers in HMOs. A chart depicting the major state consumer protections is attached.
- The Barents Group found in a January 1997 study that many PSOs are rapidly assuming the "defining features" of HMOs and, therefore, should be subject to the same regulatory oversight as HMOs. Some PSOs are increasingly becoming virtually indistinguishable from HMOs.
- Just today, BCBSA released a new report focusing on PSOs operating in rural areas. The new report, also conducted by Barents, concludes that unregulated PSOs are extremely risky for rural America. This is because rural areas have a disproportionately high level of elderly and uninsured residents; small populations over which to spread these high costs; a high rate of injury and catastrophic events; an acute shortage of health care professionals; and the frequent use of out-of-area and out-of-network health care services by rural residents. Because of these factors, the financial requirements for rural PSOs to assume risk may be higher than in urban areas. Financial failure or even significant cash flow problems of a PSO operating in rural communities can be devastating for the entire area.

MEDICARE HMO PAYMENT REFORMS

BCBSA and HIAA support reforming Medicare HMO payments to assure access and competition in all parts of the country.

The current method for developing payment rates is seriously flawed. There is a significant variation in Medicare HMO payments by geography, with 1997 monthly payments ranging from $220.92 in Arthur, Nebraska to $767.35 in Richmond, New York. Because of this large variation in payments, Medicare HMOs in high payment areas are able to offer much richer benefit packages, often at no cost to the beneficiary. In addition, there is extremely uneven enrollment patterns, with 50 percent of all Medicare enrollment in California and Florida (17 states have 93 percent of the enrollment) and there is limited cost savings for Medicare.

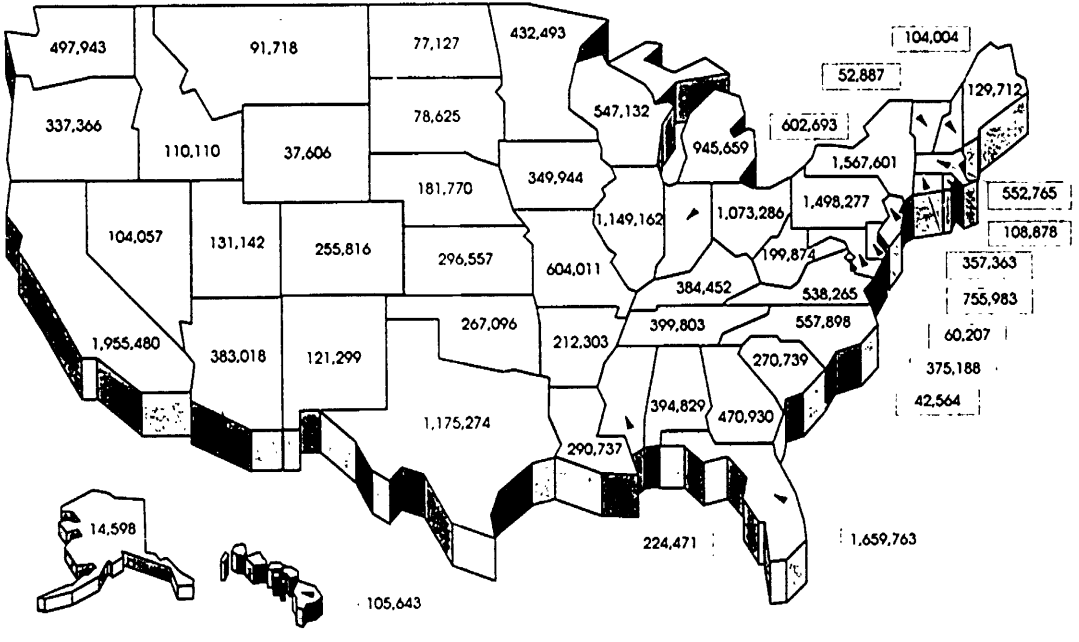
Our organizations support reform that would provide fair and equitable payments to Medicare private plans across-the-country. Any payment change should encourage HMOs in all markets—including rural and underserved areas—so access is provided for all Medicare beneficiaries.

BCBSA is now finalizing its positions on specific Medicare HMO payment reforms and will provide them to the committee as soon as possible.

Last week, the HIAA Board approved a position supporting a gradual phase-out of federal funding to Medicare HMOs for graduate medical education (GME) and uncompensated care from the AAPCC payment. HIAA looks forward to working with the Congress on the future distribution of GME dollars to ensure that academic medical centers, as well as HMOs with teaching programs, are adequately compensated for the teaching services provided. HIAA also supports a more equitable geographic distribution of HMO payments. With respect to the Administration's proposed reductions in the payment formula from 95 percent to 90 percent of the AAPCC, HIAA reserves judgment on the actual percentage of the reduction and welcomes opportunities to discuss payment mechanisms that do not use fee-for-service as a basis for payment. HIAA supports a free-market approach to risk contracting.

Thank you for the opportunity to be here today and I would be pleased to answer any questions you may have.

More Than 23 Million Medicare Beneficiaries have Private Supplemental Health Insurance



Source: HIAA 1996 estimate based upon data from U.S. Department of Commerce, Bureau of the Census, 1996, and Current Population Survey, 1994.

States Have Adopted A Broad Range Of HMO Consumer Protection Laws

State	Marketing/ Enrollment	Access & Benefits	Quality of Care	Grievances & Appeals	Info. to Enrollees	Business Operations	Financial Protections	Data Collection	Penalties
Alabama	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alaska	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arizona	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arkansas	✓	✓	✓	✓	✓	✓	✓	✓	✓
California	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut	✓	✓		✓	✓	✓	✓		
Delaware	✓	✓	✓	✓	✓	✓	✓	✓	✓
Florida	✓	✓	✓	✓	✓	✓	✓	✓	✓
Georgia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hawaii	✓	✓	✓	✓	✓	✓	✓	✓	✓
Idaho	✓	✓	✓	✓	✓	✓	✓	✓	✓
Illinois	✓	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iowa	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kansas	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky	✓	✓	✓	✓	✓	✓		✓	✓
Louisiana	✓	✓	✓	✓	✓	✓	✓		✓
Maine	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maryland	✓	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mississippi	✓	✓	✓	✓	✓	✓	✓	✓	✓
Missouri	✓	✓	✓	✓	✓	✓	✓	✓	✓
Montana	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nebraska	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nevada	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Hampshire	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	✓	✓	✓	✓	✓	✓	✓	✓	✓
New York	✓	✓	✓	✓	✓	✓	✓	✓	✓
N. Carolina	✓	✓	✓	✓	✓	✓	✓		✓
N. Dakota	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ohio	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oklahoma	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oregon	✓	✓	✓	✓	✓	✓	✓		✓
Pennsylvania	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island	✓	✓	✓	✓	✓	✓	✓	✓	✓
S. Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓
S. Dakota	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tennessee	✓	✓	✓	✓	✓	✓	✓	✓	✓
Texas	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utah	✓	✓	✓	✓	✓	✓	✓	✓	
Vermont	✓	✓	✓	✓		✓	✓	✓	✓
Virginia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington	✓	✓	✓	✓	✓	✓	✓	✓	✓
W. Virginia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wisconsin	✓	✓		✓	✓		✓	✓	
Wyoming	✓	✓	✓	✓	✓	✓	✓	✓	✓
Total	50	50	48	50	49	49	49	46	47

Source: "Provider Sponsored Organizations and Direct Risk Contracting: Who Protects the Consumer?" (January 1997)

STATEMENT OF JOHN T. NIELSEN
SENIOR COUNSEL AND DIRECTOR OF GOVERNMENT AFFAIRS

INTERMOUNTAIN HEALTH CARE, INC.
SALT LAKE CITY, UTAH

ON BEHALF OF THE COALITION FOR FAIRNESS IN MEDICARE

Before The
Finance Committee
United States Senate
Washington, D.C.

March 20, 1997

Mr. Chairman and members of the Senate Finance Committee, my name is John T. Nielsen. I am Senior Counsel and Director of Government Affairs for Intermountain Health Care, Inc., ("IHC"). IHC is a large integrated health care system based in Salt Lake City, Utah, operating in the states of Utah, Idaho, and Wyoming. IHC consists of 23 hospitals, 33 clinics, 16 home health agencies, and 300 employed physicians. Additionally, our system operates a large Health Plans Division with enrollment of 350,000 directly insured plus 430,000 who use our networks through other insurers. One of the health plans offered by IHC is known as "IHC Senior Care", a Medicare risk HMO. The plan works in conjunction with Medicare to provide all care a member may need, replacing the need for costly "Medigap" supplemental insurance. I will discuss this particular HMO plan in greater detail further on in my presentation.

I appreciate the opportunity to appear before you today on behalf of the Coalition for Fairness in Medicare and share with you some of the experiences of my company and others who make up the organization we call the Coalition for Fairness in Medicare.

What Is the Coalition?

The Coalition for Fairness in Medicare is an ad hoc group of hospital systems, HMOs, state hospital associations, and provider organizations who share a common goal: equity and fairness in Medicare payments. Attached is a list of the Coalition's current membership. The Coalition was formed in early 1995 when three Minnesota health plans saw the need to address payment inequities as Congress debated Medicare reform. The group rapidly expanded as health plans and other provider groups in all regions of the country realized that fair payment was the only way to insure that health plans could offer a wide range of benefits

which would attract beneficiaries to managed care, thereby providing the elderly with a real option beyond Medicare fee-for-service.

IHC is proud to serve the constituents of Senator Orrin Hatch and appreciate his involvement in our issues. The Coalition is grateful for the early leadership of Senator Grassley to achieve fairer payment in Medicare for rural areas and looks forward to working with all members of the Finance Committee to accomplish our mutual goals.

The Goal of the Coalition.

As a Coalition, we have been active in urging Congress and the Administration to look carefully at the wide disparity that exists in the Medicare HMO payment formula as applied to counties throughout the nation. Certainly, members of Congress are familiar with the many proposals for fixing the Medicare system, for saving the Trust Fund, and offering more choices for beneficiaries. I am here today to suggest that, based upon the experience of my company and those of others all over the country, the success of any of these reform proposals depends in large measure on addressing the dramatic regional variation in Medicare capitated payment rates.

One of the solutions to controlling the cost growth in the Medicare program and to offering beneficiaries a wider array of choices is to move Medicare beneficiaries into managed care. It is our view that neither of these laudable goals can be accomplished without addressing the wide geographic inequities in the Medicare/HMO payments.

We believe that if these unfair disparities are eliminated -- disparities that bear little relationship to the costs of providing care to patients in a given service area -- Congress can achieve its savings goals and open up markets throughout the nation to a wide variety of health delivery and financing programs, the sponsors of which are eagerly awaiting the opportunity to offer products designed for the Medicare population.

Background of Medicare Managed Care.

With the advent of the popularity of HMOs as an alternative to fee-for-service, in 1982 Congress gave seniors the opportunity to choose either traditional fee-for-service Medicare or new HMO packages. Under the HMO option called "TEFRA" risk contracts, Medicare HMO members could receive comprehensive integrated health coverage with little paperwork, potentially more benefits, no deductibles, and lower co-payments. A payment formula was developed that was tied to the

fee-for-service spending for beneficiaries in a given area. Starting with historical fee-for-service costs, HCFA calculates an average rate annually called the United States Per Capita Cost. It then calculates separate premium rates for each county in the nation.

Through a series of subsequent steps, HCFA derives what is known as the Average Adjusted Per Capita Cost ("AAPCC"). The AAPCC reflects various demographic adjusters and includes Part A, which reflects hospital spending, and Part B, which reflects physicians and outpatient services, in the fee-for-service side. Part A and Part B dollars are combined and health plans are paid 95% of that rate.

Although Unintended, the Formula Created Wide Regional Variations.

As the payment formula was developed, the use of historical fee-for-service costs from which the AAPCC is subsequently calculated, has created artificially high and low payments in different parts of the country. For instance, in 1997, the Medicare payment rates to HMOs vary geographically from a low of $221 per member per month in Arthur, Nebraska, to a high of $767 per member per month in New York City. This range reflects an extreme 347% disparity. Hence, in nearly half of all counties in America, health plans rarely offer comprehensive benefit packages because the payment rate is too low to break even. As a result, some beneficiaries in high payment areas get more benefits, more choices, and pay less out of pocket than the similarly situated elderly who happen to live in low payment areas.

Illustrating the problem, in a January 1996 report by the United States General Accounting Office to Senator John Kerry, it was observed:

> About 2.8 million Medicare beneficiaries - about 7% of the total - were enrolled in risk contract HMOs as of August 1995. This was double the percentage enrolled in 1987. The growth has been particularly rapid for the past four years and has been centered on certain states. California and Florida, for example, have more than half of all enrollees. The number of risk contract HMOs offering care to Medicare beneficiaries, while decreasing between 1987 and 1991, has nearly doubled from 93 in 1991 to 171 in August of 1995. Distribution of these HMOs across the country, however, is far from uniform: four states account for nearly half of them and 19 states have none.
>
> The available data show two key characteristics that are common to many locations where HMOs have decided to sign risk contracts with Medicare. One is that HMOs are relatively well established as medical providers to the

general population. The other is that the amount of money the government pays risk contract HMOs for each enrollee, which varies from county to county throughout the nation, tends to be relatively high where enrollment is the highest.

Rural Areas Particularly Hard Hit.

As markets become more efficient, growth in the AAPCC has declined in some areas. In other areas, primarily urban, because of overcapacity, patient demand, and lack of concern about costs and fee-for-service, volume of care has increased per capita, with AAPCCs climbing each year, often in the double digits.

The situation is particularly acute in rural areas. Because of the low number of physicians, less Medigap coverage and fewer high specialty facilities, per capita spending in rural areas lags far behind most urban areas. Historically, while the per capita spending and high volume markets have grown, rural areas have been left far behind.

Medicare HMOs must attempt to guarantee access to a wide range of comprehensive services. At the payment rates now available, it is economically infeasible to offer the choice of a managed care plan to beneficiaries in many rural and other low payment areas. There are many examples of HMOs enthusiastically experimenting with choices in rural areas only to soon discover that the low payment rate undermines their financial viability.

The Utah Experience.

Let me give you an example from the Utah experience. IHC is a not-for-profit integrated health care delivery system. We are mission driven to provide the highest quality and lowest cost services to all, irrespective of their ability to afford those services. Because of the nature of our mission and the ethical and cultural environment in which our company operates, it has been a goal to enhance access whenever possible. Accordingly, in May of 1996, IHC offered its first Medicare risk HMO called "IHC Senior Care". It currently serves approximately 5,000 enrollees in three of Utah's largest counties, Salt Lake, Weber, and Davis. It offers four plan options with monthly premiums ranging from $9 - $59 (varying mainly upon the prescription drug benefits offered). Physician office copayments range from $5 - $15 depending upon the plan option chosen.

Our experience in operating a Medicare risk plan to date has been less than successful. While the product is popular among beneficiaries, IHC is losing substantial money. Actuarial reports prepared by Milliman and Robertson warned

that, with the low AAPCC in Utah counties, this product would not be financially successful. Nevertheless, for the reasons I stated previously, IHC decided to forge ahead, hoping that we could develop additional efficiencies that might allow us to break even. This has not been the case to date.

As a company, we refuse to offer inferior products which would have the result of "skimming risk" simply to make money. We do not believe this is within the spirit of the Medicare program as managed by HCFA and certainly, in our view, would be a disservice to the Medicare population in Utah. Our actuaries and Health Plan executives all agree that the low AAPCC payment in Utah is simply not sufficient to sustain the program. This rate averages approximately $307 per member per month after demographic adjustments are applied to the $350 average per capita in the state. Moreover, the even lower AAPCC rates and/or sparse populations in Utah counties, other than the three in which IHC currently offers its Medicare managed care products, precludes IHC expansion of this product into other service areas. Our actuarial projections suggest that if the AAPCC payment to Utah counties could be increased by 15% to 20%, we might be able to maintain this program and expand it throughout our state. Without such increases, IHC seriously will have to reevaluate its ability to offer IHC Senior Care at all.

The Utah experience is not unique. Many of the plans represented in the Coalition for Fairness in Medicare, particularly those in rural states, report similar results. Any hope that Congress or the Administration has of expanding the Medicare managed care networks throughout the nation will surely fail if something is not done to provide greater equity and fairness in the way the AAPCC is calculated and paid to counties in the various states.

County by County Comparison.

The Coalition for Fairness in Medicare has developed a series of charts to illustrate geographically the unfair application of the current methodology to low rate plans. We are supplying a map showing the nation-wide disparities as part of this testimony. An examination of the nation-wide map shows that rural states and efficient markets (like Seattle, Portland, Rochester, Minneapolis, and Honolulu) suffer the lowest AAPCC payment rates, thus essentially foreclosing the development of real alternatives to fee-for-service in those areas. Indeed, it is ironic that efficient plans in these markets that have reduced utilization, closed empty hospital beds, and have aimed for the highest quality at the lowest prices are those that are penalized with wholly inadequate rates, payments which may be one-third as much as those provided in many urban areas.

In Dade County, Florida, Medicare spends more on doctors per beneficiary than all counties in Vermont spend on BOTH doctors and hospital combined! A New

England Journal of Medicine study showed that Florida beneficiaries received three times as many MRIs per capita in 1993 than did similar seniors in efficient Oregon.

Our analysis suggests that there are three types of markets that emerge from review of the AAPCC payment rates:

- Most rural areas fall into the category of low utilizers with low AAPCCs. Rural areas are often underserved because they have fewer hospital beds per thousand and fewer physicians, including specialists, available to the population.

- High utilizing areas are characterized by large numbers of hospital beds and a large supply of physicians ready to serve the Medicare population in fee-for-service. These areas reflect very high per capita spending that is in turn reflected in the AAPCC.

- Plans and providers in efficient markets have, through competition and responsible practice styles, managed to reduce excess hospital capacity and encourage physicians to practice consistent with reasonable and appropriate clinical guidelines. These markets, which have very high quality care, thus use far fewer services per capita and have below-average AAPCCs. The results are truly bizarre.

Here are some examples of the impact of 1997 payment rates in each of the three types of markets discussed above. Keep in mind that the national average AAPCC is $467 per member per month in 1997. Also attached is a chart illustrating the continued disparity in rates across these markets.

Rural:

Arthur, NE	$220
Greene, IA	$272
White Pine, NV	$297
Caledonia, VT	$324

Efficient/Urban:

Salt Lake, UT	$366
King, WA (Seattle)	$428
Hennepin, MN (Minneapolis)	$405
Clackamas, OR (Portland)	$375
Monroe, NY (Rochester)	$411

High Utilizers:

Dade, FL	$748
Richmond, NY	$767
Baltimore, MD	$632
Los Angeles, CA	$622
Philadelphia, PA	$704

Even in Congress' own backyard of Washington, D.C., monthly capitated rates vary from $400 in Fairfax County, to $446 in Prince George's County, to $584 in D.C. Yet, the costs of delivering care in these communities do not vary by as much as 50%. The variation makes no rational sense!

As the AAPCC is adjusted, it is not uncommon to see major fluctuations in AAPCC rates from year to year. The instability and unpredictability of Medicare risk reimbursement are additional factors that discourage health plans from entering and staying in markets.

Cost of Living or Healthy Lifestyles do not Justify the Existing Variations.

Some argue that these variations can be explained on the basis of cost of living differences or by reason of the notion that rural states tend to have healthier populations. Neither of these justifications credibly explain the variations. In order to determine what are real differences in costs from region to region and what differences can only be explained by utilization of services, our actuary looked to the diagnostic related groups ("DRG") program as a model. Medicare pays hospitals on the basis of DRGs for bundles of services performed. HCFA allows the DRG rate to vary from region to region, based on a hospital price index that computes legitimate differences in measurable labor and price inputs. Currently, the variation based on cost of living is only plus or minus 7%, a far cry from the wide disparity of 347% that exists across the country in AAPCC rates.

It has been suggested that AAPCC rates must be higher in urban than in rural areas because of the relatively healthier lifestyles of urban dwellers. If rates are to be based in part upon the lifestyle of the populations in a county, any differential must be related to a reliable measure of the difference in healthcare resources consumed. We are not suggesting that bringing fairness and equity to the payment system should impede the delivery of healthcare services to high AAPCC area beneficiaries. However, it appears that the differential in rates is more frequently used to provide supplemental benefits to beneficiaries, like dental or vision care. Plans in rural and efficient markets should be afforded the same opportunity to attract beneficiaries by offering a broader range of services than the traditional Medicare fee-for-service program.

Additionally, while healthy lifestyles may produce healthier and longer living seniors, sooner or later the simple ravages of old age will afflict almost everyone. While there may be less serious chronic ailments, the costs to care for an aging population are only postponed. Moreover, unhealthy lifestyles frequently manifest themselves far earlier than the age necessary to qualify for Medicare. Many are also fatal before a person ever qualifies for Medicare. It is our view that healthy lifestyles are not sufficient justification for the enormous disparities that exist between rural America and many large metropolitan areas which have been the beneficiaries of inflated AAPCC payments for years. It strains credibility to argue that the wide variations bear any relationship to health status.

Let's explore the cases of two Medicare beneficiaries who choose a managed care plan in their respective communities. Ms. X lives in Seattle. Ms. Y lives in Los Angeles.

Both have paid in the same amount in Medicare taxes (2.9% of payroll) throughout their working lives. Despite the similarity in their contributions, they will receive vastly different benefits in their HMO options due to the "fortune" of where they chose to live.

Ms. Y's HMO in Los Angeles County is paid an AAPCC of $558 per member per month. Ms. X's HMO in Kings County receives an AAPCC of $377 per member per month. Since rebates are not allowed, the Los Angeles health plan can load on additional benefits, such as prescription drugs, eye glasses and dental coverage. It may offer a generous benefit package with no additional premium, reduced co-pays and deductibles, and still make a nice profit.

The Seattle HMO cannot afford to add additional benefits and, indeed, to the detriment of the beneficiary, must charge a supplemental member premium of $50 to $150 per month to cover costs. Assuming that Ms. Y and Ms. X opt for the same benefit package, the inequitable payment rate means that a Seattle senior may pay between $600 and $1,800 more per year to participate in the managed care option with no additional benefits, while the Los Angeles senior receives a broader range of benefits free of charge. In other words, in areas with high payments from Medicare, beneficiaries get more and pay less out-of-pocket than those in low payment areas. These beneficiaries are, in theory and practice, less likely to choose the Medicare managed care option in Seattle than in Los Angeles, and health plans are consequently less likely to enter the Medicare managed care market. Attached is a chart which further illustrates this inequity.

Let me again use our experience in Utah to illustrate the effect of such disparity. In Utah, 85% of all commercial insureds are in some form of managed care. We have one of the largest managed care penetrations in the Mountain West and perhaps in the nation. Yet, only a very small percentage of seniors are enrolled in a Medicare HMO. Why such a disparate result? The answer should be obvious by

now. The AAPCC increases have been minimal in past years and we have experienced actual cuts in payments. Although we are extremely anxious to serve this portion of the population, it is becoming economically more challenging as the months go by.

What is the solution?

It is widely acknowledged that the AAPCC formula is flawed. This Committee recognized the problems with the formula in the legislation that you approved as part of your Balanced Budget package last session. There are two essential tools that will solve the problem: a blended rate formula and a minimum payment floor.

The Finance Committee, and later the Budget Conference Committee, adopted a blended rate formula that would have combined average rates and local rates in increasing proportion over time in order to reduce the extreme variation. (This tool was used in the early days of the Medicare program to reduce variation in the physician payments based on reasonable and customary charges.) As we move to rates based on national experience, the differential will diminish.

We were pleased that last year's Conference Committee accepted the blended rate formula which was included in the final Balanced Budget Act.

The Balanced Budget Act also included a payment floor which would have immediately raised the payments in most rural areas to $300 in 1996 and $350 in 1997. Raising irrationally low rates by imposing a payment floor allows rural markets to immediately offer choices and more benefits to beneficiaries. A payment floor is like a down payment that allows rural markets to offer choices and more benefits to beneficiaries. If the Balanced Budget Act had passed in 1995, the rural counties that we serve AND the more urban Salt Lake City rates would have been substantially better than the current situation.

We urge you to consider enacting similar provisions in 1997. However, the floor rates must be updated to reflect payment changes that have occurred since 1995. The most appropriate approach would be to base the floor on a percentage of the national average AAPCC.

We have not seen any legislative language from the President's proposal, but we have reviewed the county-by-county numbers distributed by the Administration. We are pleased that the Administration included a payment floor and a blending formula in its proposal. However, the other payment reforms included in the proposal, such as the reduction in the AAPCC base from 95% to 90% of fee-for-service costs, would essentially nullify the financial benefit of the payment rate floor and blend. Payments to plans in low rate areas will not significantly increase.

In order to encourage market entry, a health plan must have an adequate payment rate to start, and a reasonable growth rate over time. The Administration's numbers would not solve our problem in Utah since our payment rate in the Salt Lake region would only increase $11 in the first three years. Given that our actuaries have advised us that the current rate is too low, and given anticipated medical inflation, we would be worse off under the proposal in 1999 than we are now! We, as well as other health care systems, plans, and providers, will face formidable obstacles to offering and expanding managed care products to Medicare patients. Discouraging plan participation in rural or other currently low payment areas is anathema to the goal of expanding options available to beneficiaries.

Conclusion.

Once again, Congress has an opportunity to modernize and salvage the Medicare program. We believe this can be accomplished by offering more choices in a competitive environment and by doing so within budgetary constraints. To simply cut provider payments in order to solve the long term funding challenge could cripple the health care infrastructure, particularly in rural areas. Further, our patients in rural and other low payment areas will continue to be penalized if Medicare managed care payment rates are so low as to not provide a health plan the ability to offer a Medicare risk option with additional benefits at an affordable cost to the government and the beneficiary.

Establishing a reasonable payment rate floor and ameliorating the gross disparity in regional payment rates will bring us much closer to achieving two important governmental objectives: securing budgetary savings that would preserve the Medicare program and expanding options and services available to Medicare beneficiaries.

Thank you.

The Coalition for Fairness in Medicare

Who We Are

The Coalition for Fairness in Medicare is an ad hoc group of hospital systems, HMOs, state hospital associations, and provider organizations who share a common goal -- **equity and fairness in Medicare payments.** The Coalition was born in early 1995 when three Minnesota health plans saw the need to address the payment inequities as Congress debated Medicare reform. The group expanded rapidly as health plans and other provider groups realized that fair payment was the only way to ensure choices of health plans with a wide range of benefits in all regions of the country.

Allina Health System
Minnetonka, MN

Association of Iowa Hospitals and Health Systems

Aurora Health Care
Milwaukee, WI

Blue Cross of California/WellPoint

Blue Cross and Blue Shield of Arizona

Blue Cross and Blue Shield of Colorado

Blue Cross and Blue Shield of Iowa/South Dakota

Blue Cross and Blue Shield of Kansas City

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Oregon

Blue Cross and Blue Shield of South Carolina

Blue Cross and Blue Shield of Washington/Alaska

Blue Cross and Blue Shield of Wisconsin

Group Health Cooperative of Puget Sound
Seattle, WA

HealthPartners
Minneapolis, MN

Intermountain Health Care
Salt Lake City, UT

John Deere Health Care
Moline, IL

Kansas Hospital Association

Kapiolani Health Care System
Honolulu, HI

Legacy Health System

Maine Hospital Association

Minnesota Hospital and Health Care Partnership

Montana Hospital Association

New Mexico Hospitals and Health Systems Association

Oregon Association of Hospitals and Health Systems

PeaceHealth
Bellevue, WA

Physician Partners, Inc.

Rural Referral/Sole Community Hospital Coalition

Sisters of Providence
Seattle, WA

South Dakota Association of Healthcare Organizations

UCare Minnesota
Fairview Hospital and Healthcare services

Utah Association of Health Care Providers

Washington State Hospital Association

Welborn Clinic
Evansville, IN

Wisconsin Health and Hospital Association

Wyoming Hospital Association

3/13/97

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Susan Bartlett Foote

Mary E. Hayter

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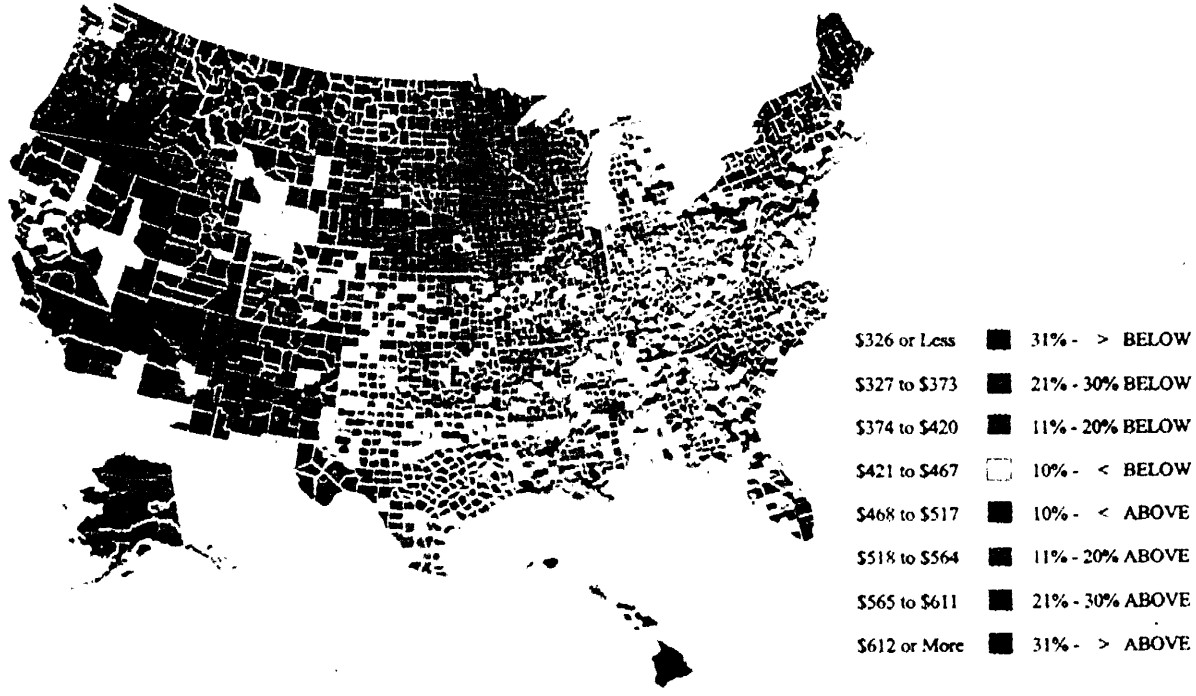
444 North Capitol Street, NW; Suite 837 -- Washington, D.C. 20001-1512
202.783.1555 202.544.5321 [Fax]

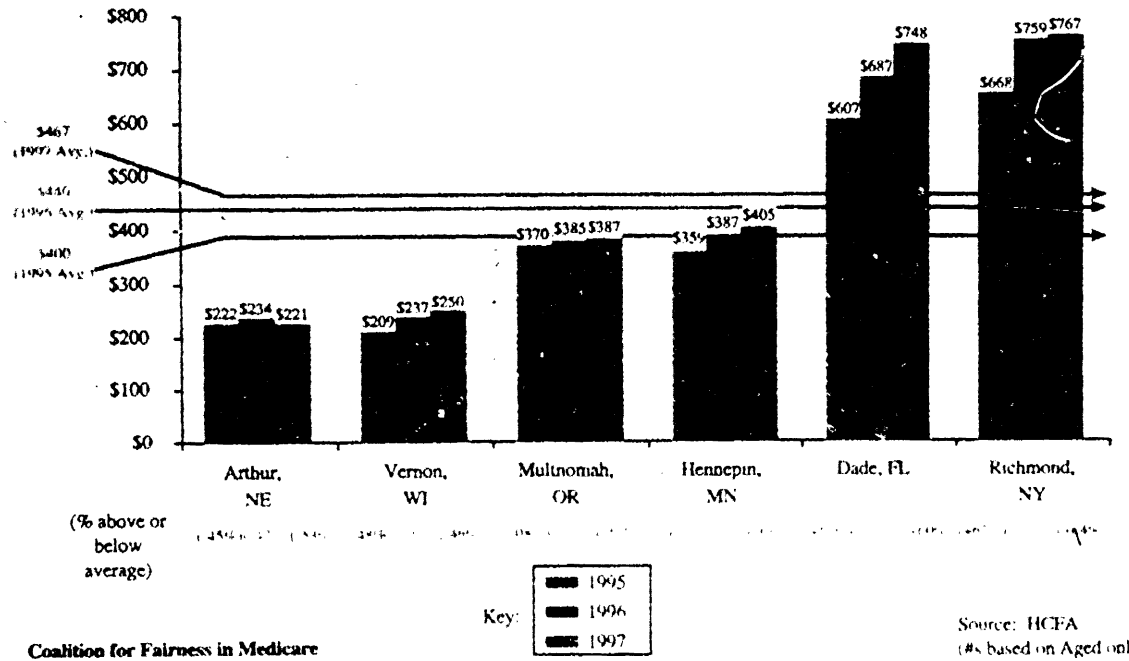
How Do United States Counties Compare with the National AAPCC Average of $467?



Source HCFA: Standard Per Capita Rate 1997

Coalition for Fairness in Medicare

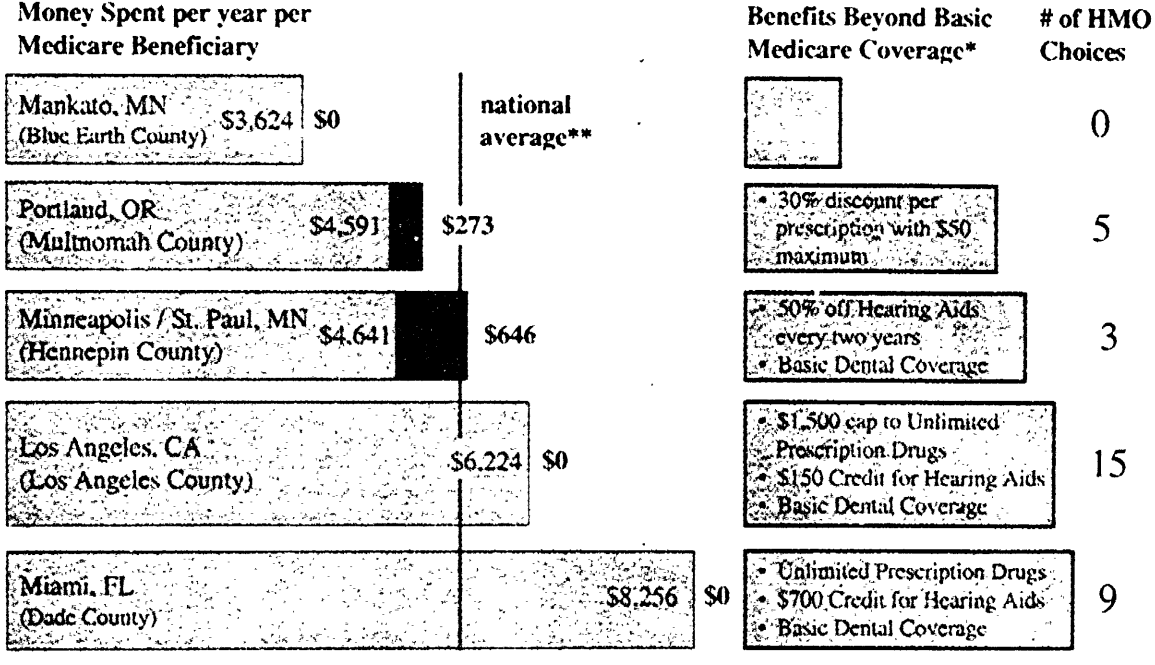
Annual Medicare Payment Increases
The Gap Widens



Coalition for Fairness in Medicare

Source: HCFA
(#s based on Aged only)

Benefit Inequity and Medicare AAPCC Payments



* The extra benefit packages offered by HMO's often vary, even within a single county. The benefits listed here are samples of standard extra benefits available in a given county.

** The green line denotes the national average Government Contribution ($440/month; $5,200/year)

PREPARED STATEMENT OF GLENN POMEROY

INTRODUCTION

Good Morning Mr. Chairman and Members of the Committee. My name is Glenn Pomeroy. I am Vice President of the National Association of Insurance Commissioners (NAIC), Vice Chair of the NAIC's Special Committee on Health Insurance, and Commissioner of Insurance for the State of North Dakota. On behalf of the NAIC's Special Committee on Health Insurance, I would like to thank you for providing me with the opportunity to address you today about the regulation of provider-sponsored health insuring organizations participating in the Medicare managed care program and Medicare Supplemental insurance.

The NAIC, founded in 1871, is the nation's oldest association of state public officials and is composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. The NAIC's (EX) Special Committee on Health Insurance is composed of 42 of our members. The NAIC established this Special Committee over three years ago as a forum to discuss federal proposals related to health insurance reform and to provide technical advice on a nonpartisan basis to all who sought our expertise. On behalf of the NAIC Committee, we would like to thank you for the opportunity to discuss with you issues related to the regulation of health insuring organizations sponsored by providers and Medicare supplemental insurance.

The states have traditionally regulated the business of insurance. This traditional role was affirmed by Congress in 1945 when Congress passed the McCarran-Ferguson Act.[1] We believe that all health insuring organizations, whether they are sponsored by providers or others, ought to continue to be regulated by the states. States welcome the expressions by Members of Congress in support of the states. In the case of insurance regulation, we urge Congress not to dilute the states' authority to regulate insurance by treating provider organizations specially in federal legislation.

We would like to state at the outset that, based on our experience in state insurance regulation, we do not view health insuring organizations sponsored by providers as substantively different from other health insuring organizations. Health insuring organizations, with varying forms of ownership and affiliations, are licensed by the several states. These organizations are required to obtain a state insurance license because of the insurance function they perform. Organizations subject to state insurance regulation include organizations that are sponsored by providers. The NAIC Committee submits that any federal proposal that would regulate provider organizations differently from other health insuring organizations first needs to demonstrate that structural differences merit different regulatory treatment. We do not believe that any such showing has been made.

Health insuring organizations contract with individuals, employers, or other groups to receive a prepayment in exchange for covering the cost of an unknown, future level of health care services. In doing so, the health insuring organization assumes what is commonly known as insurance or actuarial risk. Under this arrangement, the individual, employer, or other group transfers to the health insuring organization some or all of their own risk of financial loss as a result of the use of health care services. Because the actual level of services that will be used is unknown, the health insuring organization is at risk for financial loss if the amount of services used exceeds the amount of the prepayment (commonly known as a premium). The principal characteristic of a health insurance arrangement is not only the transfer of the risk of financial loss to the health insuring organization. The health insuring organization also spreads the risk of financial losses associated with the use of health care services by any one individual among a group of individuals insured by the organization. Organizations that assume insurance risk on behalf of an individual, employer, or other groups, such as the Medicare program, are engaged in the business of insurance and should be subject to state insurance regulation.

In addition to insurance risk, all health insuring organizations must deal with several other forms of risk, including asset risk and general business risk. All health insuring organizations face asset risk; the risk that existing assets will decline in value and erode surplus as a result of that decline. Additionally, all health insuring organizations face general business risks; the range of risks associated with any other type of business such as assessments, administrative expense overruns, and environmental changes. To a large extent, the different risks health insuring organizations face are interrelated. For example, losses associated with insurance risk affect the ability of a health insuring organization to meet the many demands associated with general business risk.

Examples of Principal Types of Risk for Health Insuring Organizations

- Insurance or Actuarial Risk
- Asset Risk
- General Business Risk

State insurance departments regulate health insuring organizations through a host of fundamental consumer protection activities. Insurance departments license organizations engaged in the business of insurance. The licensing standards include financial requirements that the organization must meet. The departments conduct extensive examinations of licensed organizations to review their financial condition and market conduct activities. State insurance departments supervise, rehabilitate, or liquidate financially distressed or insolvent organizations. Also of importance, state insurance departments handle complaints and inquiries from the general public. The departments also regulate agents and others that serve insurance organizations.

Health maintenance organizations (HMOs) and competitive medical plans (CMPs) participating in the Medicare managed care program must comply with state licensure standards in addition to federal standards. The federal standards build upon, rather than preempt, fundamental state requirements. Importantly, all health insuring organizations serving the Medicare managed care program are regulated in a consistent, level fashion. State insurance regulation serves as the foundation for the current regulatory structure. It provides fundamental protections that extend beyond financial solvency and other licensing standards to market conduct standards as well as financial examination activities. These fundamental consumer protections are essential because of the public policy concerns inherent in the health insurance function. To provide these consumer protections itself, the federal government would need to replicate the states' insurance regulatory framework. Doing so would result in significant and unnecessary costs to the federal government.

The appropriate manner of regulating provider-sponsored health insuring organizations that serve the Medicare managed care program is an important question for several reasons. First, many providers lack experience in assuming insurance risk. Second, the population served by the Medicare program, the elderly and disabled, tend to use more health care resources than other individuals. And third, some providers face complex incentives in today's competitive health care environment. For example, hospitals face added pressures in a managed care market. They have to balance the challenge of managing care cost-efficiently with the challenge of filling their beds and increasing hospital market share.[2] These challenges may make it more difficult for them to operate within the limited payment available under an insurance arrangement. Each of these factors argue for effective regulatory oversight.

Organizations that are sponsored by providers participate and make important contributions to the health insurance market. However, states believe strongly that all health insuring organizations that perform similar functions should be subject to similar regulatory standards. States have developed their regulatory standards through long-standing experience. Particularly in today's intensely competitive health insurance environment, where the risk and magnitude of insolvency can be significant, states are a necessary component to any regulatory structure for health insuring organizations participating in a federal program.

CHARACTERISTICS OF HEALTH INSURING ORGANIZATIONS

Types of Health Insuring Organizations

In the health insurance context, there are a number of types of health insuring organizations that are regulated by state insurance departments. This section reviews the types of health insuring organizations regulated by the states and the insurance functions they perform.

State-regulated health insuring organizations include:

- traditional indemnity insurance carriers;
- Blue Cross and Blue Shield plans;
- health maintenance organizations; and,
- limited health service organizations.

Under a traditional indemnity insurance contract, the health insuring organization takes on the risk of loss associated with a medical condition. The risk is assumed in exchange for a prepayment by an individual, employer, or other group. Through this indemnity contract, the insurer may promise to pay an individual who has already paid for the medical care received; this is the traditional approach for indemnity insurance carriers. Or, the insurer may promise to pay the provider for medical care received by the subscriber; this is the traditional approach for Blue Cross and Blue Shield plans. In other words, the traditional indemnity insurance

carrier and the traditional Blue Cross and Blue Shield plan pays the individual or the provider for the medical services that are received. The traditional indemnity insurance carrier or traditional Blue Cross and Blue Shield plan does not actually deliver, or contract for the delivery of, those medical services.

Health maintenance organizations (HMOs) are health insuring organizations that manage care and serve both an insurance and delivery function. HMOs may be free-standing or subsidiaries of an indemnity insurance carrier or Blue Cross and Blue Shield plan. In consideration for a prepayment by an individual, employer, or other group, HMOs deliver or arrange for the delivery of health care services. Like the traditional indemnity insurer and traditional Blue Cross and Blue Shield plan, the HMO is responsible for the cost of care. HMOs differ from traditional indemnity insurance carriers and traditional Blue Cross and Blue Shield plans in that HMOs are responsible for delivering or arranging for the delivery of that care as well. HMOs fulfill this responsibility by entering into contractual arrangements with providers or groups of providers, by providing the services directly themselves, or through some combination thereof. For example, if an individual is in need of a tonsillectomy, the HMO is not only responsible for covering the cost of the physician, hospital, and other services related to the tonsillectomy, but is also responsible for maintaining a network of available physicians, hospitals, and other health care resources to deliver the tonsillectomy.

Traditional indemnity insurance carriers may also offer services that do not involve insurance risk. These lines of businesses may include third party administrator services (TPA) or preferred provider organizations (PPOs) that do not bear insurance risk. In other words, under these arrangements, the health insuring organization is not spreading the financial risk of loss among a group of persons. Instead, it basically accepts a fee to perform administrative services, such as claims processing and marketing. Some HMOs also offer non-insurance risk TPA and PPO-type services where the HMOs "rent" the networks that they created and the renters of the network pay for health care services on a fee-for-service basis.

Limited Health Service Organizations (LHSOs) are organizations that deliver or arrange for the delivery of a limited range of health services on a prepaid basis. Examples of limited health services are dental care services, vision care services, mental health services, and pharmaceutical services.

An organization that is one of these types of health insuring organization—traditional indemnity insurance carrier, Blue Cross and Blue Shield plan, HMO, or LHSO—may or may not be sponsored by providers. As described in more detail later in this testimony, there are HMOs licensed in the states, including Wisconsin and Ohio, that are owned or controlled by providers. Under the current structure, state standards apply to organizations that perform similar functions and Medicare requirements do not undercut these requirements. Insurance regulation by ownership and acronym as opposed to by function would create an unnecessarily divided regulatory structure and severely undermine the ability to foster a competitive level playing field in the health insurance market. Further, we submit that such a split structure erodes the efficacy of state regulation of health insuring organizations.

Common Elements of Health Insuring Organizations

The activities of all health insuring organizations share the common elements of the insurance function. The extent to which an entity is provider-sponsored does not impact the analysis regarding their function (and hence, the regulatory structure to which they should be subject). Consequently, the most appropriate approach to the regulation of health insuring organizations is by function and not by acronym. This section reviews the common elements of the arrangements entered into by health insuring organizations and distinguishes these arrangements from those which generally do not involve insurance.

Whether they are provider-sponsored or not, health insuring organizations—traditional indemnity insurers, Blue Cross and Blue Shield plans, HMOs, or LHSOs—have certain key elements in common. Health insuring organizations contract with an individual, employer, or other group. The purpose of the contract is to cover payment for a range of health care services which may be required in the future. The amount of the services that will actually be utilized is unknown. Health insuring organizations accept a prepayment from the individual, employer, or other group in exchange for assuming the financial risk associated with the cost of the health care services covered by the contract. Health insuring organizations pool all of the prepayments by the individual, employer, or other group of persons to cover the cost of health care services used. Health insuring organizations are at risk for financial loss if the cost of an individual's care is greater than anticipated and exceeds the prepayment made by or on behalf of the individual. All health insuring organizations are involved in arrangements that contain these elements.

Common Elements of Health Insuring Organizations

- Contracts with an individual, employer, or other group
- Pays for or delivers a range of health care services
- Pays for or delivers an amount of services that is unknown in advance
- Accepts a prepayment for assuming the financial risk associated with health care services
- Spreads the risk of loss among a group of persons by pooling the prepayments made by or on behalf of individual enrollees to cover the cost of services for all individuals in the group
- Runs the risk of suffering financial loss if the cost of an individual's care is greater than anticipated.

General rules exist to help distinguish between arrangements that have the common elements of an insurance arrangement and those that do not. A common factor among arrangements that generally do not involve insurance risk is that the payment method is linked to the actual use of predetermined and identifiable services to a specific enrollee. Consequently, the organization receiving the payment does not rely on payments for a pool of enrollees to fund care for specific individuals. The payment of a fee that is received to perform a specific service is a factor that distinguishes an insurance arrangement from one that is not an insurance risk arrangement. No payment is received for services which are not used.

In contrast, health insurance arrangements are not directly tied to the actual use of specific services by an enrollee. In exchange for a prepayment, the health insuring organization agrees to pay for or deliver a range of services, regardless of the amount of services the enrollee actually uses. The health insuring organization is liable for expenses beyond the prepaid amount. If the enrollee uses fewer services than are covered by the prepayment, the health insuring organization keeps the remaining amount of the payment.

An arrangement involving a prepayment that is not tied directly to the actual use of specific services is insurance risk for two reasons. First, the health insuring organization bears the risk that the costs of any individual's use of services will exceed the amount of prepayment by that individual. Second, the health insuring organization pools the prepayments of all covered individuals. Consequently, the health insuring organization relies on the law of averages to ensure that any one individual's use of services will be balanced by the use (or lack of use) of other covered individuals.

Organizations that assume insurance risk through the receipt of a prepayment for an undetermined amount of services are engaged in the business of insurance and give rise to the public policy concerns that insurance regulation is designed to address. Arrangements that involve the spreading of risk often rely upon complex, actuarial analysis involving the calculation of statistical risk for their financial success. In contrast, business risk arrangements, like those that involve the payment of a fee for a specific service, do not involve risk-spreading and do not inherently carry with them the same nature of risk as insurance risk.. Additionally, prepayment for the future delivery of services in an insurance risk arrangement establishes a long-term commitment to the consumer. State insurance solvency and other standards provide fundamental protections to consumers against financial incentives inherent in health insurance arrangements. State standards also serve to strengthen the ability of participants in the health insurance market to fulfill their obligations to the consumer and other parties affected by the health insurance arrangement.

Provider organizations have argued that direct provision of services by providers transforms the financial risk of loss to a more general form of business risk rather than insurance risk. That is not the case. As long as pooling of financial risks of loss exists, insurance risk is present and they are subject to regulation by the states. Direct provision of services by providers will rarely reduce the insurance risk to a de minimis level. Many question the assertion that providers are willing to take reductions in their own salaries if the organization experiences significant losses. Nevertheless, even if providers are willing to work on greatly reduced or nonexistent additional income, the health insuring organization still may be responsible for a wide range of expenses necessary to support the provision of health care services. In addition to the expenses of physician services, examples of additional expenses may include:

- Other Clinical Personnel (including nurses, nurse assistants, physical therapists, laboratory technicians, etc.)
- Administrative Staff (including business office managers, registration clerks, secretaries, etc.)
- General Administrative Expenses (including medical and paper supplies, patient registration, information systems, data and claims processing, etc.)

- General Facility Expenses (including electricity, lights, water, phone, etc.)
- Laboratory services
- Debt Service (including for facility, equipment, etc.)
- Other Business Expenses (including legal and actuarial services, etc.)

Further, health insuring organizations must deal with the general business risks associated with having adequate cash flow (commonly known as liquidity). This is a particularly important issue for organizations that are owned or controlled by providers. These organizations, which may be nonprofit, may have inconsistent levels of cash flow available to meet expenses. Many of their assets are in buildings and equipment, which are unavailable if the organization needs additional funds to pay claims or cover general business expenses.

The ownership or control of the health insuring organization does not affect the type or magnitude of risk in an arrangement to any substantive degree. The type of risk being assumed by these organizations triggers the need for the application of fundamental state consumer protections. All organizations that perform the same or similar function, irrespective of the organization's acronym, should be subject to the same or similar standards when serving the Medicare program.

State Regulation of Health Insuring Organizations

Because of the public policy concerns present when an organization is engaged in the business of health insurance, health insuring organizations need careful oversight. States have developed significant expertise in providing this oversight as the primary regulators of insurance, which was underscored by Congress in the McCarran-Ferguson Act. The most fundamental components of state regulation include the licensing process, financial standards and examinations as well as market conduct standards and examinations. The process for the licensing of a health insuring organization is a detailed process. State regulation of HMOs can be used as an example to illustrate the states' regulatory process for health insuring organizations.

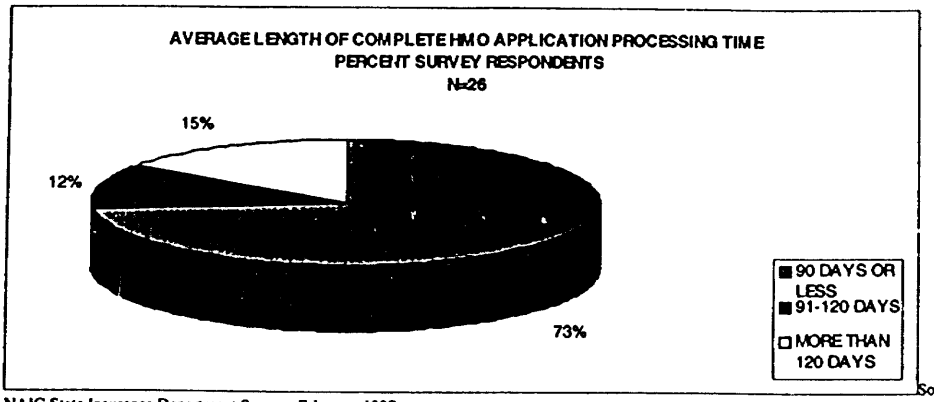
The regulation of HMOs is an apt example of the state regulatory process because most health insuring organizations currently operating in the marketplace that are sponsored by providers are licensed as HMOs.

- Licensing

The first step in the regulatory process for an HMO is to submit to the state an application for a license (also called a certificate of authority). Organizations that perform the functions of an HMO without obtaining a license are subject to a state's unauthorized insurer statute. The application includes a variety of important materials such as the organization's articles of incorporation, bylaws, proposed detailed business plan, feasibility study, financial statements, and commitment of a viable provider network. The applicant must also meet minimum start-up capital requirements. Several staff members are usually necessary to review properly each individual application.

Once an application is received, the state will review the application to determine if all the information needed to perform a proper review is included. The state will also verify the information contained in the application. For example, the state will want to make certain that there is sufficient capital and surplus deposited in an acceptable financial institution.

The length of the application processing time is dependent upon a number of factors including the length of time it takes for an application to become complete, the number of applications under consideration at a particular time, and the number of staff available to review the applications. Usually, the initial submission of the application is incomplete. The average application processing time for complete applications by most states is within ninety (90) days. For reference, the appendix of this testimony includes a list of state insurance department contacts for questions on individual state application processes. This list of state insurance department health contact persons can also be found on the NAIC's home page on the internet.



Source: NAIC State Insurance Department Survey, February 1997.

The completeness of the application and the responsiveness of the applicant can greatly affect the length of the application process. The states have found that applicants who familiarize themselves with the application process prior to filling out an application receive final responses to their licenses more quickly. State insurance departments recommend to applicants that they meet with the department prior to filling out an application to learn more about the application process, including the components of a successful application and the pitfalls to avoid. Departments also recommend that applicants maintain contact with the department while developing the application. Organizations that follow this approach tend to submit applications that are closer to completion, and consequently, tend to have applications that can be processed more quickly. Extended periods of time for application processing are often the result of inadequate information from the applicant or lack of timely response to department requests for information.

- Financial Standards and Examinations

Every state regulates HMOs as does the District of Columbia, American Samoa, and Puerto Rico. More than half of the states have HMO laws based upon the NAIC's Health Maintenance Organization Model Act (the "HMO model"). The HMO model governs persons that deliver or arrange for the delivery of basic health care services to enrollees on a prepaid basis. Under the HMO model, HMOs are subject to initial minimum net worth requirements of $1,500,000 and must maintain minimum net worth requirements of $1,000,000.[3] Contracts between the HMO and a contracting provider must contain a hold harmless provision that prevents the provider from holding the subscriber or enrollee liable if the HMO does not pay the provider.

In North Dakota, an HMO must meet an initial net worth requirement of $1,000,000. The HMO must also maintain the greater of: $1,000,000; two (2) percent annual premium revenue on the first $150 million; one (1) percent in excess of $150 million; three (3) months of uncovered health care expenditures; or eight (8) percent annual health care expenditures and four (4) percent annual hospital expenditures. HMOs must also deposit $300,000.

In addition to the financial standards that a health insuring organization must meet, states perform financial examinations of health insuring organizations; this is one of the most important aspects of state insurance regulation. These financial examinations involve becoming familiar with the company's management and operations, holding meetings with the organization, and reviewing the books and records of the organization. The examination will include a review of audit operations and controls, budgeting and budget monitoring processes, and financial planning and reporting processes. Certain aspects of the organization may be targeted by the state based upon the research leading up to the actual examination or the course of the examination itself. If there are indications of financial problems, the examination will be more comprehensive than otherwise.

One of the most important aspects of state regulation is the ability of the state to intervene in the event of financial problems. When the state becomes aware of a financial problem, it will conduct either informal or formal supervision activities which might include requesting a business plan for resolving problems or requiring a change in certain business practices to correct the problems. The state may also place the organization under its supervision until such time as the organization can

perform appropriately the necessary functions without supervision. If all else fails, the state may liquidate the organization.

Unfortunately, my predecessor had the unpleasant experience of having to place a large organization that was sponsored by providers into receivership. Because of the state's regulatory authority, the Commissioner of Insurance was able to act promptly and obtain another source of coverage for the 30,000 people insured by the organization.

• Market Conduct Standards and Examinations

Further, the states establish market conduct standards which they monitor and enforce. Market conduct standards related, but not limited to, marketing, the issuing of policies, and claims handling must be met. For health insuring organizations, such as HMOs, standards related to quality assurance, grievance, provider credentialing, and other areas are also relevant.

States perform market conduct examinations to determine compliance with state market conduct standards. In a market conduct examination, the state insurance department initiates and conducts an extensive examination of a health insuring organization, including visits to the organization's offices, to determine how the company is conducting its business within the state. These examinations focus on such areas as an organization's marketing and sales, and its payment of claims and involve the review of numerous records and files.

According to one source, approximately 15-20 percent of the existing HMOs in this country are estimated to be organizations sponsored by providers.[4] A recent NAIC survey of state insurance departments indicates that, of the 39 states which have responded to the survey thus far, at least 27 of them currently have licensed organizations that are owned or controlled by providers under their insurance laws. The vast majority of these organizations are licensed as HMOs. A number of states have applications pending or are in discussions with organizations that are owned or controlled by providers and that plan to file an application with the department. And, as will be discussed below, some states have organizations that were owned or controlled by providers upon initial licensure but have experienced change in ownership or control since that time.

A few examples of state-licensed health insuring organizations may provide a sense of the various forms of these provider-sponsored health insuring organizations. The state of Texas, for example, where approximately one-half of the HMOs licensed in the past two years are owned or controlled by providers, has recently licensed hospital organizations such as, Texas Children's Hospital, Memorial Sisters of Charity, Seton Health Systems, and physician organizations such as, Physicians Care HMO. In the state of Louisiana, licensed HMOs that are provider-owned or controlled include one that is owned by a small group practice in New Orleans, Louisiana and another HMO that is owned by a group of psychiatric hospitals.

Several states, including some that currently do not have licensed organizations that are owned or controlled by providers, reported that some licensed organizations may have been initially formed by providers but are no longer owned or controlled by providers due to mergers or management changes. Changes in ownership of an organization are not that unusual given the evolution and rapid consolidation in today's health insurance marketplace.

Even those few states that have developed provider-specific laws mostly have established standards that are similar or almost identical to the state's HMO laws. The states that have done so include Georgia, Iowa, Kentucky, New York, Oklahoma, and Texas. Where there are differences in regulation between provider-specific and non-provider-specific laws, some states tend to be leaning toward eradicating those differences. For example, the Health Systems and Plans Committee of the state of Iowa's Health Regulation Task Force recommended that differences between the provider-specific and non-provider-specific laws be eliminated. A very few states have indicated that they may not regulate health insurance organizations that assume risk under certain limited circumstances.

Consolidated Licensure Initiatives

Consistent regulatory standards according to the function of the health insuring organization rather than according to the acronym by which it is often known is the most appropriate approach to health insurance regulation in today's health insurance market. Interest in becoming a health insuring organization in the managed care market is certainly not limited to providers. Most, if not all, health insuring organizations are eager to gain a significant presence as a provider of managed care services in any given market. State insurance regulators recognize that the delivery of health services is evolving away from traditional fee-for-service insurance arrangements to managed care arrangements of many types. Through the NAIC, states are addressing the changes which are taking place in the health insurance

market. The NAIC's Regulatory Framework (B) Task Force has begun a review of NAIC model laws as part of NAIC's Consolidated Licensure of Entities Assuming Risk (CLEAR) initiative.

Through this initiative, the members of the NAIC seek to promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field. CLEAR also serves to clarify that the wide array of organizations performing managed care functions, including health maintenance organizations, preferred provider organizations, point of service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial plans, and any other plans which finance and deliver health care, fall within the scope of state regulation. The NAIC's CLEAR process will include a review of financial standards and reporting requirements as well as the incorporation of health plan accountability standards. These standards, almost all of which are completed relate to: network adequacy, quality, grievance, utilization review, provider credentialing verification, and confidentiality. Issues related to data reporting and consumer disclosure are also being explored.

Some states are reviewing their health insurance statutes with the objective of developing a comprehensive licensure scheme. The Ohio Insurance Department has been contemplating for several years a regulatory structure that defines the business of insurance for managed care entities by focusing on how they function and not merely on how they are structured. It recently developed a Managed Care Uniform Licensure Act for Health Insuring Corporations designed to achieve this end. The bill repeals the laws which govern prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations, and creates one type of regulated entity called health insuring corporations (HICs). The HIC is defined broadly enough to encompass all entities that assume insurance risk. This legislation has been sponsored by State Representative Dale VanVyven and State Senator Karen Gillmor and is currently pending in the Ohio General Assembly.

Under its uniform licensure bill, all managed care plans conducting the business of insurance would be subject to minimum financial standards. The Department feels that is appropriate for the following reasons:

- Minimum standards help to ensure that funds will be available to pay consumer claims;
- Minimum standards provide purchasers of insurance with a level of security that health insuring organizations will possess the financial ability to make good on their obligations as stated in the policy or contract; and,
- Minimum standards allow health insuring organizations, and if necessary, regulators the time to take corrective action should the organization's financial condition become impaired.

At the NAIC, an important component of the CLEAR effort is the development of a Health Organizations Risk-Based Capital (HORBC) formula. The risk-based capital (RBC) approach is a formula that sets minimum capital requirements according to the level of known risk being assumed by the health insuring organization. An RBC formula acknowledges arrangements that increase and reduce risk, such as the extent to which services are directly delivered or risk is shifted through payments to subcontracting providers. An RBC formula is a marked departure from the traditional fixed level approach that states have used to establish insurer's minimum capital and surplus requirements. RBC formulas have been in use for several years in state regulation of life and health, and property and casualty, insurers.

The NAIC HORBC Working Group is now developing a prototype health RBC formula for managed care organizations. In addition to testing, debating, and reviewing the formula proposed by the American Academy of Actuaries (which provided technical assistance to the NAIC), the NAIC is also soliciting input from interested parties, trade associations (including those that represent providers), academics and health care economists. The input from all interested parties is being used by the NAIC HORBC Working Group to develop the prototype formula as a practical regulatory tool. The working group anticipates the prototype formula will be completed this summer. As with the life and health, and property and casualty, formulas, the NAIC's HORBC formula for managed care organizations will be reassessed and refined continuously to reflect the results of ongoing evaluation and new arrangements that have developed in the marketplace.

The NAIC's CLEAR effort, as exemplified by the objectives of the Ohio bill, embodies the states' focus on regulation by function and not by acronym. All health insuring organizations engage in functions that involve a range of risks. State insurance regulation provides fundamental consumer protections for consumers and others that may be affected by the health insurance arrangement. The ownership or

control of the organization does not alter to any substantive degree the extent to which that risk is present or those fundamental consumer protections are essential.

STATE INSURANCE REGULATION AND THE MEDICARE PROGRAM

State insurance regulation complements well the objectives of the Medicare program for a number of reasons. The state regulatory framework reassures the federal government that the organizations with which it contracts have met fundamental standards for engaging in insurance arrangements. It also assures the federal government that these organizations are receiving an adequate level of oversight for those functions. These fundamental standards are not limited to financial solvency standards. State insurance regulations related to market conduct standards and financial examination activities are also essential components for effective consumer protection. Because of the activities of the states, the federal government saves considerable resources which it would otherwise have to spend in order to regulate effectively health insuring organizations.

Preemption of State Insurance Regulation

Under the current regulatory framework for Medicare, an HMO or competitive medical plan is required to obtain a state insurance license prior to serving Medicare managed care beneficiaries as a Medicare risk contractor. In most instances, the Medicare HMO is also required to serve commercial enrollees as well. However, in the 104th and 105th Congress, proposals have surfaced which would remove some of the state regulatory foundation for these plans. For example, under S. 146, the "Provider Sponsored Organization Act of 1997," health insuring organizations that meet the definition of "qualified provider-sponsored organization" (PSO) would not be required to meet either of these requirements in certain circumstances.

S. 146 defines "qualified provider-sponsored organization" as a public or private entity that is a provider or a group of affiliated providers organized to deliver a spectrum of health care services (including basic hospital and physicians services) under contract to purchasers of such services. It does list four ways in which an organization would be considered a group of affiliated providers. The specific language of S. 146 makes it difficult to understand what organizations actually would be considered a qualified PSO. The bill does not define the term provider. The definition of affiliation is also loose. Further, while qualified PSOs must provide a substantial portion of services directly, the definition of substantial portion is left to be defined by the Secretary.

The definition of qualified PSO in this bill has the same problems as other federal proposals that have attempted to differentiate a provider-sponsored health insuring organization from one that is not provider-sponsored. Health insuring organizations currently licensed by the states as HMOs are not mutually exclusive from the organizations that might fall within the proposed legislation's definition of qualified PSO. Because of the lack of substantive difference among provider and non-provider health insuring organizations, the proposed definitions for PSOs cannot help but sweep in non-provider groups. Favored treatment by acronym for organizations that are not substantively different from other health insuring organizations will result in more fragmentation of the health insurance market and undermine the state regulatory process. Further, we respectfully submit that the decision of what is an organization qualified to participate in the health insurance market, whether public or private, ought to remain with the states.

The bill recognizes that these organizations are involved in health insurance activities, and would otherwise be subject to state insurance laws by requiring that they obtain a state insurance license after January 1, 2002. Yet, the bill also establishes federal standards for these organizations, including solvency standards. Until January 1, 2002, the state may not license health insuring organizations that only provide health insurance services to the Medicare managed care program and are qualified PSOs. The bill gives the Secretary of the Department of Health and Human Services (HHS) ninety (90) days to process an application for certification as a qualified PSO after receipt of a completed application. This timeframe may be significantly less than the timeframe the Secretary currently takes to process the application of a Medicare risk contractor. According to one source, it takes approximately six (6) months to obtain approval as a Medicare risk plan once a complete application has been submitted.[5]

The bill ties the states' ability to perform its responsibilities after January 1, 2002 to the adoption of specific federal requirements shifting significant responsibility away from the states. After January 1, 2002, a state may license these organizations if the State's solvency standards are identical to the federal standards and its other standards are substantially equivalent to federal standards. Further, the bill gives the Secretary of HHS the authority to waive state licensure requirements if the

state does not act on the application within 90 days, or the state denies the application and the Secretary determines that the state's standards impose unreasonable barriers to market entry. The bill also requires that the Secretary of HHS contract with the appropriate state agency to monitor the qualified PSO's performance.

While the bill draws upon the NAIC's HMO model for solvency requirements, its differences from the model are significant. These differences include the requirements for minimum net worth, the factors that are required to be considered in the calculation of net worth requirements, and the statutory accounting treatment of health delivery assets. The adoption of these standards at the federal level will undermine effective solvency regulation at both the state and federal level.

In addition to providing for inadequate solvency standards, the bill also does not consider the differences in health insurance markets throughout the country. States have experienced different levels of managed care penetration, in part because of the different evolutionary stages of their health care markets. The level of managed care penetration impacts the kinds of standards that might be appropriate. Consequently, uniform regulatory standards across the country may hinder, instead of foster, the growth of managed care in the Medicare program or the commercial market. We respectfully request that this Subcommittee acknowledge the differences in heath insurance markets and recognize the expertise of the states in applying appropriate consumer protection standards for their jurisdictions.

Because, under this proposal, the states will not have the ability to perform basic underlying licensure activities, for the next few years the federal government will be exclusively responsible for enforcement of the bill's standards. Without the underlying licensure activities conducted by state insurance departments, the federal program will be burdened with an additional degree of monitoring and enforcement for these organizations. This burden may be particularly acute given the lack of experience of many providers in assuming insurance risk. The early years of a health insuring organization's development are the most critical and precarious. While the Medicare program has in place some standards and performs some oversight, the level of standards and oversight do not mirror the depth of state regulation.

Further, the Medicare program does not currently have in place the resources to duplicate the state regulatory framework or the breadth of experience to perform effective consumer protection. Absent significant investments in a regulatory framework by the federal government, consumers will not benefit from the necessary protections offered by state insurance regulation.

Medicare Supplemental Insurance Proposals

The Committee has also asked us to comment briefly upon the topic of Medicare Supplemental ("Medigap") insurance and some of the recent proposals in this area. We understand that this topic was covered in more depth yesterday. In addition, the NAIC Committee will continue to review the proposals in more depth and would like to reserve the opportunity to provide the Committee with more detailed comments at a later date.

A recent bipartisan bicameral proposal in this area, cosponsored by Senators Chafee and Rockefeller and Representatives Johnson and Dingell, among others, S. 302, proposes changes to enhance the portability of Medigap insurance along with a few other areas discussed briefly herein. In addition, the Clinton Administration has released a brief summary of some changes in the Medigap area that the Clinton Administration intends to include within its budget proposal; legislative language on this proposal has not yet been released.

Portability and Open Enrollment

Both the Administration version and S. 302 contain provisions that would increase portability options for the disabled and for individuals losing coverage or switching from managed care plans to Medicare fee-for-service (FFS) plans; although these proposals differ in some respects. The NAIC Committee would like a further opportunity to review the details of these and would like to offer its technical and policy support.

Guaranteed Issue for Non-Elderly Medicare Beneficiaries

On this point, the Administration and bipartisan proposals are similar. The Clinton Administration proposes to amend Sec. 1882(s)(2)(A) of the Social Security Act[6] to provide disabled individuals who have not attained the age of 65 with the opportunity to enroll in a Medigap plan before or during the six-month period in which the individual first enrolls for Part B benefits. Similar to the Administration's proposal, S. 302 would amend Sec. 1882(s)(2)(A) to prohibit preexisting condition exclusions during the initial six month enrollment period in which an individual is eligible for benefits under Part A and is enrolled for benefits under Part B. Currently, the disabled are potentially subject to a six month waiting period for preexisting

conditions during open enrollment periods. Both proposals would eliminate this limitation.

Open Enrollment Provisions

Under S. 302, individuals who (1) have been continuously covered (no break exceeding 63 days) and (2) choose a new plan with benefits that are comparable or less generous than those of the beneficiary's current plan, will be guaranteed issuance of a new Medigap policy without the imposition of preexisting condition exclusions in certain circumstances. Guaranteed issue would apply to individuals falling within the five categories listed below:

1. Medicare managed care or health care prepayment plan enrollees who move from their plan's service area or who belong to a plan that is terminated or not renewed.
2. Medicare SELECT plan enrollees who move from their plan's service area, or whose insurer becomes bankrupt or insolvent or closes the block of business to new enrollment.
3. Medigap plan participants who move to a state where their insurer is not licensed, or whose coverage is terminated because of insurer bankruptcy or insolvency or because their insurer closes the block of business to new enrollment.
4. Beneficiaries of employer-sponsored health plans that provide supplemental Medicare benefits, when the plan terminates, ceases, or significantly reduces the individual's benefits.
5. First time enrollees in Medicare managed care, Medicare SELECT or health care prepayment plans who decide to return to Medicare FFS during the first 12 months of enrollment.

Note: language in the section covering managed care health care prepayment plans specifies that termination is "by the enrollee," while the Medicare SELECT section language merely references "termination," without specifying by whom.

S. 302 includes a requirement wherein the offering organization, insurer, or plan administrator has the burden of informing the individual of his or her rights and of issuer obligations in these circumstances. The Clinton Administration also proposes to institute open enrollment in certain listed circumstances; however, that language is unavailable at this time.

Once again, the NAIC Committee would like an opportunity to work with the sponsors of both proposals in the near future and to offer the expertise its members have gained in regulating this market and helping to institute safeguards against adverse selection.

Annual Open Enrollment

A proposal for an annual November open enrollment period is unique to the Clinton Administration's proposal. This period would be coordinated among all Medigap and Medicare managed care policies. Both proposals eliminate insurers' ability to impose preexisting condition exclusions on new enrollees.

Annual open enrollment is not an untried mechanism; however it is important that any proposal be carefully crafted to avoid any adverse selection where enrollees can jump into the system when they anticipate a claim and out of the system after they get well, without a penalty and at cost to those who stay in the system regardless of their health status.

Standardization of Medicare Managed Care Plans' Benefits Packages

The Administration has proposed that the Secretary of HHS standardize Medicare managed care plans through consultation with NAIC, consumer groups, managed care plans, health care providers and insurers. After the Medicare managed care plans were standardized, the Administration would request NAIC to revisit the standard Medigap plans (A-J) and to recommend any possible restructuring of the A-J packages to "facilitate maximum feasible comparison."

The states and the NAIC appreciated their role in the original process of standardizing Medigap packages pursuant to OBRA 990. We look forward to the opportunity to review the legislative language of this proposal and to comment in more detail at that time on both the policy behind the proposal and the potential state and NAIC role in the process.

Community Rating

The Administration proposal would require community-rating in Medigap plans. As the Committee is aware, rating is an area which has traditionally been reserved to the states. The NAIC Committee will further examine the details of the proposal and provide comment at that time.

Standardization of Benefits Information

Both proposals contain provisions that would expand the content and availability of consumer benefit comparison information.

S. 302 would establish a capped, $35 million per year, grant program whereby HHS would provide private organizations and/or state agencies with money to create and distribute plan comparison information and consumer survey results for plans within a particular area. The legislation would require plan issuers to conduct consumer satisfaction surveys and to make the results available to the Secretary of HHS and state insurance commissioners.

The Administration's proposal would provide for the development of a information program through a contract and grant mechanism. The funding would include a counseling grant program. Details of the Administration's plan are not yet available.

The NAIC Committee appreciates the potential role reserved for the states under both proposals but would like to examine them in more detail. It is very important that any such program, build upon, rather than recreate or replace, any existing state counseling programs with expertise in counseling senior citizens in the Medigap area.

CONCLUSION

For state insurance regulators, the determination of whether and how to regulate an organization is triggered by the function the organization performs and not the acronym by which the organization may be known. In making such assessments, state insurance regulators focus on whether the organization engages in the business of insurance. To this end, the most essential element to consider is whether the organization has assumed insurance risk. The acronym or ownership of an organization should not impact the decision whether an organization should be treated as a health insuring organization under the existing regulatory structure. This principle applies to organizations that are provider-sponsored. Provider-sponsored organizations assume insurance risk and ought to be regulated like other health insuring organizations by the states.

State insurance regulation offers essential elements of an effective regulatory framework for organizations serving the Medicare managed care program. We urge you not to hinder the ability of the states to use their expertise and apply the standards appropriate to their market. Federal preemption of state insurance regulation will weaken protections for Medicare beneficiaries, further segment the health insurance market, and result in standards inappropriately tailored to some state insurance markets.

We also look forward to the opportunity to work with the sponsors of S. 302, as well as with the Clinton Administration, to offer the assistance of the NAIC Committee in the area of Medigap insurance.

We appreciate the opportunity to testify before you today concerning the regulation of provider-sponsored organizations and Medigap. The NAIC looks forward to working with the 105th Congress on this and other issues of mutual concern.

ENDNOTES

[1]: 15 U.S.C. Sec. 1011-1015.

[2]: Sutton, Harry L., Jr. , F.S.A., Reinsurance in the Managed Care Environment, Society of Actuaries (1996).

[3]: Specifically, the model requires that HMOs maintain a minimum net worth equal to the greater of $1,000,000; or two percent of annual premium revenues on the first $150,000,000 of premium and one percent of annual premium revenues in excess of $150,000,000; or an amount equal to the sum of three months uncovered health care expenditures; or an amount equal to the sum of eight percent of annual health care expenditures (except those paid on a capitated basis or managed hospital payment basis) and four percent of annual hospital expenditures paid on a managed hospital payment basis. NAIC Model Act Section 13 (model 430).

[4]: Pat J. Butler, J.D., Dr. P.H. and Elizabeth Mitchell, *Health Care Provider Networks: Regulatory Issues for State Policy Makers,* National Academy for State Health Policy (February 1996) citing Physician Payment Review Commission 1995 Annual Report to Congress.

[5]: Taylor, Roger S. and Craig Schub, Medicare Risk Plans: The Health Plan's View, Managed Health Care Handbook, Peter R. Kongstvedt, ed., 3d ed., 746 (Aspen 1996).

[6]: 42 U.S.C. Sec. 1395ss(s)(2)(A).

PREPARED STATEMENT OF RICHARD REINER

Mr. Chairman, I am Richard Reiner, President and Chief Executive Officer of Florida Hospital Healthcare System, a provider-sponsored organization (PSO) with a Medicare contract. In December 1996, Florida Hospital Healthcare System was awarded final approval for our Medicare Choices Demonstration Project from the Health Care Financing Administration (HCFA). I am pleased to appear today to share our experience to date.

OVERVIEW OF FLORIDA HOSPITAL HEALTHCARE SYSTEM

Organization History and Present Operations

Florida Hospital, the flagship hospital of Adventist Health System, Inc., has been providing comprehensive health care services to Central Florida residents since 1908. Florida Hospital is one of the largest Medicare providers in the nation, based on admissions, and the leading Medicare provider in the state with over 20,000 admissions per year. With a long-established, successful history of serving the Medicare population, Florida Hospital enjoys a 45% share of the Central Florida Medicare market. Of the Medicare business Florida Hospital currently does, 86% is traditional Medicare fee-for-service and 14% is from Medicare risk plans.

Of the following five Medicare risk plans in the Central Florida market, Humana and AvMed are the ones for which Florida Hospital currently is a direct hospital provider.

Plan	Medicare Membership
Humana	24,203
PruCare	6,458
AvMed	4,837
PCA Health Plans of Florida	4,579
Health Options	1,926

Source: Florida Hospital Association—September 30, 1996

With a strong desire on the part of the hospital and the medical staff to develop a more integrated system of coordinated care, Florida Hospital and its physician leadership developed in late 1994 the necessary expertise and related administrative components of a PSO called Florida Hospital Healthcare System (FHHS). FHHS is a fully integrated delivery system capable of providing the full range of Medicare benefits for members for a flat monthly fee.

The FHHS provider network for Medicare full-risk business includes 615 physicians, as well as five hospitals, 13 walk-in medical centers, and 14 ancillary providers. FHHS has the ability to negotiate and execute contracts on behalf of each affiliated provider in the network.

FHHS offers provider networks and administrative capabilities for a variety of insurance partners, including preferred provider organizations (PPOs), point-of-service plans (POSs), and health maintenance organizations (HMOs), for commercial, Medicare and Medicaid products. Key core operational areas and administrative services of FHHS include utilization management, quality management, contracting, provider relations, credentialing, medical management, claims management, financial management, information systems, sales and marketing, compliance, and member services.

Mission

One of the special features of our PSO is that we are a local hospital system offering a full range of comprehensive health care services for the Medicare community. We do not have an HMO or insurance partner, or an HMO license. We feel that the ability of the Medicare member to deal directly with providers (hospitals, physicians and ancillary providers) of health care services achieves a higher level of patient satisfaction.

As a local plan offered by a community-based hospital, our mission is to strive to improve the health of our members both now and for the future. As part of the local community, FHHS is attentive to the long-term interests of the community we serve. We have formed effective partnerships with local health care and community organizations to implement community health improvement initiatives, such as Orlando's Health Care Clinic for the Homeless.

Physician Involvement

As a PSO, FHHS is a partnership between Florida Hospital and its physicians, and is jointly governed to allow for effective integration. Our philosophy is that pro-

viders must share in the accountability of providing quality health care services that achieve the best outcomes and the lowest possible costs. We believe there is a significant opportunity to align the financial incentives of health care providers by allowing the hospital, physicians and plan members to work together to make the most appropriate health care decisions, insuring cost-effective and high-quality health care.

FHHS believes there is a substantial benefit to providers and to members when the economic and patient care incentives are all aligned. Through either direct ownership or shared substantial risk, providers affiliated with our PSO share a significant common economic interest through shared financial accountability and governance. FHHS physicians have incentives to monitor their own peers, look for under- and overutilization and questionable business practices, and resolve quality issues because of the impact these areas have on the success of the PSO. FHHS providers take total ownership for patient satisfaction, financial success and quality outcomes.

As a PSO, FHHS' physicians and other clinical staff are actively involved in decision making about medical care, and in the development of patient care, quality and operational policies and procedures. FHHS physicians and clinical staff have the ability to manage costs and efficiency, control utilization, and achieve positive outcomes of care. We believe no one can manage medical costs better than health care providers who have the right information and management tools.

FHHS is managed by a Board of Directors appointed by Adventist Health System, Inc. Board membership, consisting of 13 physicians (primary care and specialists) and five hospital representatives, jointly govern the daily operations and management of FHHS.

In addition, three committees serve and assist the Board. Each committee is comprised of 12 representatives of the FHHS physician membership, including a physician chairman:

- The Medical Management Committee is responsible for the overall clinical management of each plan member along the entire continuum of care. The Medical Management Committee is supported by six Patient Care Committees (comprised of 10 physicians each). The Patient Care Committees, which meet monthly, are responsible for day-to-day utilization review and quality activities.
- The Provider Compensation Committee oversees the development of physician, hospital and ancillary reimbursement methodology and policies.
- The Network Development Committee is responsible for maintaining a high-quality provider network which guarantees adequate geographic coverage and access.

Currently, over 100 PSO physicians participate on the Board of Directors and the various committees to make decisions about how care is delivered, how utilization will be managed, and which physicians and facilities will be part of the network. In addition, physicians determine payment methods for hospitals, physicians and ancillary providers. FHHS believes this time and energy that the PSO physicians expend is an invaluable resource that can't always be measured on the FHHS balance sheet.

THE MEDICARE CHOICES DEMONSTRATION PROJECT

History

Over four years ago prior to development of its PSO, Florida Hospital tried to develop a partnership with a local HMO in order to jointly label a product and enter into a long-term business relationship that would permit Florida Hospital to provide services to local patients for the foreseeable future. Unfortunately, we were not able to find an HMO willing to look past its next quarter's earnings in order to form a partnership with our hospital and physicians. Therefore, we decided to apply for HCFA's Medicare Choices Demonstration Project on our own as a PSO.

We recognized that in order to become a demonstration site we had to demonstrate certain core competencies. Although we knew we would be able to serve a significant number of Medicare members using the existing administrative components that the hospital and the physicians already developed through FHHS, we also needed to establish additional infrastructure for Medicare operations, compliance, enrollment/eligibility, sales and marketing. Therefore, in addition to our core competencies described earlier, we launched efforts to enhance our management information system, develop Medicare-specific policies and procedures, modify and augment existing policies and procedures, and increase staffing for sales, member services, medical management and claims management. FHHS believes these competencies, as well as the ones mentioned earlier, need to be demonstrated before a PSO is eligible to be certified by HCFA for a Medicare risk contract.

In order to obtain the necessary dollars to enhance these functions, FHHS required a capital partner willing to invest substantial financial resources. In addition, as part of the demonstration project approval process, HCFA required our PSO to meet certain solvency and capital requirements. HCFA required that two and a half months of estimated claims be covered either through the equity of a parent organization or through other mechanisms, and that we were capitalized sufficiently. HCFA recommended that our PSO borrow an additional $2 million beyond what we had already capitalized.

These requirements could be met in a variety of ways, including by subordinated debt, capital from physicians and the hospital together, or a greater proportion of capital from either physicians or the hospital. In our case, FHHS' parent corporation, Adventist Health System, Inc., with total assets in excess of $1.2 billion and equity in excess of $500 million, provided that support, including the $2 million of additional capital. Adventist Health System, Inc., made a significant investment in the PSO because its leaders understood the need to shift from focusing on hospital admissions, and treating sickness and disease to the new focus of covered lives of plan members with an emphasis on wellness and prevention.

FHHS has assumed full financial risk for providing services to Medicare beneficiaries. The amount of financial risk HMOs currently transfer to hospitals under direct contracts isn't any different or greater than what FHHS has assumed under the Medicare project. In fact, like many PSOs, FHHS has already been accepting this type of financial risk from HMOs for some time.

Application Process

In 1995, HCFA encouraged managed care organizations and PSOs to submit innovative managed care options for its Medicare Choices Demonstration Project in the form of a competitive medical plan. HCFA received a pre-application proposal from FHHS, as well as 371 other potential candidates from nearly every state in the nation.

FHHS then worked to assemble a full competitive medical plan application, which was submitted to HCFA on December 15, 1995. HCFA selected 52 plans for further consideration.

HCFA narrowed these down to 37 applications and then selected 25 of these for final consideration. The 25 finalists included HMOs, PPOs, and nine PSOs of which FHHS was one. FHHS was chosen as one of these 25 finalists (one of only two sites in Florida).

FHHS received an on-site review by HCFA on August 27-29, 1996, and was awarded final approval on December 26, 1996. FHHS' Medicare product, called Florida Hospital Premier Care, immediately went operational.

Before it would approve our Medicare product, HCFA required our PSO to meet the same criteria as a Medicare HMO, including:

- Medicare Operations—Member services; grievance and appeals process; compliance; and marketing.
- Health Services Delivery—Provider network size; specialty mix; adequate geographic distribution; availability, accessibility and continuity of services; and out-of-area coverage. In addition, for quality assurance, we had to go beyond the HMO criteria due to the waiver of the 50/50 rule (tying Medicare and Medicaid enrollment to commercial enrollment). When this rule is waived, as it was for FHHS, PSOs must meet higher quality standards by demonstrating case-by-case utilization review for evaluating patterns of care and demonstrating physician involvement in the quality and utilization review process.
- Financial plan—Solvency and capital (as described earlier)
- Legal Items—Ability to do business as a corporation; state authority to operate; and provider contracts and agreements.

For the purpose of our demonstration, HCFA, with cooperation from Florida's Department of Insurance, waived several requirements, including the requirements to:

- Have 50% of our covered lives in commercial HMO business;
- Have a minimum of 5,000 total covered lives from commercial HMO business; and
- Have a state HMO license to operate in the State of Florida.

The Florida Department of Insurance waived these items because it believed there was adequate oversight and regulation of FHHS' plan by HCFA.

Project Description

As a community-based PSO structured as an integrated delivery system, FHHS is in a unique position to provide Medicare beneficiaries with an additional delivery system choice which allows them to deal directly with the providers of health care while providing HCFA an opportunity to test an alternative payment arrangement

called a risk adjuster model. The risk adjuster model is based on the current health status and expected resource consumption of plan members.

Service Area

FHHS' Medicare product is available to Medicare beneficiaries in the tri-county service area of Orange, Osceola and Seminole Counties. The service area has over 140,000 Medicare eligibles and a 30% Medicare risk HMO penetration.

In the future, FHHS intends to apply to HCFA for a phased expansion into the rural counties of Lake, Volusia, Flagler, Highlands and Hardee, which have a combined total of approximately 163,000 Medicare eligibles. We believe the hospitals and physicians in these outlying rural markets will need to purchase infrastructure and management support from a larger affiliated entity or pool resources and form alliances with other networks, such as FHHS' PSO. This is one example of how PSOs can be expanded into rural markets at a lower cost.

Provider Network

FHHS serves Medicare beneficiaries with a comprehensive medical delivery system that includes hospitals, walk-in medical centers, nursing homes, physicians, allied health professionals and ancillary providers. FHHS, whose providers are credentialed according to the National Committee on Quality Assurance (NCQA) standards, has been successful in attracting a large number of quality providers in the service area who have not previously participated with other Medicare HMO products.

We believe the integration of our providers into our medical management process is superior to that used by traditional Medicare HMO plans. The integrated structure of FHHS involves providers in this process, making FHHS attractive to providers to participate in, and allowing FHHS to achieve increased member satisfaction by providing broad geographic access.

FHHS built its Medicare risk provider network by contracting with primary care and specialist physicians in the service area on a risk-sharing basis. FHHS expects the provider network to increase from 615 to 800 physicians by late 1997. Currently, FHHS offers a comprehensive Medicare provider network in the tri-county service area that provides broad specialty mix and geographic access consisting of over 100 primary care physicians, 416 specialist physicians and 99 hospital-based physicians.

Network Stability

FHHS is built on a stable provider network base that includes the very providers with whom many of our members already have established relationships under traditional Medicare. With FHHS, a member is more likely to maintain a stable relationship with his or her personal physician, whereas other health plans may change their participating providers frequently or merge/consolidate with other managed care organizations.

Convenience and Access

One of the key marketing strategies of FHHS for the Medicare population is to capitalize on the size, depth and name recognition of our provider network. Through our extensive provider network, FHHS offers members convenient access to medical services at five acute care facilities throughout Orange, Osceola and Seminole Counties.

FHHS also offers 13 walk-in medical care centers strategically located throughout the tri-county service area. Most facilities have extended evening and weekend hours. In addition, these centers have the ability to reduce inappropriate utilization of emergency room services by giving members another access point for non-emergency care.

For all Medicare beneficiaries in FHHS' service area, the average distance to an FHHS hospital is six miles and the average distance to an FHHS walk-in medical center is five miles. There is an average of five FHHS primary care physicians within five miles of home for all Medicare beneficiaries.

FHHS has also contracted with a comprehensive network of ancillary providers, including outpatient dialysis centers; home health and home infusion programs; durable medical equipment, prosthetic, and orthotic suppliers; skilled nursing facilities; and free-standing surgical facilities.

In addition to its multiple convenient access points, FHHS offers geriatric health care services, providing a full range of services for elderly individuals with chronic illnesses. These services include, but are not limited to, cardiology, cancer, orthopedics, rehabilitation and diabetes. In addition, demand management is offered through MedAdvice, a 24-hour telephone nurse triage program.

Benefit Plan

FHHS' zero-premium benefit plan enhances the traditional services covered by both Medicare Part A and Part B by including preventative services such as mammograms and physical examinations, a prescription drug benefit, eyeglasses and contact lenses, hearing aids, and more.

Member Services

Currently, FHHS has a successful track record in providing comprehensive and responsive member services. Our Healthcare Information Center provides complete member services to plan members and strives to meet the daily individual needs of our members by welcoming new members to the plan, answering their questions about plan benefits, assisting in selection of primary care providers, etc. In addition, member services maintains excellent member relations for retention purposes.

Reimbursement Arrangements

FHHS is designed to assume full risk for Medicare Part A and Part B services for the beneficiaries that select FHHS' Medicare plan. FHHS' primary care physicians and hospitals are capitated. FHHS' specialist physicians are paid on a fee-for-service basis from capitated pools.

Additionally, the FHHS claims system is able to pay out-of-area hospital and physician claims. This system also tracks claims payment for reinsurance reporting. FHHS has purchased reinsurance and outlier payment coverage from an independent insurance company to protect against catastrophic cases.

In addition to demonstrating PSO capabilities, FHHS is testing a new reimbursement arrangement that could possibly allow HCFA to adjust our payment based on the health status of our members. FHHS' payment arrangement with HCFA is based on a risk adjuster model which is designed to provide better data on how much to reimburse a health plan depending on the health status of its members. Based on predetermined risk-sharing corridors with HCFA, FHHS can potentially save money for HCFA depending on the health status (severity-adjusted) of the Medicare beneficiaries who join our plan.

Under this model, FHHS is paid based on a percentage of the applicable Adjusted Average Per Capita Cost (AAPCC) for each member. At year end, FHHS' reimbursement will be adjusted using the hierarchical coexisting conditions (HCCs) version of the diagnostic cost group (DCG) model, which is based on the health status of plan members and the consumption of services over the past year. Under this arrangement, adjusted Medicare payments to FHHS are built around a floor and ceiling, thus limiting FHHS' and HCFA's potential upside and downside exposure.

Data Reporting Capabilities

Unlike many HMOs, our PSO has access to hospital clinical data, as well as claims data. FHHS collects, measures and utilizes clinical data to deliver coordinated care, manage the quality of care, and aggressively manage utilization of services. FHHS is able to successfully monitor and analyze quality of care through its experience and infrastructure. FHHS has the ability to integrate, track and analyze both clinical and cost data that spans the entire PSO, including hospital cost and quality data, as well as outpatient data from the ambulatory setting and the physicians' offices.

FHHS will provide HCFA with quarterly utilization reports that include severity-adjusted and case mix-adjusted data, HEDIS indicators, and member satisfaction data. FHHS also provides HCFA with encounter data for Florida Hospital Premier Care members that encompasses all services covered by Medicare.

Quality of Care Approach

The FHHS Medical Management Program is designed to monitor, evaluate and improve the quality of care delivered to patients. The program meets all standards for both the National Committee for Quality Assurance (NCQA) and the Joint Commission for the Accreditation of Health Care Organizations (JCAHO). A critical component of the system is the ability to manage the health care needs of a population in order to provide the best care in the best setting.

Quality assurance and utilization review allow FHHS to perform continuous quality improvement, evaluate continuity of care, and monitor the over- or underutilization of services. In addition, FHHS provides each member with health education, an important factor in keeping members healthy versus treating them once they are sick. As a PSO, FHHS is leading the transition to focus on wellness instead of on sickness.

Through the quality and utilization management process, provider practice patterns are monitored and evaluated for both in- and outpatient services. If issues for improvement are confirmed, a corrective action plan is implemented which may in-

clude staff education and development, administrative changes, contract changes, intensified performance monitoring, peer review, limitation of privileges, sanctions, suspension or ultimately termination.

Other quality and utilization management resources include demand management through MedAdvice, a 24-hour telephone nurse triage program, and disease management through targeted interventions for high-risk and chronically ill members. Health education and screenings are also offered, as well as appropriate outpatient testing specific to the Medicare population.

ENROLLMENT RESULTS FOR FHHS' MEDICARE PRODUCT

Goals and Strategies

FHHS' enrollment goal for its Medicare product is 1,000 members per month for a total of at least 12,000 per year. FHHS' broad-based marketing efforts target the approximately 140,000 Medicare beneficiaries in the service area of Orange, Osceola and Seminole Counties. According to HCFA, about 30% of these beneficiaries are currently in Medicare managed care plans. This 30% has been achieved by HMOs over an eight-year period and new enrollment has been somewhat stagnant over the past year.

The target audience includes Medicare beneficiaries who are currently enrolled in a managed care program; those who have not enrolled in a managed care program due to a lack of understanding, fear of the unknown, fear of reduced access to their primary care provider, or inability to access Florida Hospital because of HMO contracting decisions; and elderly newcomers relocating to Central Florida.

Florida Hospital, which focuses on impacting quality of life through comprehensive health services and wellness education, enjoys exceptional health outcomes and name recognition with the Medicare population in Central Florida. FHHS is capitalizing on this established position in the marketplace for attracting enrollees to its Medicare product.

Initial Response and Enrollment Results

As a demonstration site, FHHS has received an overwhelmingly positive response from the local community. We believe this early success is due to Florida Hospital's name recognition and existing reputation for providing excellent care within the market.

On the day the first Florida Hospital Premier Care newspaper ad ran (December 31, 1996) in The Orlando Sentinel, over 1,000 calls were received. We ran a second ad on New Year's Day and received more than 2,500 calls. A grand total of about 5,500 calls were received during the first week of operation.

All of the pre-scheduled sales seminars (three to four daily each week) were booked within the first week as well, causing Florida Hospital Premier Care to add an additional 10 seminars per week. By the end of January, over 2,500 Medicare beneficiaries had attended one of over 60 seminars to learn about Florida Hospital Premier Care.

Currently, the close rate (individuals who join the plan) for the enrollees attending these seminars is 39%. Based on our best information about the enrollment history of HMOs around the country, this is an unusually high close rate. We believe our high close rate is due to the fact that the plan is locally organized and operated by hospitals and physicians in the community. In fact, according to many Florida Hospital Premier Care applicants, Florida Hospital would be the only hospital they would choose to go to and have been waiting for a health plan like Florida Hospital Premier Care as an alternative to joining an HMO.

Enrollment results to date are as follows:

Month	Number of Members
February	393
March	1,974
Total YTD:	2,367
Total YTD Expected After April Enrollments: 4,140	

Of the Medicare beneficiaries joining FHHS' plan, 40% are from Medicare HMOs and 60% are from traditional Medicare fee-for-service, including Medicare supplemental programs.

Disenrollment for the first 60 days has averaged under 1%. The main reason for disenrollments is snowbirds (individuals leaving the service area).

In a recent random survey of 120 current members, FHHS learned the following:

Top four reasons for joining Florida Hospital Premier Care:
- Florida Hospital Reputation.
- Doctors in Plan.
- Reduced Out-of-Pocket Expenses.
- Better Benefits.

Top four factors in the decision to join Florida Hospital Premier Care:
- Florida Hospital Name.
- Quality Physician Network.
- Access to the Physician Network.
- Benefits Offered.

The importance of joining a health plan operated by a local hospital and physicians versus an insurance company:

Very important	83% of respondents
Neither important nor unimportant (neutral)	12% of respondents
Unimportant	0% of respondents

The importance of belonging to a non-profit provider-sponsored plan such as Florida Hospital Premier Care versus a for-profit health care plan:

Very important	82% of respondents
Neither important nor unimportant (neutral)	17% of respondents
Unimportant	0% of respondents

The importance of having a health care plan headquartered in the local community versus a health care plan headquartered elsewhere:

Very important	92% of respondents
Neither important nor unimportant (neutral)	13% of respondents
Unimportant	2% of respondents

SUMMARY

Many PSOs welcome the opportunity to provide a viable alternative to how health care has been delivered to Medicare beneficiaries through HMOs over the past 10 years. FHHS has been and continues to achieve much of the theory behind what PSOs are capable of doing, such as managing, financing and coordinating care.

FHHS believes that PSOs:
- Demonstrate how hospitals and physicians can work together to coordinate the process of health care delivery, commit the necessary resources to do so, and align economic and patient care incentives.
- Increase the types of plans available to Medicare beneficiaries.
- Show that community-based PSOs are often preferred by the community over HMOs.
- Deliver high-quality, cost-effective health care which will have equal or higher levels of enrollment and stability.
- Achieve higher member satisfaction.
- Improve the health status of the local community.

Mr. Chairman, I have carefully reviewed the Frist/Rockefeller bill, S. 146, and, based on my experience working with the Medicare program in creating our PSO, I am convinced there are several reasons federal PSO legislation is needed to prevent barriers to entry from inhibiting the growth of this market and to ensure adequate choices for beneficiaries.

PREPARED STATEMENT OF MICHAEL THOMPSON, FSA, MAAA

The American Academy of Actuaries is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of clear, objective analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials and congressional staff, comments on proposed federal regulations, and works closely with state officials on issues related to insurance.

The American Academy of Actuaries appreciates the opportunity to provide comments to the Senate Finance Committee on the important issue of improving choices under the Medicare program. The Academy hopes that you find these comments helpful as you consider the various proposals on reforming the Medicare program.

The American Academy of Actuaries has analyzed numerous elements involved with health care reform initiatives. The actuarial profession is uniquely qualified to examine the various alternatives to reform Medicare due to the profession's exten-

sive practical experience designing efficient health care plans for employers and other organizations in the private sector. Additionally, the actuarial profession has provided actuarial input on the Medicare program and other social insurance programs.

The Senate Finance Committee has asked the Academy to comment on the Administration's Medicare reform proposals regarding provisions to improve choices under the Medicare program. This testimony discusses the implications of adding Medigap access provisions, including provider sponsored organizations as insurers in the Medicare program and managed care reimbursements.

Increased Medigap Access Provisions

The Administration's 1998 budget proposal would provide "new open enrollment requirements and prohibitions against the use of pre-existing condition exclusions. to help Medicare beneficiaries who wish to opt for managed care but fear they will be 'locked-in' and unable to access their old Medigap protections if they switch back to a fee-for-service plan."

Open enrollment: Currently, Medigap insurers are required to maintain a six month open enrollment commencing when the Medicare beneficiary first turns age 65 or becomes eligible for Medicare. After this mandated open enrollment period, most Medigap carriers require Medicare beneficiaries to submit some form of evidence of insurability to be eligible for all or some of the Medigap policies offered. Some existing carriers (not all) will waive this requirement if:

- The individual is currently enrolled with another carrier's Medigap policy and is enrolling in a similar or lesser policy with no greater benefits; and/or
- The individual is enrolling for one of the lesser Medigap benefit options (e.g. those without drug benefits).

These limitations on open enrollment are designed to limit the degree to which individuals can defer enrollment in one of the Medigap plans or a richer Medigap plan to when they are in poor health. These restrictions help to stabilize Medigap premiums for Medicare enrollees in these plans and limit the required subsidy for unhealthy individuals who select against the Medigap insurance pool.

Any liberalization in Medigap mandated open enrollment requirements are likely to increase the cost of Medigap coverage for some, if not all, current Medigap enrollees. The extent of increase will vary by carrier depending on the degree of underwriting requirements currently in place and on Medicare Risk plan penetration and disenrollment in the Medigap plans rating area. Allowing individuals enrolled in Medicare Risk plans to disenroll and enroll in any Medigap policy without medical evidence will also likely increase costs of the Medigap plan as well as Medicare. due to the tendency of individuals with greater health costs to favor less restrictive coverage.

A recent analysis done by the Physician Payment Review Commission (source: Physician Payment Review Commission, 1996; Washington; the Commission. 1996) is illustrative of the potential selection which can impact the costs of Medigap plans. The study examined enrollees in Medicare Risk plans between 1989 and 1994 and compared their spending with a controlled group of individuals who remained in the traditional fee-for-service Medicare environment. The analysis showed that:

- Individuals enrolled in Medicare Risk plans spent 63 percent as much as average Medicare beneficiaries during the six months preceding enrollment when both groups were enrolled in traditional Medicare; and
- Individuals who disenrolled from Medicare Risk plans and returned to the traditional Medicare fee-for-service plan spent 160 percent of the average beneficiary in the six months following disenrollment. Another potential concern is that unhealthy individuals will tend to favor Medigap plans with the richest benefits. Consequently, it is likely that many carriers will elect not to offer the richest Medicare Supplement plans (such as those with drug benefits) and those that do will likely experience even greater anti-selection. The extent of increase in Medigap premiums (and traditional Medicare fee-for-service costs) due to open enrollment requirements will depend on the specific nature of the open enrollment requirements. Increases in Medigap premiums (and in some instances. traditional Medicare fee-for-service costs) can be minimized if the:
- Open enrollment period is for a limited time period (such a 30 days) and a limited frequency (such as once per year or every other year);
- Open enrollment is limited to comparable or lesser benefit plans than those currently enrolled for;
- Open enrollment does not apply to individuals who were not previously enrolled in Medigap or Medicare Risk coverages;
- Open enrollment is limited to the basic benefit plans; and/or
- Open enrollment provisions apply universally to all carriers.

A "one time only" provision would also, theoretically, reduce the degree of anti-selection. However, this provision is likely to be difficult, if not impossible to implement or enforce.

It is worth noting that employers who offer multiple health plans typically have an open enrollment at least annually. Those open enrollments generally are for a 31-day period and generally do not apply to individuals who are not currently enrolled in any plan (new hires and individuals with life event changes are typically given up to 31 days to enroll without medical evidences). Many employers have experienced some anti-selection and increase in traditional fee-for-service plan costs, in part, due to these open enrollments.

It is important to ensure that the flexibility in the Medicare program does not result in:

- Unintended premium increases for Medicare Supplement insurance that would unfairly impact seniors who purchase Medicare supplement coverage;
- Reduced market availability of some of the standard Medicare Supplement policies; and
- Increased Medicare fee-for-service costs due to additional anti-selection.

While the proposal may provide increased access to the Medicare population enrolling in Medicare Risk programs, depending on the legislative language. it could result in unfair cost shifting to senior age Medicare beneficiaries.

Pre-existing conditions: Taken alone, limitations on pre-existing condition exclusions for age 65 and over Medicare beneficiaries should not have a large effect on the overall costs. Many health plans do not have these exclusions at open enrollment now or do not enforce them To the extent all carriers are prohibited from imposing the limitation. anti-selection is reduced. In today's market, individual carriers could be anti-selected against. since less healthy beneficiaries will tend to gravitate towards carriers who do not have the same limitations in coverage. If no carriers can place restrictions on coverage due to pre-existing conditions. anti-selection among carriers will be reduced.

On the other hand, there could be additional anti-selection among individuals electing various types of plans. For example:

- Individuals electing managed care (such as Medicare Risk) versus electing Medicare Supplement coverage;
- Individuals electing lesser benefit plans versus greater benefit plans (such as plans which cover prescription drugs); or
- Individuals electing no coverage to supplement Medicare versus those electing Medicare Supplement or Medicare Risk plans.

The effects of anti-selection may result in less market availability of the richer benefit Medicare Supplement plans.

In addition, the degree of anti-selection due to limiting pre-existing conditions exclusions will be directly related to the nature of the open enrollment provisions. The more liberal the open enrollment conditions. the greater the anti-selection concern if there is no pre-existing condition. Conversely, the degree of anti-selection due to open enrollments would be mitigated by the extent to which pre-existing condition exclusions are permitted.

Preferred Provider Organizations and Provider Service Networks

The Administration's Budget 1998 budget proposal "increases the numbers of plans -including Preferred Provider Organizations and provider sponsored networks—available to seniors . . . the plans would compete on cost and quality, not on the health status of enrollees."

The increase in the number of plans including preferred provider organizations and provider sponsored networks may provide additional choices in plan designs and service providers for senior age Medicare beneficiaries. However, consideration of these additional choices needs to take into account the potential impact of anti-selection, market availability and solvency protections for Medicare beneficiaries.

The potential for anti-selection among plans increases when multiple plans are available. As indicated above, there will be a tendency for the least healthy, most costly Medicare beneficiaries to elect the richest, least restrictive coverages and consequently for the market to be less likely to offer those richest plans. This potential anti-selection is increased in the case of provider service networks where providers will have detailed knowledge of the health status of their own patients and, on that basis, will be able to steer these patients into the program that will yield the most favorable financial outcome to the provider sponsored networks.

It is understood that the Administration's plan would apply minimum federal standards that apply to current Medicare contractors to the provider service networks. with states imposing more stringent standards after four years. If Congress is concerned about a level playing field for those participating in Medicare, it will

be necessary to ensure that provider service networks are subject to similar regulatory and solvency requirements as HMOs and traditional insurers.

Provider sponsored networks assume risks similar to HMOs or traditional insurers when they accept prepayment for benefits promised for services delivered to members. As with HMOs or insurers, there is a promise to pay for delivering a service on which the participant relies. The consequences of non-payment or non-delivery are real to the participant and just as catastrophic as they would be under a similar insurance or HMO arrangement.

Most provider service networks are currently organized similarly to existing insurers and HMOs. Their ability to provide services directly does not meaningfully reduce the actuarial risk present. In fact, while the ability to profit or lose from prepayment arrangements may rest with all or a subset of the participating providers, the obligation to provide services typically arises out of provider contractual arrangements or employment relationships which are similar to those utilized by regulated HMOs or insurers. The Academy believes that where the risk is the same, that all health organizations (insurers, HMOs and provider service networks) should be subject to similar regulatory and solvency requirements.

It is also important to recognize that the solvency of health plans will be impacted by other entities participating in the Medicare program. All the players in the system need consistent regulation to avoid adverse selection against one or more sectors. Regulation needs to ensure that all appropriate players are consistently included or excluded.

The Academy is concerned about adequate solvency standards for new health entities. such as provider sponsored networks. For a detailed analysis of this issues refer to the testimony being given today before the House Commerce Committee Health and Environment Subcommittee on solvency standards for health organizations participating in Medicare.

Managed Care Reimbursements

The Administration's 1998 budget plan would "reduce Medicare reimbursement to managed care plans from its current rate of 95 percent of fee-for-service rates to 90 percent."

The Academy was asked by this Committee to discuss alternatives to an across-the-board cut. such as modifying the risk-assessment method or modifying the current payment method which links HMO payments to fee-for service payments. Both options appear to be alternatives worthy of further discussion and consideration by Congress. Across-the-board adjustments such as the change from 95 percent to 90 percent will not address the inequities of the current system. Plans with higher-than-average cost populations will face payment cuts the same as plans with lower-than-average cost populations.

For a detailed analysis on the role of risk adjustment and HMO payment policies within the Medicare program, refer to the testimony presented by the Academy to the U.S. House of Representatives Ways and Means Committee Health Subcommittee on February 25, 1997.

Conclusion

In order to measure the actual impact of these proposals, it will be necessary to review and analyze specific legislative language. The American Academy of Actuaries is available to provide assistance to Congress and the Administration as steps to improve the current Medicare system are being considered. We offer our help in analyzing potential solutions and in helping elected officials and their staff understand the potential implications of any short-term actions.

Prepared Statement of Bruce C. Vladeck, Ph.D.

INTRODUCTION

Mr. Chairman, I am very pleased to be here to describe how the Health Care Financing Administration (HCFA) is working to make sure that Medicare beneficiaries receive high quality care under managed care. It is important that we clearly define and support measures to promote quality of care, not only for beneficiaries enrolled in Medicare managed care plans and traditional fee-for-service, but for all Americans in all types of health plans. We also are working to become more adept at being a beneficiary centered purchaser, and as the Nation's largest purchaser of health care, we want to effectively use market forces to obtain best value for our beneficiaries.

Managed care options have been a part of Medicare since the program's inception. With the signing of the first risk contracts authorized under the Tax Equity and

Fiscal Responsibility Act in 1985, managed care plans proliferated and today have become an essential part of the Medicare and Medicaid programs. As of January 1, more than 4.9 million beneficiaries have enrolled in 350 Medicare managed care plans, two thirds of which are risk contractors. Risk plan enrollment grew by 33 percent in 1996. This increase is consistent with the rapid rate of program growth in recent years. In 1994, enrollment grew by 25 percent, in 1995, the growth was 36 percent.

In a managed care plan, a network of doctors, hospitals, skilled nursing facilities and other providers offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in emergencies, services must be obtained from health care providers that are part of the plan. Care may be provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

We have found that the managed care option is attractive to many beneficiaries. In many cases, enrollees can receive the same financial protection afforded by Medicare supplemental—or "Medigap"—policies without paying a premium. In addition, most plans provide benefits not covered under the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. I should point out, however, that the ability of managed care plans to provide additional benefits is due in part to the inadequacy of Medicare's payment methodology, which we have proposed to address in this year's budget. Beyond value measured in dollars and cents, managed care plans have the potential to provide value that can be achieved when services are coordinated and when the focus of care is on prevention and "wellness."

Our mission in HCFA is to serve our Medicare and Medicaid beneficiaries. Under this Administration, HCFA's efforts are firmly focused on obtaining the best value for our beneficiaries. We work in partnership with managed care plans in this task, but as I will describe later in my testimony, we have not hesitated to take enforcement actions when warranted.

BENEFICIARY PROTECTIONS

Current law provides beneficiaries enrolling in managed care plans a wide variety of protections, many of which are not received by most commercial enrollees. Let me take this opportunity to outline briefly the protections that beneficiaries enjoy under current law and areas where improvements are warranted.

- *Beneficiaries must receive clear and accurate information about the implications of their choice of a managed care option*—Current law requires that plans provide certain information to all prospective enrollees including explanations of benefits, premiums and cost-sharing, lock-in requirement, and grievance mechanisms. However, we believe that more needs to be done to educate consumers about their health care alternatives and later in my testimony I will describe our plans for improvement in this area.
- *Beneficiaries cannot be subjected to health screening or preexisting condition limitations*—Current law is clear in this area. We enforce this requirement through careful monitoring of all marketing materials and activities of contracting plans, and by reviewing beneficiary grievances and appeals.
- *Beneficiaries must have access to medically necessary and appropriate care*—Before receiving a contract, all plans must meet Federal standards which guarantee beneficiary access to medically necessary services. HCFA is committed to ensuring that HMOs adhere to these Federal standards.
- *Beneficiaries must have access to procedures to resolve grievances and access to a neutral third party for appeals*—While this is one area where Medicare's protections are significantly beyond those generally available to managed care enrollees in the private sector, we believe that improvements are necessary. Our plans for achieving these improvements will be explained in a subsequent section.
- *Beneficiaries' care is reviewed both internally and externally*—Plans must have internal quality review mechanisms in order to receive a contract. PROs are responsible for external quality review. We have been working closely with other payers and the industry to make significant improvements in this area and, later in my testimony, I will outline these initiatives.
- *Beneficiaries are protected from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan*—Under current law, plans must be fiscally sound and must have a plan for protecting beneficiaries in the event of insolvency.

- *Beneficiaries' out-of-pocket expenses are limited*—Under current law, Medicare managed care plan enrollees are protected by limits on premiums and cost-sharing and by prohibitions against balance billing.

We have also been working toward enhancing beneficiary protections. Some steps can be taken under current law, while other actions would require legislation.

- *Improving the Appeals and Grievance Processes:* The appeals and grievance process serves as a check and balance on contracting plans and helps to ensure that beneficiaries obtain all appropriate and medically necessary services. Improvement activities include an expedited appeals process for certain time-sensitive situations, shortened time frames for all other reviews involving service denials and terminations, and improved health plan accountability on the results of appeals and grievances. However, we cannot afford to be complacent in the face of recently publicized concerns, and streamlining the appeals process is one of our highest priorities.
- *Unrestricted Medical Communication:* The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, Medicare beneficiaries are made aware of the full range of treatment options by their physicians. Managed care enrollees are entitled to the same advise and consultation. This is a basic right of the patient and we have communicated the prohibition against "gag" provisions in a policy instruction to all health plans.
- *Post-Breast Cancer Surgery Hospitalization:* The national attention given to coverage of mastectomies indicates that there is a need for greater oversight. We are committed to preventing sub-standard care in this area since Medicare pays for one-third of all mastectomies. By law, Medicare beneficiaries who receive mastectomies are entitled to coverage for all medically necessary care. The decisions about what is medically necessary should be made by a woman and her doctor. To emphasize this, on February 12, 1997, we sent a policy letter to all managed care plans, making it clear that they may not set ceilings for inpatient hospital treatment or requirements for outpatient treatment. Similarly, we recently reinforced this message in Medicare's fee-for-service sector.
- *Physician Incentive Plans:* Effective January 1, 1997, the Physician Incentive Plan Final Rule required managed care plans with Medicare or Medicaid contracts to disclose information about their physician incentive plans to HCFA or the State Medicaid agencies, before a new or renewed contract receives final approval. Plans whose compensation arrangements place physicians or physician groups at substantial financial risk must provide adequate stop-loss protection and conduct beneficiary surveys.
- *Prudent Layperson:* The Administration's plan clarifies the obligation of Medicare managed care plans to pay for emergency services rendered to their enrolles. By using HCFA's definition of "emergency services" as those services that a "prudent layperson" would reasonably believe to be needed immediately to prevent serious harm to the patient, States will be better able to determine similar requirements for commercial managed care enrollees.
- *National Marketing Guidelines:* To ensure uniform interpretation and provide beneficiaries with accurate and clear information about managed care plans, we have developed the Medicare Managed Care National Marketing Guidelines. These Guidelines, which will be released next month, were developed in cooperation with the American Association of Health Plans and representatives of the health care industry.
- *Beneficiary Information Publications:* HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.
- *Comparative Information:* We want to provide all Medicare beneficiaries comparative information that would assist them in making choices. In the President's FY 98 Budget Plan, we propose that comprehensive comparative information on all plan options, including Medigap, be provided to Medicare beneficiaries and be funded by the plans. In the interim, we are working on making comparative information available on the Internet and to beneficiary insurance counseling centers. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-

sharing requirements. Currently, many of HCFA's regional offices sponsor and disseminate comparative information for local beneficiaries.

HCFA is currently working to implement a Competitive Pricing Demonstration in Denver to test a range of new education and information resources for beneficiaries—including new formats of printed materials, in-person seminars, and a 1-800 call center, all coordinated by a HCFA-sponsored third party. The goal of these resources is to help beneficiaries understand their options under Medicare and help them make the best choices—whether it is fee-for-service, Medigap, or managed care.

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

IMPROVED MONITORING AND ENFORCEMENT

All of the beneficiary protections that I have just outlined are only words on paper unless there is an explicit commitment to enforcement. I am proud to say that this Administration has fostered significant improvements in oversight and monitoring of managed care plans. We have initiated a program of special investigations that may target a specific compliance problem, or review all plans in a heavily saturated market area. Protocol-monitoring processes have been revised to improve clarity and establish more consistency in the methods used to evaluate contractor operations. National guidelines for marketing materials have been developed to improve our monitoring of plan compliance with statutory and regulatory requirements.

For the first time in the history of the program, we have begun to impose intermediate sanctions in response to certain plan activities. If we find the same compliance problem in successive monitoring reviews, we are no longer treating the recurrence as an isolated event, but instead are taking enforcement actions. Under these sanctions, we can require a contracting organization to suspend marketing activities or enrollment of new members; in some circumstances we will suspend payments to the plan for new enrollees.

Finally, in regard to monitoring and enforcement, we also have several activities in the planning stages. First, we are evaluating our process for reviewing and approving applications for managed care contracts in order to identify potential problems with a plan's ability to meet contracting requirements before we approve the contracts. Second, we are redesigning our data system to facilitate cross-plan comparison of enrollments, disenrollments, appeals processing, complaints, quality and fiscal soundness in order to identify aberrant patterns that warrant investigation. Lastly, we have begun discussions with State insurance commissioners regarding actions that could be taken to coordinate activities. These include eliminating some duplicative oversight functions, and maximizing the sharing of information, especially with regard to plans experiencing financial difficulties. The importance of consistent and conscientious quality monitoring cannot be overemphasized, and now I would like to describe the progress that we have made in developing quality measurements and in fostering quality improvement.

QUALITY INITIATIVES

The argument for the potential of managed care to improve quality is well known. It starts with a critique of fee-for-service. Fee-for-service care tends to be fragmented with a focus on acute rather than preventive services. Economic incentives are in the direction of over-utilization of health care services. As a result, under fee-for-service, there tends to be an inappropriate and costly allocation of existing health care resources. It is then argued that the capitated prepayment made to managed care allows plans to organize care and re-allocate resources to address, in a coordinated and systematic way, the needs of each patient. In managed care, unlike fee-for-service, the organization is accountable for improving the well-being of the patient. This provides an opportunity, more elusive in fee-for-service, to improve the quality of care being furnished.

The flip side to the argument is also well known. In managed care, there is the potential for "under-service" and poor quality, if plans try to maximize short-term

profits by not delivering appropriate care. The goals of our quality initiatives are to develop mechanisms to measure quality and to hold plans accountable for quality improvement. We have two approaches toward achieving these goals. The first approach is to use utilization data or encounter data to address "inputs" into the delivery of care. Most current performance measures are "process measures." Process measures refer to clinical interventions (tests, medications, procedures, surgery) which are believed to lead to favorable patient outcomes. While this approach has limitations, encounter data and process measures provide significant insight into the quality of care.

The second, and potentially the most efficient strategy for clinical performance measures, is to move toward outcome measures. The problem is that the science of outcomes measures is in its infancy. The movement towards better outcomes measures is critical for HCFA, like-minded purchasers, and beneficiaries in order to hold plans and providers accountable for the care they deliver. HCFA and the Agency for Health Care Policy Research (AHCPR) have been active in promoting research to identify these measures. With such measurements in hand, HCFA and the public will be able to objectively compare managed care to itself and to fee-for-service, and to determine whether managed care is living up to its potential to improve the quality of care. However, more research is needed, especially with regard to the health care needs of the poor, elderly, and other vulnerable populations, and with how to present this information effectively to beneficiaries.

As I indicated earlier in my testimony, a major focus of our efforts in recent years has been in working with our partners in the managed care industry and with other payers to accelerate and standardize the development of outcomes measures.

- **HEDIS 3.0:** The latest iteration of the Health Plan Employer Data and Information Set, HEDIS 3.0, reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts, to develop a comprehensive set of measures for Medicare, Medicaid, and commercial populations enrolled in managed care plans. As of January 1, 1997, HCFA is requiring Medicare managed care plans to use HEDIS. This will facilitate comparison of plan performance measures and permit HCFA to hold plans accountable for the quality of the care they provide. HEDIS measures eight components including: effectiveness of care; access/availability of care; satisfaction with the experience of care; health plan stability; use of services; cost of care; informed health care choices; and health plan descriptive information. HCFA, working with the HEDIS Committee on Performance Management, was instrumental in adding functional status for enrollees over age 65 as a measure in the "effectiveness of care" category in HEDIS 3.0. This will be the first outcome measure in HEDIS that will longitudinally track and measure functional status. It addresses both physical and mental status through a self-administered instrument which determines whether the beneficiary perceives that his or her health status has improved, stayed the same, or deteriorated. In addition, six other measures that impact on Medicare beneficiaries have been added to the "effectiveness of care" category, including: mammography rates, rate of influenza vaccination, use of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, and utilization of beta blocker in heart attack patients.
- **Foundation for Accountability:** The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. As Federal Liaisons to the FAcct Board of Trustees, HCFA is joined by other public and private sector partners, including the American Association for Retired Persons, the Department of Defense, the Office of Personnel Management, Ameritech, and American Express. The underlying premise of FAcct is that better health care information, assembled from the consumers' point of view, should help steer Americans toward the highest quality care. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality. Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the ASPE also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.
- **Medicare Beneficiary Survey:** In cooperation with HCFA, AHCPR initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare beneficiary survey. This survey quantifies Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1 of this year, HCFA is requiring all health plans to use CAHPS, which is now available to the public. HCFA

plans to administer the survey through an objective single third party vendor in order to ensure comparability.

In addition to our quality measurement initiatives, we are actively involved in promoting quality improvement.

- **Projects to Assess Ambulatory Care in Managed Care Settings:** The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The PROs in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP. In addition, an on-going sister project, utilizing the PROs in Maryland, Iowa and Alabama, will analyze the same measures in the fee-for-service setting. The initial finding is that there is room for improvement in both managed care and fee-for-service in these two areas.
- **Medicare Choices Demonstration**—An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project, we will be developing and testing quality/outcomes and risk adjustment measurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100% encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

Other important Medicare managed care quality initiatives include the establishment of new requirements for Medicare managed care plans in the areas of quality improvement activity; health information systems; health services management; and member rights and responsibilities. In addition, as part of a project to improve efficiency in monitoring and oversight, teams of HCFA and PRO staff are being formed to target a review of managed care plans' internal quality assessment and improvement programs. We have similar quality improvement initiatives for Medicare fee-for-service plans. Our budget also includes a provision to give us the authority to develop an integrated quality management system, so that we can assess more comprehensively the quality of care provided under fee-for-service.

THE PRESIDENT'S 1998 PROPOSALS

The President's 1998 Budget Plan includes several proposals affecting areas I have already discussed. We believe these changes are important to achieve our stated goals of preserving the solvency of Medicare and enhancing beneficiary protections and choices. Our specific proposals to expand and enhance beneficiaries' choices include:

Expanding Beneficiary Choices

- **Expanded PPO/PSO Options**—Currently, HCFA can contract with Federally qualified Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.
- **Comparative Information**—Everyone agrees that "knowledge is power," and we seek to empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand. The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options—both managed care and Medigap. To help beneficiaries compare various plans, standardized packages for additional benefits offered by managed care plans would be developed. Adjustments would then be made to the current standard Medigap packages to make comparison easier for beneficiaries. As described below, Medigap plans would be required to operate under the same rules followed by Medicare managed care plans.
- **Annual Open Enrollment**—The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances—such as, when a bene-

ficiary's primary care physician leaves a plan or when a beneficiary moves into a new area. Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap.

- **Elimination of Pre-existing Condition Exclusions**—In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Senator Chafee and Senator Rockefeller and others and we look forward to working together toward enactment this year.
- **Community Rating for Medigap Plans**—Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice younger beneficiaries to enroll, but as the enrollee ages premiums become unaffordable. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an important goal, then premium structures such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age, should not be allowed.

QUALITY INITIATIVES

- **Quality Measurement System:** The President's plan would authorize the Secretary to develop a system for quality measurement which would replace the current requirement that managed care plans maintain a "level of commercial enrollment at least equal to public program enrollment," which is often referred to as the "50/50 rule." In the interim, the Secretary could waive the 50/50 rule for plans in rural areas and for plans with good "track records" or in other instances the Secretary deems appropriate.

PAYMENT REFORMS

Through a series of policy changes, the Administration's plan would address the flaws in Medicare's current payment methodology for managed care. Specifically, the reforms would create a minimum payment to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the minimum payment (generally $350 per member per month), would dramatically reduce geographical variations in current payment rates. (CHART 1)

The President's plan would reduce reimbursement to managed care plans by approximately $34 billion over 5 years. An assessment of the impact of the President's Medicare managed care proposals should consider the plan as a whole—both the merits of the components that have a budget impact as well as other non-budget components, some of which were discussed above. It should also be kept in mind that Medicare per capita costs, upon which managed care payments are based, have grown over the past two years by approximately 16 percent, while growth in payments to plans on the commercial side have been virtually flat.

Proposals With A Budget Impact

- **IME/GME/DSH CARVE-OUT (Five-year saving—$10 billion):** Payments for indirect medical education (IME), graduate medical education (GME), and disproportionate share payments (DSH) would be carved out of the blended payment rates over a two-year period (50 percent in 1998; 100 percent thereafter) and provided directly to teaching and disproportionate share hospitals for managed care enrollees and to entities with recognized teaching programs. The

carve-out of these payments does not represent a reduction in payment for managed care enrollees because these funds would be provided to teaching and disproportionate hospitals directly by HCFA for such enrollees.

- Managed care plans can consider these funds available to such hospitals when they negotiate their rates.
- A current law provision that requires non-contracting hospitals to accept the Medicare diagnosis-related groups (DRGs) amount as payment in full would be modified to require non-contracting hospitals to accept the DRG amount, minus the carve-out, as payment in full.

- **INDIRECT IMPACT OF FEE-FOR-SERVICE PROPOSALS (Five-year saving—$18 billion):** The budget proposes an update mechanism tied to overall Medicare growth. Therefore, policies that would affect fee-for-service providers would also restrain the growth of managed care payments.
- **FAVORABLE SELECTION ADJUSTMENT (Five-year savings—$6 billion):** Beginning in 2000, an adjustment would be made to payment rates to reduce Medicare's current overpayment, which results from managed care enrollees being, on average, healthier than beneficiaries who remain in fee-for-service. Research studies support basing payments on 90 percent of the AAPCC rather than 95 percent, to take into account this phenomenon referred to as "favorable selection." This adjustment would remain in place until a new health status adjusted payment methodology is implemented.
  - Some have argued that the extent of favorable selection documented by Mathematica Policy Research (MPR) in 1993 no longer exists. This perspective, however, is not supported by a recent HCFA study (HCFA Review, Summer 1996), which would justify payment at 87.6 percent of the AAPCC, or about 83 percent if we continue to pay managed care plans five percentage points less than fee-for-service.
  - In the last three years, the Medicare program has lost, at a minimum, $2.2 billion because of favorable selection into managed care plans, and over $1 billion in the last year alone.
  - HCFA is developing a new payment methodology that incorporates health status adjusters and that moves away from the current policy of ignoring differences in utilization between managed care and fee-for-service in making payment to managed care plans. A proposal could be ready for Congressional action as early as 1999, with phase-in beginning as early as 2001. Payment at the 90 percent level would be consistent with payment levels anticipated under this new payment methodology.
  - Competitive Pricing Demonstration—This demonstration will test a new market-based payment methodology as a possible alternative to the AAPCC method, in addition to offering new education and information resources to local beneficiaries. The Denver site will start in 1997, to be followed by two additional sites.

Proposals Without A Budget Impact

- **BLENDED RATE METHODOLOGY**—The budget would dramatically reduce the current wide geographic variation in payment rates to managed care plans by breaking the link between plan payments and local fee-for-service experience. The blended payment rates, minimum payment and minimum increase would be implemented on a budget-neutral basis.
  - **Impact on Relatively Low Payment Areas**—Managed care plans, now in relatively low payment counties, would benefit from the proposed blended payment rate. By 2002, 30 percent of their payment rate would be based on a higher national rate. In each year between 1998 and 2002, many of these plans would receive a "double update," with rates increasing due to both the national update and the transition to the 70/30 blend.
  - **Impact of Minimum Payment Amounts**—The President's plan would create, for the first time, a minimum payment amount which would significantly increase rates in isolated rural counties and could increase the number of managed care plans serving rural and other low payment areas, especially with the entry of Provider Sponsored Organizations (PSOs) into the Medicare program.

We have a few illustrations of the effects of our managed care payment reforms on rates in counties with various characteristics. As you can see, the impact on a particular county depends both on current teaching costs and on whether the county is currently receiving a relatively low or high payment. (CHART 2) The methodology would ensure that no county would receive a decrease during the 5 year budget window except in the year 2000. In 2000, almost two-thirds of counties (64%) would re-

ceive increases; the other counties would receive either no increase or a decrease no greater than 3.37%.

The net effect of the President's payment proposals is a balanced approach that achieves savings and significantly reduces current wide geographic variation, while continuing the trend of increased enrollment in managed care. Our actuaries project that the combined effect of the managed care reforms, both the proposals with a budget impact and those without budget impact described earlier, would result in increases in managed care enrollment compared with present law. By fiscal year 2002, under the President's plan, 22.5 % of Medicare beneficiaries would be enrolled in managed care plans, compared to 19.3% under current law. (CHART 3)

CONCLUSION

We are aware that there is still much work to do in the area of quality improvement of managed care. As the managed care market further expands and evolves, we expect to reap the benefits of innovative payment, administrative and patient care strategies. Some of these have already been applied to our Medicare modernization efforts and will contribute to Medicare savings. We would like to expand the choices available to beneficiaries; enhance consumer protections; provide comparative information to assist beneficiaries in making health care choices; and reform the payment methodology to plans. These goals are shared by all with a commitment to consumer protection and there is certainly a consensus that quality and availability of health care is our number one priority. In cooperation with Congress, the health care industry, and the research community, we will reach our goals—to extend the solvency of Medicare, and guarantee its existence for future generations of Americans. I look forward to working with you to accomplish these goals.

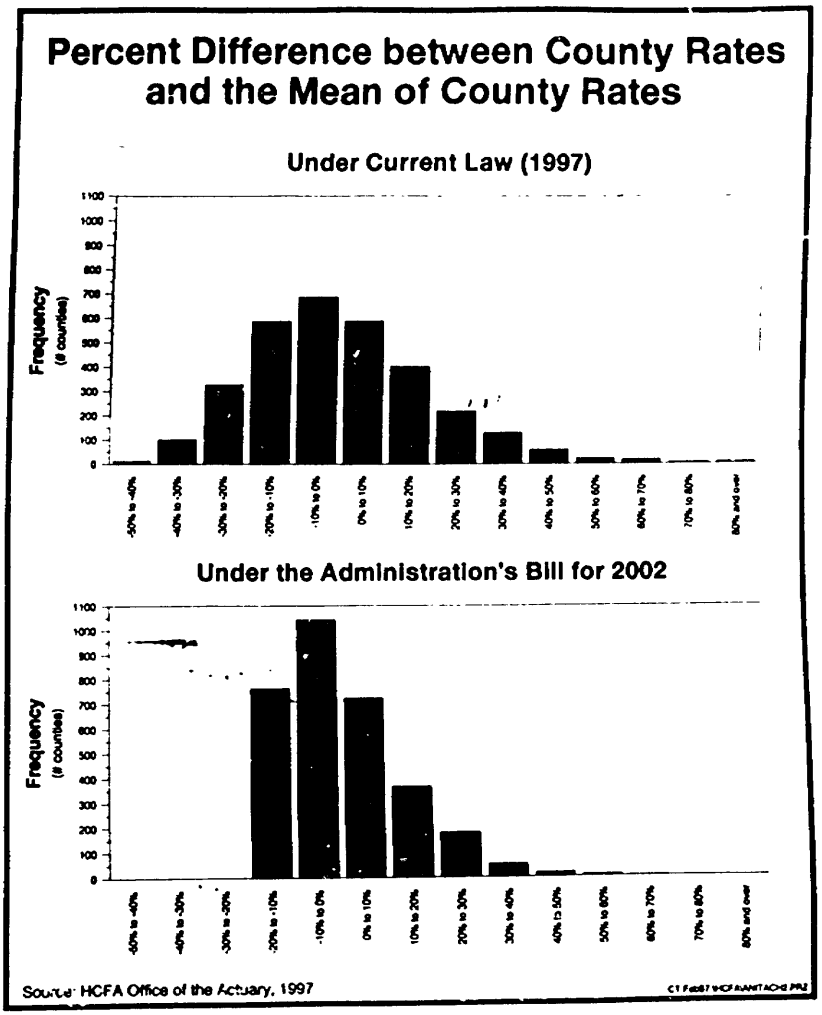

Percent Difference between County Rates and the Mean of County Rates
Under Current Law (1997)
Frequency (# counties)
Under the Administration's Bill for 2002
Frequency (# counties)
Source: HCFA Office of the Actuary, 1997

Chart 1

Managed Care Payment Rates Under the President's Proposal

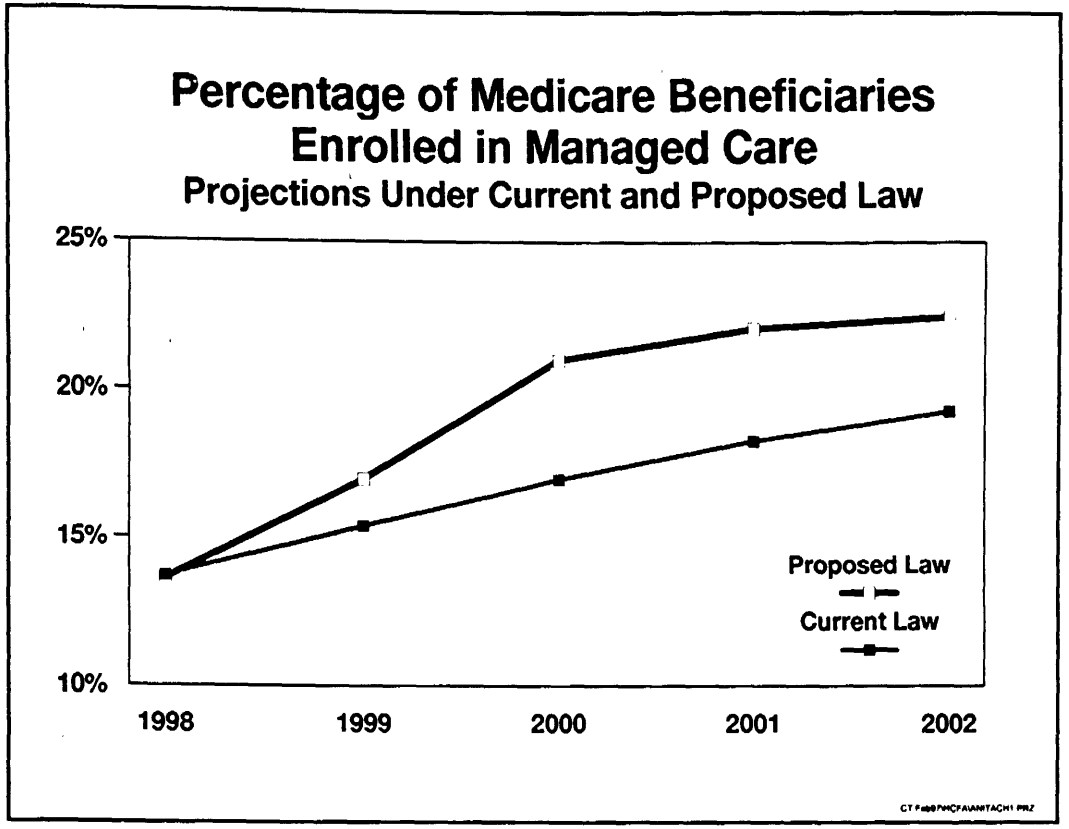
Examples

YEAR (BLEND)	Adams, NE (MedEd/DSH: 1.1%) Medicare pop 5K		Clackamas, OR (MedEd/DSH 5.8%) Medicare pop 33K		Lorain, OH (MedEd/DSH 3.2%) Medicare pop 32K		Hillsborough, FL (MedEd/DSH 5.6%) Medicare pop 86K		Orange, CA (MedEd/DSH: 6.0%) Medicare pop 242K		Bronx, NY (MedEd/DSH: 25.6%) Medicare pop 123K	
	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change
1997	$260.46	n/a	$375.32	n/a	$485.65	n/a	$486.70	n/a	$572.69	n/a	$728.24	n/a
1998 (90/10)	$350.00	+34.4%	$387.37	+3.2%	$489.11	+0.7%	$490.42	+0.8%	$572.98	+0.1%	$728.24	0.0%
1999 (85/15)	$367.55	+5.0%	$398.61	+2.9%	$499.50	+2.1%	$496.40	+1.2%	$578.54	+1.0%	$728.24	0.0%
2000 (80/20) *Favorable selection adjustment*	$365.42	-0.6%	$409.93	+2.8%	$504.19	+0.9%	$501.40	+1.0%	$584.18	+1.0%	$703.71	-3.4%
2001 (75/25)	$388.70	+6.4%	$445.36	+8.7%	$537.79	+6.7%	$534.95	+6.7%	$623.14	+6.7%	$717.78	+2.0%
2002 (70/30)	$414.66	+6.7%	$483.78	+8.6%	$573.67	+6.7%	$571.22	+6.8%	$665.03	+6.7%	$732.14	+2.0%
Percent change 1997–2002	+59.2%		+28.9%		+18.1%		+17.4%		+16.1%		+0.5%	

NOTE: These rates are estimates, based on estimates of components of the rate setting methodology, such as the Medicare per capita growth rate. No county would receive a decrease in rates during the five-year budget window, except in the year 2000. In 2000, almost two-thirds of counties (64 percent) would receive increases; the other counties would receive either no increase or a decrease no greater than 3.37 percent

Source: HCFA Office of the Actuary, 1997

Chart 3


Percentage of Medicare Beneficiaries Enrolled in Managed Care
Projections Under Current and Proposed Law
25%
20%
15%
10%
1998
1999
2000
2001
2002
Proposed Law
Current Law

Materials for the Record
Hearing on Medicare Managed Care: Improving Medicare Choices
Senate Committee on Finance
March 19, 1997

From Senator Baucus

Q: **Last week, I asked you a few questions about the low managed care payment in rural areas. And I will have some additional questions on this in a few minutes. But your testimony focused on different ways to assure quality in managed care plans. I appreciate HCFA's efforts to collect information on managed care. But could you go into greater detail about the proposal to disseminate comparative information to Medicare beneficiaries? For example, if HCFA finds a problems with a managed care plan, will they let Medicare beneficiaries know? How?**

A: It is our plan to emphasize and reinforce positive plan performance in our consumer information, and to move toward a system of incentives whereby plans are encouraged to attain higher quality. Thus, an informed consumer in an active, competitive market will then make the purchasing decisions that will drive continuing increases in quality, satisfaction, and cost performance.

Some of our regional offices have developed and made available comparison of the benefits and premiums for managed care plans in their areas. We hope to have comparative information for all geographic areas available soon for distribution on the Internet Once HEDIS measures and results from our satisfaction surveys are available, we plan to add this information to the data base to further inform beneficiary decision making and to create additional incentives for improved plan performance.

We are examining the types of information that would be appropriate to provide to plan enrollees in situations where a plan is out of compliance with program requirements Such notification raises many issues, for example: should enrollees be notified of compliance issues that do not impact on the quality of care that they are receiving; is it relevant to enrollees with a given plan in a given county that their plan has compliance problems in another county if the plan's operation in their county is trouble free. Clearly, we need to strike a balance between informing beneficiaries without unnecessarily raising concerns.

Q: **I appreciate the Administration's efforts to address the wide variation in the managed care payment between urban and rural areas. Unfortunately, setting a payment floor at $350 is not enough to attract managed care to my neck of the woods. Montana's payments is already $350 now. And the blended rate proposed by the Administration helps, but does not make enough of a difference. Are there other ways Congress can increase the AAPCC in rural areas?**

A: Our projections indicate that in 1998 about 20 Montana counties would receive the minimum payment of $350. About 15 of those would remain on the minimum payment

amount for the full period for which we have done projections, 1998-2002. The rest of Montana's 56 counties would benefit from the proposal to blend local and national rates.

In order to provide higher rates to rural areas, Congress could legislate blended rates that rely more on national experience than would a 70/30 blend, or it could provide a higher minimum payment. Either approach would reduce the rate of increase provided to plans in other parts of the country. Alternatively, the Congress increase payments to rural areas in a manner that would not be budget neutral.

Currently the difference between the highest and the lowest county rates is about 250%. Under the Administration's proposal, this difference is reduced to about 100%. We would suggest that the Congress enact the Administration's proposal, which would substantially reduce geographic variation. After we have experience with these changes, we can address whether an additional reduction in geographic variation is warranted.

Q: **I understand that the Administration is cutting managed care payments because they believe the healthier people are choosing HMOs. But that isn't happening in Montana. We only have one Medicare managed care plan in Montana, and it is very new. Would exempting low payment areas from this reduction help attract managed care to rural areas? Do you have any data suggesting that favorable selection occurs in rural areas?**

A: The Administration's proposals are designed to meet several goals, including (1) reducing current significant variation in county rates and (2) increasing rates in areas whose rates are among the lowest, which tend to be rural areas, relative to payments in the areas whose rates are higher. The relatively higher payments for rural areas combined with the option for hospitals and physicians to create provider-sponsored organizations (PSOs) should facilitate the increased availability of managed care in rural areas.

While we are not aware of any studies that examine favorable selection in rural areas, in general studies of new enrollees indicate that they are on average healthier than other Medicare beneficiaries. The 1997 annual report of the Physician Payment Review Commission states, on page 93, that:

> A wide variety of studies have demonstrated that Medicare managed-care enrollees have low costs before they join a managed-care plan Last year, the Commission found that, for the six months prior to enrollment, new enrollees' costs were 63 percent of those of a fee-for-service comparison group (PPRC 1996) That estimate was roughly comparable to many earlier estimates.

Because we have no evidence that rural areas are different from the Medicare population as a whole with respect to the experience of new enrollees, we did not propose a rural exception to the favorable selection adjustment included in the President's budget.

Q: ProPAC has released a chart suggesting that if you adjust rural and urban payments based on the hospital wage index, the payments are much more equitable. However, the chart fails to take into account low utilization in rural areas, especially the lack of high-cost specialty care. Nor does it take into account non-health related costs such a housing and air travel. What are your thoughts on this? Is this the best way to measure maldistribution? Does HCFA believe this is accurate?

A: While there are various ways to look at the wide geographic differences in Medicare payments to managed care plans, there is also a relatively broad consensus that the current degree of variation is unjustified. The Administration proposes to reduce this variation by a combination of changes to the current methodology. In brief, payments in areas with lower rates would be increased relative to those in areas with higher rates Areas on the lower end of the scale would receive a minimum payment amount of $350 in 1998 or else would benefit from the proposal to blend national and local rates In contrast, counties on the higher end of the scale would not receive increases in 1998 and 1999 and their increases through 2002 would be limited to 2 percent These proposals reduce the degree of variation, from its current level of about 250 percent to roughly 100 percent

From Chairman Roth

Q: Dr. Vladeck, last year the Administration proposed, as part of the annual coordinated enrollment process, to actually have HCFA enroll individuals in managed care plans or Medigap plans? Is this still part of your proposal? You indicate in your testimony that the provision of coordinated information to Medicare beneficiaries is to be funded by an assessment on the health plans that participate. Is this current? How much do you estimate the assessment will be? Will all health plans selling Medicare managed care plans or Medigap insurance be required to participate in this information activity?

A: Under the Administration's FY 1998 budget proposal, Medicare beneficiaries would enroll in managed care plans through a third party designated by the Secretary. Plans with good compliance records would also be able to enroll beneficiaries Our proposal however would not affect enrollment in Medigap options Under the budget proposal, HCFA would develop and distribute standardized comparative materials about Medicare managed care and Medigap options to enable individuals to compare benefits, costs, and quality indicators Each Medicare managed care and Medigap plan would contribute its pro rata share (which has yet to be determined) of the estimated costs of both the enrollment and information activities

Q: I understand that the Administration has proposed to standardize the extra benefits provided by Medicare HMOs. Would this include all extra benefits provided by HMOs, including such things as exercise or educational programs? Would this standardization also apply to employer provided retiree health plans that contract with Medicare HMOs? Are you at all concerned about how this might stifle innovations in benefits design?

A: Currently, Medigap benefits are standardized. The Administration's proposal would create standardized benefit packages for managed care plans, as well as a review of the current standardized Medigap packages. Both of these activities would include consultation with the National Association of Insurance Commissioners (NAIC), consumer groups, managed care plans, providers of health care, and insurers.

In regard to managed care plans, any service included in a standardized benefit package could be offered only in a manner provided for in a standardized package. Any service not included in the standardized packages could still be provided in a manner determined by the plan. This standardization of key benefits would apply to all enrollees, including enrollees for whom a former employer makes a contribution. We believe that this approach will make it feasible for beneficiaries to compare their choices while still allowing for plan innovation in regard to benefits that have not been standardized.

Q: (Roth) The Administration proposed to allow PSOs as a new managed care option for Medicare beneficiaries. Isn't it true that PSOs are already available as an option under the risk-contracting program as long as they have a state license? What exactly is the Administration proposing for PSOs?

A: It is true that PSOs could contract with Medicare today as long as they are state licensed and meet the other standards applied to managed care plans that contract with Medicare, including fiscal solvency standards applied by states as part of their licensure requirements. However, the Administration believes that, in view of the fact that PSOs provide services directly through affiliated providers, they merit special consideration regarding the solvency standards they are required to meet. The Administration's bill provides that Federal solvency standards be established for PSOs and that there be a process for Federal certification that PSOs meet these standards until such time as a state adopts the Federal standards for PSO solvency. In addition, states would be able to impose more stringent standards on PSOs, beginning January 1, 2000.

Q: I understand that in your Medicare Choices demonstration project there were nine provider-sponsored organizations that were included among the 25 finalists. Why did only one PSO, the Florida Hospital Healthcare System who we will hear from tomorrow, end up participating?

A: Our solicitation for the Medicare Choices demonstration indicated that we were interested in including PSOs in the demonstration. At this time, we have made final demonstration awards to four PSOs: Florida Hospital Healthcare System, Crozer-Keystone Health System, Memorial Sisters of Charity Health Network, and Mt. Carmel Health System. In addition, we are working with several other organizations, including several PSOs, that continue to want to participate in the Choices demonstration. We anticipate the participation of at least 6 and up to 11 PSOs in the Choices demonstration.

Q: Dr. Vladeck, I understand that currently HCFA, in making a determination on a risk contracting organization's financial adequacy, relies heavily on the fact that these organizations must have state licenses. If PSOs are not required to have a state license, won't HCFA have to significantly beef-up its capacity to regulate in this area?

A: Under the Administration's proposal, Federal involvement in the review of solvency for PSOs is transitional. After a state adopts Federal standards, that state is responsible for determining whether the PSO meets solvency standards. We anticipate that states will adopt the Federal standards relatively quickly.

Q: The Administration proposes to add a preferred-provider organization, or PPO, option to Medicare. Could you describe this option for us?

A: Under the Administration's proposal, a PPO would be required to provide all Medicare-covered services (except hospice services) through its providers. In addition, it would be required to pay for any Medicare-covered service if the enrollee seeks that service from a non-PPO provider (that otherwise meets Medicare requirements for payment). In this circumstance, the beneficiary's liability could not exceed that under traditional fee-for-service Medicare.

Q: I understand the Administration proposed to retain the "50/50" rule until an adequate quality measurement system is in place. How long do you think it would take to put such a system in place? In the meantime, how would the "50/50" rule be applied to PSOs that do not have commercial enrollees because they do not have state licenses?

A: The 50/50 rule is considered by many to be a "proxy for quality". For this reason, the Administration has proposed retaining it, with modifications discussed below, until a final rule implementing a quality measurement system is in place. Based on our work to date in developing a quality measurement system, we believe that we will have the necessary quality measurement systems available within the next year, and therefore the Administration's bill specifies that a notice of proposed rulemaking will be published by July 1, 1998. In the interim, the President has proposed to exclude Medicaid enrollees from the 50/50 calculation. In addition, the President's proposal would give the Secretary additional authority to waive the rule for plans serving rural areas, for plans with good track records and in other circumstances the Secretary deems appropriate.

With respect to how the 50/50 rule would be applied to PSOs, the President's plan would allow PSOs to meet the rule by counting as commercial enrollees individuals for whom the PSO providers were at substantial financial risk. For example, if the physician group of a PSO had received capitated payments from an HMO for a number of the HMO's enrollees, those individuals would count toward meeting the 50/50 requirement.

Q: What effect do you think the Administration's proposals for guaranteed issue and community rating will have on the cost of Medigap premiums?

A: The Administration looks to the States' experience in this regard. None of the states that currently go beyond the Federal guidelines for rating and open enrollment practices have retreated from their policy. Nine states go beyond the Federal requirement and restrict Medigap rating practices: six states mandate community rating of all Medigap plans, and the remaining three states ban attained age rating. Eleven states go beyond the Federal requirements regarding open enrollment periods for Medicare beneficiaries: two states mandate an annual open enrollment period, three states require continuous open enrollment of Medigap plans, and the remaining six states extend an open enrollment period to disabled and ESRD beneficiaries after they enroll in Medicare Part B.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

(SUBMITTED BY SHELDON L. GOLDBERG)

INTRODUCTION

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit written testimony on Medicare Provider Sponsored Organizations to the U.S. Senate Committee on Finance.

AAHSA is a national nonprofit organization representing over 5,000 not-for-profit providers of health care, housing, long-term care, and community services to more than 600,000 individuals daily. More than half of AAHSA's membership is affiliated with religious organizations, while the remaining members are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. Our members include not only nursing facilities, but also affordable elderly housing, continuing care retirement communities (CCRCs), and providers of assisted living, home health care, adult day care, respite care, meals on wheels and other services. Each of our members has long-standing relationships with the communities in which they operate; some even predate the Constitution.

For the past thirty-six years, the Association has been an advocate for the elderly and has striven in the public policy arena to create a long-term care delivery system that assures the provision of quality care to every individual our members serve in a manner and environment that enhances his or her quality of life. The Association's vision is of a world in which every community offers an integrated and coordinated continuum of high quality, affordable and innovative health care, housing and home and community-based services. We believe that such a continuum must include not only acute care but the whole spectrum of care and services, especially for those with chronic care needs. If our society can create such a system, it will be less confusing to the consumer and more cost-efficient than the current fragmented one we now see. Long-term care must play a central role in the development of the integrated future, and the provisions of S.146 are but one component.

THE ROLE OF LONG-TERM CARE

As an Association whose members have a long-standing commitment to delivering care to some of our nation's most vulnerable citizens, we believe that any discussion of Provider Service Networks (PSNs) or Provider Sponsored Organizations (PSOs) for the Medicare population must recognize the importance of integrating acute and long-term care services. Currently, there is little consensus about what constitutes "integration" in the delivery system. One view conceives of integration as improving the transfers and referrals between acute and long-term care services. An alternate conceives of integration as dramatically changing how acute and long-term care services are provided, with multidisciplinary geriatric teams at the center of the care process. The nation's changing demographics and growing needs of our chronically ill population support the latter view. The complex needs of the chronically ill require not only traditional primary and acute care services generally covered by managed care plans, but also institutional and community-based long-term care services. Currently, Medicare is the primary funding source for primary and acute care services, whereas Medicaid covers the majority of long-term care services.

At the time of enactment 30 years ago, Medicare was patterned on the health insurance models then widely used by private employers and insurers for the under age 65 population. The primary function was simply to pay the bills. Today, Medicare remains essentially a bill paying insurance program somewhat disconnected from the evolving role of the government as purchaser in the health care market-

place, the Medicare beneficiaries' growing need for long- term chronic care and consumer preferences concerning both location for and types of care and services. Managed care is rapidly gaining acceptance as an appropriate vehicle for serving the elderly and persons with disabilities. The need to restructure Medicare becomes compelling in light of the demographic and financial challenges in the next millennium.

THE ELDER EXPLOSION

The aging of the baby boom will mean an explosion in the number of elders. The Medicare populations has been growing steadily at about 2 percent per year for the last decade. This growth will accelerate in the next several decades, with forecasts of the proportion of the U.S. population 65 years of age and older increasing from about 12 percent of the population in 1990 to 20 percent in 2030; during the same period the proportion of people 85 years of age and over is expected to double, from 1.2 percent to 2.4 percent.

These demographic changes promise to generate an unprecedented increase in the demand for long-term care. Despite the recent good news by researchers at Duke University ("Chronic Disability Trends in Elderly United States Populations: 1982-1994") that the aging population is experiencing a decline in disability, the increased numbers of old- and chronically ill persons necessitate a system with the capacity to serve the full continuum of needs. More elders will be aging in place in their homes or congregate housing settings, which will increase the need for home and community based services as well. The vision of an integrated delivery system is both a necessary antidote to the growing problems in the nation's health care system and a means for long-term care providers to ensure that "health" services to the chronically ill are not over medicalized, emphasize both quality of care and quality of life, and are provided in the most cost effective manner.

THE CHRONICALLY ILL

People with chronic diseases and disabilities represent the highest cost and fastest-growing service group in health care. The term "chronic care" often is used interchangeably with "long-term care" in reference to nursing homes and home care agencies. AAHSA believes that chronic care is a broader concept, encompassing a spectrum of integrated services—medical, personal, social and rehabilitative care, taking place in hospitals, nursing homes, other facilities, and in the home that assist people with chronic health conditions in living fuller lives. See the recent Robert Wood Johnson Report, *Chronic Care in America: A 21st Century Challenge,* 1996 (hereinafter, "RWJ").

Despite the recent growth of managed care and capitation under Medicare and Medicaid, few initiatives have addressed the needs of the chronically ill or functionally disabled beneficiaries who account for a substantial share of the spending. A relatively small portion of the Medicare population consumes a significant share of total program spending. Ten percent of Medicare beneficiaries account for 70% of program expenditures. A handful of efforts, many operated under federal demonstration waivers by members of this Association, have attempted to develop capitated managed care arrangements to serve the frail elderly and the disabled. These experiments have tested the theory that the integration of acute and long-term care services in a single managed care program could improve coordination of services and reduce costs. Examples include HCFA's demonstrations such as the Social Health Maintenance Organizations (S/HMOs) and the Program for All Inclusive Care for the Elderly (PACE). AAHSA supports the shift of the PACE demonstration sites into full provider status because the model has proven to be a cost-effective way to provide integrated care to frail elders. At the same time, states are currently exploring ways to incorporate long-term care into their Medicaid managed care programs.

The RWJ report identified individuals with two or more chronic illnesses as 5.7 times more expensive than individuals with only an acute condition. These higher per capita costs make chronically ill individuals especially vulnerable in a managed care environment. In addition, the chronically ill use a different configuration of services than the acutely ill, underscoring the need for appropriate care management for this population.

PSO DEFINITION

The Provider Sponsored Organization option as introduced in S. 146 would allow federally qualified PSOs to contract directly with Medicare and other payers to assume risk. PSOs would be groups of providers that are "affiliated," a bond much closer than many current relationships between health care providers. Affiliation re-

lationships require greater integration of provider interests and activities, theoretically leading to better coordination of care among providers and greater efficiency than may be afforded through contractual relationships with HMOs or other "at risk" payers. PSOs would be predominantly care delivery organizations with more dollars going directly to patient care. There are many communities, especially in rural areas, where there are no Medicare managed care plans. In these areas PSOs are especially attractive vehicles for serving community needs.

The movement to wider consumer choice in Medicare, including PSOs, is likely to have a profound impact on the way long-term care services are financed and delivered. Despite the existing demonstration projects, Medicare managed care plans have had little experience with the severely impaired elderly beneficiaries, a group that is likely to grow. Looking well into the future, we believe that integrated, high quality care demands meaningful participation by AAHSA members. They will be providing care and services financed by systems that coordinate care across time, place and provider. These systems will emphasize prevention, risk-sharing and appropriate utilization of services based on consumer and community demand for high quality health and well-being at lower overall cost. We see the beginnings of these systems now, as evidenced by the growth of managed care and Medicare beneficiaries' growing participation in HMOs. There is a greater use of cost-effective, post-acute services and fewer days spent in expensive, acute care hospitals by managed care enrollees. Managed care organizations already receive substantial cost savings from the use of subacute care services without a three day prior hospital stay and from the substitution of post-acute care for unnecessary hospital days. Unfortunately, the Medicare program currently cannot reap the same savings from these trends.

AAHSA members are united by a commitment to address the needs of the chronically ill. If Medicare were restructured to allow for a full range of primary, acute and long-term care services, acute care savings could be achieved by using more cost effective services across the continuum of care.

In particular, PSOs represent an opportunity for our members to demonstrate their expertise in managing a primarily elderly, chronically ill population and to reaffirm their commitment to community. Medicare qualified PSOs must offer the full range of Medicare primary, acute and skilled nursing services, and may offer additional benefits, including vision, hearing, pharmacy and domicilliary services. Organizations that permit affiliated providers to join in a risk sharing network should provide as many opportunities as possible for diverse participation by long-term care providers. Otherwise, PSOs could serve only to further entrench an acute care/disease treatment model of care, rather than spurring the transition to a preventive/chronic care model better suited to the changing needs of the nation and its elderly. To enhance their responsiveness to consumer demand, PSOs also should arrange to provide preventive community services such as nutrition, health screenings, home care, transportation, etc.

ENROLLMENT PROVISIONS

Waiver of the "50/50 rule": The current Medicare requirement is that no more than 50 percent of a health plan's members may be Medicare or Medicaid enrollees. At least half the plan's enrollees must come from the "commercial" population. We believe that the "50/50 rule" should be waived for PSOs and any other Medicare plans that meet enhanced quality standards and have demonstrated experience in delivering coordinated care. This is especially important for rural and other PSOs, by recognizing provider experience in delivering coordinated care, albeit under contract with private payers, managed care organizations or Medicaid programs. If the "50/50 rule" were maintained, otherwise qualified PSOs could not be offered to Medicare beneficiaries because most PSOs, particularly those organized by providers with experience in managing care for a Medicare-eligible, chronic care population, are unlikely to enroll commercial populations. Waiving the 50/50 rule when enhanced quality requirements are met would retain all of the current beneficiary protections, including internal grievance procedures, beneficiary appeals processes and enrollment and marketing requirements, and would more directly address quality of care and experience issues. The additional quality standards of the legislation would provide better assurance of quality than the current enrollment requirement.

Reduced Minimum Enrollment: AAHSA supports the lower minimum plan enrollment provisions of S.146. Changes are needed to reduce barriers to providing coordinated care to Medicare beneficiaries and to reflect that PSOs may be directly "enrolling" only Medicare beneficiaries. Minimums should not drop below proposed levels, however, because the absence of any floor could jeopardize a PSOs ability to spread risk and, thereby, threaten the provision of care.

SOLVENCY

Solvency standards are necessary to ensure the fiscal soundness of PSOs. S.146 sets solid, quantifiable net worth and reserve requirements. Most importantly, S.146 adjusts solvency and reserve requirements to reflect the value of capital assets and direct services provided by PSO operations. This adjustment is crucial in recognizing the health delivery assets specific to a PSO. It acknowledges that for a PSO, only a portion of the revenue is at full risk because the affiliated providers are producing their own services. The proposed PSO requirements still require demonstrated fiscal soundness, albeit through alternative net worth and reserve requirements or through reliance on a combination of factors which may include net worth and reserves (modeled on the National Association of Insurance Commissioners Model HMO Act- proposed).

QUALITY ASSURANCE / QUALITY OF CARE

S.146 would require effective ongoing quality assurance systems. The new standards address many consumer concerns about managed care. They ensure that PSOs evaluate the continuity and coordination of care and monitor possible patterns of under- as well as over-utilization.

Long-Term Care and Quality

The primary function of a PSO must be to meet consumer and community demand for the delivery of quality health services under a system that coordinates care across time, place and provider. To ensure quality of care for vulnerable populations like the chronically ill, quality of care plan standards for PSOs should require a specific plan for delivering care to the chronically ill. This would ensure that chronically ill individuals in PSOs receive appropriate and necessary services.

The quality assurance provisions included in the PSO legislative proposals are concepts already supported and embodied by long-term care providers in managing the chronically ill and assuring the adequacy and provision of needed and appropriate services to the frail and elderly.

Outcomes vs. Process

The emphasis on quality measures based on health outcomes rather than process is crucial to evaluating the provision of care and continuous quality improvement. The measure of a provider's ability to meet patients' needs must be based on actual performance rather than on the provider's potential capacity to assure adequate services. However, health outcome measures for long-term care, where individuals are frequently being treated for multiple chronic conditions, have limited prognoses for healing or "cure," and are experiencing the natural declines in status associated with aging, must remain distinct from outcome measures generally applied to patients in acute or subacute care settings.

This shift in focus from process to outcomes is one that AAHSA has strongly supported within the long-term care arena. Because of their history in managing chronic care populations and progressive efforts over the past ten years to develop and use outcomes-based measures to assess the quality of long-term care, AAHSA's members and nursing facilities more generally bring unique experience and perspective to the implementation of this type of quality assurance system.

The focus on outcomes contained in the OBRA '87 nursing facility reform provisions has proven consistent with the increased concentration on outcomes as a quality measure across provider types and health care settings. In the rising tide of managed care, purchasers, payers and consumers increasingly want to know what they are getting for their dollars. For long-term care facilities, at least, this standard has been codified in the OBRA mandate that each resident must attain or maintain the highest practicable degree of physical, mental and psychosocial well-being.

In addition, no other provider type must serve as many masters as nursing facilities (SNFs and NFs). No other health care provider, including hospitals, physicians and home health agencies, is subject to the volume of regulation and oversight by such a plethora of federal and state agencies. Currently, nursing facilities must comply with regulations promulgated by the Health Care Financing Administration (HCFA), the Food and Drug Administration (FDA), the Occupational Safety and Health Administration (OSHA), the Department of Justice (DOJ), the Environmental Protection Agency (EPA), the Department of Labor (DOL), the Office of Civil Rights (OCR), the Federal Communication Commission (FCC), and State Survey and Certification and Medicaid agencies. Nursing facilities are challenged daily to strike the balance that will allow them to achieve and maintain compliance with the requirements issued by these varied regulatory authorities, while simulta-

neously ensuring optimal well-being for residents ranging in extremes across age, acuity level, physical independence, and cognitive ability.

AAHSA supports the Congressional intent conveyed through these proposed requirements—that is, to promote state-of-the-art continuous quality improvement and to ensure that consumers of health care services have useful quality information for comparison and choice. We agree that providers must take action to improve quality, evaluate the effectiveness of their programs, and be publicly accountable for those results. Any standards promulgated to achieve this goal, however, must recognize the substantial advances already made by nursing facilities and must hold all provider types to both substantially similar outcomes and measures of those outcomes for substantially similar population-based needs.

UTILIZATION REVIEW (UR)

The PSO legislative proposal requires that, if a PSO uses case-by-case utilization review, it must base review on current medical practice standards, coordinate review with the quality assurance program, and transition to focusing on patterns of care. The utilization review provision reflects the commitment to move away from UR processes that overly intrude into the doctor-patient relationship by involving its local physicians in reviewing patterns of care.

Long-term care facilities are already moving in this direction. UR ceased to be a requirement, but remained optional, for Medicare/Medicaid SNFs/NFs effective October 1, 1990. The repeal was based on the premise that the OBRA-mandated Resident Assessment Instrument Minimum Data Set (RAI/MDS) would replace and enhance the UR function. AAHSA supports enhanced UR standards provided that they recognize the advances that long-term care providers already have made, and assure the use of geriatric and gerontologic best practices, not merely extension of concepts created by evaluation of younger and healthier populations.

Outcome measures for long term-care must be established and defined in the context of the populations being served. In recent years, large employers have imposed standards beyond state licensure minimums, including demands that HMOs be privately accredited by independent entities, such as the National Committee on Quality Assurance (NCQA). Accreditation standards are often similar to licensure requirements, but may exceed the licensing standards established by states. Requiring PSOs to outline and implement specific procedures and mechanisms to ensure quality care compels better monitoring of utilization and quality. Once again, however, any accreditation or certification programs approved by the federal government for PSOs or other Medicare risk contractors must reflect the outcome goals and measures upon which a truly integrated and effective care delivery system should be based.

DUALLY ELIGIBLE POPULATIONS

S.146 provides for at least 10 state demonstrations that will allow a State's Medicaid program to become an eligible organization (i.e., a Medicare- qualified PSO) to provide for the delivery of primary, acute, and LTC through an integrated delivery network that emphasizes non-institutional care. The term "dually eligible" refers to the group of Medicare beneficiaries who also qualify for Medicaid benefits. Approximately 13% of Medicare beneficiaries, nearly 6 million Americans age 65 or older, receive some assistance from Medicaid.

AAHSA strongly supports this demonstration provision because it permits integration of the Medicare and Medicaid funding streams for the dually eligible population and presumably would permit the rationalization of conflicting requirements of the two programs. It enlarges the role of LTC providers from the relatively narrow Medicare benefit, broadens the range of services that could be included and enhances the opportunity to integrate care. Unfortunately, the demonstrations would place the state Medicaid program in the role of the PSO and would not permit the providers to form the PSO directly. Absent oversight, there is a legitimate concern that state governments could, as an effective monopolist, improperly exercise market power to underpay providers for needed care and services. Such an outcome clearly threatens the quality of care provided to beneficiaries of both programs, particularly those with chronic conditions that require more coordinated case management.

Nevertheless, these demonstrations could identify methods for integrating medical and institutional care with a broad range of home and community based services. They also would highlight administrative requirements in both Medicare and Medicaid that would need revision if such integration is to be streamlined. Assuming adequate research design, evaluation and oversight, cost savings from such integration also might be identified. The demonstration provision for the dually eligible popu-

lation will enhance the development of integrated care, particularly for the chronically ill.

MEDICAID HMOS

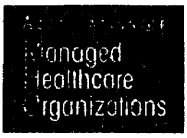
S.146 broadens the Medicaid definition of HMOs so that states may include PSOs in the Medicaid program. Opening Medicaid markets to PSOs is critical for LTC providers because Medicare pays for a very limited share of LTC services compared to the Medicaid program. For example, NFs receive approximately 5% of their revenue from Medicare and over half from Medicaid. Also, a higher proportion of Medicaid enrollees are in managed care than are Medicare beneficiaries, though not necessarily by choice, and they might be more receptive to this new form of managed care. Although, State Medicaid programs to date have targeted primarily the AFDC population, not the elderly, for managed care, several are exploring PSO-concepts for long-term care/managed care waivers.

AAHSA is concerned, however, because the Medicare and Medicaid programs have differing requirements and regulations concerning participating MCOs. These differences affect enrollment, quality improvement and administration, among other issues. These differences may mean that a dually eligible individual who belongs to a Medicaid HMO may not be able to use the same HMO for his or her Medicare benefits and may have to join another HMO if the managed care option is preferable under Medicare. There are other structural differences between the two programs that would not be eliminated merely by this definitional change for Medicaid and have other potentially adverse implications for truly integrated and coordinated care. Although states may circumvent certain federal Medicaid requirements through waivers that could benefit PSOs trying to operate in both programs, a waiver approach ultimately may prove too cumbersome for successful integration.

By permitting Medicaid contracting with Medicare PSOs, the legislation opens PSOs to both another funding stream and a new source of patients. It also creates a new provider category without the conflicting regulations that hinder other managed care organizations that try to participate in both Medicare and Medicaid. Particularly in this context, long-term care providers offer a wealth of experience and expertise in managing a dually eligible population.

CONCLUSION

AAHSA is committed to affording provider organizations, including PSOs, the opportunity to contract directly with the Medicare Program and other purchasers of health care and services. AAHSA strongly believes that such opportunities must extend to appropriately qualified groups of long-term care providers because they have the experience and ability to manage a predominantly aging chronic care population, precisely the group that does and increasingly will cost the most to serve. For the elderly, the advent of provider sponsored organizations will bring a less confusing system of care and services. PSOs comprised of not-for-profit providers of long-term care would bring stability and connections to the community based on their long-term commitments to providing care and services throughout the nation's history. In expanding choices for Medicare beneficiaries, AAHSA urges Congress to ensure that PSOs include not-for-profit long-term care providers in order to develop an effective and integrated delivery system for the special needs of vulnerable populations. To do less would ill serve the twin goals of enchanced quality and controlled costs.



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March 21, 1997

The Honorable William V. Roth, Jr.
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr Chairman

The Association of Managed Healthcare Organizations believes its members have a key role to play in improving choices in the Medicare program, the subject of the Finance Committee's March 19 and 20 hearings Accordingly, we ask that this letter be included in the formal hearing record

Challenged by looming insolvency and a growing beneficiary population, Medicare must look to the private sector's example of cost containment through managed care. While enrollment in Medicare HMOs is increasing, the bulk of the beneficiary population remains in the fee-for-service component of the program Meanwhile, the potential of the predominant form of private-sector managed care, the PPO, remains untapped

PPOs have gained wide acceptance among both patients and physicians, as attested by the 117 1 million Americans eligible to participate in PPOs through their employer-based or individual health coverage and the average 7300 doctors per network. This popularity is due in large measure to a flexibility not found in existing Medicare risk contracts. Beneficiaries participating in a PPO retain the freedom to choose their own doctors They are given financial incentives to seek care within the PPO network, but are not prohibited from -- or expected to bear the full cost of -- seeing a non-participating doctor. PPOs have the capacity to absorb large numbers of Medicare beneficiaries Because both their provider networks and their geographic areas typically are larger than HMOs', PPOs can more readily absorb rapid enrollment

PPOs can bring to Medicare the same management expertise and patient-friendly attitude that have made them a success in the private sector. For optimum effectiveness, however, PPOs should not be forced into a regulatory framework that changes their very character. While some PPOs will be able and willing to seek licensure as full risk contractors, Medicare would be best served by a range of risk options. S. 146, sponsored by Senators Frist and Rockefeller, would permit the Secretary of HHS to enter into partial-risk contracts. AMHO supports this concept, and advocates one further step as well: allow PPOs to take the lead in creating *managed fee-for-service*. In this environment, HCFA would retain the insurance risk (much as a self-insured

employer does), delegating administration and utilization/quality management to a contracted PPO. PPOs would demonstrate their compliance with quality and consumer-protection standards, and might negotiate with HCFA a means to condition a portion of their administrative fee on the attainment of savings or other performance targets.

Within the fee-for-service portion of Medicare, a PPO option would offer beneficiaries a way to access the benefits of managed care (credentialed providers, a quality management program, perhaps additional coverages, such as a wellness program) without feeling locked into a limited choice of providers.

AMHO has made or will make arrangements to discuss this range of risk options in greater detail with your staff. Thank you for your attention to our views

Sincerely,

Gordon B. Wheeler
President and Chief Operating Officer

cc: The Honorable William Frist
Julia James
Kristin Testa

HOME HEALTH SERVICES & STAFFING ASSOCIATION

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April 4, 1997

The Honorable William V. Roth
Chairman, Senate Committee on Finance
219 Senate Dirksen Office Building
Washington, D.C. 20510

Re: Statement for the Record: Hearing on Medicare Choices March 19-20, 1997

Dear Senator Roth:

The Home Health Services and Staffing Association (HHSSA) submits the following statement for the record in the above-captioned hearing. HHSSA is an association of more than 35 companies providing home health services in 46 states and the District of Columbia through 1,600 member offices to more than 750,000 patients. HHSSA includes some of the largest providers of home health care in the country, as well as some organizations that qualify as small businesses.

Our members were most interested in the hearings to the extent that they concerned legislative proposals to permit "provider-sponsored networks" (PSNs) to qualify for managed care contracts under the Medicare program. We understand that the Committee may be considering the "Provider-Sponsored Organization Act of 1997" (S.146), which was introduced by Senators Frist and Rockefeller.

HHSSA's member companies have a significant amount of experience in providing services under managed care contracts and believe that this method of health care delivery appropriately furthers the objectives of providing cost-effective, high quality health services. We are concerned, however, that the proposed legislation appears to require "more than the majority" of services to be furnished through affiliated providers. See section 4. The statement that such services would have to be furnished through the PSN's "own" affiliated providers implies that such providers would have to be under common ownership. That interpretation of the legislation would, in effect, permit only hospital-sponsored delivery systems to qualify as PSNs, because only hospital systems own the range of providers needed to furnish the covered services.

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Another provision in the bill states that an affiliated group of providers might be a lawful combination "under which each provider shares, directly or indirectly, substantial risk in connection with their operations." If the intent is to permit providers which are not under common ownership to qualify as PSNs, then the statement that PSNs "own" affiliated providers should be deleted.

We do not believe that common ownership of all providers is necessary for the efficient delivery of health care services. These services can be provided safely and effectively by providers related by contract. In fact, most managed care is furnished by providers connected to a health maintenance organization "hub" by contract. Permitting networked providers to qualify as PSNs would simply mean furnishing services by connecting the "spokes" of the health delivery wheel. Permitting networked providers to qualify as PSNs should substantially enhance competition and thereby reduce the cost and increase the quality of the care provided.

Home health companies have particular skill in coordinating and managing health care through the use of lower cost, non-institutional services. For many years, home health agencies have been required to coordinate patient care under the Medicare home health conditions of participation. See 42 C.F.R. § 484.14(g). Many health maintenance organizations are now using home health to manage health care services in a more cost-effective manner.

Accordingly, we believe that PSNs should be defined in a way which would permit groups of providers, including home health companies, to furnish services through a network of providers related by contract.

We would be glad to work with your staff and the Committee to ensure that any PSN bill enhances quality, cost-effectiveness, and access to health care.

Sincerely,

James C. Pyles

NATIONAL GOVERNORS' ASSOCIATION

NATIONAL CONFERENCE OF STATE LEGISLATURES

March 20, 1997

The Honorable William V. Roth, Jr.
Chairman, Finance Committee
United States Senate
Washington, D.C. 20510

Dear Chairman Roth:

On behalf of the National Governors' Association (NGA) and the National Conference of State Legislatures (NCSL), we are writing to express support for the positions set forth in the testimony of the National Association of Insurance Commissioners (NAIC) regarding the regulation of provider-sponsored organizations (PSOs).

The regulation of health care networks is currently and should continue to be the responsibility of the states. Based on states' experience, we believe that all insurers, regardless of sponsor, should be treated similarly. We believe there are no substantive differences between provider-sponsored health insurers and other health insuring organizations. Due to the hard work of governors, state legislators and insurance commissioners from across the country, states have established a level playing field in the private market through the imposition of standardized licensing requirements, the enforcement of comparable quality assurance and solvency standards, and the establishment and enforcement of essential consumer protections. These standards and requirements differ among the states, reflecting difference in the structure and conduct of the health care market in the fifty states.

Federal preemption of state regulatory authority in this area will adversely affect the health care delivery system by creating additional fragmentation and complexity in the market. We believe that a partnership between the states and the federal government, built on the foundation of the existing state regulatory structure, is the best way to assure Medicare recipients that they will receive the high quality health care services they desire.

In summary, we believe: (1) states should continue to regulate all health care networks; (2) provider-sponsored health insurance organizations are not substantively different from other health insuring organizations; and (3) a partnership between the states and the federal government should be established, built on the existing state regulatory structure to assure that the appropriate oversight of provider-sponsored health insurance organizations occurs. We urge you to carefully consider the testimony presented today by the NAIC and we look forward to working with you to establish a partnership to assure the appropriate oversight of provider-sponsored organizations.

Sincerely,

Raymond C. Scheppach
Executive Director
National Governors' Association

Carl Tubbesing
Deputy Executive Director
National Conference of State Legislatures

PREMIER

Statement of
James L. Scott
President, Premier Institute
Premier, Inc.
For the Senate Finance Committee
Hearing on
Medicare Choices

March 20, 1997

MR, CHAIRMAN, I am pleased to write you today on behalf of Premier, Inc., the nation's largest healthcare alliance. Premier represents more than 240 owner hospitals and hospital systems that own or operate 700 healthcare institutions and have purchasing affiliations with another 1,100. Premier owners operate hospitals, HMOs and PPOs, skilled nursing facilities, rehabilitation facilities, home health agencies, and physician practices. Through participation in Premier, healthcare leaders can access cost reduction avenues, delivery system development and enhancement strategies, technology management, decision support tools, and a variety of opportunities for networking and knowledge transfer.

I very much appreciate this opportunity to share our views and recommendations on the need to expand participation in Medicare managed care options to include provider-sponsored organizations (PSOs). As the Medicare program faces its most serious crisis since its inception over 30 years ago, we are convinced that expanding beneficiary choice of private health plan options is an essential component of any strategy to preserve and strengthen the program for the 21st century.

Today's hearing brings into focus very significant advances that are occurring in the private sector to improve the quality and affordability of care through greater reliance on organized systems of care. As employers and other purchasers of health care services have put pressure on providers and insurers to limit premium increases and overall health care costs, new models for organizing and delivering care have emerged. We have seen the first generation of managed care plans --

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group and staff model HMOs -- give way to HMOs with point-of-service options and preferred provider organizations (PPOs) promoting best clinical practices through utilization management. More recently, some employers have begun to contract directly with locally-based provider-sponsored organizations that are capable of providing a comprehensive array of health care services.

One purpose of this hearing is to learn more about how PSOs are serving patients in many communities and to consider how their advantages can be made available to the Medicare program and its beneficiaries. First, we do want to extend our appreciation to Senators Frist and Rockefeller for introducing S.146, a bill that would make qualified PSOs eligible as a Medicare coverage option. This measure carefully sets forth the terms and conditions for PSO participation in Medicare -- holding them fully accountable while recognizing their unique structure.

What are PSOs?

Very simply, a PSO is an organized system of care serving patients in a local community. Typically, PSOs are sponsored by local hospitals, physicians and other licensed providers who are affiliated with each other through common ownership or control and share financial risk. These organizations are an attractive option to consumers who want to receive their health care from a network of local providers that have a long-term commitment to their communities. With their local base, PSOs are able to focus on improving health throughout their communities while coordinating care across the continuum of services required to diagnose and treat illnesses and injuries for its enrollees.

What really distinguishes PSOs from other forms of managed care is their provider base in contrast to an insurance plan or HMO where the insurer or plan is not directly involved in the provision of care. Insurers and HMOs generally must make arrangements with facilities and practitioners in order to deliver care to their enrolled members. In contrast, PSOs are both the plan and the direct provider of care. As such they can more easily put patients first and maintain a proper balance between the need to achieve efficiencies and the obligation to ensure the highest quality and consumer protection standards.

While not all PSOs are structured in exactly the same way, they all share some common features including:

- Integration of all clinical services supported by clinical and financial information systems and by adherence to community standards of practice;
- Direct provision of a substantial portion of services by providers that share financial risk; and
- Flexibility in the design of medical management approaches that are adapted to local needs and coordinated with other community resources.

We believe PSOs can offer a patient-focused delivery system that is equally attractive to beneficiaries in urban areas with considerable managed care competition as well as in rural areas where coordinated care systems have not often been available.

PSOs and Medicare

It is widely recognized that organized systems of care have been responsible for reducing the cost of private health coverage to employers and workers. In contrast to the fragmented, episodic fee-for-service system, coordinated care systems can also improve the quality and outcomes of care. The Medicare program has moved much more slowly than the private market in making managed care options available to beneficiaries. We believe there is now an opportunity, indeed a mandate, to begin taking advantage of these private sector successes by expanding beneficiary choices to include PSOs and other integrated care systems that meet appropriate standards.

Enrollment of Medicare beneficiaries in qualified HMOs has been growing dramatically recently -- more than 25% per year -- and the Congressional Budget Office in January predicted that the percentage of beneficiaries in risk-based HMOs would nearly double -- from 11.7% to 22.9% -- over the next 5 years. However, these figures remain quite low in comparison with the private sector where fully two-thirds of workers with health coverage are in managed care plans.

One reason that Medicare lags behind the private sector with regard to managed care participation is that the program has limited private plan options to traditional HMOs and Competitive Medical Plans (CMPs.) We strongly supported provisions included in the Balanced Budget Act of 1995 that would have established federal standards and certification for PSOs in the Medicare program. However, in the final bill -- which was vetoed -- we believe the standards were too restrictive and that significant discretion was ceded to the states which would likely take very different approaches that could impede opportunities for PSOs and restrict beneficiary choices in some states.

Since that time, the Medicare program has launched a series of demonstrations designed to test the acceptability of a wider range of private plan options. As you may know, the Medicare Choices Demonstration involves 25 sites, 9 of which are PSOs. One of our owners, the Florida Hospital Healthcare System in Orlando, has already begun enrolling Medicare beneficiaries under a capitation-based risk contract with Medicare. Within its first two months of operation, the plan enrolled more than 4000 beneficiaries. Significantly, the plan was qualified directly by HCFA and was not required to obtain a state HMO license.

We are greatly encouraged by the strong interest that beneficiaries have displayed in the Orlando PSO. We know that many Premier hospitals and systems are capable of coordinating care for Medicare beneficiaries and are anxious to have this opportunity in their communities. Enactment of S.146 would make PSOs more widely available and hold them accountable to appropriate financial, quality, and patient protection standards.

S.146, The Provider-Sponsored Organization Act of 1997

The legislation introduced by Senators Frist and Rockefeller on January 21st, S.146, includes a number of specific and important changes from the proposals that were offered during the Medicare debates in the last Congress. In our view, this legislation holds PSOs to even higher standards than are currently in place for HMOs that contract with Medicare. We think it is critically important to recognize that this measure is not an effort to lower Medicare standards or put beneficiaries at risk.

S.146 sets forth the terms and conditions for PSO participation in the Medicare program. The measure builds on the requirements already in place under the current risk contractor program. A Medicare qualified PSO must have the

capability to provide the full benefit package under a capitation payment including the direct provision of substantially all the covered benefits by providers who are under common control and share substantial financial risk. Financial solvency must be demonstrated by meeting a series of specific measures based on the current NAIC model HMO act. PSOs must also meet all current Medicare quality standards plus enhanced standards related to utilization review programs and physician participation in designing quality improvement programs.

We also believe that it's important to make sure that the enforcement and oversight of PSOs are carried out in an efficient and fair manner. Historically, state regulatory systems have not kept pace with the changing delivery system models in terms of the application of their licensure statutes. Thus, PSOs and other integrated delivery systems face in many states regulatory requirements designed for traditional health insurers or HMOs that must set aside reserves against claims and must contract with the providers that actually render services. As a result, S.146 seeks to coordinate federal and state regulatory efforts by initially calling for federal certification of PSOs. After four years, state licensure would be required for PSOs in any state that adopted standards equivalent to the federal standards.

Finally, S.146 includes a number of other provisions such as limited waivers of the enrollment composition rule (the so-called 50/50 rule), authorization for partial risk payment arrangements combining capitation with cost-based payments, and a limited preemption of state laws that prohibit the operation of managed care plans. These provisions help to ensure a level playing field for PSOs and a more consistent and appropriate set of standards through which they can be held accountable.

Conclusion

MR. CHAIRMAN, we believe PSOs show great promise as an option for Medicare beneficiaries by giving them access to community-based, patient focused, coordinated care. This translates into real value for those who rely on Medicare for their health coverage. PSOs will expand the range of beneficiary choices, they will put clinical decisions back into the hands of local practicing physicians, they will meet current consumer protection and quality assurance standards, and they will reduce the burden and frustration of the traditional fee-for-service claims system.

We believe that the enthusiasm with which Medicare beneficiaries have embraced the PSOs that are participating in the Medicare Choices demonstration is indicative of the reception they will receive if they become more widely available. It's important to remember that S.146 represents a significant and much more comprehensive approach to establishing the conditions for and assuring the accountability of provider-sponsored organizations.

We urge this Committee to include this legislation in any Medicare reform legislation that may be recommended later this year. We look forward to working with you, MR. CHAIRMAN, and the other members of the Committee in moving this bill forward.

Thank you for this opportunity to present our views and recommendations on this critical opportunity to expand Medicare choices.

STATEMENT OF
USA MANAGED CARE ORGANIZATION, INC.
TO THE
SENATE FINANCE COMMITTEE
ON
IMPROVING MEDICARE CHOICES
MARCH 19, 1997

Mr. Chairman and Members of the Committee:

We at USA Managed Care Organization, Inc. (USA) are pleased to submit testimony regarding improving Medicare choices for beneficiaries. We commend you for holding these hearings and recognizing the importance of expanding opportunities for Medicare beneficiaries that go beyond the traditional fee-for-service arena. Among the various health care delivery options we believe the committee should consider are what are commonly known as preferred provider organizations, or PPOs. Today, we want to recommend Congress expand Medicare beneficiary choices by creating a national PPO option.

Background on PPOs

It is important to first define what a preferred provider organization is. A PPO is primarily a hybrid between indemnity health insurers and HMOs, which limit the number of doctors from which a member can choose. With a PPO, the patient's care is more self-directed, since the number of physicians a patient may choose from increases. In this delivery model, practitioners are reimbursed on a fee-for-service basis and agree to abide by stringent utilization controls.

Depending upon a PPO member's benefit plan, the member generally can seek treatment from any physician and be covered, but receives incentives for selecting a doctor from the PPO. In the event the member accesses a non-member physician, typically he/she will pay 80 - 90 percent of the costs involved when a patient uses a physician or hospital not covered by the PPO.

In an HMO, the physicians work under contract, generally in a limited number of provider sites, wither through a medical group or individual practice association. In a PPO, physicians generally continue to practice from their own private sites. However, the doctors, hospitals and other health care professionals who offer services to the patient-members of the PPO are subject to utilization and cost-control reviews.

The following are questions that might be asked about a PPO:

Is the PPO economically viable? Good indicators of viability are profitability, enrollment

levels and trends. A good PPO has diversified revenue sources, with a sophisticated information system able to produce meaningful reports detailing how and where the PPO is spending their health care dollars.

How comprehensive is its network? Many purchasers want a one-stop shop. A good PPO offers a comprehensive network of conveniently located general practitioners and specialists. If network doctors are not easily accessible, the purpose of the PPO is defeated. Most good PPOs currently operating have access to all types of medical facilities to place patients at the appropriate level of care. The broader the range of benefits, the greater the cost containment potential.

Does the PPO have direct contracts with providers and facilities? Many PPO's are made up of rented networks of providers and facilities. The most significant issues created by this is that of the "silent PPOs/" Silent PPOs do not identify the proper health plan covering that patient, resulting in the provider or facility being unable to determine the financial arrangement surrounding that patient's care until she/he receives reimbursement. The American Medical Association's and the American Hospital Association's opposition to these arrangements are well documented. Any PPO participating in the Medicare program should be required to maintain a minimum of 80% of their providers and facilities under contract.

Is the PPOs Accredited? Although PPOs continue to grow their businesses by increasing their covered life base, regulations guarding the health and welfare of the public have been slow to materialize. The result has been the emergence of the fore-mentioned "blind or silent" PPOs; " lack of accessibility to providers; insufficient attention to patient rights and responsibilities; inadequate scrutiny of a contracting provider's credentials; a void in terms of patient education and health promotions; a significant lack of performance improvement programs, and generally the potential for poorer quality of care being delivered. Requiring participating PPOs to seek and maintain accreditation establishes benchmarks for quality within the industry and provides patients with the assurance that the network has been reviewed by an outside and independent third party.

How are providers selected and paid? Effective PPOs have a formal selection process for each provider type which relies upon strict credentialing criteria for participation. There is a wide variety of payment procedures with PPOs, but successful ones have four basic characteristics: competitive and equitable levels of payments, strict guidelines regulating increases, flexibility to respond to different levels of purchaser sophistication and use of a reimbursement mechanism to create incentives for efficient and quality provider practice.

Capabilities of USA Managed Care Organization

We are a managed health care company located in Austin, Texas and established in 1984. Our flagship product, a preferred provider organization, has become the largest privately held preferred provider organization in the nation. We serve about 11 million people. Our clientele is represented by roughly 30 insurance companies, 100 third-party administrators

and 300 multi-state employer groups. Our client list includes such noteworthy organizations as Black & Decker Corporation, Kinko's, Lockheed/Martin Marietta, Service Merchandise and the State of Tennessee.

In addition, we are the only accredited PPO in the nation. USA earned this unique distinction from the Joint Commission on Accreditation Healthcare Organizations in May, 1996.

Our provider network consists of over 4,000 facilities and 170,000 credentialed practitioners, and all necessary ancillary services delivering health care to 47 states. We provide our patients with the greatest flexibility in choosing physicians and facilities while, at the same time, controlling the costs of the health care provided by those physicians and facilities.

A brief overview of a few of USA's auxiliary services is provided below:

1) USA markets a transplant network product called USA Transnet, developed in 1992 as a specialty network that provides managed care through Premier Elite Centers for Catastrophic Illnesses and Injuries. USA Transnet transports the patient to a Premier Elite Center for specialized tertiary care services such as organ transplantation, burn care or AIDS, and covers all solid organs and bone marrows commonly transplanted.

2) Another product within our PPO system is USA's Exclusive Provider Point-of-Service model network which is currently being marketed and developed across the country. This product calls for a USA-approved benefit plan design that specifically penalizes out-of-network admissions. Provider and facility fee arrangements are unique and highly competitive and the utilization approach is more stringent that which is utilized in a PPO. USA's EPO is currently available in the entire State of Tennessee and the greater Chicago area, including Northern Indiana. Other markets nearing completion are Atlanta, Orlando, Tampa, Houston, Dallas, San Antonio and Austin.

3) Our PPO has had considerable success with various state and local authorities throughout the nation. For instance, we have developed an outcomes measurement program for the State of Tennessee Employees Workers' Compensation Program. This program addresses patient outcomes in three dimensions: sociologic, physiologic and economic. Sociologic outcomes are defined as the satisfaction received by the employee, family and employer from the care, kindness and consideration given by the provider to the employee and the employer, and the extent to which the employees rights were met. Physiologic outcomes are defined as the best possible outcome achievable, based upon the assessment and evaluation by the provider. The physiologic outcome is also measured by the course of treatment as compared to similar types of patients, and in the opinion of the peer group reviewing the patient's current level of wellness, the status of their disability and their ability to return to work. Economic outcomes are defined as the cost for the episode of care as being

reasonable for the diagnosis and treatment. This measurement evaluates whether the tests, procedures and treatments were appropriate based upon an appropriate assessment and evaluation.

Beneficiary Option of National PPO

We firmly believe PPOs would work well as an option for Medicare beneficiaries. Specifically, we propose a PPO system that expands development of a managed care relationships with physicians and ancillary providers, as well as implementing leading edge medical management programs. This integrated delivery system would have the ability to bear risk based on a hybrid version of Medicare Select's "Plan C."

A national PPO could be a particularly attractive choice for two groups of Medicare beneficiaries. One group is those who live in rural America and beyond the range of big city-oriented HMOs. Another group is those beneficiaries who spend time in other areas of the country, such as the "snowbirds" who winter with us in the Sunbelt and people who travel extensively.

At a minimum, the Medicare Select program should be expanded to include such a beneficiary option.

As a Medicare provider, our PPO would propose a combination of capitated and risk-sharing arrangements. The plan would incorporate all the existing benefits of Plan C. Participants would be responsible for a $5 co-pay for physician visits. If an insured chooses to use a provider outside of the PPO they would be responsible for payment of the Part A deductible. The in-network provider would accept 80 percent of Medicare or our negotiated rate (whichever is less), as payment in full.

Contracted hospitals would have to accept the lesser of our contracted rates or the DRG schedule as payment in full. In addition, USA has national contracts with most of the major ancillary service providers at rates far below those allowable by Medicare. As we develop our core beneficiary census, we would begin to change some of these contractual arrangements to capitated fee basis contracts.

USA would manage care through its subsidiary, National Utilization Management Corporation (NUMC). NUMC is accredited by the Utilization Review Accreditation Commission and licensed to perform utilization review in all states requiring licensure.

NUMC's proactively evaluates all patient cases for potential case management. Early assessment and intervention improves coordinated care for seriously ill patients while saving payors substantial dollars. NUMC's medical professionals utilize pre-certification concurrent review and retrospective reviews to determine the medical appropriateness of proposed treatment. They utilize *Inter-Qual Guidelines* to determine medical necessity for outpatient, as well as inpatient procedures. NUMC's Quality Assurance Program reviews all services to

ensure they are delivered in an effective clinical, timely administrative, and economical fiscal manner. It's highly skilled nursing staff would serve as beneficiary coordinators for directing specialized care.

The development of an accountable delivery system begins with the commitment of the physicians to provide quality treatment to beneficiaries. To facilitate this objective, USA has developed peer review programs that will address clinical line management issues and outcomes measurement. USA's peer review model is a checks and balances system whereby physicians of the same specialty as other contracted physicians provide case analysis in determination of the medical necessity and appropriateness of services provided. USA strongly believes the delivery of health care is a local issue. Therefore, we are dedicated to establishing peer review programs which incorporate locally based physicians in the clinical line management function.

These are but a few of the many innovations developed by our PPO that can be utilized within the Medicare program to ensure the efficient delivery of quality health care. We believe this type of proposed managed care product, with all the components and providers fully contracted and in place with the ability to direct care, would present a significant savings to HCFA, while at the same time providing quality health care and granting patients a considerable network of local physicians and hospitals from which to choose.

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