FEHBP AS A MODEL FOR MEDICARE REFORM

HEARING

BEFORE THE

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UNITED STATES SENATE

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CONTENTS

OPENING STATEMENTS

Page

Roth, Hon. William V., Jr., a U.S. Senator from Delaware, chairman, Committee on Finance ... 1
Moynihan, Hon. Daniel Patrick, a U.S. Senator from New York ... 2
Breaux, Hon. John B., a U.S. Senator from Louisiana ... 3
Grassley, Hon. Charles E., a U.S. Senator from Iowa ... 4

CONGRESSIONAL WITNESSES

Gregg, Hon. Judd, a U.S. Senator from New Hampshire ... 5
Wyden, Hon. Ron, a U.S. Senator from Oregon ... 7

PUBLIC WITNESSES

Butler, Stuart M., Ph.D., vice president for domestic research, The Heritage Foundation, Washington, DC ... 9
Reischauer, Robert D., Ph.D., senior fellow, The Brookings Institution, Washington, DC ... 11
Thorpe, Kenneth E., Ph.D., professor and director, Institute for Health Services Research, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA ... 13
Anderson, Richard V., vice president, Health Policy, Kaiser Permanente, Oakland, CA ... 29
Hustead, Edwin C., FSA, senior vice president, Hay/Huggins, Inc., Washington, DC ... 31
Wyckoff, Peter, executive director, Minnesota Senior Federation-Metropolitan Region, St. Paul, MN ... 32

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Anderson, Richard V.:
- Testimony ... 29
- Prepared statement ... 43

Breaux, Hon. John B.:
- Opening statement ... 3

Butler, Stuart M., Ph.D.:
- Testimony ... 9
- Prepared statement ... 54

D'Amato, Hon. Alfonse M.:
- Prepared statement ... 71

Grassley, Hon. Charles E.:
- Opening statement ... 4

Gregg, Hon. Judd:
- Testimony ... 5
- Prepared statement ... 73
- "Proposal to Reform Medicare" ... 77

Hustead, Edwin C., FSA:
- Testimony ... 31
- Prepared statement ... 87

Moynihan, Hon. Daniel Patrick:
- Opening statement ... 2
- "Teaching Hospitals Under the Knife," New York Times article ... 95

	Page
Reischauer, Robert D., Ph.D.:	
Testimony	11
Prepared statement	98
Responses to questions from Senator Kerrey	112
Roth, Hon. William V., Jr.:	
Opening statement	1
Thorpe, Kenneth E., Ph.D.:	
Testimony	13
Prepared statement	113
Wyckoff, Peter:	
Testimony	32
Prepared statement	122
Wyden, Hon. Ron:	
Testimony	7
Prepared statement	133

FEHBP AS A MODEL FOR MEDICARE REFORM

WEDNESDAY, MAY 21, 1997

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

The hearing was convened, pursuant to notice, 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 Chafee, Grassley, D'Amato, Jeffords, Mack, Moynihan, Rockefeller, Breaux, Moseley-Braun, and Bryan.

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

The CHAIRMAN. The Committee will please be in order.

This week, both Chambers of Congress will vote on budget resolutions that call for $115 billion in savings to the Medicare program over the next 5 years.

And while this amount of savings was arrived at after more than 2 years of off and on again negotiations with the White House, it will have only a minor impact on the health of the Medicare program.

It does not begin to address the long-term fiscal health of Medicare. Demographic trends will continue to increase financial pressure on the Medicare trust funds.

The challenge of strengthening the Medicare program and insuring its long-term viability is too great to solve by simply continuing to tinker around the edges of an outdated health care system.

The most important thing we can do for Medicare beneficiaries is to immediately begin a step-by-step process of fundamentally updating this program.

Today will focus on a successful health care program, which I strongly believe could serve as a model for modernizing and strengthening the Medicare program while expanding choices for Medicare beneficiaries, the Federal Employees Health Benefits Program.

The FEHBP program has worked well during its 40-year history, requiring little Congressional oversight. Satisfaction reported by its 10 million Federal enrollees has always been high. It offers a wide range of options in a competitive marketplace model. Members are provided with standardized information describing their options every year during the annual open season. And FEHBP has kept cost increases below the private sector without onerous Government price fixing.

The Medicare plan reported out of the Finance Committee and passed by the Senate in 1995 restructured Medicare to be a health benefits system very similar to FEHBP. Seniors would have been able to choose from among a wide variety of private health plans, the type of coverage that met their needs and preferences.

Such a private market-based approach would have fostered competition among health plans. Competition would have given providers the incentive to deliver more and efficient high quality care to our seniors. It would have given beneficiaries access to coverage for additional benefits such as prescription drugs and preventive benefits at little or no additional cost.

I am glad to see that my friend and colleague, Senator Breaux, has also expressed that he too believes we need to take a look at the successes of this program as a model for Medicare.

And the witnesses testifying today will help us examine the FEHBP features that could be adopted for Medicare. We will also discuss some modifications of certain FEHBP features that would be necessary to make the model an ideal model for Medicare beneficiaries.

At this time, I would like to call upon my good friend and colleague, Patrick Moynihan.

Senator MOYNIHAN. And co-authors.

The CHAIRMAN. And co-authors. Yes, sir.

Senator MOYNIHAN. In this morning's *Washington Post* op-ed page. If you have not read it, you ought to.

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

Senator MOYNIHAN. Mr. Chairman, I welcome this hearing.

I would diverge just one small bit to note that one of the questions we come upon in almost any direction you look at health care is the question of the viability of our teaching hospitals and our medical schools.

In the 103rd Congress, when we first began year-long hearings on health insurance and health care, one of the more striking events was the testimony from heads of these institutions about the situation they were in.

One morning we had a professor of ethics from Fordham University, Father Fahey, tell us that what we were seeing was the commodification of medicine, the bringing in of market forces and market analysis.

And the following week, the head of the UCLA Medical School said, "If you would like an example, in southern California we now have a spot market for bone marrow transplants."

This is all to be welcomed in terms of the efficiencies of the system, but those efficiencies do not provide for what economists call public goods. The market will not provide for public goods, which are the teaching hospitals, without which you cannot have the medical schools, without which you cannot have the present age of discovery in medicine.

This committee, by a vote of 13 to 7, created a trust fund for teaching hospitals and medical schools. I hope we will find a way to address that subject in the course of this year.

Thank you again for these hearings.

The CHAIRMAN. Thank you, Senator Moynihan.
I share your interest and concern as to the teaching hospitals.
Senator Breaux.

OPENING STATEMENT OF THE HON. JOHN B. BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman, first of all for calling these hearings, and for our colleagues who are also testifying today, and are embarking on the same quest to try and find a solution to the Medicare problem.

I would just make a couple of brief comments. Number one is that this committee will very shortly be getting budget reconciliation instructions calling upon this committee to do all sorts of things with regard to Medicare, which is a real crisis in this country. We have all heard the actual, factual information that it will go broke in the year 2001, run out of money.

We will get instructions from the budget reconciliation that basically says, cut Medicare spending by $115 billion. And it does not recommend any fundamental reform to the system, but rather tells us to do what we have been doing every year to try and save a program that was a wonderful program in 1965 when it was created, but today has not kept up with modern medicine practice.

So what we are going to be getting from the committee is basically instructions to use a band-aid type of approach, to use the same old method of trying to fix something that never reforms it.

We will be instructed to reduce reimbursements to hospitals and doctors to the tune of $115 billion. We are going to be fast approaching the day that doctors and hospitals no longer want to treat senior citizens in this country because their reimbursements have been reduced below the cost of treating those senior citizens.

So it is very clear in my opinion, and I think in a growing number of Members, that we have to use this as an opportunity to fundamentally reform the system.

And the hearing today is about seeing how we as a Government treat our employees.

Every year, every Senator, every Member of Congress, plus 9 million Federal employees and Federal retirees get a book. And the book is the "FEHBP Guide". And in that book we find that there are literally hundreds of health plans that are competing to offer health services to Members of Congress and other Federal employees.

They compete by offering these services, which are fairly standardized. Some offer better benefits than others. Some of them offer more choices. Some offer more information. Some offer more comparisons. But the point is that 9 million people have the benefit of the competitive marketplace who are trying to get their business, our business. And it has worked very well because the costs are based on competition, not on an arbitrary fee schedule fixed by a bureaucrat in Washington.

I want to see the day when the 38 million senior citizens have the same option that we have as Members of Congress to have people compete for our business, both on choice, quality of service, comparability of who does the best job.

We should at least offer to the seniors the same opportunity, not forcing them to take it, but offer as an option that they too can get a book every year where people have competed for the right to treat them. And through that process, they would get more choices, more coverage and, I would think, at a better price than we have right now.

That would be fundamental reform, as opposed to the band-aid type of approach.

My proposal, which is on our colleagues' desks, does not just take the FEHBP program, but suggests something modeled after that, with risk adjustments, with standardized programs. It is more than just giving a voucher to senior citizens and say good luck, go find some health care.

But I think that when we explore it further we will see that this type of approach is one that merits our consideration.

Thank you.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. For the very same reason, for years I was active in applying laws to Congress that we had exempted ourselves from over the last 40 years. I do not think Congress should have been exclusive in that regard of having two sets of laws. If they were good enough for the public, they ought to be good enough for Congress.

It seems to me that we have something that works well within the Federal Government, working well as we try to have different kinds of plans for different people, from the standpoint of protecting our country, our taxpayers, from too much inflation that we generally have in health care. It has worked very well to keep this inflation under control.

So we have something within the institution of Government that works well, that we ought to give other people an opportunity to participate in.

And I am glad that we are learning from that. Hopefully, we will be successful in giving people outside of Government some of the same choices that people in Government have.

It is a track record we ought to build on. It is one which we ought to be proud of. In so many respects, we often say that the Government never does anything right. This is one of those areas where Government is doing something that is very right. And it could very well be a pattern for helping us right the inflation that permeates health care costs outside of Government.

The CHAIRMAN. Thank you very much, Senator Grassley.

While it is a pleasure to welcome our two distinguished colleagues, I am going to have to ask you to keep your comments to 5 minutes, as we have a full morning session. But we do appreciate the opportunity to hear from you.

Senator Gregg.

STATEMENT OF HON. JUDD GREGG, A U.S. SENATOR FROM NEW HAMPSHIRE

Senator GREGG. Thank you, Mr. Chairman. I appreciate your holding this hearing, and I certainly appreciate the opportunity to participate in it, along with Senator Wyden.

Let me summarize my proposal, which is a proposal that has been significantly vetted already. It has been around for a while. I originally introduced it last year. It has been scored by the Congressional Budget Office. It is a win/win proposal. It is based essentially on the Federal Employees Health Benefits Plan, but goes beyond that. I believe it adds variables and improves upon that system for our seniors.

It is called Choice Care. It has already been scored as a $10 billion savings over the next 5 years by CBO. So of the $115 billion that you are going to be asked to save by the Budget Committee, should the budget pass, this is a number that can assist you in that matter.

And it is fundamental reform. It is not a band-aid approach. It is very much fundamental reform based on a market approach, but a market approach that also protects senior citizens and gives them more choices.

Essentially, what it does is create the opportunity in the marketplace for seniors to go out and buy from any number of plans that may want to compete for their health dollars.

It says that plans have an obligation to meet the basic benefit package which is presently given to seniors under Medicare. So it does not create a situation where seniors might get less than they are getting today.

It says that seniors cannot be kicked out or not be accepted into a plan because of a preexisting condition, so it protects seniors in that category.

And it creates a market incentive on the part of seniors to be cost efficient. It does that in the following way: Essentially what this plan says is that seniors can buy any type of health care package which is presented to them which meets the conditions of having the basic underlying Medicare package, plus they could have other items added into that package.

In making those proposals, the way that seniors make the decision will be by getting a booklet much like you outlined, or maybe even more extensive information if that is appropriate as some sort of way of informing seniors as to the options that are available to them, or various plans that might want to compete for their health care dollars.

And then we will essentially say to seniors, you have the right to go out and participate in any plan you want. But to the extent that the plan you decide to participate in costs you less than what the Federal Government is now paying as the average cost per senior citizen to buy health care, we are going to return to you, the senior citizen, 75 percent of the savings.

So, for example, today we spend about $4,800 for a senior citizen's Medicare plan, if the senior is able to find a plan that is going to charge $4,500—again, the plan would have to meet the preexisting tests, which are quality and the basic package which Medicare

supplies, as a minimum—then the senior gets to keep 75 percent of the $300.

This creates three events in the marketplace. Number one, it makes the senior citizen a cost-effective or cost-conscious purchaser of health care, so that the senior has an incentive to go out and shop around and look.

They may find a plan that gives them a health care proposal that is more tailored to their needs. They may find a plan which includes eyeglass care, which they may want. Or they may find a plan that includes some sort of pharmaceutical support that they want.

And, second, it creates in the marketplace the incentive for various groups who wish to supply health care to the senior citizens to come forward, in whatever formation they decide to put themselves together—HMO's, PPO's, PSO's—and compete for the senior citizen's dollars, which is a very lucrative market.

At $4,800 per senior citizen, we are paying a fairly high price for health care and there is a very competitive market out there. Of course, by making it a situation where they have to take all comers, we eliminate the adverse selection issue.

Third, it gives the Federal Government a predictable rate of growth for the costs of Medicare. We have seen in the private sector, as the private sector has gone to competition, that the rate of premium growth has dropped dramatically.

There is still a rate of growth; I think it was about 1.5 percent last year. But there has been a dramatic drop as compared with the Federal system which is still running at about 10 percent, and is a function of the fact that we have a cost-plus system for all intents and purposes.

The plan also addresses the fact that different regions are being unfairly reimbursed, and tries to bring the AAPCC into a more reasonable band of reimbursement so that different regions will be on the same playing field level and you will have an equal competition.

So that is a quick summary. It is regrettable that I do not have more time. But I suspect that, from your point of view, it is not regrettable.

But in any event, let me again point out the highlights. This package has been vetted. It has been through the process. It has been reviewed by just about everybody. It works. It will create competition in the marketplace. It will continue to maintain a high quality of health care for seniors. It will give seniors dramatically more options than they have today, and more opportunities than they have today. And at the same time, it protects the quality of health care they are getting.

And in addition, you folks can pick it off the shelf knowing that you are going to save $10 billion right up front over the first 5 years, $28 billion over 7 years, $93 billion over 10 years, as already scored by CBO. So it lessens your need to go out and make other very difficult decisions on the provider side.

The CHAIRMAN. Well, thank you very much. We too regret that the time is limited. As we proceed, we will undoubtedly want to consult with you, as we hope to do more than just reduce provider care costs.

Now it is a great pleasure to call on Senator Wyden for his comments.

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

STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Well, thank you very much, Mr. Chairman. I want to commend you and the committee for the way you are going about this.

It seems to me what you are doing today is sending a message that this is not going to be business as usual with respect to the Medicare program. We understand that there is a demographic earthquake coming. Seventy-five million baby boomers are going to be retiring in the next century. And a kind of business-as-usual approach simply is not going to do it with respect to Medicare reform.

I think what is clear is that the Federal Employees Health Benefits Plan really can provide a road map to making sure that choice and competition is offered in a responsible way to older people.

In much of the United States, senior citizens either have no choice with respect to Medicare—we have talked about that in rural communities—or they have choices that are almost incomprehensible because information is not laid out to them in an understandable way so as to empower them to make the marketplace work.

In my 5 minutes, I would like to touch on just a couple of issues that I think are central to the whole question with respect to how the Federal employee model really can be used with respect to senior citizens, but with a couple of changes.

The Federal employee model, as we all know, is based on what is called a defined contribution kind of system. Essentially, Medicare takes the fee-for-service kind of model in an individual community and then sets the HMO rates at that threshold.

The Federal employee model is different. It basically says it will not pay anything more that a competitive reimbursement rate for a particular community. Plans just take it or leave it; it is called defined contribution. The problem is that it can lead to what Senator Breaux was talking about, which would be that a senior citizen just gets a voucher.

If a senior citizen gets a voucher, however, you have got a problem in that maybe the cost of their care is greater than their voucher, and then the senior citizen has great difficulty.

I am very hopeful that we can get a bipartisan agreement to use the Federal employee model but to focus on defined benefits, rather than a defined contribution system.

Defined benefits means that every senior citizen across our country can be secure in knowing that they are getting guaranteed benefits, and we are not just playing Russian roulette by giving them a voucher.

I would submit that in my community, where almost 60 percent of the senior citizens have a managed care plan, we have shown that you can make a defined contribution plan, consistent with a pro-competitive kind of model, and make it work.

I know that you are going to have Mr. Butler here, Marilyn Moon, Gail Wilensky and others. I would also say that if we look at some of the scholarship that has been done, they have essentially argued that the Medicare system has an alternative lever on the marketplace to this notion of defined contribution.

And that is the millions and millions of enrollees that are part of the Medicare program that can be a very powerful negotiating instrument in terms of making a competitive marketplace work, and could be an alternative to defined contribution.

Let me wrap up by saying that I think there are a number of features that are in the Federal employee health plan that are analogous to a competitive Medicare model.

The first would be that Federal employee plans use a competitive bidding in high payment communities. I think that ought to be done.

The Medicare program has a creaky, ineffective grievance and appeal process that would not be tolerated in the private sector. It is not tolerated in the Federal employee plans. Let us not use it Medicare either.

The Federal employee model is looking to alternative providers and practitioners. We have seen this in the Oxford plan.

And finally, the Federal employee plan does a much better job of getting out understandable, comprehensive information to beneficiaries than is Medicare.

So I would submit that those four features that are present in the Federal employee model can be used in the Medicare program.

One of the interesting points—I think Mr. Butler may touch on this—is that if nothing else we might want to take some of the people from the Federal employee model, when they are done with their bargaining and plan selection period, and have them move over to the Medicare program to coordinate some of the approaches that are used initially.

I will wrap up with this point. For example, in my legislation, the Medicare modernization bill, we take the features that I have outlined today and put them into the Medicare reform bill. But we also have what are called open enrollment fairs to deal with this adverse selection kind of issue.

If we had open enrollment fairs, and maybe use some of the people from the Federal Employees Health Benefit Plan to be part of the effort to coordinate those, I think we would be on our way to 21st century Medicare that modernizes this program, brings in real choice in competition, and protects patients' rights.

I thank you very much, Mr. Chairman, for the chance to come.

The CHAIRMAN. Well thank you for taking the time and letting us have the advantage of your thoughts and recommendations.

I am hopeful that we are going to be able to work in a bipartisan way, and really move in the direction of real reform.

Senator MOYNIHAN. Mr. Chairman, I think you see it before you.

The CHAIRMAN. I agree.

Thank you, gentlemen, very much for being here with us today.

Now it is my pleasure to introduce our first panel. Today we will be hearing from Dr. Stuart Butler, vice president for domestic research at the Heritage Foundation.

We are also happy once more to welcome an old friend, Dr. Bob Reischauer, who is currently senior fellow with the Brookings Institution, and a former Director of the CBO.

Finally, we are pleased to have Dr. Kenneth Thorpe, professor and director of the Institute for Health Services Research at Tulane University School of Public Health and Tropical Medicine.

Dr. Butler, we would be pleased to begin with you.

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT FOR DOMESTIC RESEARCH, THE HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you, Mr. Chairman.

If you are familiar with the works of author Conan Doyle, you may recall in the "Adventure of the Silver Blaze", Sherlock Holmes solves a mystery by drawing attention to the dog that did not bark in the night. He pointed out that the silence of this dog spoke volumes about the case and how to solve it.

I think in health care, we have a dog that does not bark, or at least it does not bark loudly, which is the FEHBP. We do not have conferences to talk about the crisis of the FEHBP; we do not have a collapse imminent; you do not have sackloads of mail and phone calls from people complaining about it. In fact, very few Americans outside the Washington beltway know anything about the FEHBP or that it even exists.

I think the silence in fact speaks volumes. As others mentioned, we have a program that actually does work well and should indeed be considered as a model for Medicare.

Let me point out, as Senator Wyden did, some of the main points of the FEHBP which I think suggest a possible foundation for Medicare reform. The first is that the FEHBP does indeed have a range of plans, and types of plans and benefits. OPM, which administers the program, does not run a plan itself.

And yet the system is stable despite strict community rating, which of course means that people who are 18 and 65 have to be charged the same premium.

This does suggest that within Medicare, with some appropriate risk adjusters and other steps that are not in the FEHBP, it would be possible to run a program that does in fact give choices of benefits and premiums.

Second, the FEHBP uses negotiation to establish premiums and benefits, and then pays a percentage of the premium. It does not have a crude formula to pay its HMO's, unlike Medicare. It does not try to micromanage thousands of doctors and hospital fee schedules. It does it in a very different approach, which I think has a lot of opportunities within the Medicare system.

Third, the individual costs of the FEHBP are highly competitive with the private sector. The CRS drew attention to this in 1989 in its major study, which made a point of saying that the choice between plans is one of the driving factors in keeping costs under control.

Lewin-VHI did an analysis in 1992 showing similar results. And in 1995, Frank McAardle of Hewitt Associates also pointed out that the program is very effective at keeping costs under control, in large part by competition, particularly price competition.

Four, we are not only just talking about insurance plans in the FEHBP. It has been pointed out that many organizations, particularly unions, are major providers of plans to Federal employees and retirees.

And that may suggest that organizations like those themselves in the FEHBP, and other organizations such as AARP, may play a similar role in a future restructured Medicare, membership organizations exerting clout, working on behalf of their individual members, to strike a good deal and to get good benefits.

And finally, as has been pointed out, I think the information system in the FEHBP is a real standard that has been set for other programs. I think Senator Breaux pointed out the guide itself. We have "Washington Consumers' Checkbook", which I am sure you are all familiar with, which does the same for the private sector.

And yet, the GAO says that despite HCFA demanding mountains of information, it does an abysmal job of informing Medicare recipients of the kinds of choices available and giving them useful information.

So I would suggest that there are certain elements of this that really ought to be applied to Medicare.

First of all, Congress should permit private plans to be offered to senior citizens. Maybe start with the FEHBP plans that currently exist, the organizations that are already familiar with offering plans to the FEHBP. And look in particular at other organizations like AARP as additions to that mix of private plans.

Second, get HCFA out of trying to run a medical system and into negotiating with plans and beefing up information. You can do this in several ways. One is to set up an independent board to run the Medicare fee-for-service system. Give it some discretion to adjust benefits, subject to Congressional oversight, and thus let a separate group of people with consumers in mind, rather than the bureaucracy at HCFA, run the fee-for-service system.

HCFA officials should be in the business of negotiating with those individual plans to set benefits and prices. If they do not feel up to it, as Senator Wyden pointed out, maybe you can detail a few dozen people from OPM to do it for them.

You should look right now at introducing various risk adjusters into the Medicare system to allow this process to work more smoothly. PPRC, in its most recent report, explores a range of possibilities in introducing risk adjusters into the Medicare system, based on an FEHBP model.

And then finally, rather than a simple defined contribution in the form of a voucher system which, as Senator Breaux pointed out, does raise a number of concerns for the sick and the very elderly, look at some kind of combination of a defined contribution and the FEHBP system of a percentage of premium.

Perhaps set a basic contribution to each plan, risk adjusted, and then cover a certain percentage of the premium up to that, and have a maximum based on the area fee-for-service plan. I think that would be the root of trying to deal with this issue and get you that combination that I think would work very well.

Let me end by saying, as I think Senator Breaux has observed before, that most Americans assume that Federal employees and Members of Congress probably have the best medical system avail-

able. And they are right. And it is about time that we do in fact make this more widely available to the seniors in Medicare.

Thank you.

The CHAIRMAN. Thank you.

Dr. Reischauer.

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

STATEMENT OF ROBERT D. REISCHAUER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. REISCHAUER. Mr. Chairman, I appreciate the opportunity to participate in this hearing.

I will summarize my prepared statement which addresses three different questions. The first of them is, what insights for Medicare reform can be drawn from the experience of FEHBP?

The second is, to what extent might FEHBP serve as a model for a restructured Medicare program?

And the third is, how important is it to begin restructuring Medicare sooner rather than later?

To establish a context for this discussion, let me start by noting that a consensus seems to be developing around two propositions. The first of these is that Medicare will have to undergo some form of structural transformation if it is going to cope successfully with the pressures it will face when the baby boom generation begins to retire, and if it is ever going to offer participants a more adequate package of benefits.

The second is that the most promising way to meet these two challenges is to gradually transform Medicare into a system that provides participants with the opportunity and incentives to choose cost-effective health care delivery systems in a competitive but regulated marketplace.

As analysts and policymakers have looked around for examples of how such a system might work, they have understandably focused on the FEHBP system which, in many respects, follows this structure.

There are number of useful insights and lessons for Medicare reform that can be drawn from FEHBP's experience. The first of these is a simple one. It is that FEHBP shows that it is possible to create a smoothly functioning market system of national scope in which different types of health plans compete for enrollment. That has been proved quite clearly by FEHBP.

A second lesson, relevant to Medicare reform, is that it does not take a huge bureaucracy to operate a competitive system. OPM does this with a staff of fewer than 150 full-time equivalent employees and an administrative budget of around $20 million. For a number of reasons mentioned in my testimony, this is an understatement of the true costs, but it makes the basic point.

A third insight that can be drawn from FEHBP's operations is that it is possible to develop and disseminate comparative information that participants find both intelligible and useful when they are faced with the task of choosing among the competing plans.

A fourth insight that can be drawn from FEHBP's experience is that competitive markets can be stable. There is some fear that changes in premiums and changes in consumer ratings might cause

huge shifts within the marketplace that could be destabilizing. But FEHBP's experience shows that this not likely to occur.

Fifth, the FEHBP experience suggests that an effective competitive marketplace can function without sophisticated mechanisms for risk adjusting payments to plans. FEHBP in fact has no risk adjustment. This has caused some problems. But what is surprising is that the system has functioned as well as it has.

While FEHBP offers encouraging evidence that an efficient, high quality system of competing health plans can be developed, it does not provide an appropriate model for restructuring Medicare for several reasons.

The first of these is that the FEHBP model is incomplete from Medicare's perspective because some of the functions that are carried out by the employing agencies would have no comparable entity in the Medicare system. This of course involves enrollment, disenrollment, development and dissemination of comparative information and helping participants handle problems that they might encounter when dealing with these plans.

A second aspect of FEHBP that makes it inappropriate as a model is that it has no method for adjusting the Government's payments for differential risk. This creates inequities across participants. Some participants have to pay higher premiums simply because they are in a plan with less healthy enrollees rather than that their plan has more generous benefits, or is less efficient. It also creates instability.

Third, FEHBP is an inappropriate model for a restructured Medicare program because it lacks a common benefits package. A common benefits package is necessary to allow meaningful comparison across plans.

Fourth, the lack of a fixed market area is another problem that the FEHBP structure has that should not be carried over into a reformed Medicare system.

And finally, the way FEHBP has structured and determined plan premiums is not appropriate. Here I would urge a competitive model.

Let me close by saying a few words about when structural reform should begin. Once the bipartisan budget agreement of 1997 has been turned into law, there is going to be a great temptation to celebrate that accomplishment with a period of legislative rest.

In no area is this reaction going to be stronger than it will be in the area of Medicare, which is being asked to bear 42 percent of the reduction in non-debt-service spending that will occur over the next 5 years.

It would be a big mistake, however, to delay further Medicare restructuring . It is only going to get tougher the longer you wait. We are in a situation where economic conditions are conducive to restructuring. Demographic conditions are favorable for the next few years. And conditions within health markets are favorable because we have a significant excess supply of providers.

None of these situations will hold 10 years from now, and it will make the job of you or your successors much more difficult. So I urge you to act sooner rather than later.

Thank you.

The CHAIRMAN. Just let me say that I think that admonishment is very much in order. I hope that we are able to make some significant changes.

All your statement will, of course, be included as if read here.

Dr. Thorpe, it is a pleasure to have you.

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

STATEMENT OF KENNETH E. THORPE, PH.D., PROFESSOR AND DIRECTOR, INSTITUTE FOR HEALTH SERVICES RESEARCH, TULANE UNIVERSITY SCHOOL OF PUBLIC HEALTH AND TROPICAL MEDICINE, NEW ORLEANS, LA

Dr. THORPE. Well thank you, Mr. Chairman, Members of the Finance Committee. I am pleased to be here with you today to talk about the FEHBP as a model for Medicare reform.

I am going to focus my remarks in three areas: First, the short-run issues; second, some transitional issues that would be important to look at; and, third, some of the key design and policy choices that you would face in implementing an FEHBP-type model.

First let us talk about the next 5 years. As has been alluded to several times, the existing budget agreement on the Medicare side, if enacted as discussed, would generate a rate of growth in the Medicare program, per enrollee, that is below the growth in private health insurance premiums over the next 5 years. So I think it is important to think about structuring and building on a new Medicare program, if you will, that builds on that momentum that came through as part of the budget process.

The second point is that managed care enrollment has grown rapidly. About 14.3 percent of beneficiaries are in risk programs today, over 5 million Medicare beneficiaries. Yet unlike the private sector, where additional managed care penetration has generated program savings for employers, it has not generated savings in the Medicare program.

One of the goals, it seems, of a restructured program is to make sure that some of the movement into managed care does generate program savings for the Medicare program, as well as provide high quality plans and choice of health plans as well.

A second set of issues deals with transitional movements. I think there are several things that could be done immediately to get the marketplace ready for a restructured program.

I think the first is really outlined in part in the President's fiscal year 98 budget proposals, where the President asks for expanded authority to pursue competitive bidding, both within the fee-for-service market and to build on their authority to do demonstrations in the managed care market. That should perhaps be expanded, having Congress give the administration more explicit direction in the approach they should take.

Second is that the variety of plans that are available to seniors will have to expand. Largely, they have the choice of an HMO, if that is available. Other types of plan choice options can be available as well, such as preferred provider organizations and provider-sponsored networks. I think we should try to expand those choices as soon as we can.

Risk adjustment has already been talked about. That is an important element of any movement to a system like this.

Finally, as a transitional move, I think seniors need clear, consistent information on benefits, their price and the quality of the plan. This information is imperative to provide in a structured manner to senior citizens.

The third set of issues is the actual movement into a competitive bidding type of approach. There are several critical design and policy options embedded within a movement to competitive bidding.

Perhaps the most important change is the method Medicare would use to determine its contribution to health plans. One approach is perhaps to use a competitive bidding model where HCFA or some other entity would structure a bidding process among health plans. Based on that bidding process, Medicare could calculate the average bid and pay seniors an amount that would allow them to buy a typical plan in the market. If they use a less expensive plan, the beneficiary would share in some of the savings and the Medicare program would share in some of the savings.

A second part of this would be to develop a standard benefit package. I think you could look at a benefit package along the lines typically found in today's HMO packages, which include not only the basic set of benefits but also prescription drugs and other benefits as well.

A third point is that it is probably important to perhaps use a similar model that FEHBP does to negotiate rates with managed care plans. They use a variant of the most-favored-customer approach where they negotiate rates with the managed care plans based on what is generally offered for similar benefits in their commercial market.

One issue that has not been talked about here, but which is quite critical, is the shape that a fee-for-service plan would take in a restructured market. Here there are really two options: One is to retain it as it is traditionally provided and as administered by HCFA; or the way it is provided in the FEHBP where the fee-for-service benefits would be provided by a health plan such as Blue Cross standard option.

Those are really important choices. My sense is that if you selected the second option, we really would need to have a next generation method of adjusting for risk selection among plans in order to make sure that we are adequately protecting the fee-for-service plans and the managed care plans in a competitive model.

Just in summary, I think that many of these long-term reforms that I have talked about, changing the method from a AAPCC method to a competitively bid approach, allowing Medicare to enjoin some of the savings of those choices, will allow the program to sustain much of the momentum that has already been started with the budget agreement over time.

Thank you very much.

The CHAIRMAN. Thank you very much, Dr. Thorpe.

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

The CHAIRMAN. Let me ask the other two witnesses to comment on your question about bidding out the fee-for service.

Dr. Reischauer, what would your recommendations be with respect to fee-for-service? Should they be bid out?

Dr. REISCHAUER. In the long run, I do not think it is sustainable to have both a capitated portion of Medicare and the traditional fee-for-service unmanaged system that we have now.

Presumably, in the capitated world you would have a more adequate benefit package than exists in the Medicare fee-for-service world right now. That would create immense political pressure to raise the benefits in the traditional fee-for-service world, pushing up costs still further.

So what I would like to see is fee-for-service and PPO-type plans offered within the capitated world for new participants in Medicare, and grandfather those who wish to stay and are already in the existing fee-for-service system for some time, but without enhancing the benefit package that they receive.

The CHAIRMAN. Dr. Butler?

Dr. BUTLER. I think that makes a good deal of sense, and it is maybe wise politically to go in that direction.

I think Dr. Thorpe's point about the options in the fee-for-service, to allow the Government to offer the fee-for-service system through a chosen plan, whether it be Blue Cross or whatever, is exactly the kind of thing I would imagine the independent board I mentioned would do. The board could be making those kinds of decisions over time, and maybe deciding which plans to offer, and under what of circumstances. So I think it is possible to blend that with this idea.

I think it is very important to run the fee-for-service system in a much more structured way, and in a way much more compatible with what goes on in the private sector and FEHBP, and to get away from the current system we have.

As I mentioned, HFCA is trying to micromanage every single element and every fee schedule in the entire system. This is quite frankly beyond the capacity of the bureaucratic mind.

The CHAIRMAN. Let me ask you this further question, Dr. Butler. You point out in your testimony that OPM negotiates a fixed profit per subscriber for the participating fee-for-service plans. Is this consistent with a truly competitive model?

Dr. BUTLER. Well, I am describing what happens. Essentially, you have a system in the fee-for-service which is a little different from what a lot of people typically think of as a free and open competing system based on driving for profit. Essentially, the plans are competing on their ability to provide a certain level of service to beneficiaries and, in a sense, competing upon their ability to deliver a product to a particular person.

I think that at the very least, as a transition to a more open type of system, that would certainly make a lot more sense than we currently have within the Medicare program. It would be an approach that would make a lot of people who might otherwise be skeptical about going in the direction of a more open market, see it as an intermediate step that they might consider reasonable.

The CHAIRMAN. Dr. Reischauer, in your testimony you gave many reasons why FEHBP may not be an adequate role or model for Medicare. For example, you indicate that the absence of risk adjustment would be much more consequential in FEHBP than Medicare.

Let me ask you this. With some modifications of the FEHBP model, such as adding risk adjustment, defining market areas, de-

veloping a better way to dispense information, do you believe a restructured Medicare could achieve the same successes that FEHBP has?

Dr. REISCHAUER. I think it can achieve more success than we have seen in FEHBP. Medicare is a bigger market player in most areas. And if you put it in a competitive framework, I would expect it to do better than FEHBP does.

The CHAIRMAN. And, Dr. Thorpe, you stated that the Medicare spending reduction just passed in the budget resolution would bring Medicare spending down close to the spending growth level of the FEHBP program.

Since this is so, can you elaborate on the merits of such budget strategies versus the merits of remodeling Medicare similar to FEHBP?

Dr. THORPE. I think the choices are what mechanism are you going to use to sustain savings beyond the year 2002? And you really do have two options. One is the usual method that we have tried in the Medicare program which is a combination of basically slower increase in payments to payments to providers primarily.

We are not generating savings on the managed care side. And as we see managed care growth rising, I think that is a cause for concern.

So that is one option. Basically continue to reduce payments, perhaps arbitrarily, to managed care plans, as well as on the fee-for-service side, or develop a system that allows some of the competition that is evolving in the managed care marketplace to provide seniors more choice, to perhaps provide expanded benefits to seniors, but also allow the Medicare program to enjoy some of the savings of the rise in managed care enrollment, which is not happening under today's market.

So I think the 5-year window gives you a nice time frame to build the transitional steps, to think through the precise way of enacting a program that takes you into the 21st century.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I just want to welcome all of our panelists.

We have seen the cost of private health insurance, the annual increases, drop by two-thirds. Is this just the continuing rationalization in the marketplace? Is that what you would assume?

And is it your judgment that we can do the same with Medicare as we quickly move from a population which only knew fee-for-service in 1965 to a population that is familiar with managed care plans?

Dr. THORPE. Yes, Senator. Certainly in the private sector, the major reason why the growth in private insurance premiums has fallen off in the past 2 years is the dramatic shift into managed care. Between 1993 and 1995, we had 20 percent of the work force shift from fee-for-service plans into managed care plans.

Senator MOYNIHAN. Twenty percent?

Dr. THORPE. So we now have about three-quarters of the private sector in some form of managed care.

Senator MOYNIHAN. I see. I see.

Dr. THORPE. If the Medicare program were structured in a similar way, where Medicare is developing a competitive market, using

some of the techniques that the private sector is using to negotiate with managed care plans, it seems to me that the year-to-year growth in managed care premiums in the Medicare market could rise at rates similar to what we are seeing in the private sector.

Senator MOYNIHAN. Which is about what?

Dr. THORPE. On a per insured life basis, about 4.7 percent per year.

Senator MOYNIHAN. Could I just ask something? It is a little bit of a preoccupation. You are from the Tulane University School of Public Health and Tropical Medicine. Have you felt in Tulane, as I believe is the case, the pressure on the teaching hospitals, and in consequence the medical schools, by this move to managed care?

Dr. THORPE. I think that Tulane is probably not different from the situation in a lot of teaching hospitals, that as teaching hospitals are forced to compete with community hospitals on price with managed care plans, it makes it increasingly difficult to do two things. One is to cross-subsidize through the revenue they get from private health plans, their teaching missions and teaching functions. But it also makes it difficult for them to cross-subsidize the high level of uncompensated care they provide to uninsured patients.

So I think on both fronts, that as competition has diffused in the market, it has generated some savings. It has created some pressures in the market because it has broken out all the cross-subsidies that are built into the pricing system that we have traditionally used to pay for the uninsured and pay for graduate medical education.

This is a little off the topic what I am going to say next, but it seems to me that some substantial care should be taken as we move into more competitive market situations that perhaps we think through auxiliary mechanisms to fund GME as well as care for the uninsured.

Senator MOYNIHAN. Yes, graduate medical education.

Dr. THORPE. Graduate medical education.

Senator MOYNIHAN. This is a normal fallout of a rationalization process in a large economic center that those institutions that provide a public good, such as research on malaria, are not going to be provided for in the market. And therefore, you have to make other special provisions.

You are beginning to talk about mergers down there at Tulane, are you not? Or so the *New York Times* reported yesterday.

Dr. THORPE. Well, sure.

Senator MOYNIHAN. Everywhere in the country.

Dr. THORPE. The market is consolidating quickly there as the State of Louisiana is getting higher levels of managed care penetration. So it is putting pressure on admissions and on revenue streams flowing into teaching hospitals.

Senator MOYNIHAN. We now find it all over the country as the rationalization goes on. And you are going to tell Senator Breaux, are you not, that we ought to do something about that?

Senator BREAUX. I am on board.

Senator MOYNIHAN. He is very definitely on board.

Thank you very much, Doctor.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I thank the panel. There is a wealth of information at this panel on medical practices and medical reform. We thank them for their continued help.

You know, the panel talked about HMO's. And I guess about 13 percent of the Medicare recipients in the country are under an HMO type of group. But I think it is important for all of us to realize that only with the Federal Government's running of HMO's do we lose money. The only HMO systems in the country that lose money are the ones that are paid for by Medicare.

We had hearings yesterday that said that Medicare overpays HMO's by about $2 billion a year. The only place HMO's are not cost efficient is under Medicare because we reimburse HMO's not based on competition, but we reimburse the HMO's based on the fee for service. And we give them 90 percent of the fee for service regardless of what that reflects on their actual costs.

We are spending $2 billion a year more on HMO's under the Federal Medicare system than we should be. That is right out the window.

I think the whole point here is that the Medicare system is archaic as far as how we price it. It is not based on competition.

I for one am sick and tired of having providers come to my office and argue about whether or not we ought to be paying for barium enemas or colonoscopies under Medicare. I do not know what we should be paying for, and whether we should be reimbursing vaccines IV administered versus oral vaccines being administered.

But we are trying to micromanage the system out of Washington instead of basing it on competition. It is the only health care system in the country that is not based on competition in the marketplace.

And what we are trying to offer is an opportunity, not to mandate it to the seniors, but give them the opportunity, based on a type of FEHBP plan—not the same, but based on that—that would give them more choices, more information, better services and more coverage, and the same plan that Members of Congress have.

And I want to talk to you, Dr. Reischauer, because you make some good points and I agree with them. What I am suggesting is an FEHBP model, not the same thing, but one that has risk adjustment in it and one that starts with a standardized set of benefits, at least covering Part A and Part B, probably prescription drugs.

Does that help get at some of your concerns with regard to FEHBP?

Dr. REISCHAUER. Yes. The plan that you are working on now has FEHBP in the title but then corrects all of the aspects that I think are deficient in the FEHBP model for Medicare.

I am not saying that it does not work adequately for the Federal work force, but it is not something that can blindly be transferred to the aged and disabled populations, which is a very different group to cover.

Senator BREAUX. I think that all of us are trying to come up with something that protects seniors and brings about competition, and brings about better services.

Dr. Butler, again, let me ask the same question I asked Dr. Reischauer. I mean FEHBP cannot be just taken and plunked down for Medicare. We have got to do risk adjustment. We have

got to do a standardized package of benefits. Do you think we can do it basing on the current FEHBP basis?

Dr. BUTLER. I would agree with Dr. Reischauer. I do not think that any of us that support the idea of looking at the FEHBP as a perfect model, say to just take it in its entirety and plunk it down into Medicare.

For all the reasons that Dr. Reischauer mentioned, there are very positive elements of the FEHBP, but there are things that in fact should be corrected and improved. And that is what we would be looking at. I think you can do that and, as I pointed out and others pointed out, there are very specific elements you would want to put into place.

Let me just make one cautionary point though. I think it is very important to appreciate the distinction between talking about broad sets of benefits and talking about absolute microdetail of every element.

The FEHBP effectively sets broad standards of benefits but it allows a lot of variation in terms of the way those are provided, and wide variation in the way they are paid for, in terms of making sure that people get the best care.

So I think it is extremely important that you do not wander into micromanaging benefits as you try to set broad standards of benefits that people can understand and make comparisons between.

Senator BREAUX. We as a Federal Government pay about $5,000 per beneficiary, per year, for Medicare for every senior out there. And that does not even take into consideration about $1,600 they pay in premiums plus their Medigap insurance.

And I will tell you, I just know if we had that amount of money out there and said to companies and plans, come and try to get the seniors' business, they can come up with something that would be more efficient, more effective, more choices, more coverage, more information, better comparisons than we have right now.

And I would say to this committee, Mr. Chairman and my colleagues, this is a real opportunity for us to do some real reform as opposed to just cutting reimbursements to doctors and hospitals. That is the challenge.

Thank you.

The CHAIRMAN. Dr. Reischauer, I would just make one comment on the Federal Employees Health Benefits Program. Forty-one percent of those enrolled are retirees or retirees' families. So there is some experience there that seems to me would be relevant.

Dr. REISCHAUER. But a good chunk of those folks are early retirees. They are people between the ages of 55 and 64. And then there are those over 65 who are in the Federal program.

But it serves as a wraparound policy because most also have Medicare. So it is quite a complicated thing to disentangle exactly who is being covered and how it compares to the Medicare population, which of course has a large disabled component to it as well.

The CHAIRMAN. But, for example, on enrolling them, there are some experiences there that I think could be helpful. Anyway, I think it is important to recognize that there are a significant number of retirees in the FEHBP.

Dr. BUTLER. Mr. Chairman, with regard to the provision of information to those individuals, affinity organizations advise the very

elderly in the FEHBP. NARFE, for example, provides a handbook and rates plans, and so on. I think that aspect is important too.

The CHAIRMAN. Thank you.

Senator Mack.

Senator MACK. Thank you, Mr. Chairman.

First I want to say that I have been working with Senator Breaux now for the last couple of weeks on various proposals and ideas, and want to commend him for the work that he has done. I look forward to its coming to conclusion.

Again, thank you for the leadership you have provided on this issue.

I also want to clarify something in my mind. As I was listening to Dr. Reischauer, I think you listed five areas of concern with moving from the Federal employees' system, taking that and moving it into Medicare. I was curious as to how Dr. Butler might respond to those various points you raise.

As questions were being asked, there seemed to be agreement from Dr. Butler with some of the things you said. So I would like to have a little bit more dialogue there so that I would have an understanding about where both of you are with respect to these issues.

Dr. BUTLER. I must admit I made cryptic notes so I am not sure I necessarily have all his points.

I may put some words into Bob's comments, but I am sure he will correct me. As I understand it, he said, first of all, that the FEHBP is incomplete in the sense of some of the features of the role of employers as bargainers within the system.

I do think that there is a role of affinity organizations within FEHBP, and I mentioned unions. I think anybody in the Mail Handlers Plan, for example, knows that they have a pretty strong bargaining power with regard to providers and hospitals in any particular area.

Second, I think he mentioned the lack of a risk——

Senator MACK. Let me hop in there for just a second. What you are saying is that you believe that the marketplace, working as the marketplace does, would create these entities.

Dr. BUTLER. Yes. You can either charter existing groups in some way or explicitly set them up. I do not think you need to set them up, but you could do that I suppose. Or you could perhaps seed the market by reaching agreements with some large organization, maybe unions who are already in the FEHBP, for example.

Senator MACK. Or the LLP's I mentioned. So that would be one way.

Dr. REISCHAUER. Just at a simplistic level. I think Stuart is right on that score. The fact is that benefits administrators and agencies enroll people, disenroll people and provide them with information, and that is something that we would have to create some comparable entity to do. It is not a difficult task. It certainly could be done.

Dr. BUTLER. I would agree.

To move on to the next one, I am not sure I caught this exactly right, but I think the method for adjusting payments to different plans, which is a little simplistic in a way in the FEHBP as a

straight percentage, would need to be changed. I totally agree with that.

I think it is not clear what the right way to do would be. That is an area to explore, and maybe to combine a modified version of the AAPCC today, with a percentage arrangement, which I alluded to.

I am not convinced that the lack of a common benefit package is the scale of problem that Bob suggests. I think it is true to say that one may need a broad basic set of basic benefits within a system. But it makes sense to allow variations beyond that, subject to negotiation, which is similar to what the FEHBP does.

I think the lack of fixed benefit areas is solvable within the Medicare, maybe within a State or area of a State. Again, that should be open to negotiation with plans.

Look at the Washington area. We would clearly want to have a benefit area that involved the whole Metropolitan Area, which is two separate States and D.C. It does not seem to me that that is beyond the realm of capability to look at negotiating an area and saying to plants that if they are going to offer benefits they must do so within that entire area.

And finally, the setting of premiums—I am not sure I actually did understand this point, the last point with the prices.

Dr. REISCHAUER. Well, OPM is a passive price taker, as Dr. Thorpe described, with respect to HMO's. It says, what is the best price you offer in this area to big employers? We will take that price, with some small modifications.

That makes sense for OPM. The Federal workers are often a tiny piece of the business in any particular area. For Medicare, it does not make sense. And it is not clear at all that the folks that would be covered in the Medicare system would be at all comparable to the private sector participants of the HMO. So I would want a competitive bidding system for that.

Dr. BUTLER. I would agree with that.

Dr. REISCHAUER. For the national plans, OPM negotiates a price of for the fee-for-service plan, the Blue Cross-Blue Shield Plan, across the whole nation. And what this leads to is some significant inequities in the sense that one premium is charged everywhere.

So those in a low-cost rural area in Iowa, for example, or in a low-cost metropolitan area like Portland or Minneapolis, are paying too much. They are subsidizing the care that is being provided to participants in the New York area. I think it would be much better to have regional variation in these premiums and prices.

Dr. BUTLER. I strongly agree with that. And I think a trial and error negotiation system may be the best practical way to begin to get the right price. You have got to move away from formula pricing.

Initially, some of the corporations started looking at managed care in the early eighties by setting a formula payment, and they had exactly the same problem. In fact, it even shows the same percentage in Medicare—95 percent. And they learned in about ten minutes not to do that, and changed it. We have taken 15, 20 years and we are still doing the same thing.

Senator MACK. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bryan.

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

This has been a very interesting panel this morning. We thank you very much for your testimony.

I think most of us agree that the present system is simply inadequate to the task and the challenges that lie ahead. And I think most of us are open and receptive to some of the competitive models that you all have outlined, and some of the things that we might do.

I am less than clear as to what the overall impact would be in terms of what the beneficiary himself or herself would ultimately pay.

If these competitive models are created, and we would hope to achieve some efficiencies, and undoubtedly, we could. It has been suggested here that maybe even the benefits provided would also be expanded.

But ultimately, what would the cost be to the individual beneficiary? Would it be comparable, as you view it, to what beneficiaries currently pay? Would it be less than what they pay? Would it be more than what they pay? I recognize we are talking about various options here that would provide minimal coverage, better coverage, best coverage.

But within that framework, can you give us some forecast as to what you see as the cost beneficiaries would ultimately be required to pick up?

Dr. BUTLER. I think it would be dishonest to try and answer that question directly in the sense of promising either more or less for individual people. It depends entirely on how you structure the contributions and payments, and what you require to be covered under the plans.

I would say, however, that the crucial thing I think we are all arguing is that you have got to change the process.

Senator BRYAN. I do not disagree with that.

Dr. BUTLER. I think that is the key.

Once you allow people to start gravitating to plans that contain benefits at the margin that are what they want, rather than having to pay out of pocket, clearly they are going to be better off under that kind of arrangement.

The more you can encourage HMO's instead of just simply raking off whatever they can under a strict formula, to negotiate good value and benefits, that is clearly going to be in the interests of the eligible population.

And then, as far as the bottom line is concerned, it depends on what method and what scale of contribution the Federal Government is prepared to pay.

I know that does not answer your question directly but I think it——

Dr. REISCHAUER. Well let me be a little bolder and say that the cost of a competitive system will be less than the cost of the current system operating in the future. You then face a decision of how those savings are going to be allocated.

Some savings should be captured for the Government, in terms of reduced Federal spending on Medicare. Some you want to provide in the form of an enriched benefit package because the Medicare benefit package is rather inadequate. And some could be pro-

vided to the participants in the program. How they divide the savings is really a design decision and a value judgment for the policymakers of this country.

If you are asking is the pot of money 10 percent or 22 percent of the cost of the system in the future, if we leave it unchanged, we do not know but it could be almost anything you want, depending on the design you put forward.

Senator BRYAN. Dr. Reischauer, please talk me through this transition process. Obviously, as Dr. Butler points out, we will not know what the bids would be in any one of the potential structures that might be created. So it seems to me that you would not be able to make a quantum leap until you had some idea of what the cost of these packages and the allocations that you are talking about would be.

Assuming we wanted to go to one of these new competitive models—and I think a lot of us on the Committee are interested in doing so—how would we tentatively get some handle as to what the cost would be, recognizing that there would be some savings, so we could make some adjustments?

As you have recognized, there are some political constraints on all of us. We cannot move to a system in which the cost implications for the beneficiary would be enormously higher than they are today. That is not politically sustainable.

Help me out in terms of how we would get some kind of indication of the cost of the structure. Then, based upon that, we could go as far as we were emboldened to do.

Dr. REISCHAUER. I think the first thing to keep in mind here is that you need to build an institutional infrastructure. And that is going to take a lot of time. You should view structural reform as a solution to the problem that Medicare will face in the next century, not as a way to save money over the next 10 years.

In fact, I would not be distressed if more money was spent in the short run on the new system. It is an investment in a new institutional structure. You are going to have to establish market areas. You have going to have to establish new entities. You are going to have to define benefit packages. You are going to have to get participants familiar with the system, work out all the wrinkles, the problems.

You want to save money? Do it the old fashioned way. Slash provider payments in the fee-for-service system. Raise Part B premiums. Raise HI taxes. I hope I do not get driven out of this room for suggesting that.

By 2005 you will have a mechanism established and an institutional infrastructure in place that covers most of the people participating in the system. Then you will have some dials you can turn and levers you can pull to save.

We want to keep in mind that current participants in this program pay a good deal. They pay Medigap premiums. They pay Part B premiums. They pay co-payments out of pocket. To the extent you expand the benefit package, you should expect to absorb in the premium payment those costs that they are now bearing.

This is going to be a gradual, evolutionary process.

Senator BRYAN. I thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. I would like to talk about the quality of care. We are just setting up a commission to study FEHBP with respect to quality. We have been concentrating on reducing costs in the managed care area. Now we are considering the same approach with Medicare.

First of all, will we be able to apply to Medicare the same quality of care checks devised by the commission? And what impact would such checks have upon the fraud and abuse that we have seen in the Medicare system? I pose these questions because—at least in my experience, both personal and otherwise—no one really cares about the cost because Uncle Sam is paying.

Also, there is tremendous pressure on providers to extend life support systems and various other treatments, in order to make the cost that we have shifted back to them.

What would be the impact if we shifted to an FEHBP model on these problems?

Dr. REISCHAUER. Let me make just a couple of observations. With respect to fraud and abuse, if we move into a capitated system, plans are going to control fraud and abuse. They and will be a lot more effective than HCFA is when it is trying to deal with tens of thousands of individual providers who are springing up and then going out of business. And plans will have a definite incentive to reduce fraud and abuse.

With respect to quality, that is of course a primary concern, and should be. We are slowly and imperfectly moving towards systems that will measure and evaluate the quality of services provided by plans.

Many people are dissatisfied with the pace of the movement and our ability to measure these dimensions. But let us keep in mind the counter-factual. What do we do to measure the quality of care in the fee-for-service system? And how can you measure that?

And the answer is, we do a terrible job. It is very hard to do because you cannot measure the quality of care provided by tens of thousands of individual providers out there.

So I think we are moving in the right direction.

Dr. BUTLER. Let me just add to that. I agree on the fraud issue. One has got to remember that this is not just a question of outright fraud in the traditional sense of the word, but also maneuvering the system. When you have a very regulated price control system, you invite all kinds of creative methods of maximizing returns, which we see routinely.

And as Bob said, the more you move to any capitated system, the more the plans themselves have a powerful incentive to remove those kinds of perverse incentives.

I think it is also important to recognize that there are two types of quality, which are related of course. One is technical medical information, which is normally not very digestible by ordinary people. But in terms of any negotiation process, it may be very crucial.

This is what employers do when they band together in certain cities and demand information from hospitals about outcomes and so forth.

Then there is a second kind of quality which is really the basic information that people use to make decisions once there is a clear standard of care and quality set. And that quality such things as

how quickly can I see a specialist? Can I see a specialist? What do other people think of this plan? Is there a huge turnover of people?

That is the kind of information you see in FEHBP, for example. And it is the kind of thing which ought to be incorporated much more into the Medicare system. And I think it could be done under the restructuring we are talking about. FEHBP has a lot of lessons about how to do that.

So I think both of those kinds of pieces of information on quality are crucial to get the right outcome.

Senator JEFFORDS. Dr. Thorpe?

Dr. THORPE. I agree with that.

One of the important parts of this transformation really is to insure that the quality of care continually improves within this program.

One of the ways to insure that is to make sure that the program is at least at the level, if not even pushing the private sector, to develop quality measures, to develop measures of plan satisfaction.

But most importantly then, collect it, provide it and present it to seniors in a clear, consistent and easy to digest basis. We can measure it, we can look at it. But if it is not available at the time of plan enrollment, and if it is not clear and understandable, then it is not particularly useful.

So I think a lot of thought needs to be given to developing a structure like this so that senior citizens can have this information, very much the way people have in the "Checkbook Guide," which is a good start in the FEHBP, where there a number of measures of plan satisfaction and disenrollment rates for most of the health plans in the FEHBP program.

That is probably a good starting point for Medicare to look at, collecting similar information and providing it at least on an annual basis on health plans.

Senator JEFFORDS. Thank you, Mr. Chairman.

Senator BREAUX. Mr. Chairman, could I just make a comment?

The CHAIRMAN. Yes.

Senator BREAUX. The outline that Senator Mack and I have been working on incorporates the quality assurance provisions from the Jeffords-Lieberman-Chafee, others and myself bill that is out there and that you all have worked on.

We have taken that quality assurance part of it and incorporated it into our suggested outline. So it goes a long way.

Senator JEFFORDS. Thank you.

The CHAIRMAN. Senator Moseley-Braun.

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

I concur that this is really an interesting hearing. I thank you and thank the panelists for the discussion this morning.

One of the reasons that seniors are so concerned about the future of Medicare, I think, is that they are concerned about the quality of care, whether or not they will be able to go to their own doctor to deal with their illnesses, and not be hamstrung in the options and choices that they will have.

So the quality issue is a very important one as we look at what FEHBP provides, in terms of it being a model for any transition to Medicare.

This may be a provocative question, but I am going to ask it. We have been talking about health care policy for a number of years now, in a number of different ways. I was struck by the similarity. And I would put the question to you whether or not the FEHBP really winds up being a functional single-payer system.

To what extent does FEHBP resemble the traditional, single-payer systems in which individuals can have the choice, can have the flexibility, maintain the quality in terms of their own options, with regard to health care choices under a single-payer arrangement?

Dr. BUTLER. Well, this may be an issue of definition, of semantical differences, as indeed the term "managed care" means a whole range of things. I was brought up under an explicitly single-payer system, which I can assure you looks a lot different from the FEHBP.

It is true that in both cases the Government pays a portion or some contribution. It is true that in both the FEHBP and the British system you have all kinds of choices.

But you have a whole infrastructure of choices in the FEHBP. You have private plans that you can opt in or out of over time. It is certainly a very different arrangement from the Canadian system or the British system. But certainly, if you want to define the FEHBP as a single-payer system, then I am in favor of a single-payer system in the United States. [Laughter.]

Senator MOSELEY-BRAUN. I said it was a provocative question.

Dr. Reischauer?

Dr. REISCHAUER. I said I must be against it if Stuart is in favor of it. [Laughter.]

But let me say that the FEHBP system provides resources to plans. And the plans buy services from providers. So it is not a single-payer system in the sense that there is no single payer paying directly to providers. Medicare fee-for-service is a single payer svstem for that group of people. So it actually is quite different.

And on your initial remarks about the concern of seniors, legitimate concerns about being able to see their own doctor or choose their own doctor, I think we have to keep in mind that unrestricted choice of providers costs money, costs more money than a constricted choice of providers. And that unrestricted choice was the model for the nation back in 1965 when Medicare was established.

But the overall system has changed rather fundamentally in the last 10 years. And now the working population and their dependents do not have the same unrestricted choice that they once had.

So the question is, over the years, are we going to move Medicare so it more resembles the health insurance that is being provided to the average worker and his or her dependents, and restructure it so that it is a similar social contract to what existed in 1965?

Dr. BUTLER. And I think, as you well know, that the more we see restrictions on fees within the system, we are increasingly seeing a lot of areas where free choice of physician is not all it is cracked up to be, or is not always meaningful.

Senator MOSELEY-BRAUN. And it is not always in the interest of quality either.

Dr. BUTLER. That is right.

Senator MOSELEY-BRAUN. But that is where the concern proceeds from.

When we talk about definitional issues—I mean a lot of what we do here is definition—and what labels you put on things matter. But in terms of the payment system, if indeed what we are talking about is a modification on single payer—not to say that the British experiment did not give single payer a bad name, no offense—the fact is that if we are talking about a variation on that, then I think it does make sense for us to be clear about what the similarities are, what the differences are, and how we therefore can approach this evolutionary model for reform of the Medicare system.

Would it be all right if Dr. Thorpe responded? He looks like he had a response on the tip of his tongue.

The CHAIRMAN. Yes.

Dr. THORPE. Yes. I think that Dr. Reischauer explained the fundamental difference. The fundamental difference is the process by which payment rates to plans flow from the Government. Therefore, payment rates from plans flow to providers. It is generated in a completely different process than an administered pricing setting. So I think it is importantly different in that respect.

On the quality side, I think one of the positive things that the FEHBP does is collect information—now on a yearly basis—about plan satisfaction, and provides that information as part of the packet that people receive. It is available in the "Checkbook Guide", for example.

If you look at those data, what they show is that two-thirds of plan participants are either very satisfied or satisfied with the health plan they have selected. That goes for both prepaid health care plans as well as fee-for-service plans. So that data is now available on an annual basis as part of the "Checkbook Guide". And I think that is a very important starting point for Medicare to look at.

Senator MOSELEY-BRAUN. Mr. Chairman, a short question?

The CHAIRMAN. Yes.

Senator MOSELEY-BRAUN. It is my understanding from some of the documentation we have here that the measurements of quality have been flawed with regard to FEHBP, that they have been a little lax, and they have not done a very good job in measuring quality. They have only recently started just kind of periodically measuring, you know, what do you think about this, but instead of using more specific scientific modeling approaches.

Dr. THORPE. This has been available now for two or 3 years. I would agree with you that there are really several layers in which quality could be measured and reported. Basically, they do report the most fundamental information in terms of information about access to health care, access to plans, general satisfaction with health care plans, and so on.

There is no doubt that more can be done. And better, more sensitive measures which exist today could be included as part of the plan reporting. I was just offering it as a starting point. It certainly could be improved. But at the very least, this information should be provided today in a coordinated, consistent and clear way to senior citizens as well.

Dr. REISCHAUER. Let me just add that measuring quality is going to be a huge problem. There are many dimensions to quality, and we are too often drawn to consumer satisfaction.

We have to remember that the vast majority of participants in any plan have no serious medical involvement during a year. Nice potted plants, access to well care visits, lots of magazines, a doctor who smiles, maybe leads to great satisfaction.

But that same plan might be lousy when it comes to bypass operations or something which 2 percent of the population experiences in a single year.

And you, choosing a plan, would care much more about the health outcomes of low probability events than how well watered the palm was in the office.

Senator MOSELEY-BRAUN. Thank you.

The Chairman has been very generous. Thank you very much, Mr. Chairman. Thank you.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, I am not concerned, but I just want to note that we probably will not get to the nomination of Bob LaRussa before noon. Do you think that is a safe statement? If that is a safe statement, in that I strongly support him, I would like to put a statement in the record about him, and also ask my leader to vote aye, with all due respect.

The CHAIRMAN. Without objection.

Senator ROCKEFELLER. Second, just a comment on the quality of health care. I think it is one of the most interesting, complicated issues in the evolution of health care. And I think back to the days of the so-called health care bill, when that was just too much, being tried by too few, for too many, or however one phrases those things.

But there was one part that I think was very strong, and that was the Health Care Quality Review Board. As I recall, there were only seven people. They were professionals, all experts, and no alliance or HIPAC—it seems like a word from 10 years ago, does it not? Remember that word? Now that was Big Daddy, yes. It was a seven-person bureaucracy and that was it.

But it is very, very troublesome, very complicated. And I think that we in Congress have to be very careful how we do it, if we are going to do whatever we do. We have to watch it closely because I think people in regard to health care are more easily duped or misled, or simply do not know; even though health care may be one of the two or three most important.

Dr. Thorpe, I just want to ask you a Medicaid question about crowding out. It is not exactly on target here, but it is a point that I really want to make. And that is the concept that somehow Medicaid expansions have pushed people out of the private insurance market. It is my understanding that you have done some research on this, and I would be very interested in what you have found out.

Dr. THORPE. Well, Senator, we have conducted a couple of studies looking at Medicaid expansions, staring in 1990 through 1995. And the issue was, as new children enrolled into the Medicaid program, were some of them currently covered or would have retained their coverage in employer-sponsored insurance, as opposed to enrolling in the Medicaid program?

What we have found is that most of the children who have enrolled into Medicaid were and would have been uninsured in the absence of the Medicaid expansions.

We found that there was some enrollment of children that formerly had employer-sponsored insurance. But as a percentage of new enrollees, it was quite small, something on the order of 8 to 12 percent of enrollees were such children.

So at least within the current Medicaid expansion thresholds of 100 percent, 133 percent and 185 percent, depending on the age, certainly there is some substitution but it is quite small, and I think understandably so, given the fact that this is a marketplace.

There are those income thresholds where there is relatively little private health insurance. Many of those children are in families where, if they did have private health insurance, their parents have lost their jobs and become uninsured, and so on.

I know there are other studies, but we have found that it is substantially less of an issue.

Senator ROCKEFELLER. Dr. Thorpe, I appreciate it. I wanted to get that on the record. And I also want to get on the record an additional thing. And that is that as we discuss choices for seniors, I think the whole concept of portability is extremely important. That is a choice that people in Medigap do not now have.

And Senators Chafee, Jeffords, and a number of us have put in a bill that I think frankly really speaks to the heart of choice issues. If you cannot take it with you, it really does not do that much.

Seniors sometimes tend to get more confused about health care because they have to make more difficult choices than younger people. So I would hope that portability is something that we in the Finance Committee can be looking at.

And I thank the Chairman.

The CHAIRMAN. I want to thank the panel. I think has been excellent and very helpful. We look forward to consulting with you as we progress on these important matters.

I would now call forward our second panel.

We will hear from Mr. Richard Anderson, vice president for health policy at Kaiser Permanente; Mr. Edwin Hustead, former Chief Actuary for the FEHBP program at the Office of Personnel Management, and currently senior vice president of the Hay group; and Mr. Peter Wyckoff, who is representing the National Council on the Aging as liaison for the National Coalition of Consumer Organizations on Aging.

Gentlemen, it is a pleasure to welcome you.

We will be happy to start with you, Mr. Anderson. Your full statements, again, will be included as if read.

STATEMENT OF RICHARD V. ANDERSON, VICE PRESIDENT, HEALTH POLICY, KAISER PERMANENTE, OAKLAND, CA

Mr. ANDERSON. Thank you, Mr. Chairman and Members of the committee. I really appreciate the opportunity to discuss this subject matter with you today.

For nearly 40 years, Kaiser Permanente has had two very large Government programs which have been a very important part of Kaiser Permanente. One is FEHBP, with currently more than

600,000, and the other is about the same size. It is the Medicare program.

I would like to try to briefly summarize my written testimony. There you will find suggested principles to guide effective competition, and then an exploration of what Medicare could look like, consistent with these principles.

Following that is an examination of how FEHBP matches up, and then a discussion of issues, many of which have already been raised.

Let us start with the principles. They are pretty simple but I think they are pretty powerful. First, competition should encourage efficiency in the marketplace.

Second, it should be based on value. And value is a combination of quality, service and price.

Third, it should not be based on risk selection, deeming, buying the business or other factors which cause the markets to fail.

And finally, it should be structured to allow some flexibility in responding to the needs of beneficiaries as well as purchasers, including predictability and stability in benefits as well as cost.

Now what do these principles suggest for Medicare? Beneficiaries would participate in Medicare by enrolling in competing health plans. All plans would have premiums, including traditional fee-for-service.

Medicare would contribute a fixed amount for a standard set of benefits. The remainder would be paid by beneficiaries.

The Medicare contribution would be the same for all beneficiaries in a given area. Price competition would take different forms, including reduced premiums, reduced cost sharing, or increased benefits. And there would be state-of-the-art risk adjustment methods to compensate for risk selection problems.

There would be incentives to enroll in care for vulnerable populations. There would be informed choice for beneficiaries that would include comparable, meaningful information about quality, access and outcomes of care.

There would be uniform health plan standards designed to protect beneficiaries. And all plans that met the standards would be allowed to participate in Medicare.

Now much of what I just described is included in FEHBP, but there are some key features which are missing. And those have been mentioned by others already.

First, basic FEHBP benefits are not standardized. I think for Medicare there should be a core set of standard benefits that covers at least all statutory benefits for all health plans. I would suggest including preventive care.

And I think the plans should be allowed to offer a few additional supplements, including prescription drugs, eyeglasses and such.

Second, FEHBP contribution is not locally based. And I believe that Medicare contribution should be. It should be calculated on a weighted average of local plans' premiums.

There also should be deterrents to low-balling or other gaming. There should be a mechanism to help stability payments. And I think the Federal employees' so-called contingency reserve fund is a model for that.

Third, there is no FEHBP mechanism for risk adjusting payments, and I think Medicare needs this. As soon as feasible, I believe Medicare should implement new risk adjusters such as methods based on diagnostic information and functional health status.

Fourth, there is no FEHBP mechanism to protect plans against catastrophic, unpredictable losses.

Fifth, FEHBP-coordinated open enrollment does not permit timely disenrollment if a beneficiary is dissatisfied. And there are good reasons to maintain the current Medicare rules that permit beneficiaries to continuously enroll or disenroll from Medicare plans.

And finally, FEHBP has not been as aggressive as Medicare in encouraging competition based on quality. We applaud Medicare's leadership role in this area.

Mr. Chairman and Members, thank you for this opportunity.

I would be pleased to answer any questions you might have.

The CHAIRMAN. Thank you.

Mr. Hustead, please.

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

STATEMENT OF EDWIN C. HUSTEAD, FSA, SENIOR VICE PRESIDENT, HAY/HUGGINS, INC., WASHINGTON, DC

Mr. HUSTEAD. Thank you.

As you know, I was the actuary involved in the negotiations of this plan for many years, and I have followed it since then, both in the private sector and in the Government.

With respect to the prior panel, it is always interesting to hear the economic theory of what a system is doing and compare that to what actually is happening. And I see a good deal of difference here.

First of all, FEHBP is not anywhere near a classic competition model, as was proposed in 1994, and I think as was suggested earlier. It is anything but a competition model in that sense.

The question of what happens during the open season when the choices are made, is that very little does happen as far as the cost of the system.

The question was asked several years ago, and we worked with the Congressional Research Service to study that. We found that the overall effect of all of the open season actions was very negligible. It did not either increase or decrease costs.

What has led to this sharp drop in rate increases in both the private sector and FEHBP? What has happened is a lot of tough, head-to-head negotiations with the employer, such as OPM, and the providers of insurance and the insurers with the providers of health care.

The realization has been, if you are going to control costs, if you are going to create efficiency in the model, you are going to do it at the point of service. In fact, many of the new, popular plans are called point-of-service plans.

And at that point, you give the individual the choice of using the in-network services or the out-of-network service at a financial difference. And that is where the cost saving has been achieved.

And I also heard that what should be happening is that we should open the program on standard benefits, and let insurers bid.

In fact, that is not what OPM does. What OPM does is negotiate; they do not accept bids. And I do not think bids would work in FEHBP.

What lessons can be learned from FEHBP for Medicare, as has been said throughout this morning, with the realization that these are very different systems?

One is that the competition, where it works, takes place on the style and the type of plan, not on the benefit provisions. And the styles that are increasingly in FEHBP, and are being used somewhat now in Medicare, and have been used extensively in the private sector, are Preferred Provider Organizations, point-of-service plans, in addition to Health Maintenance Organizations.

That could be achieved on the FEHBP model by establishing nationwide plans where the Government would negotiate closely with the providers of those plans on a nationwide basis.

And they could adopt the OPM techniques of negotiating—negotiating for premiums, negotiating for benefits, oversight of the plan once the benefit is in place, and using the communication process that OPM uses.

And I think, in order to achieve that—again, as has been mentioned several times—the administrator, HCFA or whoever administrates Medicare under the system—would have to have the same type of flexibility that OPM has to arrange the benefits and deal with the contractors. As you were saying, you cannot go benefit by benefit.

So I think you could adopt within Medicare three nationwide plans and a choice of HMO locally.

I mentioned four concerns there with Medicare. One is the quality of care. This is the backlash that has been discussed quite a bit recently. In squeezing costs, has quality been destroyed?

One big problem you are going to have to deal with is Medigap plans because Medigap plans can destroy the choice that is needed at the point of service.

How do you determine an equitable Government and enrollee contribution? That is going to be very critical throughout the process.

And I think, at least in the transition, you will have to figure out how to continue the current Medicare choice for the individual, so that you do not force them into a managed care system.

Thank you very much.

The CHAIRMAN. Thank you.

Mr. Wyckoff.

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

STATEMENT OF PETER WYCKOFF, EXECUTIVE DIRECTOR, MINNESOTA SENIOR FEDERATION-METROPOLITAN REGION, ST. PAUL, MN

Mr. WYCKOFF. Mr. Roth, good morning Mr. Chairman and Members of the Committee.

I am Peter Wyckoff, the executive director of the Metropolitan Region of the Minnesota Senior Federation. I am testifying today on behalf of the National Council on the Aging. NCOA, as you may

know, is a center of leadership, innovation and nationwide expertise on the issues of aging.

Under the auspices of NCOA, we have formed the National Coalition of Consumer Organizations on Aging, a coalition of broad-based community organizations, currently in 12 States.

All these organizations are run and directed by older people in their communities. They are all very local, but they provide a true, authentic consumer perspective on issues facing older Americans.

The Minnesota Senior Federation has been involved in health care, providing both objective consumer information and negotiating on behalf of seniors for improved access to quality health care.

For example, we are the primary source of objective information on Medigap options in Minnesota, counseling over 30,000 seniors annually, with highly trained volunteers and professional staff.

We do side-by-side comparisons of programs. We have also directly negotiated with hospitals and physicians to create Senior Partners Care, a Statewide program with thousands of providers who accept Medicare not only on assignment but as payment in full for 7,000 enrollees who have modest assets and incomes.

From our experience in those 25 years, beside the kind of issues that Senator Breaux raised, and the inequities of AAPCC, we see major obstacles in managed care as providing affordable, consumer-responsive health care.

There is a disempowerment of Medicare beneficiaries to actually negotiate quality health care on their own behalf.

Throughout the country, employers and unions negotiate health benefits with providers. They negotiate with managed care organizations and insurers.

However, upon receiving Medicare, most retirees are on their own in dealing with Medicare risk and supplemental products. And they are on their own, without the technical expertise and without the buying clout to really affect managed care organizations.

So seniors have no choice but to accept the rates and the quality of care that has been set by the HMO and approved by HCFA and State regulators.

However, approval of rates and negotiation of rates on behalf of beneficiaries is not the same thing. Seniors become passive recipients in the health care system, and not active participants.

The National Council on Aging is firmly committed to helping to address this and other issues facing the Medicare trust fund and Medicare beneficiaries.

As a result, we have initiated a 15-month study of the feasibility of a Medicare consumer cooperative, or MCC. The study is funded by the Retirement Research Foundation, a charitable foundation in Chicago, Illinois.

In a Medicare consumer cooperative, beneficiaries would have the option of joining a State or regional pool that could actually negotiate the health marketplace. At a minimum, MCC's provide members with consumer information, counseling, ombudsman and advocacy service. And under certain circumstances, it is hoped that MCC's would actually negotiate preferential rates on behalf of their members.

The concept of Medicare consumer cooperatives has parallels in other sectors. Many companies have joined together to form pur-

chasing alliances to negotiate managed care on behalf of their employees and unions.

An important example of the purchasing alignments is FEHBP, the subject of this hearing.

One State-sponsored plan that has considerable experience with Medicare beneficiaries is the California Public Employees Retirement System, or CALPERS, which administers the retirement program for California State employees. Approximately one million people, active employees, retirees and their dependents, are covered by the program.

MCC's could potentially yield major results for consumers, managed care organizations and the Government. Managed care plans and insurance companies could also benefit from MCC's. They would allow companies to reduce their marketing and enrollment costs significantly for the benefit of all. Also, MCC's should also produce substantial savings for the Federal Government.

Nevertheless, there are legitimate concerns and unanswered questions about MCC's, whether or not they are really feasible. Some people are concerned that MCC's could lead to fragmentation of the Medicare market, make it easier for HMO's to skim and enroll only healthy seniors.

Others question whether it is really appropriate for anyone other than the Federal Government to bargain on behalf of beneficiaries. These and other questions are being dealt with within MCC's.

MCOA is currently engaged in an active effort to systematically and feasibly look at the merit of Medicare consumer cooperatives. Under the direction of Dr. James Firman, president and CEO, and chief of policy, NCOA is now working with a distinguished panel of health experts.

They are going to look at outcomes, look at maximizing the value of health care dollars expended, assuring that no harm results from those not electing to join, increased consumer education, protecting Federal expenditures, and insuring that cooperatives remain consumer-driven, financially sound and viable.

They will be working during the next 8 to 15 months with HCFA, with managed care organizations, with consumer organizations, looking at various models. We expect that this will develop a new body of knowledge which will, by this time next year, provide you with the kind of data that can see whether a consumer-driven health care system is feasible, and whether we can work out the kinks.

Mr. Chairman, this concludes my statement. Additional material has been submitted for you.

Thank you.

The CHAIRMAN. Thank you, Mr. Wyckoff.

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

The CHAIRMAN. Let me ask Mr. Hustead and Mr. Anderson. It is my understanding that OPM negotiates premiums with each plan on an individual basis.

Could one or both of you elaborate on the leverage that OPM has in negotiating with these plans? That is, what if a plan with significant enrollment is to simply say to OPM, we just cannot meet

your price, and we are backing out? What are the potential consequences of using this pricing method for Medicare?

Mr. HUSTEAD. Actually, they have come very close to that. Aetna did pull out several years ago when they could not do it. They have come very close to the end of negotiations with several plans over the years.

First of all, other than the HMO's, the nationwide plans are fully experience rated. All they pay for over the years is the cost of Federal employees' claims and their administrative expenses. So it is really a matter of how do you best establish this year's premium.

The profit, as is mentioned earlier, is fixed. Administrative charges are often fixed. So it is a very tough negotiation. It is like any tough negotiation between two very large parties. And over the years, there have been points at which somebody has pulled out and/or OPM has said, we just do not accept it. And they have gone to the boards on it.

The CHAIRMAN. Mr. Anderson?

Mr. ANDERSON. Mr. Chairman, let me first say what I think it is not. And it is not a negotiating situation in FEHBP where the Federal employees try to drive down profits or try to eliminate large increases in payments and so on.

I think the stages are as follows: The first is to set forth some objectives for the year in terms of overall budgets, and then try and work as much as possible within a budget-neutral situation for an individual plan. If a plan offers additional benefits, they have to reduce elsewhere.

There is an exception to what I just said. And that is that the two California plans for Kaiser make up part of the big six formula for FEHBP. And the premiums for the two Kaiser plans not only affect their own members, but they have a very profound effect on national budget for FEHBP because it is part of fixing the national contribution.

So OPM does look with much greater scrutiny at the premiums and the submissions for those two plans. But they have not been as aggressive, for example, as PERS has in California where they basically said, if you have an increase, your enrollment is frozen. So from my point of view, there is a less aggressive negotiation in FEHBP.

The CHAIRMAN. Mr. Wyckoff, I understand that you do have a long career working with seniors. Could you give us your insight on how best to go about a transition in the Medicare program without creating fear and dread among the seniors that are very accustomed to, and in many ways very satisfied with, the program as it now exists?

Mr. WYCKOFF. Senator Roth, I think you raise a good question. Being in Minnesota, we are kind of the cutting edge of managed care, at least in the Twin Cities.

And that issue of choices is a real concern. As Senator Moseley-Braun has pointed out, the ability to be able to choose your doctor, especially among this population, is a critical concern. This is the way it has always been, and it is often the issue that is there.

I think it has got to be voluntary, which you need to look at to be able to move into these systems. And let the carrot as opposed to the stick encourage people to do that.

When the Senior Federation first started working with managed care programs with Dr. Paul Elwood, back in the late 1970's, fee for service was a standard operating procedure.

When managed care programs or risk contracts came in, the costs were one quarter of fee-for-service programs. It was a carrot and not a stick that brought people into those programs. And so it was sheer operation.

Likewise, we had strong consumer issues. And we also began in Minnesota to have standardizations between policies. So it is in those areas that we get there.

The other side of that is I think there ought to be strong consumer ownership of whatever kind of program is worked, and not simply something that is coming from providers or, for that matter, the Government. And the kinds of things we are looking at in the MCC's are one mechanism for doing that.

The CHAIRMAN. Thank you.

Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, just to continue on a subject I cannot get away from, I met yesterday with Martin McGunn, who is the head of the New York University Medical School.

He was describing a new device they are about to launch called a gamma knife, which can eliminate tumors deep in the brain without a single surgical touch. A laser does it all—bang! And you get up and walk away. It might be able to make heart bypasses without any breaking of bones. It is an extraordinary change.

This brings to mind the occasion when we started out in this Committee to talk about health care, and the legislation that was sent to us from the Administration in late 1993, but actually the beginning of 1994.

I asked Paul Marks, the head of Sloan-Kettering, to "teach" me a little about medicine and health care. Could you give me a seminar or something like that? And he said he could, and he did.

One January morning, we all gathered in his conference room on the east side of Manhattan, about 10:00 o'clock. At 10:20, the dean of the Johns Hopkins Medical School, said you know, the University of Minnesota may have to close its medical school. And then I knew I had just heard something I had never heard before. Minnesotans all are Swedes. They do not close medical schools; they open medical schools.

I had heard all the other stuff about health care, but this is a new idea—close a medical school. And it was explained that, being a progressive State, the managed care had come moving east from Kaiser Permanente on the west coast, and they were really getting into cutting down prices, getting efficiencies in the market. And the market does not have any place for a teaching hospital. And if you do not have a teaching hospital, you cannot have a medical school.

And indeed yesterday, Mr. Chairman, the *New York Times* had a long, fascinating article entitled, "Teaching Hospitals Under the Knife; Longtime Missions Pressed by H.M.O.'s." And notice that the University of Minnesota Academic Medical Center has been merged with stronger, non-profit local institutions.

The provost at the University of Minnesota says the managed care market says, "We have no responsibility for medical education or clinical research." In other words, tough cookies!

Could I place this in the record, sir?

The CHAIRMAN. Without objection.

[The information appears in the appendix.]

Senator MOYNIHAN. I just wanted to say, do you not think we have to begin to think of how we can provide for the public good associated with medical research, which markets cannot accommodate?

Mr. Anderson, you must have been working at this for 40 years.

Mr. ANDERSON. Senator, I think we have been thinking about this since the inception of the program. And I actually, personally—and I believe our program strongly agrees with the proposition you are advancing—that for managed care there is a very important role for training of physicians and non-physicians, for working to support the missions of academic health centers, and so on.

In fact, in the early history of the program we established a nursing school. I think 2 years ago, we had nearly 1,000 approved residencies that we support. We work effectively with them.

Senator MOYNIHAN. You do that on your own?

Mr. ANDERSON. Yes. Although part of it is paid for through Medicare payment mechanisms.

Senator MOYNIHAN. Well I just think, sir, we are going to have to address this.

Mr. WYCKOFF?

Mr. WYCKOFF. Senator Moynihan, I also being from Minnesota, agree with you. We have not lost our medical school though; we have lost our university hospital. And there is a distinction there.

Senator MOYNIHAN. Well, sure but——

Mr. WYCKOFF. And that piece goes.

Senator MOYNIHAN. But 10 years ago, could you have imagined that happening?

Mr. WYCKOFF. No. It is very hard for us as good Swedish Minnesotans. But I am Dutch from New York, by the way. But as a good Swedish area to look at that loss for this community.

But we have also not been honest in the way we have funded health institutions and health research in those areas. And we have been looking at Medicare as a cash cow to do that. And we did look at insurances under that.

Managed care will not allow that. Medicare per se, it is not part of its mission to do that. We need, through the kind of trust funds you were talking about, through State initiatives, to find those dollars to support the quality research and the quality education we need in this country, and not to try to build it off of some other system.

I agree with what you are doing entirely.

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

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you very much.

I want to thank all the members of the panel, particularly you, Mr. Wyckoff. A lot of times, we have to tell people to get closer to the microphone. You have got it down very well. [Laughter.]

Senator BREAUX. You are not only an eloquent spokesman for seniors; you are a clear spokesman for seniors. We thank you.

I think everybody needs to understand that what we are trying to propose here is what I would call the most significant changes in Medicare since 1965, when it was established.

From my perspective, we are essentially talking about junking the status quo and trying to replace it with a system that will give seniors more choices, more information, more benefits, more negotiating strength and power in using the 38 million seniors that are out there as a marketing force to get companies and health delivery systems to compete for their business.

Now, Mr. Hustead, you have experience with OPM, and I appreciate your comments and your thoughts about how it works. And while it is correct that they do not actually competitively bid who gets to do the business, the fact is that what they do do through negotiations is similar to bidding in the sense that all the companies know that they will be selected on who offers the best package and gets to negotiate.

And when you negotiate, you know that there are others out there. If you do not come up with the right price and the right package, there will be others who will be able to step in and offer the right package at the right price. So there is a negotiation which is similar to a bidding process.

My suggestion is an actual competitive bidding process on a standard set of benefits, with risk adjustment as part of that procedure. And while the Federal plan may not be actual competitive bidding, we do know factually that their costs have been increasing at about 4 percent. And Medicare, with less benefits, has been increasing at about 9 percent a year.

So the FEHBP is bringing down costs, and at the same time allowing for greater benefits.

I do not have any real questions. I think you were very clear in what you are saying. And what we are trying to do is structure something that takes some of the top features of FEHBP and incorporates them as an option to Medicare.

And Mr. Wyckoff, I think Senator Roth asked a question about how do we do this without scaring seniors. One way, I think, is to offer this as an option.

Mr. WYCKOFF. Exactly.

Senator BREAUX. Which is what my proposal is, that this is one option. They can keep the fee for service. If they prefer that, they stay with that. But if they think this new plan is better, then they can move into it. Does that give some comfort?

Mr. WYCKOFF. It gives some comfort.

The two issues you raise though need to be addressed with whatever you are doing. And that is those risk status adjustments are crucial. Right now, we as taxpayers are losing under managed care systems. And unless we do this, we cannot either deal with acute care health care or even begin what we ought to be doing in merging chronic and acute care under a system without that kind of issue.

Second, the very way AAPCC is formulated is obviously highly discriminative against conservative practicing States like Minnesota. We will go broke if you cut it across the board. So that needs to be addressed.

So both of those need to be dealt with. Especially with a voluntary system, you have got to put both of those in place or else you are going to lose money big time.

Senator BREAUX. Thank you.

Mr. Hustead, do you think we can kind of mesh or meld the two of competitive bidding and negotiations together in a way that works?

Mr. HUSTEAD. Well, if I could just make one comment, the plans in the program are fixed under law and regulation. There is no bidding for plans, so you have to deal with the same ones.

Senator BREAUX. But the plans offer different things.

Mr. HUSTEAD. They do offer different things.

I would also remind you that in considering particularly the Medicare population, in picking plans, you should keep in mind the disarray and the tremendous overinsurance that occurred before the Medigap policies were regulated.

I would be very cautious about simply providing the authority for plans throughout the country to go directly to the people covered by Medicare with their plans.

Senator BREAUX. Thank you. I thank the panel very much.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. I would like to inquire in the area of risk management. What happens to the chronically ill, the bedridden, and the already sick if we switch to this plan? Who takes care of them?

Mr. WYCKOFF. Without a health status adjustment, we have proved that managed care treats well people very well. And there have been examples under social HMO's and other demonstration projects where I think we have shown that long-term care and chronic care be delivered efficiently under managed care programs.

But we cannot do it without decent risk adjustments that would allow for a person with a chronic care condition to get reimbursed under a risk arrangement at a rate that would be able to deal properly with that kind of health status situation.

Senator JEFFORDS. Mr. Anderson?

Mr. ANDERSON. Well, Senator, I think that there are a number of things that could be done in Medicare to provide greater incentives for people to seek out and provide care to vulnerable populations.

I concur that risk adjusters is an important place to start. The idea is, if you make a fair payment to an organization for the risk that they will incur, they ought to have incentives to try and provide care. You cannot save money on people who do not use medical care. You ought to have this as the underlayment.

There are some interesting directions that this could go. And there are some experiments that are underway at the moment to begin thinking about paying for improving the health of beneficiaries, or reducing the rate of decline and disease.

Ultimately—and I am not sure that this is going to happen until at least day after tomorrow—this could really change the incentive structure for caring for vulnerable populations.

Mr. HUSTEAD. I think we have evidence in FEHB of what happens when the chronically sick get in one plan. And that is what happened to the Aetna plan. That is what drives up the cost of Blue Cross high option. So it is something to be very concerned about.

Unfortunately, we talk a lot about risk adjusters and using them. The state of the art in risk adjusters is still very primitive. Nothing has been done that, at least prospectively, works well. In this country, and other countries where it has been tried, it does not.

So while we talk about risk adjusters, it is a very complex and unproven process at this time.

Senator JEFFORDS. Mr. Anderson?

Mr. ANDERSON. I concur with Mr. Hustead that the state of the art currently is not very good. But I think a system of risk adjustment that takes into account the latest available approaches, plus an overlay of some kind of a system of outlyer payments, reinsurance mechanism or an approach, for example, that New York State is using to make fixed payments for certain high cost conditions, can begin to deal comprehensively with the broad problem of risk selection.

If you layer on top of that other kinds of things—more responsive due process for grievances, an improved system of enrollment in informed choice, it is possible that it would be good enough.

Senator JEFFORDS. Thank you.

I think this is something we must look at carefully as we proceed. We have a system now which is a virtual dumping ground, and which is not what society ought to provide.

Thank you very much.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much.

This is kind of an actuarial question. And it really is a legitimate question because I do not know the answer. All right? That is rule number two. You do not ask a question you do not know the answer to. But this one I do not.

I am concerned about the whole issue of poverty, how we compensate for it, how we track it, and how we quantify it in the course of the risk adjustments and in the course of the actuarial assumptions that go into the formulas for payment.

We make up for poverty on the back end of the process now under Medicare with the disproportionate share. We say to poor institutions, well, we know that you have got special costs associated with the fact that you have all these poor people who are sicker, who get more gunshot wounds, and things like that. So here, just take some extra money to make up for that.

If we went to a system that did not have that, then it would seem logical to me that you would have to make up or have some way that poverty gets counted as one of the actuarial assumptions when you talk about health risk.

I mean right now you look at conditions and age and things like that. But do the actuaries actually count, or is there any way they

quantify the high costs associated with poverty with poor individuals in creating the formula for payment?

Mr. HUSTEAD. In a system like FEHBP or Medicare, fortunately in that respect, everybody is covered. So you do not start with the idea of putting people into certain areas by wealth or poverty or anything else.

The risk adjustment process that is being referred to should take care of adjusting for differences in health status, for whatever reason, among the different plans.

I think more directly to the question of the income level of the individuals in Medicare, that would require a careful structuring of what the individuals can and should pay themselves, the portion of the premium.

So I think as long as you have a closed system with everybody in it, then the key is to make sure that you do not structure plans that will attract the wealthy or attract the poor without making an adjustment for their health status.

Senator MOSELEY-BRAUN. Let me rephrase my question. Not just in terms of how much the individual has to pay for the health services, but in terms of the analyses that we do—and, again, Kaiser Permanente serves a lot of people—is there any difference in the numbers you use in reaching your costing assumptions?

Is there any difference made between people who are at risk because of their poverty versus other people in the population groups you serve?

Mr. ANDERSON. Senator, in our pricing we use a modification of pretty vanilla community rating. We do not make any differentiation based on poverty status or many of the other differentiators that experience-rated plans use.

Maybe in part what you are raising here is an issue of how to identify vulnerable populations, including indigents. And there has been some good work recently, I think, by PPRC on monitoring vulnerable populations based on certain kinds of characteristics, including things that should not happen to them after they receive care.

And I could imagine at some point that new indicators could evolve which could be used in a risk adjustment system.

Senator MOSELEY-BRAUN. Mr. Wyckoff?

Mr. WYCKOFF. Senator Moseley-Braun, I think also as we look at the benefit package, we look at the basic benefit package of Medicare. For instance, prescription drugs being an optional situation, obviously at much more expense, because it tends to pull a sicker pool of people into it.

So under whatever comes out of this, we would hope that there will be some standardization in benefits in things like prescription drugs, which need to be covered universally. Otherwise they are going to be out of the reach of lower income people to be able to do that. And that is what has happened now with both supplemental policies and risk policies.

Senator MOSELEY-BRAUN. Thank you.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Mr. Chairman, let me thank you for holding the hearing. I have no questions.

I have a statement to be placed in the record.

[The prepared statement of Senator D'Amato appears in the appendix.]

The CHAIRMAN. Well thank you, gentlemen. We appreciate your being here today. Again, we will look forward to further discussions with you.

At this time, we will turn to a nomination.

[Whereupon, at 12:19 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Dick Anderson

Mr. Chairman and members of the Committee, I thank you for the opportunity to present my views on "FEHBP As a Model for Medicare Reform". I am here today representing the Kaiser Permanente Medical Care Program, a non-profit integrated medical care program that provides predominantly prepaid comprehensive health benefits and serves 7.9 million members in 18 states and the District of Columbia. It is the largest private health care delivery program in the United States with 90,000 employees and 9,400 full-time equivalent contracting physicians.

Kaiser Permanente has participated effectively in the Federal Employees Health Benefits Program (FEHBP) from its inception. Today, we serve 633,000 Federal members, including both employees and dependents. Of that total, 480,000 are active Federal members and 153,000 are annuitants. Most of the annuitants are entitled to Medicare benefits. The FEHBP has been very important to Kaiser Permanente, not only because of the responsibility we have undertaken to provide integrated health care to this many members but also because it has been an effective model that many others have emulated for providing multiple choice of competing health plans. We have partnered with FEHBP to develop new benefits and services that have positively affected many others. The predictable and steady growth in our federal enrollment has contributed materially to our stability and success as an organization. There are features of FEHBP that should be seriously considered for inclusion in Medicare reform proposals. I will examine these with you and discuss related issues.

Before I do that, I will first lay a framework by articulating some general principles which, I believe, should guide the design of an effective Medicare competition model and explore what Medicare could look like in the future under this design. Then I will describe how FEHBP currently fits within this framework—where it matches and where it doesn't. Finally, I will elaborate on issues and implications of the FEHBP model for Medicare.

Some Principles to Guide Effective Competition Between Health Plans

Competition should encourage efficiency in the marketplace.
- Prices in a competitive market should reflect efficient costs of providing care.
- Competition should be structured to provide incentives for plans to establish prices that reflect efficient costs.

Competition should be based on "value'—a combination of "price" and quality
- Beneficiaries should be rewarded if they join efficient, high quality plans.
- There should be disincentives for them to join inefficient, low quality plans.
- Rewards should be in the form of lower cost sharing, richer benefits, superior quality of care, and/or better access to care.

Competition should not be based on risk selection, "gaming", "buying the business", or other factors which cause markets to fail.
- The prices faced by beneficiaries should reflect differences in plan efficiencies, not risk selection.
- Rules should be designed to minimize "gaming" and manipulation, including disincentives against bidding excessively high to "pad" the Medicare contribution and requirements that premiums be actuarially sound.

Competition should be structured to allow flexibility in responding to needs of enrollees and group purchasers.
- Plans should have some latitude in designing benefits and structuring premiums to meet varying requirements.

Competition should be structured to achieve and maintain marketplace stability.
- Short-term savings should not be achieved at the expense of long-term savings.
- Disruptive changes and volatility should be minimized for beneficiaries, providers, and plans.
- There should not be barriers to entry or to continued participation by efficient, high quality plans.

Given this as a general framework, the following is a picture of what a reformed Medicare could look like in the future if it were to evolve into a program with more effective competition between health plans based on price and quality.

Choice of Health Plans
- Beneficiaries would participate in Medicare by enrolling in a health plan.
- Health plan choices in an area would include comprehensive plans and at least one fee-for-service plan option.

- **All Medicare options would be "full replacement" plans with premiums, that is, all would be required to offer at least a minimum, standard level of coverage that would be specified in law. Traditional Medicare fee-for-service would be converted into one or more plans with premiums.**
- **Beneficiaries would periodically be given the opportunity to choose among available health plan options and would have timely opportunities to change plans if they were dissatisfied with their choices.**

Basis for competition

- **Beneficiaries would make choices based on quality, service, price, and other dimensions of value. They would pay more if they joined inefficient plans and vice versa. Price competition would take different forms, including reduced premiums, reduced cost sharing at the point of service, or increased benefits.**
- Competition based on "risk selection", "gaming", or misinformation would be effectively precluded by structuring appropriate payment incentives, providing informed choice for beneficiaries, imposing marketing restrictions that would limit abuses, standardizing benefit options, and limiting opportunities for plans to disenroll higher risks.

Informed Choice and Accountability

- Beneficiaries would make informed choices, based on uniform, accessible, comprehensible, and fairly presented information. Information would include valid comparisons of the performance of each health plan option (including measures of quality, health outcomes, access, and satisfaction). Such information would be in a form that is relevant to beneficiaries. Performance data on health plans and providers would be risk adjusted to ensure fair comparisons.
- There would be appropriate beneficiary and provider protections, embodied in standards that would be comparable for all health plans. All plans that met Medicare standards would be allowed to participate in Medicare.

Payment

- The basic payment made by Medicare (the Medicare contribution) in a given area would be the same for all beneficiaries. This payment would be based on premiums charged by plans in a local area and would be determined in a manner that is consistent with Medicare budget objectives.
- Medicare payments to individual plans would only vary based on adjustments for differences in the risk of their members. There would be "state of the art" applications of risk assessment and risk adjustment to remove the effects of risk selection from "prices" faced by beneficiaries.

- There would be appropriate incentives for plans to charge premiums that reflect costs of providing efficient, high quality services to Medicare beneficiaries. There would be disincentives for plans to engage in strategies (e.g., "low balling" premiums, targeting favorable risks, or misinforming beneficiaries) that would undermine fair competition.
- There would be appropriate mechanisms to protect plans against catastrophic, unpredictable losses.
- Payments would be structured to preserve stability in benefits and cost sharing for beneficiaries.
- There would be appropriate incentives for plans to enroll "vulnerable" (e.g., chronically ill and disabled) beneficiaries and provide appropriate service to them.

FEHBP Features

Many, but not all, of the features described above are embodied in the FEHBP model. Federal employees and annuitants have significant choices which include competing comprehensive plans and government-wide fee-for-service plans. All plans that meet FEHBP standards are allowed to participate in the program. Enrollees are annually given the opportunity to change plans during an open enrollment period which is designed to inform choice through the provision of standardized information about plans.

FEHBP makes fixed contributions toward the costs of plans' premiums.[1] All FEHBP enrollees must share in meeting these premium costs. They must pay the difference between a fixed government contribution amount and their plan's premium. The higher a plan's premium, the more that enrollees must pay. Premiums vary based on differences between plans in efficiencies, generosity of benefits, and to some unknown extent risk selection. These factors are the primary basis for competition.

This model has been effective. FEHBP has been popular with Federal employees. They have experienced stability in coverage and costs over long periods of time. While there have been some prominent casualties due in part to risk selection problems (for example, the elimination of the nation-wide Aetna high option plan), choices of comprehensive plans have generally broadened and the other nation-

[1] For most of the plans, the government contribution is set at 60% of the unweighted average of premiums for the "Big 6": the nation-wide Blue Cross/Blue Shield high option plan, the two largest employee organization plans, the two largest HMOs (Kaiser Permanente Northern and Southern California), and a "composite" of these five plans that serves as a place holder for the former nation-wide Aetna plan. For any plan, the government-wide contribution is limited to a maximum of 75% of the plan's premium.

wide options appear to be healthy. It is noteworthy that annual rates of increases in premiums and the government contribution have been low and relatively stable from year to year. During the five year period ending in 1997, annual average compounded rates of premium increases were as follows:

	Employee Only	Employee + Family
BC/BS high option plan	-1.44%	-1.04%
GEHA	1.07%	1.07%
Mail Handlers	4.37%	4.34%
Kaiser-Northern California	-0.28%	0.23%
Kaiser-Southern California	0.07%	-1.14%
"Big 6" average	0.41%	0.35%
Gov't-wide. contribution (60%)	0.41%	0.35%

These data reflect remarkable success in containing increases in FEHBP costs during the past five years. Medicare has not enjoyed similar success.

Some Features not Included in FEHBP

Some of the features of the competitive model described above for Medicare reform are not included in the FEHBP design.

- There is no standardized benefit design, even for basic FEHBP coverage options. FEHBP permits significant variation in benefits, including the offering of both high and low option coverages by some plans.
- The FEHBP government-wide contribution is not directly based on local premiums of plans. The amount of the contribution varies with local premiums only to the extent that the 75% limit in the contribution is applicable.
- There is no FEHBP mechanism for risk adjusting payments to compensate for differences between plans in the health risk of enrollees. There are not strong deterrents against plans competing on the basis of risk selection.
- There is no FEHBP mechanism to protect plans against catastrophic, unpredictable losses. (However, plans may reinsure through their own devices.)
- The FEHBP coordinated annual open enrollment period limits opportunities for enrollees who are highly dissatisfied with their plans to disenroll in a timely manner.
- FEHPB has not aggressively encouraged competition based on quality. While FEHBP has periodically measured attitudes of enrollees, it has been somewhat slow to adopt more definitive measures of quality and access and to communicate findings. There is little information currently available to

enrollees that enables them to fairly compare performance of plans in these areas.

Key Issues in Applying the FEHBP Model to Medicare

Let us return to the subject at hand. What issues need to be addressed when considering the applicability of the FEHBP model to Medicare?

How much benefit standardization should there be?

As indicated above, there may be significant variations in benefits offered by FEHBP plans. Some competition advocates believe that all plans should only offer a standard benefit package to enrollees. In their view, this is necessary to reduce confusion about cost differences between plans and limit opportunities for plans to achieve favorable risk selection. Importantly, a standard benefit package would offer a common denominator upon which plans would establish premiums. Others argue that there would be greater value for beneficiaries if plans were given significant flexibility to compete on the basis of benefits as well as price. They suggest, moreover, that some types of benefits are more appropriate for some options than for others (e.g., coverage of preventive health care services for HMOs but not for fee-for-service options). In my view, some flexibility should be permitted. It would be preferable if all plans were required to cover at least a standard package that included all services currently covered by Medicare (with no or low levels of cost sharing) and preventive care. However, plans should be free to offer a few additional benefit options such as coverage for prescription drugs and/or eyeglasses.

What about the FEHBP method for determining payments?

The FEHBP method results in a fixed contribution that is quite stable and predictable from year to year. Basing the payment on the "Big 6" formula ensures that the contribution is essentially unaffected by fluctuations in prices that may occur for rapidly growing plans, for plans that are inherently unstable, or for plans than deliberately engage in strategies to undermine fair competition. Moreover, the FEHBP model discourages plans from bidding excessively high (the fixed government-wide contribution is a ceiling and excess plan premium amounts must be borne fully by federal enrollees) or bidding excessively low (payment to any plan is limited to 75% of the government-wide contribution amount).

Basing the Medicare contribution only on the premiums for selected large plans would provide stability. However, this could create other problems. It would

probably focus an inordinate amount of Medicare's attention on the appropriateness of premiums for the few selected plans. (This raises a question about equity in oversight.) And, this approach would tend to preserve the status quo if the selected plans were large, stable, and dictated market conditions. I believe it would be preferable to base the Medicare contribution on an average of the plans' premiums (weighted by the number of enrollees in each plan).

It is critically important to design the Medicare contribution method so that it discourages inappropriate bidding, including "low-balling" or other gaming that could significantly disrupt the market. This could lead to significant problems for beneficiaries, including abrupt changes in benefits and out-of-pocket costs. A more effective means than the 75% rule to discourage excessively high or low bidding could be to impose "penalties" (for example, to reduce payments by some fixed percentage for increments of premiums which fall either above or below a range that falls around the average weighted premium amount).

To help preserve stability of payments and benefits, Medicare also could adopt an approach similar to the way FEHBP plans use their "contingency reserve funds". The Medicare "Benefit Stabilization Fund" for risk contracting plans is seldom used for this purpose because of the severe restrictions placed on its use.

As noted earlier, the FEHBP government-wide contribution is not directly based on local premiums of plans. There is no variation in the contribution to reflect geographic differences in costs. This may result in excessive payments in some areas and inadequate payments in others. An alternative to the FEHBP formula would be to establish the Medicare contribution for a local area based on premiums quoted by plans for statutory Medicare benefits or for a standard Medicare coverage that is offered by all plans.

<u>How much should be passed on to beneficiaries?</u>

The FEHBP model requires enrollees to pay the full amount of the difference between the federal contribution and a plan's premium. This provides a strong incentive for plans to offer low premiums in order to increase enrollment. However, this approach precludes plans from waiving premiums to attract enrollment, as is now permitted under Medicare risk contracting. A combination of these two approaches may be appropriate. (For example, there could be some reduction in Medicare payment that is proportional to the amount of premium waived.) If so, care should be taken to ensure that incentives to create cross subsidies between Medicare and non-Medicare enrollees in a plan would be minimized.

What about risk adjustment of payments?

As described above, the FEHBP model makes no provision for risk adjustment of either the government-wide contribution or beneficiaries' shares of premiums. There is growing support for implementing proper risk adjustment of Medicare payments, based on state-of the art methods. Methods that incorporate diagnostic information (e.g., the "HCC" methodology) and take into account variations in functional health status (e.g., based on self-report) show great promise. Adjustments to account for differences in risk between newer members and older members in a plan (e.g., to account for "regression to the mean") also may be appropriate.

An important objective is to remove the differing effects of risk selection from the prices faced by Medicare beneficiaries. One way to achieve this is to have all plans submit prices for a fixed level of benefits, assuming that they will enroll a standard Medicare population. Resulting premiums for beneficiaries (reflecting differences between the premiums submitted by plans and the Medicare contribution) would, by definition, be adjusted for differences in risk. Under this approach, the actual payment from Medicare to plans would have to be adjusted to reflect differences in risk between the standard population and beneficiaries who ultimately enroll in a plan.

What about highly unpredictable costs?

Risk adjustment of payments will not completely compensate for risk selection problems, especially those associated with extremely unpredictable, catastrophic costs. The FEHBP does not address such problems. To ameliorate them, some form of "outlier" payment should be considered, in addition to the risk adjustment system. Models include reinsurance for costs which fall above certain thresholds (aggregate or per case), the approach used in New York state to pay plans fixed amounts per occurance of selected conditions, or a similar approach adopted for the California Health Insurance Purchasing Cooperative.

What about an annual coordinated open enrollment?

Some believe that the FEHBP approach to annual coordinated open enrollment period with annual "lock-in" should be adopted by Medicare. They argue this would provide for more informed choice for beneficiaries and would reduce opportunities for plans to "dump" higher risk beneficiaries or to "cherry pick" lower risks.

I believe the current Medicare continuous enrollment and disenrollment provisions for risk contracting plans should be retained. Maintaining existing rules would:

- provide important protection to beneficiaries, by ensuring that there would be a timely "escape valve' in the event that a plan would prove to be unsuitable.
- allow plans to be more responsive to the needs of many group purchasers who help to organize and finance Medicare coverage for their retirees,
- allow plans to ensure that the timing of enrollment would be consistent with the orderly development of the capacity to serve new members, and
- provide maximum opportunities for beneficiaries to enroll in efficient, high quality Medicare plan options,

An annual coordinated informational and enrollment period could be adopted to supplement the continuous enrollment and disenrollment provisions. This would help to inform choice and reduce confusion. Opportunities for new beneficiaries to disenroll at anytime during a fixed period following their initial enrollment in a plan could be a compromise between annual "lock-in" and current risk contracting rules.

What about competition based on quality and access?

We applaud the leadership role that Medicare is taking to better understand dimensions of quality and access, to develop related measures of performance, and to effectively and fairly communicate findings to beneficiaries. As mentioned, FEHBP has been less active in this area. We support continued evolution of comparable measures (such as the HEDIS indicators), improved processes for assuring quality, and efforts to personalize findings so they have meaning to beneficiaries. We hope the Medicare will continue to partner with others to achieve greater standardization and efficiency in measurement.

A difficult issue is how to operationalize rewards and incentives for beneficiaries who choose efficient, high quality plans, especially those who are vulnerable and have the greatest needs for health care. We urge that the federal government support research in this area, including approaches to adjusting payments for plans that improve health or reduce the rate of decline for those who are chronically ill.

Mr. Chairman and members, this concludes my remarks. Thank you for the opportunity to appear before you. I welcome your questions.

OUTLINE OF THE BREAUX MEDICARE RESTRUCTURING PLAN

Restructures Medicare by using features of the Federal Employee Health Benefits Plan (FEHBP)-- The objective is to establish a competitive bidding model as an option for Medicare. Plans would bid on a core package of standardized benefits and compete on the basis of price and quality. This would be a premium contribution/ support system that gives seniors a range of options to choose from while letting the government's payment for Medicare enrollees be competitively determined. Seniors would have more choices, better information and better benefits. This is not be a voucher system or pure defined contribution approach.

Options

- Seniors can choose between staying in traditional Medicare fee-for-service or electing to participate in a new plan based on competitive bidding.
- There would be a 30-day annual enrollment period. Beneficiaries would be allowed to disenroll within the first three months of enrollment without cause. Beneficiaries would be allowed to disenroll from a MediHealth plan outside the open enrollment period for cause (to be defined by the Secretary of Health and Human Services).

Setting the federal payment

- Medicare would solicit bids from health plans which would competitively bid on a core package of standard benefits and supplemental benefit options.
- The government contribution would be set at some average of the bids received (i.e. median bid, weighted average). The Secretary would adjust payments to reflect the relative health risks of beneficiaries. Risk adjusters would be periodically updated and incorporated into payments to plans.
- The federal contribution would never be greater than the adjusted fee-for-service costs in the market area.

Core package of benefits

- Qualifying plans would submit bids on a core package of standardized benefits which would include services currently covered under Part A and B as well as additional benefits such as prescription drugs. Plans would be allowed to bid on the core package and one or two standardized supplemental benefit packages which would be included in the comparative information provided to beneficiaries.

Enrollees cost-sharing

- Beneficiaries would be required to pay a minimum of 10% of the premium, which is comparable to the percentage of Medicare benefits currently paid for by beneficiaries.
- A portion of the savings based on the beneficiary's choice of plans would be returned to the beneficiary. If an enrollee chooses a plan that costs **less** than the maximum government contribution, the beneficiary would be able to: 1) apply the difference towards the costs of supplemental benefits; 2) apply the difference towards a savings account to purchase long-term care; OR 3) receive a rebate that equals 25% of the difference between the federal contribution for a particular plan and the maximum federal contribution, but the beneficiary would in no case pay less than 5% of the plan's premium.
- If an enrollee chooses a plan that costs **more** than the federal payment, the beneficiary will have to pay the difference.

Beneficiary Information

- In addition to quality information, the Office of Competition would distribute to beneficiaries additional information 30 days prior to the annual election period. Each beneficiary would receive comparative information about the health plans they could enroll in. Comparative information would include: premium rates (for core and supplemental benefit packages), a description of services covered, applicable cost-sharing amounts, comparative quality indicators, beneficiary access to out-of-network providers, disenrollment rates, information on enrollee satisfaction and health outcomes, and other information that would be helpful for beneficiaries.

Quality Assurance Program

- Beneficiaries would receive information on quality such as HEDIS indicators, satisfaction surveys and accreditation status. Specific minimum federal standards would be established for health plans participating in the program.
- A variety of statistical data not currently gathered by HCFA relative to its managed care plans would be compiled. (i.e. medical loss ratio, disenrollment data, etc.).

Transition/Phase-in

- As part of the transitional step towards competitive bidding, various parts of this program (competitive pricing, risk adjustment, beneficiary information) would be test-marketed as demonstration projects prior to the target implementation date of 2003.

Stuart Butler
Vice President
Domestic Policy Studies

My name is Stuart Butler. I am Vice President for Domestic Policy Studies at The Heritage Foundation. I am also a member of the steering committee of the National Academy of Social Insurance's project on long term Medicare reform. I must stress, however, that the views I express are entirely my own, and should not be construed as representing the position of either organization.[1]

It is wise of the Committee to explore the applicability of the Federal Employees Health benefits Program (FEHBP) as a model for reform of the Medicare program. There are a number of working systems in the country, including the California Public Employees' Retirement System (CalPERS), FEHBP, and may system in the private sector, that contain key features that should be considered in a reformed and modernized Medicare program. These should be explored in Congress' discussion of introducing wider choice with cost control in the Medicare program.

The FEHBP is an interesting contrast to Medicare. Both are large health care program run by the federal government. But there the similarity ends. The FEHBP is not experiencing the severe financial problems faced by Medicare. It is run by a very small bureaucracy, who, unlike Medicare's staff, do not try to set prices for doctors and hospitals. It offers choices of modern benefits and private plans to federal retirees (and active workers) that are unavailable in Medicare. It provides comprehensive information to enrollees. And it uses a completely different payment system, blending a formula and negotiations.

It is time for Members of Congress to examine the system they are enrolled in and incorporate key features of the program into Medicare.

Section I: Summary Points

Let me summarize the key points that are developed in the body of my testimony.

<u>Key features and lessons of the FEHBP</u>

1) The FEHBP offers a wide range of plans, with a variety of benefits. While there are some adverse selection pressures in the system, these are surprisingly small given the fact that FEHBP is by law community rated (without regard to age and other risk factors) and there are quite wide plan variations. The FEHBP experience thus should make Congress confident that, with modifications to the basic FEHBP design, it is possible to design a stable choice system for Medicare that would provide constantly upgraded benefits to retirees.

2) Unlike Medicare, the FEHBP neither pays for specific services according to a fee schedule, nor does it (for HMOs) pay plans according to a flat formula. Instead it

[1] Much of the material in the main section of this testimony is drawn from Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare program *Health Affairs*, vol. 14, no. 4 (Winter 1995).

invites plans to submit bids and then negotiates prices and benefits, plan by plan. The FEHBP pays a percentage of the negotiated premium, up to a dollar limit.

The FEHBP indicates that there are very different ways in which the Medicare payment system could be altered to address the chronic problems in today's Medicare. The Physician Payment Review Commission, in its 1997 report, examined a variety of ways in which FEHBP-type payment systems could be applied to Medicare(see Chapter 9 of the report).[2]

3) The FEHBP plans include several offered by employee co-operatives and major unions. One reason these plans are popular is that they are organized by groups that actually represent the enrollees, rather than by HMOs or insurance companies that often perceive the enrollee as a passive buyer in an individual market. This feature of the FEHBP could be a particularly attractive part of a reformed Medicare system. One might imagine plans offered through the American Associations of Retired Persons (AARP), or major unions, or even churches.

4) The FEHBP has a comprehensive system of information distribution to aid beneficiaries making choices, complemented by a sophisticated system of information provided through consumer organizations. This could be a model for Medicare, whose information system has been roundly criticized by the general Accounting Office.[3]

5) The negotiations on premiums and benefits are held between the Office of Personnel Management (OPM), which runs the FEHBP, and the individual plans. For HMO and POS plans, OPM typically starts its negotiations based on the local market for these plans (it does not, as in the case of Medicare, apply a formula based on the local fee-for service market). In the case of fee-for-service and PPO plans, OPM negotiates a fixed profit per subscriber, usually between O.5 percent and 0.75 percent of premium. Thus the plans make money through negotiated service contracts rather than traditional profits. While these plans must accept market risk, they must lodge revenue surpluses in special reserve accounts which can enable them to bid more competitively in future years. This variation of the normal market answers many of the concerns voiced against allowing competing private plans in Medicare.

How Medicare could be reformed to incorporate the lessons from the FEHBP

[2] Physician Payment Review Commission, *Annual report to Congress, 1977* (PPRC, Washington, D.C., 1997).

[3] *Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information*, Testimony of William Scanlon (GAO), Special Committee on Aging, US Senate, April 10 1997.

1) Create a semi-independent congressionally-appointed board to operate the traditional fee-for-service Medicare in all parts of the country. The board would also have power to make variations in the benefits, including deductibles and copayments, subject to an up-or-down vote by Congress without amendment.

2) Shift the payment system for retiree health care to a modified defined contribution system. While many variations are possible, and should be explored, the best structure might be to pay a percentage of the premium above a fixed dollar contribution, with a ceiling to the total government contribution linked to the cost of the traditional fee-for-service plan in the area.

3) Invite initial bids from private plans meeting specified minimum requirements (including requirement s on information disclosure, underwriting limitations etc.) Then allow HCFA to negotiate premiums and benefit packages with individual plans, prior to a final price and benefits package that is then offered to Medicare enrollees in a particular area. Plans should have a basic core of benefits (as FEHBP requires), but negotiators should be able to develop a variety of plan benefits and prices in any area. The traditional Medicare fee-for-service plan also should be required to offer a bid with the price established through negotiation in conjunction with Congress.

4) Operate an annual open season in which retirees can choose a plan for the following year.

Section II: Lessons of the FEHBP

Created by Congress in 1959, the Federal Employees Health Benefits Program (FEHBP) offers over 400 competing private plans to active and retired Members of Congress and Congressional staff, as well as active and retired federal and postal workers and their families -- altogether almost 9 million people.[4] The FEHBP works well despite some aspects of its enrollment and design dealt with in a redesigned Medicare program would significantly improve the program for the nation's elderly and disabled.

The FEHBP population is not an ideal insurance pool. For one thing, the FEHBP population of active employees is older (43.8 years) than employees in the private sector (37.4 years).[5] For another, enrollment is optional and eligibility requirements are quite

[4]For a detailed discussion of the FEHBP, see Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employees Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6,1992; see also, Walton Francis, "The Political Economy of the Federal Employee Health Benefits Program," in Robert B. Helms (ed.) *Health Policy Reform: Competition and Controls* (Washington D.C.: The American Enterprise Institute, 1995), pp. 269-307.

[5]Based on a 1989 analysis of private and public sector employee age factors, the difference in age between federal employees and private sector employees means that federal employees would have health care costs

liberal. Also, plans may not impose "waiting periods" or limitations or exclusions from coverage for pre-existing medical conditions.

Further, the proportion of higher-cost federal retirees in the program has steadily grown, meaning the FEHBP has been facing a growing proportion of higher-cost-enrollees. In 1975, 858,000 retirees comprised 27 percent of the FEHBP's policyholders. By 1992, some 1.6 million retirees accounted for 40 percent of the entire FEHBP policyholders.[6] And according to OPM's actuaries, the average age of the covered TK in the program (which includes dependents) also has been increasing.[7] The plans are prevented by law from pricing their coverage differently for this higher-risk group by the program's strict community rating requirement.

How the FEHBP Works

Federal workers and retirees can choose from a variety of health plans, ranging from traditional fee for service plans to insurance plans sponsored by employee organizations or unions, to managed care plans. Approximately, 40 percent of all federal subscribers, and 18 percent of all federal retirees, are now enrolled in HMOs. All HMOs in FEHBP have benefits that are especially attractive to the elderly, including catastrophic coverage and mental health coverage. Almost all cover care in an "extended care facility," some with no dollar or day limits. No federal retiree has a range of choice of fewer than seven plans.[8]

The National Association of Federal Employees (NARFE), the major organization representing federal retirees declares that "All FEHBP plans are good. All cover hospital and physician care, prescriptions, outpatient diagnostic lab tests, treatment of mental illness, home health care, routine mammograms for women over 35, routine prostrate cancer tests for men over 40, and stop smoking programs."

And unlike Medicare, most FEHBP plans cover prescription drugs and include a wide range of dental services. Furthermore, the elderly can choose very specialized items, such as diabetic supplies.

How The Elderly Pick Plans. Each year, in preparation for the Fall annual "Open Season," when retirees and regular employees pick plans for the following year, the Office of Personnel Management (OPM) sends beneficiaries an *FEHBP Guide,* which includes a health plan comparison chart. Health plans also provide retirees with information on benefits and premiums in a variety of ways, including advertising.

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averaging 22 percent higher than private sector workers. *Focus 89*, Proposed Changes in the FEHBP Program, CNA Insurance Companies, 1989.

[6]Carolyn Pemberton and Deborah Holmes (eds.), *EBRI Databook on Employee Benefits* (Washington, D.C.: Employee Benefit Research Institute, 1995), p. 278.

[7]Information from Nancy Kichak, Director of the Office of Actuaries, Office of Personnel Management.

[8]Smith, *op. cit.*, pp. 14, 62.

Perhaps the most valued consumer resource for federal employees and retirees is *Checkbook's Guide to Health Insurance Plans for Federal Employees*, published by a consumer organization. The popular *Guide* compares plans, gives employees and retirees general advice on how to pick a plan, outlines plan features and special benefits, presents detailed cost tables (including the out-of-pocket limits for catastrophic coverage), and presents "customer satisfaction surveys" on the performance of plans. The *Guide* also provides specialized advice for federal retirees, including retirees with and without Medicare and information on HMO options and Medicare.

The *Guide*'s "customer satisfaction surveys" are quite detailed, rating plan performance in such areas as access to care, the quality of care, the availability of doctors, the willingness to provide customer information and advice by phone, the ease of getting appointments for treatments or check-ups, typical waiting times in the doctor's office, access to specialty care, and the follow-through on care. The surveys also review patient experience with such things as explanation of care, the degree to which the patient is involved in decisions relating to care, the degree to which the plans' doctors take a "personal interest" in the patient's case, advice on prevention, the amount of time available with the doctor, the available choice of primary care physicians and access to specialists, and the speed with which the patient can contact the plan's service representative.[9]

Beyond this valuable information, federal retirees receive additional guidance from the National Association of Retired Federal Employees (NARFE), a private organization representing approximately 500,000 current and retired federal employees. With a network of over 1,700 chapters throughout the country, NARFE works closely with the OPM in answering questions and resolving problems related to health insurance and retirement matters. In preparation for "Open Season," NARFE publishes its annual *Federal Health Benefits and Open Season Guide*.[10] Most important of all, NARFE actually rates plans on benefit packages that would be most attractive to the elderly. For example, for prescription drugs, NARFE ranks Alliance and Blue Cross/ Blue Shield as the best choices for the elderly.[11]

The Role of the Office of Personnel Management OPM is given authority in the FEHBP statute to: contract with health insurance carriers; prescribe "reasonable minimal standards" for plans; prescribe regulations governing participation by federal employees, retirees and their dependents, as well as to approve or disapprove plan participation in the FEHBP; set government contribution rates in accordance with federal law; make available plan information for enrollees; and administer the FEHBP trust fund, the special

[9] *Ibid.*, pp. 49-79.
[10] Smith, *op. cit.*, p. 50.
[11] *Ibid.*, p. 63.

fund containing contributions from the government and enrollees and from which all payments to health plans are made.[12]

Unlike HCFA, OPM does not impose price controls or fee schedules, issue detailed guidelines to doctors or hospitals or standardize benefits. Private plans within the FEHB? must meet "reasonable minimal" standards regarding benefits.[13] But the law creating FEHBP does not specify a comprehensive set of standardized benefits. Congress merely defines the "types" of benefits that "may be" provided.[14]

OPM sends out a "call letter" in the Spring of each year to insurance carriers, inviting them to discuss rates and benefits for the following calendar year.[15] In these confidential discussions, OPM outlines its expectations on rates and benefits to the carriers, and the carriers invariably respond by offering proposals. This is an unusual, and largely successful, mixture of discussion and jawboning. Congress rarely intrudes into this process.

In setting the government contribution to retirees health benefits, OPM must make its calculations according to a formula established by law. OPM determines the government contribution on the basis of the average premium of the government-wide service benefit plan, the indemnity benefit plan, the two largest employee organization plans and the two largest comprehensive. This is commonly called the "Big Six" formula.[16] OPM calculates the average premium of these six largest plans, and multiplies that average by 60 percent. This determines the *maximum* annual government contribution, which is applied to each plan and option. This maximum contribution in contribution was $1,600 for individuals and $3,490 for families. The formula has one

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[12]This summary of legal authorities can be found in the *Federal Employees Health Benefits Program* (Washington, D.C.: Congressional Research Service, 1989), p. 238.

[13]For purposes of the FEHBP, a health plan is defined as "a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services." *Code Federal Regulations* Chapter 16, 1602.170-8. The minimum standards for health benefits carriers includes a requirement that the carrier be lawfully engaged in business of supplying health benefits meet financial solvency standards, including "reasonable financial and statistical records; open access to records by OPM and GAO investigators or auditors; an acceptance of payment in accordance with contract and contingency receive requirements; a requirement to perform the contract in accordance with 'prudent business practices'." See 48 CFR, Chapter 16, Part 1609 "Contractor Qualifications" OPM's other regulatory prohibitions and restrictions deal primarily with consumer protection, including prohibitions against false misleading, deceptive or unfair advertising, and a requirement for retention of financial records.

[14]Title 5, *United States Code*, Section 8904.

[15]In this process, OPM maintains strict confidentiality. OPM staff historically have not even shared the document with the Office of Management and Budget.

[16]In recent years, the government-wide "service benefit plan" has been Blue Cross and Blue Shield, the two largest employee organization plans have been the Mailhandlers and the Government Employee Hospital Association Plan, and the two largest comprehensive medical plans have been the Kaiser Foundation Plan of Northern California and the Kaiser Foundation Health Plan of Southern California. With Aetna dropping out of the program in 1989, OPM staff have used a mathematical formula to calculate the service indemnity component of the Big Six formula.

other crucial adjustment. In no case can the federal government contribute any more than 75 percent of the cost of the premium of any plan. The federal contribution for individuals ranges from about $1,000 to about $1,600. According to the PPRC, premiums for individuals range from about $400 to about $1,800.

OPM prepares kits outlining rates and benefits for the coming calendar year, disseminating information on the plans. Beneficiaries then pick a plan during open season. OPM maintains an "Open Season Task Force" to help in making decisions, and a hot line that retirees (or regular workers) can call during open season.

Whatever the plan chosen, the government's premium is sent directly to the plan. The enrollee's premium contribution normally is deducted from the enrollee's paycheck (for workers) or annuity (for retirees) and also sent by OPM directly to the chosen plan. OPM also helps retirees and employees settle disputed claims.

Adverse Selection. While the FEHBP has been successful, there have been two persistent and interrelated problems associated with its design: adverse selection in the program, and an outdated system of insurance underwriting.

Adverse selection has been an irritant in the FEHBP for many years, and is exacerbated by the strict community rating requirement. Still, it has not undermined the program. To be sure, OPM has taken steps to limit the variation in benefit packages to limit some of the risk selection, and, during the negotiation process, has allowed some plans with particularly generous packages to eliminate some benefits. Even so, in its exhaustive 1989 analysis of the strengths and weaknesses of the FEHBP, the Congressional Research Service concluded that the program at that time was structurally sound. According to the CRS, "That FEHBP has continued to 'work' over the years, despite major changes in the environment in which it has operated, reflects the soundness of its basic design."[17]

Section III: Using the FEHBP Model to Reform Medicare

Transforming Medicare into a program similar to the FEHBP would mean changing fundamentally the role of the federal government, and more specifically the Department of Health and Human Services (HHS) and the Health Care Finance Administration (HCFA). It would mean that instead of setting prices, paying for specific services, and regulating virtually every facet of the system, HHS would -- like OPM in the FEHBP system -- have only two broad functions: calculating and dispensing a payment to Medicare beneficiaries, to be used for the purchase of health care; and overseeing a market of health plans approved for sale to the Medicare population.

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[17]CRS, *op. cit.*, p. 231.

A new Medicare system conforming to this framework might be designed in the following way.

Element 1: Change the Government's role

In a reformed Medicare system based on the FEHBP, HHS would have monitoring and payment clearing house functions similar to those of OPM within the FEHBP program. It would be responsible for making disbursements to the plans selected by Medicare beneficiaries. But it would not regulate the premiums of plans or the prices of services. Nor would it actually run any plans, any more than OPM does. On the other hand it would negotiate directly with competing plans offered to beneficiaries on premiums and benefits. Specifically:

a) The government would maintain the "traditional" fee-for-service Medicare plan which would be available everywhere. However, it would no longer run that plan. Instead, Congress would establish a federally-sponsored not-for-profit corporation to sponsor a "Medicare Standard Plan." The corporation would be governed by its own government-appointed board and would offer the standard Part A and Part B benefits. However, the board would also recommend to Congress each year changes in the services, premium, deductibles and copayments for the Standard Plan. These changes would have to be ratified by Congress in an up-or-down vote without amendment.

b) The government would allow private plans meeting certain requirements (see below) to submit bids to offer a set of services to the elderly. HCFA would negotiate with each plan on the benefits, premium, service area etc. After these negotiations, the plan could be offered to Medicare beneficiaries.

c) Like OPM in the FEHBP system, HHS would conduct the annual Medicare open season in which private plans . During open season, beneficiaries would choose their plan for the following year. Before open season, each Medicare beneficiary would receive an information kit from HHS, including standardized information on prices, benefits and consumer satisfaction for Medicare-approved plans in their area, including the Standard Plan. Beneficiaries would also receive a selection form on which to indicate their choice.

d) Once the selection had been made, HCFA would send the appropriate contribution to the chosen plan (see below). The beneficiary would be responsible for any difference between the voucher and the premium costs, but could elect to have the government pay that difference and reduce the beneficiaries Social Security check (similar to the part B option today). If no plan were selected, the beneficiary would be assigned to the Standard Plan.

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Element 2: Change the Medicare payment system

There has been considerable interest in recent years in refining the way in which the government makes payments for the care of Medicare patients. Among the concerns with the current system is that Medicare appears to be overpaying many HMOs because of the payment formula based on the cost of fee-for-service plans in an area. Another is that the defined benefit nature of Medicare and its payment system necessarily drives up cost. To deal with this second concern, many policymakers and Members of Congress have argued for some form of defined contribution. But a worry with this alternative approach is that an "arbitrary" budgeted contribution could leave seniors carrying an unacceptable degree of risk.

Fortunately, the FEHBP's payment formula and plan negotiation system appears to be a good model to solve these problems. Some combination of the following options should be considered.

Option 1: A market adjusted but government-set contribution to plans
Although the FEHBP does not use a "voucher" to make payments to plans (it uses a percentage of premium with a limit), a modified voucher system could work in an FEHBP-style Medicare program. Essentially this would be a modification of the Average Area Per Capita Cost (AAPCC) mechanism used today to set capitation amounts for HMOs under the risk contract program. The law sets this fee at 95 percent of the estimated average cost of fee-for-service care for Medicare patients in the area. It then adjusts this rate for certain demographic characteristics such as age, sex, Medicaid eligibility, and institutional status, to determine the capitation amount.

Under this modified system, HCFA would calculate the contribution amount for each Medicare beneficiary, using the primary risk factors and income information, and an adjustment to reflect the total Medicare budget for the year and the estimated average enrollee cost of a weighted local basket of plans (based on plan information supplied for the open season). This basket would comprise "typical" plans, such as the Medicare Standard Plan, a catastrophic/MSA plan, a Blue-Cross standard plan, and a comprehensive HMO plan. This is a refinement of the "big six" formula used by OPM to set the government contribution to the FEHBP. The calculation of the Medicare voucher would be made *after* the plans had filed their price and benefit information for the open season, so that the voucher would reflect the actual market formula encountered by the beneficiary.

The distinction between Part A and Part B would disappear under this reform, and the budgeted net Medicare expenditure for the initial year of the new program would be divided by the number of eligible individuals to determine a base rate for the voucher. In future years the combined cost of the vouchers would be adjusted in line with the Medicare budget to be determine the base rate for the year. This base rate would then be adjusted according to three factors:

Primary risk factors. The base rate would be adjusted according to the enrollee's age, sex, reason for eligibility (age or disability), institutional status, and ESRD status.

Local market variance. The base rate also would be adjusted to reflect a weighted average enrollee cost of a "basket" of plans offering certain categories of benefits (discussed later).

Income adjustment. To incorporate the objective of income-adjusting the general revenue subsidy to the current Part B program, the portion of the base rate roughly equivalent to the government's net Part B contribution would be adjusted in this way. The portion equivalent to Part A would not.

This payment system would link payments to the risk and income of the beneficiary, and in that way avoid much of the concern that high risk or poorer beneficiaries would shoulder too much of the cost. Yet the incentive for individuals to seek out the best value for money in plans would be strong.

Option 2: A negotiated premium with a formula payment

A variant to consider is first for HCFA to invite bids and negotiate benefits and premiums, as outlined above. Then a minimum contribution could be made by the government, based on the general criteria discussed in option 1 but based on the lower cost plans. In addition, HCFA would pay a fixed proportion of the premium above that minimum amount, up to a limit linked to the cost of the traditional fee-for-service plan in the area – which would have to submit a bid in the same manner as other plans.

This modification would slightly weaken the incentive to seek the best value for money (since the enrollee would be insulated for part of the cost above the base amount). On the other hand, an individual would still be able to choose the traditional plan with the government ensuring that the individual's net premium payment would be fixed.

Element 3: Standards for participation by a plan

Any private health plan would be eligible to receive an individual's Medicare benefits in part payment for providing health care providing it met certain threshold requirements. The requirements would apply to plans marketed by affinity organizations, such as churches, unions or elderly groups, not merely to plans marketed by insurers or provider organizations. There would be no restrictions on the number of plans available in an area or the types of plan, and plans could operate in different service areas and provide different benefits. A plan could gain approval to market to the Medicare population provided it:

a) Has a license to issue health insurance in the state, or gains approval directly from HHS.

b) Will provide services in a service area acceptable to HHS.

c) Meets solvency requirements.

d) Includes a core of basic coverage determined by legislation. The basic package would have to cover "medically necessary" acute medical services, including physician services, inpatient, outpatient and emergency hospital services, and inpatient prescription drugs, with a catastrophic stop-loss amount for these services. A plan thus could offer a much leaner package than today's Medicare (although it would have to provide catastrophic protection, unlike Medicare), but it could offer a range of services beyond the base coverage. For example, some plans might offer dental benefits or drug coverage. States would be preempted from mandating additional benefits for plans serving the Medicare population.

e) Files with HHS a standardized statement of benefits , a table of rates for the same actuarial categories used to determine Medicare benefits (age, institutional status etc.), and consumer information as determined by an advisory board. Plans would not be able to deny coverage or change rates because of health status. The price, benefit and consumer information also would have to be available to any Medicare beneficiary upon request (see *Information, marketing and consumer decision-making*)

f) Accepts and continues coverage for any Medicare beneficiary applying during the annual open season.

Section IV: Issues Associated With The Proposed New Medicare System

Under this reformed system, Medicare would operate much like the FEHBP serves retired federal workers and retirees. Medicare beneficiaries would be able to pick a private plan which included the services they wanted (beyond the core package), delivered in the way they wanted, and, if they wished, perhaps through an organization with which they were affiliated (as many FEHBP enrollees do). Or they choose the Medicare Standard Plan. Because beneficiaries would receive a defined contribution (based on the options discussed earlier), they would have a strong economic incentive to pick the plan that best met their objectives of price, quality and services.

The organization of services, the selection of benefits, and payments to providers would be in the hands of the plan managers competing for enrollees. Unlike the federal

officials managing Medicare today, these managers would have the freedom and the financial incentive to experiment with new ways to deliver care at a competitive price.

In stark contrast to today, HCFA would have no role in setting the provider reimbursement rates, deductibles or cost-sharing levels of any private plan, nor any role in requiring benefits beyond the care benefits required by statute. The federal corporation, not HCFA, would be responsible for these decisions in the case of the Medicare Standard Plan.

Can a consumer-choice system reduce costs?

Whether the proposed program "reduces costs" costs depends on how it addresses two distinct aspects of cost. The first of these is the total net outlays of the Medicare trust funds. In other words, would it cut the government's Medicare budget? The second perspective on cost is how the program would affect the gross costs of serving the elderly. Would a trimming of government outlays merely shift greater costs to the elderly, or would a consumer choice system slow down the growth in service costs? And linked to this second question, could the voucher be designed so that it tracks reasonably accurately the market costs of serving enrollees with certain health conditions in different places?

A defined contribution, in contrast with a defined benefit, controls net government outlays directly because the total contribution is determined by a budget. But, would savings for government merely result in extra enrollee costs? In fact, there are good reasons to expect that this combination of market competition and enrollee incentives would reduce the growth of total medical costs for the elderly and hence the financial exposure of the elderly. The FEHBP's premium and budget experience suggests strongly that major savings could be achieved in Medicare with a similar market-based design, although conclusions have to be somewhat guarded because so little scientific research has been carried out on the program. In spite of its design shortcomings, the FEHBP has generally outperformed private sector employer-based health insurance and has significantly outperformed Medicare. A comprehensive 1989 study of the FEHBP by the Congressional Research Service concluded that the FEHBP cost increases were lower than those of the private sector.[18] Subsequent analyses have come to similar conclusions.[19] Analyzing the FEHBP's premiums in the 1980's, for instance, Lewin-ICF noted that "The available evidence suggests that the FEHBP competitive market dynamics, combined with increased emphasis on cost control, has outperformed the private sector despite increasing benefits in recent years and the impact of an increasing share of retirees." Most recently, Frank McArdle also concludes that the FEHBP's rate of premium increases has been lower that the private sector.[20] During the 90's the premium

[18]*Ibid.*,

[19]See Walton Francis, "Political Economy of the Federal Employee Health Benefits Program." See also, Allen Dobson, Rob Mechanic, and Kellie Mitra, *Comparison of Premium Trends for Federal Employees Health Benefits Program to Private Sector Premium Trends and other Market Indicators* (Fairfax, Virginia: Lewin-ICF, 1992).

[20]Frank McArdle. "Opening Up the FEHBP." *Health Affairs*, Vol. 14, No. 2 (Summer 1995).

performance of the FEHBP has indeed been remarkable. In 1994, the average annual premium increase was only 3 percent, and 40 percent of all enrollees in the program, including retirees, saw decreases in their premiums. In 1995, the entire program experienced an average annual *decrease* in premiums of 3.3 percent.

Another reason to feel confident that converting Medicare into a system of competing and flexible plans is that Medicare is so far behind other sectors in introducing design innovations. Enrollment in HMOs is growing but still small, for instance, while PPOs are heavily restricted and point-of-service plans unavailable. Admittedly, the very elderly now in Medicare may be disinclined to switch to different service arrangements, but more recent retirees, and the disabled, typically are quite familiar with them from their working days. These elderly likely would choose plans containing service innovations if they had the incentive to do so, just as large numbers of FEHBP enrollees do today. With so much ground to make up, giving Medicare beneficiaries the incentive and opportunity to enroll in plans using less costly arrangements could sharply reduce the growth in total costs. One recent study estimates that a 10 percentage point increase in HMO market share within Medicare would be associated with a 1-3 percent decrease in aggregate Medicare spending.[21]

To be sure, the FEHBP does not operate in a market that is completely free of government efforts to regulate prices. Government managers negotiate premiums before they are posted for the open season. Some skeptics of consumer-based approaches suggest that this means the "price maker" power of a government "buyer" actually is holding down costs because plans are afraid of losing access to their market.[22] Nonetheless, the plans still must design and price their product shrewdly in strong competition with each other for enrollees if they are to remain in business. Significantly, OPM devotes most of its negotiating energy with the large plans that undermine the government's maximum contribution, and largely ignores the pricing of other plans. So it is not clear that the government's "jawboning" function in the FEHBP is important in holding down costs than this competition for price-sensitive enrollees. But what is clear is that OPM bargaining with competing plans is far more successful at holding down costs than HCFA issuing edicts to hospitals and physicians.

Enrollee costs in local markets. The enrollee's financial exposure is affected by the local market, of course, and not just by the economics of the system as a whole. To keep this exposure reasonable, the voucher amount must closely track the local market for serving an individual with the enrollee's health care needs.

The closest equivalent to a Medicare voucher today is the adjusted average per capita cost (AAPCC),

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[21] Laurence C Baker, *Can Managed Care Control Health Care Costs: Evidence from the Medicare Experience* (Washington, D.C.: National Institute For Health Care Management, 1995), p. 22.

[22] See Joseph White, "Managing Health Care Costs In The United States," in *Health Care reform Through Internal Markets: Experiments and Proposals* (Washinton, D.C.: The Brookings Institution, 1995), p. 148.

This method of determining the capitation amount has been criticized for a number of shortcomings which blunt potential savings to Medicare and make the market less efficient.[23] For instance, all HMOs in an area are paid the same capitation rate, linked to fee-for-service costs. In some cases this more than Medicare would pay for a particular enrollee in fee-for-service. So, HMOs can often game the system by attracting lower-cost enrollees for any given capitation amount and keeping the difference in cost (subject to profit controls). These and similar problems have led several experts to call for greater flexibility in setting the AAPCC and the incorporation of more sophisticated risk adjustments.[24]

A voucher approach can deal with these deficiencies because it introduces a very different incentive from that in the risk contract system. Because the voucher is not a full payment made to a plan, but a degree of financial support for an enrollee choosing between plans with different prices, it triggers a much stronger price/quality competition between plans seeking the business of enrollees. Plans would not be able to price themselves to take advantage of the shortcomings in a bureaucratic structure of capitation payments. They would instead have to compete to satisfy a customer who is motivated to pick a plan according to the full package of premium, services, quality and anticipated out-of-pocket costs.

Is adverse selection a serious problem?

Policymakers naturally are concerned about the possibility that adverse selection might destabilize a consumer choice Medicare system, particular a system as proposed here, that allows plans to vary benefits.

We believe that a stable market with acceptable differences in cost would result from the proposed system without any special risk adjustment mechanism in addition to the primary risk factors used for the vouchers and premiums But it would be wise to establish a review commission to monitor this aspect of the program and to recommend additional risk adjusters if necessary. Still, while there is little research available on how problematic undesirable adverse selection might be in a voucherized Medicare program, there are reasons to suppose it would not be severe.

Perhaps the most persuasive reason for optimism is the experience of the FEHBP. The community-rated FEHBP permits plans to offer a wide range of benefits, yet requires plans to charge exactly the same premium to a perfectly healthy 19 year old as to a chronically sick 89 year old. It also has no special risk adjustment mechanism. This

[23]See, for instance, *Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs* (General Accounting Office, September 1994), GAO/HEHS-94-119. See also Ratner, *op. cit.*
[24]See Gail Wilensky, "Incremental Health System Reform: Where Medicare Fits In," *Health Affairs* (Spring 1995), pp. 179-180.

would seem to be an open invitation to destructive adverse selection pressures. Yet, although there clearly is some adverse selection in the program, it is remarkably stable.

We incorporate the features of the FEHBP into the proposed Medicare reform which seem to explain its ability to withstand destructive adverse selection, and include other features that improve upon the FEHBP in this regard. Three features are particularly important.

First, limiting plan switching to once a year (in Medicare today, an enrollee in the risk contract sector may switch after just 30 days), using the same open season procedure as the FEHBP. This would make it more difficult for enrollees to destabilize the market by transferring to generous, unrestricted plans just to cover an expensive illness or elective treatment.

Second, allowing plans to vary their premiums according to a range of basic risk factors, which the FEHBP does not. This premium variation would reduce the financial attraction to plans of seeking out enrollees likely to be healthier because of their demographic characteristics. Adjusting the voucher according to the primary risk categories would also insulate enrollees in higher risk categories from their generally higher premium costs.

Third, the central marketing and information-distribution arrangements (an elaboration of the FEHBP open season) would help to limit cherry-picking by plans, as these features appear to do in the FEHBP. Because Medicare enrollees would receive standard information on all plans in their area, it would be impossible for plans to "hide" themselves from applicants they do not desire. And to retain their approval to market to Medicare enrollees, plans could be required to adopt other marketing guidelines to reduce unfair practices.

We do, of course, propose to retain a "traditional" Medicare plan as an option for beneficiaries. Would there be significant adverse selection against the government because only very old and chronically sicker beneficiaries remained with the plan? And would these enrollees face spiraling net costs under the defined contribution system?

While both results are theoretically possible, especially if the government-operated plan remains as inflexible and outdated as today's Medicare, the design of the proposed system reduces this danger. For one thing the premium of every plan is adjusted by the major risk factors, and so a plan attracting a large share of very old enrollees would receive much higher premium income from these enrollees -- who in turn would qualify for a larger voucher. For another thing, the voucher amount would be adjusted in each area according to the weighted costs of a basket of plans, which would include the Medicare Standard Plan, giving a further refinement to the voucher and thus helping to limit the potential for large net costs to enrollees in the Standard Plan.

Further, it is by no means obvious that chronically sicker beneficiaries generally would avoid private plans in favor of the standard plan. The private plans could not turn away any beneficiary during open season, no matter how sick the person was. And unless its structure of coverage were significantly changed from today's Medicare, the Standard Plan would not provide stop-loss protection and would lack coverage for services (such as prescription drugs) that is routine in private plans.

Information, marketing and consumer decision-making.

A final concern is information. For a market to function that is both efficient and that satisfies consumers, those consumers must be armed with the information they need to make good decisions. Health care decisions can be confusing enough for young, well-educated people, so it is reasonable to question whether elderly people -- who in many cases are easily confused -- could make informed decisions in a market of competing plans.

There is little research available on exactly what information the elderly require to make sensible decisions in health care, but several categories suggest themselves. These include premium and likely out-of-pocket costs, benefits, information on customer satisfaction, and some measurements of quality.[25] In the information clearing house function assigned to HHS, standardized consumer information on prices, benefits would be included, as would "consumer information." This latter category might take the form of such things as categorization of plans (similar to the Medigap market); information on typical costs for certain illnesses, perhaps using the "illness episode approach"; and patient evaluations, such as these prepared for FEHBP enrollees by *Washington Consumers' Checkbook*. To make this information as helpful as possible, it would make sense to create a "Consumer Advisory Board", consisting of representatives of Medicare beneficiaries and the health care industry, to recommend to HHS what information should be made available to beneficiaries and how. Plans would be free to supply additional information, and to advertise, as they can in the FEHBP, but they would have to meet certain disclosure criteria to remain Medicare approved.

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[25]For a discussion of this issue, see Shoshanna Sofaer, "Informing And Protecting Consumers Under Managed Competition," *Health Affairs*, (Supplement 1993), pp. 76-86.

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Statement by Senator Alfonse D'Amato
Senate Finance Committee Hearing
Federal Employees Health Benefit Program (FEHBP)
May 21, 1997

Mr. Chairman, I commend you for holding this hearing today to continue our discussion of increasing choices for Medicare beneficiaries. I wish to thank my esteemed colleagues, Senator Gregg and Senator Wyden, for testifying today. I also wish to thank the distinguished panelists for sharing with us their insights and concerns about this topic.

Medicare provides affordable health care to 38 million older and disabled Americans. It is essential to preserve Medicare for its present beneficiaries and for future generations of Americans. At the same time, it is important that we spend Medicare funds wisely, and look for more cost-effective ways to deliver basic benefits.

The Federal Employees Health Benefits Program (FEHBP) is a successful program that covers 9 million federal employees and their dependents and includes some 400 different health care plans across the country. Employees can choose the plan they prefer, and they can pay higher premiums for a plan with additional benefits if they wish. They can also change plans during an annual "open season."

Many health economists have suggested that the federal employees program could be a model for Medicare in the future. It would afford beneficiaries with additional choices in selecting the health care plan that best suits their needs.

Mr. Chairman, 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. We must guarantee certain minimum benefits and standards of quality for all health care plans. 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.

United States Senate
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(202) 224-3324

TESTIMONY OF U.S. SENATOR JUDD GREGG BEFORE THE SENATE FINANCE COMMITTEE MEDICARE CHOICE CARE May 21, 1997

Good morning, Mr. Chairman, and thank you for this opportunity to present my Choice Care plan for restructuring and strengthening Medicare.

Mr. Chairman, this Committee has a unique and fleeting opportunity to strengthen health care for America's senior citizens. You are about to determine the details of a balanced budget plan that will likely enjoy broad bipartisan support. How you choose to deal with Medicare in that process is absolutely crucial.

I have brought with me various materials describing Choice Care, and enumerating the extra savings and stability it will help to bring to the Medicare program. These show that small short-term savings resulting from structural reforms can amount to huge savings over the long-term.

As you well know, Mr. Chairman, the stability of Medicare in the long run does not really depend on how much Medicare cost growth is reduced in just the next five years. The real test is whether we can, in this reconciliation process, reform Medicare in a fundamental, structural way, so that it can withstand the enormous fiscal pressures that will be engendered when the baby boomers begin to retire, and thereby remain a reliable guarantor of health care services for America's senior citizens.

I strongly believe, Mr. Chairman, that structural reform, in the case of Medicare, means bringing the program into the marketplace. Only if we do this will it become a state of the art program that is as efficient and cost-effective as are health care delivery services in the private sector.

My Choice Care bill has been scored by CBO as producing approximately $10 billion in savings over five years, $28 billion over seven, and $93 billion over ten years. And, the budget resolution that we are debating this week specifically mentions this plan as a type of reform that we should strive to include in the reconciliation process.

I should mention, Mr. Chairman, that this CBO score understates the amount of true savings that would result from enacting these reforms. The CBO score reflects the schedule in Choice Care for growth in AAPCC payments, which I will describe in a moment. CBO has not taken into account the savings that will accrue to the Medicare system every time a senior finds a better deal under Choice Care. Unable to estimate the numbers of seniors that would benefit from such choices, CBO has not provided a savings figure associated with that event. Thus, the savings that you see described here are only a part of what we would achieve by enacting Choice Care this year.

Under Choice Care, Mr. Chairman, seniors would enjoy the same protections and guarantees that they do now -- but they would also be empowered with an additional tool -- consumer choice.

Under Choice Care, seniors would be permitted to choose from a range of health care purchasing options -- just as federal employees do today. They would be allowed to buy the health care insurance product that works best for them.

All the while, they would be protected by the same guarantees currently provided by traditional Medicare. Plans that offer the same package of benefits as traditional Medicare would not be permitted to charge them any more -- in premiums, deductibles, and copayments -- for the same services.

Plans could, if they chose, offer additional services, and of course could charge additionally for those. Thus, if seniors wish to, they could conceivably be able to buy a single policy that does what Medicare and Medigap combined currently do for them -- "one-stop shopping."

Seniors would have the same incentives and prerogatives that now exist for every other customer in the marketplace -- most notably the desire to save money. They would be guaranteed a certain amount of federal support for their health care services, equal to the current amount of their combined Part A and Part B benefits, and growing each year. If they find a plan that costs less than that amount, then the senior pockets 75% of the savings -- and the other 25% goes back to strengthen the Trust Fund. Thus, every time a senior makes a cost-effective purchasing decision, the trust fund becomes healthier, and the senior gets a refund.

The benefits of such an approach are several-fold: Seniors would have more options. They would be fully protected by the current Medicare guarantees. They could change their minds later, and go back to traditional Medicare, if they bought a plan that they didn't like. Plans, forced to compete with each other for purchasing dollars, would offer the best product for the best price. And Medicare would be strengthened by this competition.

I would simply stress again, Mr. Chairman, that under Choice Care, seniors who prefer to remain in the traditional Medicare program, instead of buying from a new provider, could

continue to do so. And, that traditional Medicare would also be strengthened by infusions of revenue resulting from choices by other seniors who believe they can get a better deal.

There is an additional element of this plan that I wish to call to the attention of the Chairman. My Choice Care bill would begin to reduce the inequities in the reimbursement levels for Medicare benefits provided to different regions of the country.

Under current law, Mr. Chairman, HMO plans under Medicare are reimbursed according to the going rate for fee-for-service benefits in that locality. Since these vary widely from region to region, and there is little or no incentive provided by the government for the more expensive areas to reduce their costs, HMOs are not able to provide the same types of benefits in every place, simply because they cannot afford to. In other regions, where reimbursement levels are high, HMOs can not only operate, they can offer additional benefits that those in low-cost areas cannot.

As we reform Medicare into a choice-based, market-driven system, it is essential that we remove the tremendous disparities in reimbursement levels -- which currently range from as low as $200 per capita in South Dakota or Nebraska, to more than $750 in other parts of the country. These disparities have been shown to bear very little relationship to local variances in the cost of living, or to the local quality of health care. More frequently, it is the case that some areas have done a better job in weeding out inefficiencies than others.

My bill would permit per-capita health care costs to grow more quickly in regions that are currently spending below the national average. This is essential for a couple of reasons: Firstly, it is important to target Medicare savings on those regions that can best afford to accommodate it, and to protect those regions that have already reduced cost growth. Secondly, it is important for the operation of the Choice Care rebate system -- seniors in different parts of the country would then have more comparable opportunities to find better deals under Choice Care, as these regional reimbursement variances are brought into line.

In sum, Mr. Chairman I wholeheartedly commend my Choice Care plan to your for inclusion in the reconciliation bill. This would be a an important step with far-reaching benefits, both for our seniors individually as well as the health care system generally. I thank you for the opportunity to present the plan to you.

###

JUDD GREGG
NEW HAMPSHIRE

CHIEF DEPUTY WHIP

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Dear Colleague.

Now that the President and Congressional negotiators have agreed on the broad outlines of a balanced budget plan, we must seize an important opportunity to strengthen Medicare for the long term. This will not be done by reaching a particular short-term savings target, but by enacting structural reforms that will keep Medicare strong and healthy long beyond the time frame for balancing the budget.

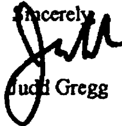
Many Senators have recognized that the key to Medicare reform lies in empowering seniors with consumer choice. My Choice Care plan, reintroduced earlier this year as S.246, meets all of the goals that have been articulated. This is why the essential provisions of my legislation were included in last session's balanced budget reconciliation bill and should be adopted again.

The Congressional Budget Office has scored my plan as saving $10 billion over the next five years and $28 billion over the next seven. Moreover, these projections do not include estimates of the savings that will come to the Trust Fund, and to senior citizens, whenever a more cost-effective purchasing decision is made under the plan. The lasting benefits of improved health for the Trust Fund, added efficiency within Medicare from bringing it into the marketplace, and increased opportunities for quality care will be incalculable.

The essence of Choice Care is that senior citizens, protected by the same guarantees regarding benefits, premiums, copayments, and deductibles, which exist under traditional Medicare, will be able to buy the health care plan that works best for them. By allowing health care providers to compete for the right to spend the health care purchasing dollars of our senior citizens, we will force Medicare to be more competitive and cost-effective, while at the same time offering new choices and opportunities to our senior citizens.

I hope that you will join me in ensuring that this program for reform remains a top priority throughout the reconciliation process.

Sincerely,



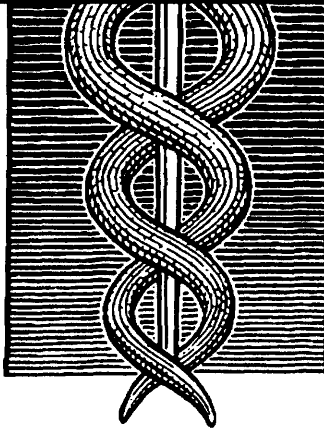
Judd Gregg

Choice Care

S.246

A Proposal To Reform Medicare By

Senator Judd Gregg



Choice Care

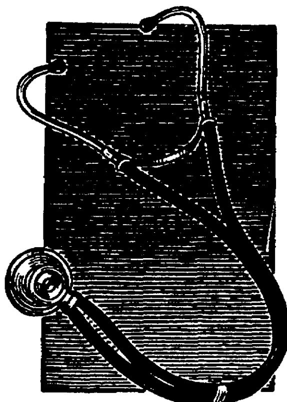
S. 246

by Senator Judd Gregg

- Bringing Medicare into the Marketplace

- Giving Seniors More Choices

- Reforming Medicare for the Long-Term



Why Medicare Must Enter the Marketplace

1. **A government-run health care system, shielded from accountability to the marketplace, will never match the efficiency of the private sector.**

   Costs in public health care systems, most especially Medicare, continue to rise dramatically faster than in the private health care market. If Medicare is going to meet the health care needs of a rapidly aging U.S. population, it must be forced to compete with private health care plans for the right to spend the purchasing dollars of its customers, our senior citizens.

2. **The Medicare Hospital Insurance (HI) Trust Fund will avoid eventual bankruptcy not by focusing on a short-term savings target, but by turning Medicare into a market-based program that is more capable of withstanding future demographic pressures.**

   The HI Trust Fund is losing money now, but this is only a symptom of runaway cost growth which threatens the future of both Medicare Part A (HI) and Medicare Part B (SMI). The HI Trust Fund is already spending more money than it takes in — in 1996, $129.9 billion was spent from the fund, in comparison with $124.6 billion in HI revenue, a loss of $5.3 billion. Only previously accumulated surpluses will keep the fund afloat in the short term. Even with a transfer of Home Health services from Part A to Part B, these surpluses will be depleted by 2007, and the fund will be completely broke. Moreover, the Medicare Supplementary Medical Insurance Trust Fund remains unsustainable, and payments for physician services will therefore be jeopardized as well.

3. **We can do more to protect Medicare by enacting structural reforms than by pursuing additional short-term cost savings.**

   If we fail to implement reforms that begin to transform the dynamics of Medicare, Medicare's internal structural problems and runaway spending growth will require additional Congressional attention in the years ahead. Each year of delay in pursuing structural reform only makes the eventual changes more painful for beneficiaries and providers alike.

4. **The driving principle behind the Choice Care bill is accountability to the consumer and to the marketplace.**

   Under Choice Care, private health care plans would be permitted to compete with traditional Medicare for the purchasing dollars of our senior citizens. Protected by the guarantee that they will continue to receive Medicare's traditional benefits, seniors will be able to buy the health care plan which suits them best. Every time a senior makes a more cost-effective purchasing decision than traditional Medicare, he or she saves money, as does the Medicare Trust Fund. This is why Republicans embraced Choice Care as a component of the Balanced Budget Act in the last Congress, and should do so again.

Senator Gregg's Choice Care Proposal: An Outline

1. Beneficiary Choices

- Beneficiaries may remain in traditional Medicare program.
- Beneficiaries may instead choose private plan coverage options.
- Beneficiaries continue to receive federal support for Medicare coverage, but may now control how their health care dollars are spent.
- Beneficiaries are assured that private plan options may not charge more than traditional Medicare for the same benefit package.
- Legislation, as currently drafted, would permit choice of HMO, PPO, FFS, or PHO plans. Open to public comment as to whether and how to include other types of health plans, such as PSO plans.

2. Enrollment Process

- Medicare Trustees establish a 2-month "open season" for annual enrollment process, similar to FEHBP.
- Enrollees may disenroll at any time in first year of program, which eventually phases into arrangement whereby enrollees remain in their plans of choice for a 1-year period.

3. Payments to Plans/Rebates

- Government pays Choice Care Value Amount to the beneficiary's choice of private plan coverage options.
- If beneficiary's plan is less expensive than Choice Care Value Amount, beneficiary receives 75% of the difference, with the remaining 25% allocated to Trust Fund.
- Part B premiums are not affected by choice of Choice Care plan.
- Government contribution based upon sum of Part A and Part B Annual Average Per Capita Cost (AAPCC) for 1998 in county or Metropolitan Statistical Area.
- AAPCC reform to address current wide disparities in per-county payment rates.

Subsequent year contribution equal to base year increased by:

11%, if Value Amount (VA) equal to or less than 85% of national average.
7.5%, if VA equal to or less than 95% of national average.
2.5%, if VA equal to or greater than 105% of national average.
0.5%, if VA equal to or greater than 120% of national average.
5%, for all other areas.

3. Payments to Plans/Rebates (cont.)

- Value Amounts adjusted to reflect enrollee distribution and claim costs, by following classes:
  - Sex
  - Age
  - Medicaid Status
  - Institutionalized Status
  - Disabled
  - ESRD
  - Other classes determined appropriate by HHS.

4. Strict Plan Standards and Informational Requirements

- Establish Standards of Enrollment, Coverage, Benefits, Enrollee Notification, Quality Assurance, Delivery of Services, Solvency, Liability Protection, Plan Capacity, Grievance Procedures, Acceptance of Beneficiaries, Submission of Rates for All Classes, Non-Discrimination, Accreditation, and Premium, Copay, and Deductible Amounts.

- Medicare Trustees to develop enrollment materials informing seniors of their options and rights.

How Choice Care Can Work For Seniors

With Choice Care.....

- Seniors could choose the health care plan which suits them best — whether traditional Medicare coverage or an alternate plan.

- Seniors would continue to receive federal support for their Medicare benefits, but with the added feature of personal ownership and control over how and where those dollars are spent.

- Seniors could shop for alternate health care plans, knowing that no plan could charge them more than traditional Medicare for the same services.

- Seniors would enjoy "one stop shopping." Because Choice Care would allow them to buy a different health care plan offering more services, they could opt for a plan which combines the features of Medicare and Medigap insurance.

- Seniors who choose a less expensive health care plan would actually get money back.

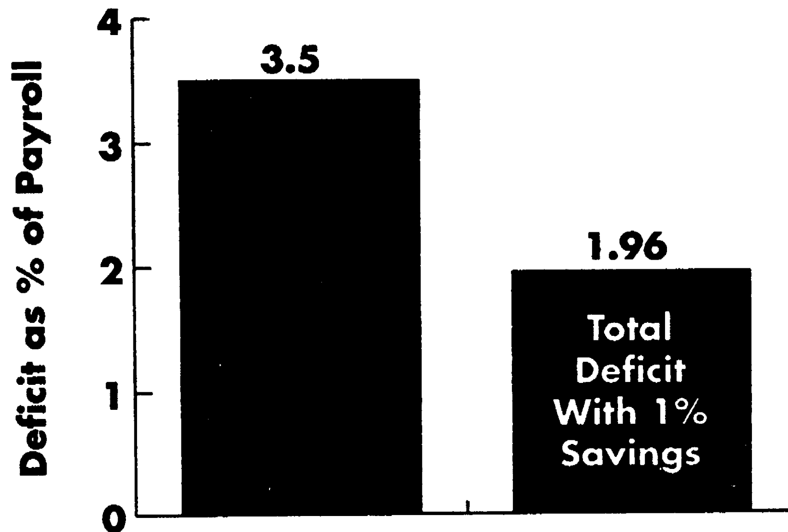
- Seniors would have the added security which comes from a stabilized Medicare program, instead of the repeated threats to their coverage which arise from runaway Medicare cost growth.

- Seniors would receive more information about their health care purchasing options, learning of their purchasing options at least 30 days before having to decide whether to enroll.

- Cost savings would come from the operations of the marketplace and the exercise of consumer choice, instead of asking providers, beneficiaries, and the workforce to continue to shoulder the continually increasing burdens of an uncontrolled Medicare expensing system.

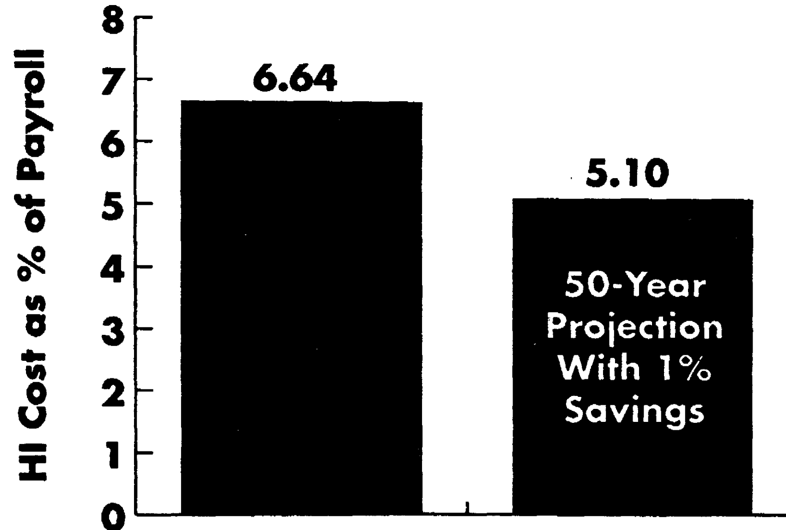
- Medicare HMO/Choice spending would be more equitably distributed across the country, allowing millions more seniors the opportunity to select from additional health care coverage options.

Even If Structural Reform Reduces Health Cost Growth By Just 1% Per Year, It Will Eliminate Almost Half of Medicare HI's 50-Year Deficit:



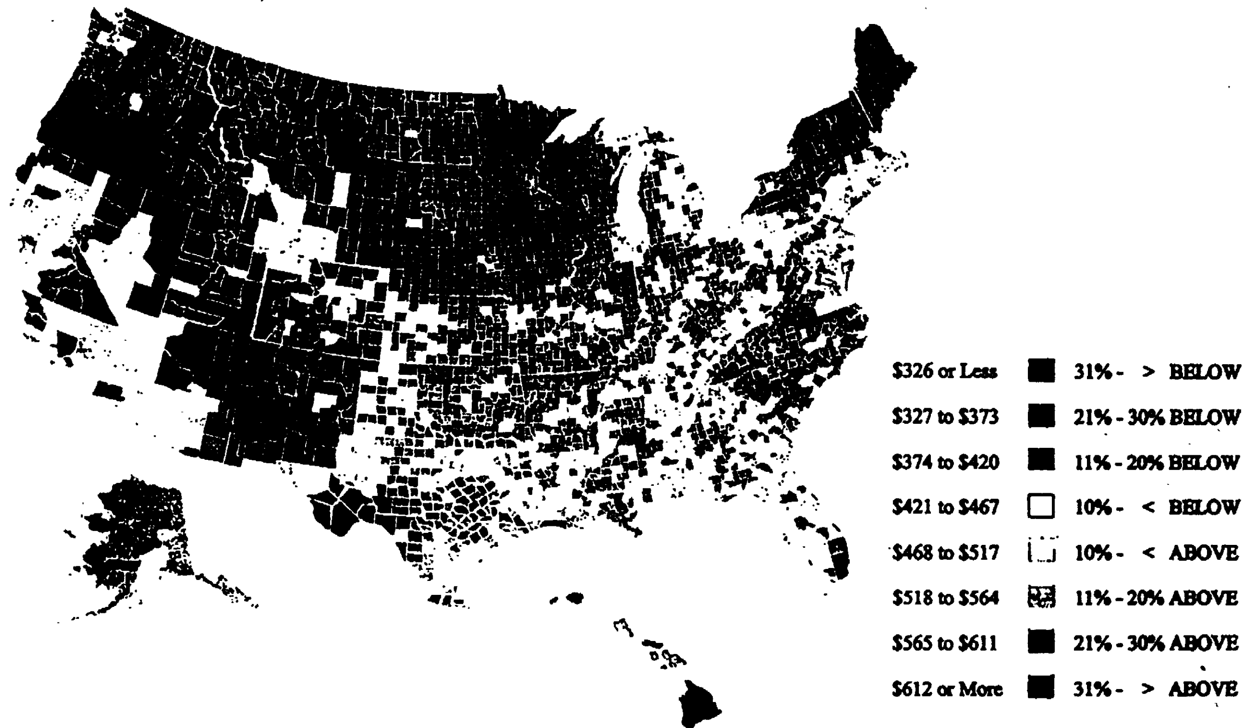
Source: 1997 Medicare Trustees Report, page 66

Even If Structural Reform Reduces Health Cost Growth By Just 1% Per Year, It Will Save More Than A 1.5% Payroll Tax Hike Over the Next Half Century:



Source: 1997 Medicare Trustees Report, page 66

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

CBO - Scored Savings From Senator Gregg's Choice Care Bill S. 246

- **$10.1 Billion over 5 Years**
- **$28.4 Billion over 7 Years**
- **$93.5 Billion over 10 Years**

PREPARED STATEMENT OF
EDWIN C. HUSTEAD
SENIOR VICE PRESIDENT
HAY GROUP

Thank you for the opportunity to address the Senate Finance Committee on the issue of FEHBP as a model for Medicare reform. I am a Senior Vice President with the Hay/Huggins division of the Hay Group. We are an international benefits and compensation consulting firm. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

As a former Chief Actuary of the Office of Personnel Management, I conducted the premium negotiations for the Federal Employees Health Benefits Program (FEHBP). At the Hay Group, I have worked on a number of analyses of FEHBP, health care reform, and Medicare for the Congressional Research Service (CRS). We assisted CRS in producing their 1989 study on Possible Strategies for Reform in FEHBP. The Hay Group maintains extensive survey data on private-sector health plans in the annual Hay/Huggins Benefits Report (HHBR).

The Federal Employees Health Benefits Program

The Federal Employees Health Benefits Program offers 374 health plan options to Federal employees and annuitants. These include seven plans that are available to all employees and some plans, like BACE, that are only offered to specific groups. Most plans are ***Health Maintenance Organizations*** (HMOs) that are available to enrollees in the service area of the plan. Depending on the number of HMOs in an area an enrollee can choose from 10 to over 20 plans.

The Office of Personnel Management (OPM) annually conducts intensive negotiations with the FEHBP health plans beginning early in the year, and culminating in the open season in November and December. Key phases in the year are benefit design, premium setting, and communication.

OPM begins the negotiation process with a call letter to the health plans. This call letter specifies the design changes that OPM will consider as part of the annual plan redesign. Similar to the PAYGO restraints in the Budget Enforcement Act, OPM requires that any revised benefit package should not be more expensive than the current package. That means that any substantial benefit increase has to be offset by a benefit reduction.

After the benefits are set, OPM and the plans negotiate the premiums. This negotiation is a careful detailed process that examines all aspects of the plan's operations. The non-HMO plans are, in effect, totally "experience rated". That means that, over time, the premiums paid for each plan equal the benefits paid for the Federal enrollees in that plan plus related administrative costs and profit.

The premium-sharing formula set in the FEHBP law is applied to determine the share of each premium to be paid by the government and the enrollee. The government pays 60 percent of the average premium for six of the largest plans, but no more than 75 percent of the cost of any individual plan. As a result of collective bargaining, the Postal Service pays a greater share of the cost for its employees.

The six plans used in the determination of the government share include the Aetna plan, which is no longer an option. A temporary provision in the law uses a "phantom" premium, based on an estimate of the rate Aetna would be charging if they were in the program. That provision is due to expire. If there is no legislative change, the government contribution will be based on the remaining five plans. Since the phantom Aetna rate is greater than that of the other five plans, default to the permanent provision will lower the government contribution and raise many of the enrollee contributions.

The benefits and premium information is announced in September and distributed to employees and annuitants before the open season. The enrollees can change, add, or drop coverage to be effective in January of the following year.

OPM asks *The Gallup Organization* to conduct an annual survey of plan satisfaction These results are published with the open season information and provide the enrollees with a qualitative guide to the benefits and services being offered by each plan. Ratings for the nationwide plans range from 74 to 92 percent satisfaction.

Before proceeding to FEHBP as a model for Medicare reform, I would like to discuss three aspects of FEHBP in more detail. These are the process and effect of competition in the program, use of health-care cost management, and a brief comparison of FEHBP and the private sector.

Process and Effect of Competition in FEHBP

How does FEHBP differ from the theoretical competition approach that was developed by health economists, including Dr. Alain Enthoven, and adopted as a major feature of President Clinton's health care reform proposal?

The theoretical approach would have enrollees choose among identical benefit designs. The employer would pay the same premium for each plan, so the enrollee would pay the cost of any difference between the premiums for any two plans.

There are two very important differences between the theoretical competition approach and the reality of FEHBP. First, while OPM has made standardized terminology and presentation and narrowed the range in the total value of the different plans, there remain complex differences in the scope and level of reimbursement of health care expenses. It is very difficult for an enrollee to quantify the overall difference in benefits between two plans and compare that difference to the premium difference.

Second, many enrollees only pay 25 percent of the difference in cost between plans as a result of the 75 percent limit on government contribution to any plan. The theoretical competition approach would require the enrollee to pay the full difference in cost.

For these and other reasons, such as adverse selection, FEHBP only presents an approximation to the theoretical model. There has been extensive discussion over the years as to whether FEHBP competition results in higher or lower costs than the typical private-sector approach of limited choice. The May 1989 CRS study demonstrated that choice in FEHBP has little impact on cost and, over time, mirrors the cost impact of the limited choice private-sector model.

Health Care Management in FEHBP

As shown in Table 1, annual premium increases have dropped from double digits in the late 1980s, to below the rate of inflation in the last four years. The most important factor in this sharp reduction in trend, in both FEHBP and the private sector, has been the substantial growth of and changes in health care management techniques. Ten years ago, the two models of health care were the Fee-for-Service (FFS) plans, which largely reimbursed any treatment requested by physicians and hospitals; and the HMOs, which monitor the patient treatment from the point that service is first needed.

During the last decade, two other models have become popular. The ***Preferred Provider Organization*** (PPO) design requires the patient to choose between in-network and higher cost out-of-network providers for each service. The ***Point-of-Service*** (POS) design also requires the patient to clear any use of in-network services with a gatekeeper. The POS choice is similar to the choice between FFS and HMO plans, but at the point-of-service rather than during the open season. Even the FFS plans have adopted extensive management controls. As a result, there are very few health plans that now permit the complete freedom of choice granted by traditional FFS plans.

OPM and the health plan options have gradually added the PPO and POS features to many of the plans. For example, an enrollee in the Blue Cross/Blue Shield Standard option can choose a $10 visit to an in-network physician, or opt for an out-of-network physician and pay 25 percent of a scheduled charge plus all charges above the usual and customary fee. The POS approach is being tested in five areas in the Blue Cross/Blue Shield plan, and will undoubtedly be proposed by other plans in the program.

Much of the health care debate in the last few years has been about whether the adoption of these much stronger management approaches has sacrificed the quality of care. Introduction of greater efficiency in the delivery of health care should not sacrifice the quality of needed health care.

Comparison of FEHBP and the Private Sector

Premium Trends

Table 1 compares the average premium changes from 1970 through 1997 of FEHBP and the private sector. The first line is the trend for private-sector plans drawn from the Hay/Huggins Benefits Report, and measured by dividing the average premium for all employers for the current year by the average premium for the prior year. The FEHBP increases are the weighted average for all plans, as reported by OPM, before considering changes in enrollment in the open season. The National Health Expenditures, as reported by the Health Care Financing Administration, Office of the Actuary, consist of spending for health care services and products throughout the United States.

Table 1 - Health Care Trends
Increase in Health Expenses from Prior Year to Indicated Year
Selected Calendar Years From 1970 to 1996

	1970	1980	1981	1982	1983	1984	1985	1986	1987
Private Sector*						17.1%	3.7%	2.6%	8.5%
FEHBP			15.4%	17.3%	17.6%	9.9%	(1.1)%	(11.4)%	17.5%
National Health Expenditures	7.8%	8.6%					8.5%		
	1988	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**
Private Sector*	16.7%	20.8%	16.8%	12.9%	11.5%	8.3%	2.7%	1.2%	(2.5)%
FEHBP	25.8%	20.7%	10.8%	4.7%	7.5%	9%	3%	(3)%	0%
National Health Expenditures			9.9%	11.6%	12.9%	10.6%			

* From the Hay/Huggins Benefits Report. If an employer offers more than one plan, then the most prevalent plan is used for the trend.

Two important patterns shown in the table are the double-digit increases in the late 1980s and the very low increases in 1994 through 1996. The FEHBP increase for 1997 was 2.4 percent. The low increases in both FEHBP and the private sector are primarily attributable to the move to tighter management controls.

While FEHBP and private-sector premium increases can be significantly different in any given year, the overall patterns of increases are similar. Year-to-year differences between FEHBP and the private sector are attributable to factors such as differences in the adoption of changes and unexpected reserve increases or decreases.

Benefits Design

The broad design of private-sector plans is similar to that of the FEHBP options. Enrollees in traditional FFS plans typically pay 20 percent of the covered health care costs after a deductible of $200 to $300. Total annual out-of-pocket expenditures by the patient are normally limited to $1,000 to $2,000. Enrollees in PPO and POS plans, who choose in-network providers, often pay less of the total cost. Many private-sector plans charge those who use out-of-network providers a higher percentage of the cost. The HMO plans offer similar or identical provisions to FEHBP and private-sector enrollees.

The major design difference between the typical private-sector and FEHBP plans is the dental plan. The typical private-sector dental plan reimburses 50 to 80 percent of most expenses, and fully pays for preventive care. The typical FEHBP plan only pays a small fixed fee for each procedure. For example, the Blue Cross/Blue Shield Standard option only pays $8 of the fee for an oral evaluation for adults. This difference is a result of the OPM requirement that design changes that increase cost must be accompanied by a change with an offsetting cost decrease. The policy was in place before dental benefits became common in employer-sponsored health plans. As a result, the FEHBP plans were not able to add substantive dental plans in line with the private sector.

Hay conducts annual evaluations of the relative value of Federal and private-sector compensation. We find that the value of the FEHBP plans is about ten percent lower than the average value of private-sector health plans. The lower value of the FEHBP plan is primarily a result of the difference in the dental provisions.

Health Care Management

The most important trend in private-sector health plans has been the move from FFS to the managed-care approaches in the last decade. In the last four years alone, HHBR reports that managed care has increased from 38 to 76 percent of all plans.

The usual approach in the private sector is to replace the FFS plan with the PPO or POS plan. FEHBP has maintained the choice of plans and that would probably be a necessity in any redesign of Medicare.

Important Differences Between FEHBP and Medicare

There are important differences between Medicare and FEHBP that make many of the design, premium setting, and management aspects of FEHBP inappropriate as models for Medicare. Medicare is a uniform national program that applies to almost all individuals over age 65. FEHBP is an employer-sponsored program that applies to Federal employees and annuitants. FEHBP coverage of annuitants over age 65 is limited to paying a portion of the benefits costs that are not reimbursed by Medicare.

Medicare, as it is now structured, cannot respond quickly to changes in the health care environment. FEHBP can respond to developments in health care design and financing much more rapidly than Medicare, because control of most aspects of the design, management, and pricing rests with OPM. Major changes in Medicare can only be achieved through an extensive legislative process that necessarily requires input from all affected segments of the economy. For example, further restrictions on Medigap policies would be strongly opposed by the insurance industry and many Medicare enrollees.

The population covered by Medicare has many different health needs, and a much higher cost, than the FEHBP population that spans all age groups. The average per capita cost of Medicare, at around $5,500, is almost triple the cost of the FEHBP population. This difference is magnified by the fact that the average income for Medicare enrollees is much lower than for the FEHBP population.

Differing health care needs, and political and budgetary considerations, have resulted in important benefit design differences between the two programs. For example Medicare does not have a maximum out-of-pocket limit, and does not cover out-patient prescription drugs or dental care. On the other hand, Medicare has extensive provisions for skilled nursing facilities, home health, and hospice care benefits that are not duplicated in FEHBP and private-sector plans.

Another difference between Medicare and FEHBP that limits introduction of major nationwide changes is the ability to communicate quickly and effectively with the enrollees. The workplace is a critical channel of information for FEHBP and other employer plans to convey information on plan changes and address questions and concerns about the health plans. Medicare enrollees, with their extensive health needs, would find the choice to be much more complex and important than most enrollees in FEHBP. It is also much more difficult for Medicare to provide extensive information and quickly address questions than it is for an employer. This limits the number and complexity of options that can reasonably be offered to Medicare enrollees.

A final very important difference is the existence of Medigap polices. These will limit the potential effectiveness of PPO and POS approaches if they are allowed to reduce the financial incentive to use the network providers. If, for instance, Medicare charged the

patient $100 more for use of an out-of-network physician but Medigap paid the $100 then there would be no incentive for the patient to use the in-network physician.

Lessons of FEHBP for Medicare

The important differences between FEHBP and Medicare limit the direct application of some concepts from one program to the other. However many of the principles of cost control and negotiation of FEHBP can be transferred to Medicare.

Medicare already offers HMOs, and it is expected that the popularity of HMOs will continue to grow. Now that Medicare HMOs have passed beyond the experimental stage and are predicted to enroll an increasing number, the Federal government could apply the negotiation and communication procedures developed in FEHBP to the Medicare HMOs. These include working with the HMOs to design the most appropriate benefit package, negotiate a fair premium, and communicate the options to the population.

As in FEHBP and the private sector, substantial savings could be achieved by careful application of the PPO and POS design to Medicare. Medicare is initiating demonstration POS contracts, but substantial savings will only come with nationwide availability of such options. The role of Medigap plans will have to be carefully considered in the design of a such options. The government will also have to balance the health care needs of the patients with the controls of the PPO and POS plans.

Choice in FEHBP is far from the theoretical competition approach, and does not have a significant cost impact on the cost of FEHBP. The differences between FEHBP and Medicare make choice in the latter program even less amenable to the theoretical competition approach. It is unlikely that competition among plans of identical design can ever be achieved in Medicare. Instead potential savings can best be achieved by providing choice among health management approaches.

A reasonable goal for competition in Medicare would be to provide three nationwide options with one each of the FFS, PPO and POS designs. Medicare enrollees could choose among the three nationwide plans and the local HMOs. Key questions in designing PPO and POS options in Medicare are:

- How to keep the Medigap plans from defeating the PPO and POS designs?
- How to determine an equitable government and enrollee contribution?
- How to continue availability of the current FFS plan at a reasonable price for those who prefer not to participate in the PPO or POS options?

Thank you for the opportunity to present this testimony to the Committee. I would be happy to address any questions you may have on the application of FEHBP concepts to Medicare.

55-303 - 99 - 4

Opening Statement
Senator James M. Jeffords

U.S. Senate Finance Committee
May 21, 1997

Thank you Mr. Chairman for holding this important hearing. Each year the Federal Government pays billions of dollars for health care. An important focus of Federal health policy should be to learn from private-sector strategies and other programs like the Federal Employees Health Benefits Program to purchase better quality health care at lower costs.

The FEHBP model holds the promise of providing greater health care choices to beneficiaries throughout the United States. But as we begin to examine approaches to improving the Medicare program it is worth remembering that the Federal government is the largest purchaser of health care in the country. It is time that we focused that purchasing power to bring about a Medicare program based on quality of care.

Some of us are working on legislation that will make sure that federally funded health care programs ensure that the plans offered to beneficiaries meet certain basic quality criteria. By focusing on accreditation and standardized information, we will help to ensure that health care plans are competing based on quality and not just cost.

I look forward to hearing today's witnesses and especially their views on how the FEHBP model can help to ensure that quality of care remain as a key component of the Medicare program.

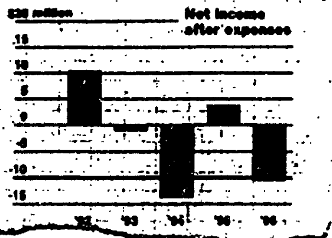
[Submitted by Senator Moynihan]

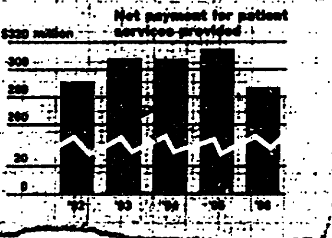
Business Day

D1

TUESDAY, MAY 20, 1997

The New York Times





Source: New England Medical Center Hospitals Inc.

Diagnosis: Critical

Across the country, prestigious teaching hospitals are being forced into mergers and alliances by cost-cutting unleashed by managed care companies and government agencies. Boston's New England Medical Center, left outside the network of the region's biggest health maintenance organization, has run a deficit three of the last five years as its income from patient care stagnates.

Teaching Hospitals Under the Knife

Longtime Missions Pressed by H.M.O.'s

By MILT FREUDENHEIM

BOSTON — It began as a charity supported by Paul Revere that sent out doctors to the poor. It evolved into the New England Medical Center at Tufts University, a research powerhouse that ranks among the leaders in New England in liver transplants, breast-cancer research and complex heart procedures.

But now, the biggest health maintenance organization in Boston threatens to starve New England Medical by refusing to pay for its patients to go there, even though the costs are as low or lower than at other Boston teaching hospitals.

The H.M.O., Harvard Pilgrim Health Care, has forged ties with other health care providers that would be delighted by the disappearance of a rival in the overcrowded Boston market. Struggling to stay afloat, New England Medical is selling its sparkling new Boston hospital and trying to force its way into Harvard Pilgrim's network.

The squeeze on academic medical centers like New England Medical is particularly brutal in Boston, which has seven prestigious teaching and research hospitals and far too many hospital beds, and where costs per patient are among the nation's highest. But dozens of teaching hospitals across the country face similar challenges, and they are responding by reaching out for business partners.

Some, like the George Washington University Hospital in Washington, D.C., and state university hospitals in California, Oklahoma and South Carolina, are being sold to for-profit chains; others, like New England Medical, Columbia University's Presbyterian Hospital and the University of Minnesota Academic Medical Center, have merged with stronger, nonprofit local institutions; still others, like Beth Israel and St. Luke's/Roosevelt in New York, are merging into holding companies that will run their finances.

Harvard Pilgrim makes no apologies for its treatment of New England Medical — quite the contrary. The H.M.O. says the whole point of managed care is to cut costs by making deals with a few providers of health care, and New England Medical just plain represents too much fat. "To us, it is a redundant hospital," said Dr. Patrick H. Mattingly, a senior vice president of Harvard Pilgrim.

He expected New England Medi-

Continued on Page 4

Photographs by Michael Quan for The New York Times

Dr. Lawrence Blaszkowsky, left, an oncologist at New England Medical, says managed care pressures to see more patients sometimes prompt him to skip daily bedside teaching rounds with medical students. Carol Durocher, right, a bank teller in Sturbridge, Mass., had to fight with Harvard Pilgrim Health Care to stay in an experimental program for liver disease at New England Medical.

Continued From First Business Page

cal to survive, probably through a merger with another Boston hospital, but said that it missed the chance to dictate its own destiny back in the 1980's, when "everybody was choosing their marriage partners," and it played coy instead. Now, he said, it is paying the price.

Whatever the choices of the past, the squeeze on academic medical centers today is real. It is forcing cutbacks in teaching and research and a slowdown in testing of new therapies, as H.M.O.'s make it harder to recruit patients to try them out. Patients already have to fight to stay in some experimental programs.

Carol Durocher, a bank teller in Sturbridge, Mass., is one of them. Ms. Durocher had been treated successfully at New England Medical for eight years for a rare liver disease, averting the risks of a transplant. But after her employer switched from Blue Cross to Harvard Pilgrim in January, she said, her new health plan repeatedly rejected requests to authorize payment of her costs for periodic checkups with her doctors.

Managed care forces cuts in research and tests of new therapies.

It finally relented, she said, only after she let her employer know that she planned to testify at a legislative hearing on H.M.O.'s that exclude hospitals from their networks.

The search for new cures is also suffering, according to Dr. Jack Erban, director of the breast-cancer program at New England Medical. He said his team's contribution to national tests of a new drug was delayed for 18 months because participants who had Harvard Pilgrim insurance could not be treated at New England.

The teaching mission at many academic medical centers has also "taken a back seat," Dr. Erban said. Health plans insist on rates that are based on the costs at community hospitals that do not have the expenses of teaching and research. "We're looking at a time bomb waiting to go off," Dr. Erban said.

Dr. Lawrence Blaszkowsky, a young oncologist on Dr. Erban's team, said he saw so many patients that he sometimes had to skip the daily bedside teaching rounds with the medical students and residents. He said that the frustrations were enough to prompt him to consider leaving the academic world for the rewards of private practice.

After a barrage of criticism in the State Legislature last week, Dr. Mattingly conceded that Harvard Pilgrim probably needs to "rethink what we are willing to do" for patients at New England Medical — but only "on a case-by-case basis."

For 15 years, teaching hospitals have dodged the cost-cutters by juggling a hodgepodge of revenue sources. Federal money flowed freely for new buildings, and the medical schools were deluged with applicants, as they still are.

But now, academic medical centers have been knocked off balance as Washington and states try to cram a lid on spending for health and welfare, and the tight-fisted tactics of managed care spread to Medicaid and Medicare.

"The managed care market says, 'We have no responsibility for medical education or clinical research,'" said Frank Cerra, provost of the University of Minnesota Academic Health Center, which recently sold its hospital to a Minneapolis community hospital system. "In other words, 'tough cookies.'"

Dr. Mattingly of Harvard Pilgrim agreed that managed care executives tended to look askance at academic medical centers. "They start out as inherently the most inefficient hospitals with the biggest surplus of specialists and beds," he said.

Rather than divert patients from teaching hospitals entirely, though, Harvard Pilgrim's strategy has been to form close partnerships with several hospitals affiliated with Harvard Medical School, he said.

According to Dr. James Muller, a longtime Harvard cardiologist and researcher, who eluded the Boston managed care squeeze by moving to the University of Kentucky, the nation's teaching hospitals used to take in $2.4 billion a year in patient-care fees that could be used for doctors' salaries and research. Now, he said, "That money is coming out of the system, with devastating effects."

In a further turn of the screw, Government cost-cutters are drastically reducing payments for the inner-city poor, who make up a big part of the teaching hospitals' patient load. The University of California at Irvine's UCI Medical Center, which is in Orange, Calif., lost 65 percent of its subsidies for the indigent last year, though the patients did not go away. UCI executives threw up their hands and opened negotiations to lease the medical center to a for-profit hospital chain.

Meantime, Federal investigators have been grilling bookkeepers at several university medical centers, seeking evidence of improper allocations of Medicare and Medicaid funds. To Dr. Muller, the investigations are akin to "kicking a sick patient."

The pressures vary from city to city, depending on the buying power of H.M.O.'s, the financial strength of the hospitals, and whether there are two or more teaching hospitals the H.M.O.'s can play against each other to force fees down.

In New York and its suburbs, where nine hospitals have announced mergers and one merger fell through (over differences between faculty doctors of Mount Sinai Medical Center and New York University), no H.M.O. is strong enough to try to freeze out an important hospital. But that, said James Tallon, president of the United Hospital Fund, a New York research center, will change as competition heats up and buyers force down prices.

Sales or mergers of teaching hospitals have been announced or completed by at least 18 state universities across the country. In deals involving for-profit hospital chains, the Columbia/HCA Healthcare Corporation bought an 80 percent stake in the Tulane University Medical Center in New Orleans in 1995. Columbia/HCA is negotiating with Oklahoma and South Carolina and is bidding against the Tenet Healthcare Corporation for the UCI Medical Center lease. Universal Health Services, another for-profit chain, recently agreed to buy an 80 percent stake in the George Washington University Hospital.

In Boston, New England Medical says it lost $13 million in annual patient fees after it was dropped by Pilgrim Health Care in 1993. (Pilgrim Health later merged with the Harvard Community Health Plan to create Harvard Pilgrim Health Care.) Today, Harvard Pilgrim's primary-care doctors routinely refer patients to every major teaching hospital in Boston, with the sole exception of New England Medical.

Struggling to stay afloat, New England Medical considered and rejected alliances with just about every hospital in town last year, when it also had discussions with Columbia/HCA. Several local hospitals, supported by the mayor, expressed alarm at the prospect of inviting the huge chain's cost-cutters into Boston's high-priced medical mecca.

Finally, in January, New England Medical said it would be acquired by Lifespan Health Services, a strong hospital group based in Providence, R.I. The Lifespan hospitals already had a contract with the Harvard Pilgrim network.

Lifespan says that under that contract, Harvard Pilgrim must now admit New England Medical to its network, too. Harvard Pilgrim disagrees: Referring patients to the Tufts teaching hospital would disturb close ties between the H.M.O. and the big Harvard teaching hospitals, and it would upset the hundreds of doctors already in its network, executives said.

New England Medical's predicament elicits little sympathy from rival hospitals. With so many surplus beds out there, "Some hospitals will go down more than others," said Dr. Samuel Thier, president of Partners Health Care, a three-year-old marriage of Massachusetts General Hospital and Brigham's and Women's Hospital.

Last year, Partners suggested converting New England Medical into a chronic care and rehabilitation hospital and moving the Tufts teaching units to designated floors at Massachusetts General.

The Tufts doctors were not amused. "The faculty view was that they would be absorbed by the Harvard Medical School," said John DiBiaggio, president of Tufts University. He added that it was "critically important to us that we have an adjacent affiliated hospital."

Dr. Mattingly of Harvard Pilgrim brushed aside such concerns. The Tufts school, he said, is "not our burden."

Changes in Academic Medical Centers

Here are some of the deals that have occurred in the teaching hospital sector within the past three years

ACQUISITIONS

Academic medical centers acquired by non-profit health systems

HOSPITAL	ACQUIRED BY
New England Medical Center (Boston)	Lifespan Health Services* (Providence, R.I.)
Hahnemann University Hospital and Medical College of Pennsylvania (Philadelphia)	Allegheny Health Education Research Foundation (Pittsburgh)
University of Minnesota Hospital (Minneapolis)	Fairview Hospital and Healthcare Services (Minneapolis)

MERGERS

Hospitals that have merged with others to form one entity, but usually retain autonomy.

HOSPITAL	MERGED WITH
Boston University Hospital	Boston City Hospital
Presbyterian Hospital, Columbia Presbyterian Medical Center (New York)	New York Hospital* (New York)
University of Massachusetts (Worcester)	Memorial Healthcare* (Worcester)
Barnes Hospital (St. Louis)	Jewish Hospital (St. Louis)
The Medical Center at the University of California at San Francisco	Stanford University Medical Center* (Palo Alto, Calif.)
Indiana University Medical Center (Indianapolis)	Methodist Hospital (Indianapolis)

NEW ENTITIES

Holding company or other entity formed to control management.

HOSPITAL	FORMED WITH
Penn State's Milton S. Hershey Medical Center (Hershey, Pa.)	Geisinger Health System* (Danville, Pa.)
Massachusetts General Hospital (Boston)	Brigham's & Women's Hospital (Boston)
Beth Israel (Boston)	Deaconess (Boston)
Beth Israel (New York)	St. Luke's/Roosevelt (New York)

OFFER FOR SALE

For-profit hospital chains are buying control of academic medical centers.

HOSPITAL	MAY BE LEASED BY
University of California Irvine Medical Center	Columbia/HCA Healthcare or Tenet Healthcare
	PURCHASED BY
Tulane University Medical Center (New Orleans)	Columbia/HCA Healthcare
Medical University of South Carolina (Charleston)	Columbia/HCA Healthcare*
The University Hospital of the University of Oklahoma (Oklahoma City)	Columbia/HCA Healthcare*
George Washington University Hospital (Washington)	Universal Health Services*

Source: University Health System Consortium

*Pending.

Medicare Reform and the Federal Employees Health Benefits Program

Statement of Robert D. Reischauer*

Committee on Finance
United States Senate
May 21, 1996

Mr. Chairman and members of the Committee, I appreciate this opportunity to discuss with you the relevance of the Federal Employees Health Benefits Program (FEHBP) to the future of Medicare. My statement addresses three questions:

- What insights for Medicare reform can be drawn from the FEHBP experience?
- To what extent might FEHBP serve as a model for a restructured Medicare program?
- How important is it to begin restructuring the Medicare program soon?

Congressional leaders and the President have just concluded a bipartisan budget agreement that, we all hope, will keep the Hospital Insurance (HI) Trust Fund solvent through 2007 and lead to a balanced budget by 2002. The agreement calls for $115 billion in net reductions in Medicare spending over the fiscal 1998 to 2002 period and $319 billion over the following five years. These savings are expected to be generated primarily by reducing the growth of payments to providers and secondarily by increasing Part B premiums. If the agreement's goals are realized, Medicare spending will be some 13.9 percent below baseline levels by fiscal 2002.

These reductions are significant and will be difficult to realize. Nevertheless,

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* Senior Fellow, The Brookings Institution. The views expressed in this statement are those of the author and should not be attributed to the staff, officers or trustees of the Brookings Institution.

everyone knows that they are not sufficient to deal with the challenge Medicare will face after 2010 when the first of the baby boom generation turns 65 and becomes eligible for benefits. The Congressional Budget Office (CBO) has projected that baseline Medicare spending will rise by 3.5 percentage points of GDP between 2010 and 2035, while Social Security outlays are projected to increase by only 1.5 percent of GDP over the same time period.

The challenge posed by the baby boomers' retirement and the continued unrestrained increase in utilization in fee-for-service Medicare will have to be met by structural reforms because the traditional ways of holding down Medicare's budgetary impact–raising payroll taxes, increasing Part B premiums, and slowing the growth of payments to providers–probably are not capable of doing the job over the long haul. But what type of restructuring would be most appropriate and when should the effort get underway?

Growing numbers of policymakers and analysts have concluded that, to meet the challenge of the next century, Medicare should be transformed into a system that provides participants with the opportunity and incentives to choose cost-effective health care delivery systems. This could be accomplished if participants were allowed to choose among a number of competing health plans, each offering a more adequate package of benefits than Medicare's current coverage, which close to 90 percent of participants choose to supplement. In such a system, participants who selected more expensive plans would be required to pay higher premiums out of their own pockets while those who joined inexpensive plans would pay lower amounts. Plans would compete to deliver cost-effective care.

The Federal Employees Health Benefits Program (FEHBP) is a system that, in many respects, resembles this structure of competing health plans. It provides coverage to some 9 million people including 2.3 million active federal workers, 1.8 million annuitants, and the dependents and survivors of active and retired workers. Some of the annuitants are covered by Medicare, others are not. While 388 separate plans are available under the program this year, the vast majority are HMOs that are offered only in a particular geographic area and a few are open only to workers in particular agencies (for example, the plans for employees of the FBI and for foreign service officers). Most participants, therefore, can choose among ten to twenty plans. The federal government pays 75 percent of the plan's premium up to a maximum which is set at 60 percent of the average premium for six plans with large enrollments ($1,599 in 1996 for single coverage).[**]

FEHBP has had performance that is similar to that of large private employer-sponsored plans with respect to both participant satisfaction and cost growth. Some 95 percent of the participants feel that the options they are provided compare favorably with those offered by private sector employers and over 85 percent are satisfied with their own plan. Over the 1983-96 period, the average participant premium rose by less than 4 percent a year. Federal costs grew at a faster pace--over 8 percent a year--because the shift in enrollment from the more expensive to the less expensive plans held down the growth of employee premiums but not the government's contribution. Since 1992, the growth rates of both the government's and the participants' premiums have slowed to a crawl--around 2 percent a year--as has been the case for large private sector plans as well.

[**] Aetna, which was one of these plans, dropped out of the program in 1989 and, ever since, a synthetic or "phantom" Aetna-like premium has been used in the formula.

The general, but not unreserved, success of FEHBP has led some analysts to suggest that this program could serve as a model for a restructured Medicare program. While the FEHBP experience does offer a number of useful lessons and insights for Medicare reform, there are several reasons why FEHBP would be an inappropriate structure for the Medicare program of the future. The problems that FEHBP has muddled along with over the years would be exacerbated if it served only the aged and disabled and did not have its participants concentrated in a limited number of geographic areas.

Some insights from FEHBP for Medicare reform

FEHBP offers a number of positive lessons or insights for those who seek to transform Medicare into a more competitive system with broader consumer choice. First, FEHBP shows that it is possible to create a smoothly functioning market system of national scope in which a number of different types of health plans compete for enrollment. While many large employers offer their employees a choice of two or three or even five plans, there are not a lot of examples where participants can choose among two or three dozen alternatives as is often the case for FEHBP participants. The range of options is also broader under FEHBP than under most private and public sector systems. Traditional fee-for-service, preferred provider organization (PPO), independent practice association (IPA), health maintenance organizations with point of service options (HMO-POS) and HMO plans are offered to most participants. Moreover, participants are usually given a choice of more than one plan for each type of insurance, which is rarely the case with private employer-sponsored systems. Furthermore, the system works with a more heterogeneous pool of participants than most private sector systems encounter. FEHBP covers not only the core

clientele of the typical employer-sponsored health plan--active workers and their dependents--but also large numbers of annuitants between the ages of 55 and 64 and their dependents. It also provides primary insurance for federal retirees who are 65 and older but not eligible for Medicare because they spent their entire careers in federal employment before federal workers were brought into the HI program in 1984.

A second lesson from FEHBP relevant for Medicare reform is that it does not take a huge complex bureaucracy to operate a competitive system. The Office of Personnel Management (OPM), which is responsible for administering the program, accomplished the task in 1996 with a staff of fewer than 150 full-time equivalent employees and a modest administrative budget of around $20 million. It should be noted that these figures significantly understate the total resources devoted to running the program for several reasons. For example, information dissemination, enrollment, disenrollment, and initial handling of questions and complaints are performed by the human resource staffs of the various federal agencies. Nevertheless, the FEHBP experience does indicate that the job of administering a competitive system can be handled well without high administrative costs or a large bureaucracy.

A third insight that can be drawn from FEHBP's operations is that it is possible to develop and disseminate comparative information that participants find both intelligible and useful as they decide which health plan to join. This is important because a competitive market will not work efficiently unless consumers are informed. Health plans are complex entities and it is difficult to compare their various dimensions, let alone the quality of the service they provide. Yet over 90 percent of FEHBP's participants were satisfied with OPM's annual *FEHBP Guide* which provides comparative information on the benefits and

costs of the various plans. In addition, several non-profit organizations publish information that describes, evaluates, and grades the choices available to participants. These include *Checkbook's Guide to Health Insurance Plans for Federal Employees* and the *Federal Health Benefits Information and Open Season Guide* published by the National Association of Retired Federal Employees (NARFE). The FEHBP experience suggests that if Medicare were transformed into a program offering more choice, clear and informative material comparing plans could be provided by both HCFA. In addition, private and non-profit organizations would undertake the task of ranking and evaluating the quality of the services provided by plans.

A fourth insight that can be drawn from the FEHBP experience is that competitive markets are likely to be fairly stable. Some analysts have expressed concern that differences in premium increases, performance, or consumer ratings might cause large swings in plan enrollment in a competitive Medicare market. This could cause capacity problems for plans that gained participants and consumer dissatisfaction if participants could not join the plan of their choice or if a surge in enrollment caused a degradation in their plan's service quality. The FEHBP experience suggests that, in an established system, these are not significant problems because few participants switch plans when they have the opportunity. Each year, only about 5 percent of participants choose to switch from one plan to another. While sudden disenrollment might significantly affect a plan with limited enrollment, the balance of the market can easily absorb its members.

FEHBP's experience also suggests that an effective competitive market can function without a sophisticated mechanism for risk adjusting payments to plans. OPM does not adjust its premium payments to plans despite the considerable variation in the expected cost

of the various classes of participants. In other words, for any given plan, the total premium payment for a single 25 year old male federal worker is the same as for the 75 year old annuitant who lacks Medicare coverage. This policy has caused some problems and inequities. The premiums paid by the participants in plans that have attracted less healthy enrollees are unfairly high because federal premium payments are not risk adjusted. In extreme cases, efficient plans whose benefits have been particularly attractive to those with health problems or to high-cost annuitants have been forced to drop out of FEHBP. This has occurred when a plan's adverse risk pool has caused participant premiums to rise and healthier enrollees to drop out of the plan. What is noteworthy is not these problems but rather that the FEHBP system has functioned as well as it has without any explicit risk adjustment. This suggests that the imperfect risk adjustment mechanisms that are presently available should be sufficient for developing a more competitive Medicare system. As more accurate and sophisticated tools are developed, they can be used to improve that system.

Finally, FEHBP's experience has reenforced the conclusions of many private employers that it is neither necessary nor efficient to allow participants to change health plans more than once a year. Medicare currently allows participants who have selected an HMO to disenroll from that plan and choose another HMO or return to the traditional fee-for-service system with 30 days notice at any time during the year. FEHBP, and most private employers that offer more than one plan, restrict this freedom to a fixed "open season" period that occurs once a year. There is no indication that this has caused problems for federal annuitants who most resemble Medicare participants. This is not surprising considering that these retirees can simply choose to remain in the health plan they were enrolled in during their working years and hence are most familiar with. A

similar set of circumstances should develop under a competitive Medicare system where participants might be expected to have a choice of plans, some of which would be similar or even identical to the ones that covered them during their final years on the job.

Can FEHBP serve as a model for a restructured Medicare program?

While the FEHBP experience offers encouraging evidence that an efficient, high-quality system of competing health plans can be developed, FEHBP does not provide an appropriate model for a restructured Medicare system for several reasons. Some relate to differences in the populations served by Medicare and FEHBP, some to specific design characteristics of the FEHBP system, and some to the interaction between the two.

Covering the Medicare population is a much more complex undertaking than providing health insurance to federal workers, retirees, and their survivors and dependents. While the participants covered by the FEHBP plans are a diverse lot, they are nowhere near as diverse as the Medicare population. For the most part, FEHBP participants are fairly well educated and overwhelmingly middle- or upper-middle class. They are, presumably, fairly sophisticated consumers. They are largely workers in secure, safe, white or pink collar jobs or retirees whose needs are relatively well met because of the generosity of the federal pension system. They are disproportionately concentrated in relatively few metropolitan areas. In contrast, Medicare participants are older and more likely to be disabled or infirm. They are less educated than the FEHBP population and many have very modest incomes. Medicare beneficiaries are spread throughout the cities, suburbs, and rural areas of the nation.

In a competitive Medicare structure, some entity would have to be established to

55-303 - 99 - 5

perform the functions that the employing agencies fulfills in the FEHBP system. This entity, which could be a government or non-profit organization, would be responsible for enrollment, disenrollment, and developing and disseminating to participants comparative plan information. It would also help participants handle problems that they might encounter with their plans. The task of informing Medicare consumers about their choices would be significantly more challenging than it is under the FEHBP system, in part because of the differences between the two populations. But in addition, one valuable source of comparative information about health plans would not be available to Medicare participants. This source is the informal office discussions that workers have with their colleagues about the performance of various health plans. While many Medicare participants do share such information with retired friends some lead relatively isolated lives.

Several design characteristics of FEHBP make it an inappropriate model for a restructured Medicare system. First and foremost among these is the lack of a mechanism to adjust the government's premium payments for the differential risk or health status of each plan's participants. While this has caused some problems for FEHBP, the consequences for a competitive Medicare system are likely to be far more serious. Foremost among these is the inequity that is created when participants must pay higher premiums not because their plan provides more generous benefits or is less efficient but because its enrollees are less healthy. The lack of a risk adjustment mechanism also increases the incentive that plans have to enroll healthy participants, a response that public policy should seek to discourage, not encourage. Furthermore, if government payments to plans are not risk adjusted, the market will be less stable and there will be less plan

continuity. For the elderly and disabled population, market stability is undoubtedly more important than it is for those of working age.

A second design characteristic of FEHBP that makes it an inappropriate model for a restructured Medicare program is its lack of a common benefit package. While all plans are required by law and regulation to meet certain minimal standards of coverage, plans are free to vary their benefit packages. Over time, the benefits offered by the various plans have become quite similar as plans have attempted to avoid the adverse selection that might result if they offered a comparatively rich package of benefits. Nevertheless, subtle differences in benefit packages, if they were allowed, could be used by plans to attract the healthier participants in a restructured Medicare program. In addition, it is more difficult for consumers to make meaningful comparisons of plans when each offers a different benefit package. For these reasons, it would be best to require that all plans operating in a restructured Medicare program provide the same core package of benefits. Supplemental benefits could be permitted, but they would have to be sold separately and priced to cover any indirect impact they might have on the utilization of core benefits.

The lack of fixed market areas is another aspect of FEHBP that would not be appropriate for a restructured competitive Medicare system. For the most part, FEHBP plans are free to specify the geographic area in which they will provide services. This has not caused significant problems because the FEHBP population is relatively homogeneous. But that is not the case with respect to Medicare population as the large variations in Adjusted Average Per Capita Cost (AAPCC) rates within many metropolitan areas demonstrate. Gerrymandering of service areas can be used to avoid participants with higher-than-average expected costs. Unique plan service areas also can complicate both

comparisons of plan performance and the choices facing Medicare beneficiaries. For these reasons, a restructured competitive Medicare program should establish defined multi-county service areas and require participating plans to offer their services to any Medicare participants in the area.

Finally, the way in which FEHBP has structured and determined plan premiums is probably not appropriate for a restructured Medicare program, at least in the long-run. FEHBP is a relatively passive buyer when it comes to determining the premiums it pays to local HMOs. OPM requires that these plans charge FEHBP no more than they charge their large private sector customers. Adjustments are permitted to reflect differences in the characteristics of the private sector and FEHBP enrollees and in the various benefit packages. This procedure makes a great deal of sense considering that FEHBP enrollment constitutes a relatively small share of most participating HMOs' business. Furthermore, it would be a significant burden on OPM to negotiate actively with hundreds of HMOs scattered throughout the nation. But Medicare's market position would be quite different from that of FEHBP. It would represent a very large purchaser in almost every market. Furthermore, premiums for private employer-sponsored coverage have little relevance for the costs of covering the Medicare population.

Under FEHBP, premiums for the nation-wide fee-for-service and PPO plans are negotiated by OPM. They are uniform across the nation. Thus, plans must lose money on participants in high cost areas such as New York City and make healthy margins on enrollees in low-cost markets in rural areas and in such metropolitan regions as Minneapolis-St. Paul and Portland, Oregon. Under this structure, these plans have an incentive to market more aggressively in low-cost areas. In addition, a system of uniform

national premiums is inequitable because a portion of the premiums paid by participants in low-cost areas is used to subsidize services provided to those in high-cost areas.

Rather than adopting the FEHBP method of setting premiums, a restructured competitive Medicare program should establish premiums through competitive bidding. Medicare's payment level for each market area could be set at the median bid as long as the plans submitting lower bids were capable of serving at least half of the market's Medicare population. The Medicare payment level should incorporate the participant's contribution which would subsume the Part B premium and an amount equal to the average cost of Medigap insurance as long as the required benefit package under the new system was enriched to cover the benefits currently provided by supplementary insurance in addition to the core Medicare services. Those who chose plans with premiums below the Medicare payment level would receive rebates while those who joined more expensive plans would be required to pay additional premiums. Such a system would balance equity and efficiency and use market forces to restrain the growth of federal costs.

When Should Structural Reform Begin?

Once the bipartisan budget agreement of 1997 has been turned into law, there will be a great temptation to celebrate the accomplishment with a period of legislative rest, particularly in those areas which have been cut the most to balance the budget and pay for tax relief. Few will have the stomach to revisit these policy areas for fear of reopening old wounds. In no area will this reaction be stronger than in Medicare which, under the budget agreement, has been asked to bear 42 percent of the net reduction in non-debt service spending that will occur over the next 5 years.

It would be a major mistake, however, to delay dealing with the long-term challenge facing Medicare. The sooner the nation begins the task of restructuring Medicare, the more options policymakers will have to choose among and the less wrenching the changes will be.

In a number of respects, current conditions are relatively salutary for beginning the restructuring process. But these conditions may not last long. The economy is strong and lacks any significant structural imbalances. Under such circumstances, the dislocations which are an unavoidable part of any major restructuring effort should be accommodated relatively painlessly.

Demographic conditions are also favorable. The next decade will see a lull before the demographic storm breaks. The population aged 65 and over is projected to grow only 0.9 percent a year during the next decade–less than it did during the previous decade and much less than it will in the decade after 2007. The 65 and over group will edge up from 12.7 percent of the population in 1997 to 12.8 percent in 2007. This period of benign demographics means that any new institutional structures that are created over the next few years as part of Medicare reforms will have time to become established and be fine-tuned before the first of the babyboomers begin to turn 65 in 2011. If the new structures are put in place later, they may be overwhelmed by the explosion in the number of new participants. Over the next 14 years, Medicare will have to cope with an average increase in elderly enrollment of only 395 thousand a year; during the 14 years following 2010 the comparable figure will be 1.5 million.

Health market conditions too are conducive for Medicare restructuring. Providers, particularly hospitals and physicians, are in excess supply. As employer-sponsored plans

have constrained their payments to providers, Medicare's payment levels have become relatively generous. Medicare hospital margins--estimated at 12.7 percent for 1997--are higher than they have been in over a decade. Introducing structural reforms, even with the inevitable slips and stumbles, will be unlikely to restrict access or compromise the quality of care received by Medicare participants. This may not be the case a decade from now if private plans successfully wring some of the excess capacity out of the health sector.

From a political standpoint, there is never an easy or good time to restructure a program as popular and successful as Medicare. But the present is as good as it is likely to get because the political environment is likely to become increasingly inhospitable to reform efforts as the years pass. By 2004, when the next President will be up for reelection, about 45 percent of the voters will be 50 and older and justifiably concerned about the adequacy of their retirement benefits. Equity considerations require that structural change be implemented gradually to give those nearing retirement an ample opportunity to adjust to a new system. For these reasons it is important that Congress turn to the long-run problem facing Medicare as soon as its work on the balanced budget agreement is completed.

Responses to Questions of Senator J. Robert Kerrey

Question 1: You note that FEHBP's lack of a risk adjustment mechanism is a critical problem when considering this program as a model for Medicare restructuring. Do you believe that current research on risk adjustment will adequately address this issue and ensure that premiums reflect differences in plan efficiency rather than risk-selection activities? How much variation in health costs is likely to be explained by risk adjustment mechanisms? How critical is benefit design to controlling risk-selection?

Answer 1: It is, and probably will continue to be, impossible to develop a perfect mechanism to risk-adjust payments to plans for the differential health status of their enrollees. Fortunately, perfection is not needed; the problems created by adverse selection can be adequately ameliorated with imperfect mechanisms and by imposing certain other constraints. There are a number of mechanisms that would represent significant improvements over the current demographic risk adjustment mechanism implicit in the AAPCC. Joseph P. Newhouse and his colleagues have summarized the state of the art in a recent paper (Risk Adjustment and Medicare) that was presented at the February 27-March 1, 1997 conference of the Council on the Economic Impact of Health System Change in Princeton, N.J. As this paper explains, the two leading risk adjustment methods, Hierarchial Co-Existing Conditions and Ambulatory Care Groups, use diagnostic information to estimate future spending needs. At best they may be used to explain 9 percent of the variance but can reduce the expected gain from creaming by a much more significantly amount. In addition to adopting one of these less-than-perfect mechanisms, Newhouse has suggested that payments to plans could be based partially on capitation and partially on service use. Also, the opportunity for creaming could be reduced by imposing a large minimum size on plans (say 10,000 participants), requiring plans to offer services over entire metropolitan areas and across multi-county rural areas, and mandating standard benefit packages. Standard benefit packages are vital because they rule out the possibility that plans will use subtle differences in benefits to attract low-cost participants. Increased funds should be devoted to research to improve risk adjustment methodology. Nevertheless, the tools now available are sufficient to make a marked improvement in policy.

Question 2: You outline several factors that make FEHBP an inappropriate model for Medicare--including an insufficiently competitive premium structure and the variation in benefit package. Do you have specific recommendations for addressing these issues?

Answer 2: With respect to premiums, Medicare should establish a system of competitive bidding. Each year, the plans in each market area would be required to submit a bid for the cost of providing services to the average beneficiary. Medicare would establish a payment level that might be set at the median bid as long as the capacities of the plans submitting lower bids were equal to at least 70 percent of the Medicare participants in the area. Payments to the plans would be adjusted for difference between the health risks of the plans participants and that of the average participant in the nation. It would take a number of years to introduce such a system.

With respect to the benefit package, it would be best if a common benefit package were offered by all plans. This package should be more comprehensive than the current Medicare package. At a minimum, it should cover prescription drugs, preventive services and catastrophic expenses, in addition to Medicare services. This would mean that Medigap policies would not be essential. Nevertheless, supplementary benefits should be available if they are marketed and priced separately from the basic coverage. In other words, plans could not exclude from basic coverage participants who did not want to purchase the plan's supplementary coverage. The premiums for the supplementary coverage should include the costs of any increased utilization of basic services induced by the supplementary coverage and the basic plan should be reimbursed for these costs.

STATEMENT OF
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Introduction

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

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

Cost Containment

One of the goals of a restructured Medicare program would be to re-align the per enrollee growth in Medicare spending with the growth in private health insurance. At least through 1993, per enrollee growth in Medicare spending has been lower than the private sector. The recent substantial shift of private sector workers and their families from fee-for-service to managed care over the past three years changed this trend. Between 1993 and 1995, private health insurance increased 3.5 percent per enrollee compared to 9.7 percent for the Medicare program (see Figure 1). With respect to the future, the Congressional Budget Office projects that private health insurance will rise at 4.7 percent per enrollee and Medicare at 7.5 percent per enrollee. However, the recent budget agreement between the President and Congress would reduce the per enrollee growth in Medicare spending to 4.4 percent over the next five years--0.3 percentage points below that expected in the private sector. Thus, the case for structural reform, it would appear, seems to

hinge on the ability of the reforms to sustain this rate of growth past the year 2002. Alternatively, it could be argued, the more incremental changes made recently to Medicare payments to HMOs under its risk program could, if coupled with continued savings generated in provider payments, yield a similar rate of growth that the broader structural changes would yield. However, even with Medicare rising at rates slightly below the expected growth in the private sector, the Medicare HI trust fund is still expected to be exhausted before the year 2010. In short, simply re-aligning the growth in Medicare spending with the growth in private health insurance spending will not, by itself, provide a long-term solution to financing problems plaguing the HI trust fund.

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

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

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

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

private sector as well as the variation in the Medicare AAPCC (see Table 1).[2]

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

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

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

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

Plan Choice

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

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

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

Plan Satisfaction and Quality

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

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

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

SOURCE: Checkbook Guide

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

- The FEHBP conducts an annual open enrollment, whereas most HMOs in the Medicare program have continuous open enrollment, allowing beneficiaries to join at anytime. Beneficiaries can also disenroll each month.

- The methods used by Medicare and the FEHBP to pay plans differ significantly. Medicare payments are set in advance based on the Average Adjusted Per Capita Cost (AAPCC). The AAPCC is based on the experience of the fee-for-service sector. In contrast, the FEHBP pays each plan a fixed dollar amount up to 75 percent of the plan premium. The fixed dollar amount is set at 60 percent of the average premium charged by the "Big Six" plans.

- Plan rating differs substantially between the FEHBP and Medicare risk HMOs. Under the

FEHBP, fee-for-service plans (for example:Blue Cross standard option) charge a single national premium. The FEHBP pays $134.83 per month for each person enrolling in the Blue Cross standard option plan, with the FEHBP enrollee paying $44.94 per month for single coverage in New York City, New Orleans or even Indiana, Pennsylvania. In contrast, managed care plans are rated locally. As Medicare payments to hospitals, physicians and other providers in the traditional program vary across and within states, the AAPCC also varies dramatically. As a result, there is substantially greater variation in payments to managed care plans under the Medicare program than exists in the FEHBP.

- The FEHBP does not make risk adjusted payments to health plans, while Medicare attempts to account for risk using the AAPCC.

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

Transitional Steps

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

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

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

- *Redefine Managed Care Market Areas*

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

- *Risk Adjustment Demonstrations*

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

Key Design Features of an FEHBP Model As Applied to Medicare

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

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

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

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

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

- Solicit bids from health plans in each area, and bargain multilaterally with each plan over

the premium charged and scope of benefits offered. The bidding process would stop when either the Health Care Financing Administration (HCFA) or the health plan agreed on a counterproposal;

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

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

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

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

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

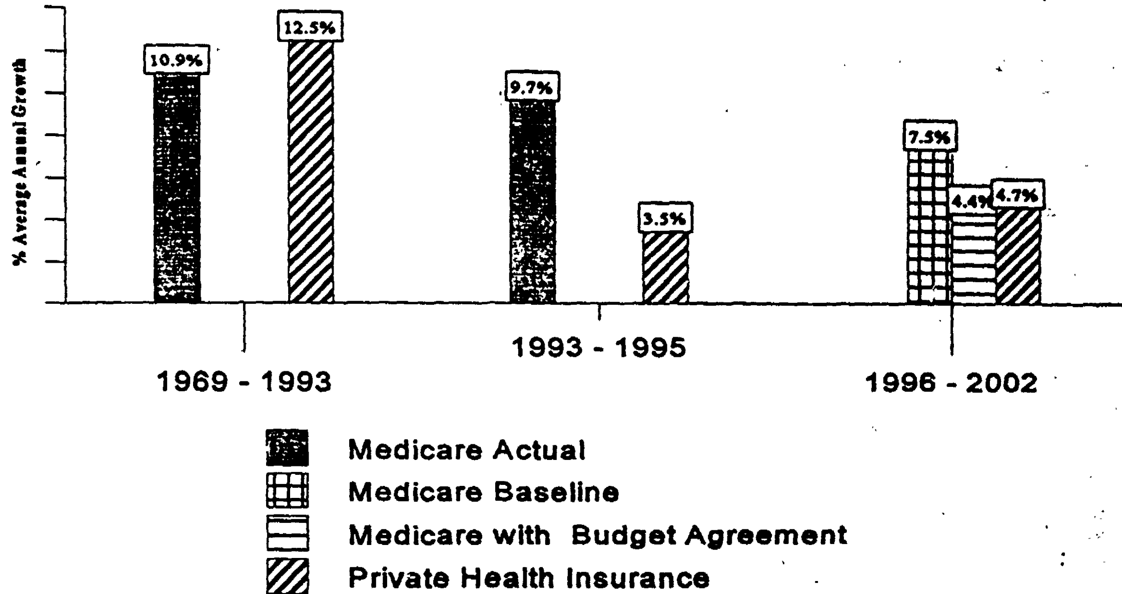
The second option is how fee-for-service benefits are provided within the FEHBP. These are the most popular plans in the program (approximately 30 percent of enrollees select one of the managed care options). A key issue if Medicare adopted this approach for providing fee-for-service benefits is whether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

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

Conclusions

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

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



Source: HCFA and CBO Projections

Peter Wyckoff

I am Peter Wyckoff, Executive Director of the Minnesota Senior Federation-Metropolitan Region, testifying on behalf of the National Council on the Aging (NCOA). NCOA is a center of leadership, innovation, and nationwide expertise on issues of aging. Founded in 1950 and headquartered in Washington, D.C., NCOA is a private, nonprofit organization with a diverse national membership of more than 7,500 organizations and individuals who work with and on behalf of older persons including professionals, volunteers, service providers, consumers, labor groups, businesses, government agencies, and religious and voluntary organizations.

I represent a coalition of broad-based community organizations of older persons from 12 states. Under the auspices of NCOA, we have formed the National Coalition of Consumer Organizations on Aging (NCCO). Organizations are located in Minnesota, Rhode Island, New York, Louisiana, Florida, California, Indiana, Maine, Massachusetts, North Carolina, Pennsylvania, Wisconsin and the District of Columbia. These local coalitions, through their individual members, local governance, and thousand of affiliated organizations provide an authentic consumer perspective on issues facing older Americans. They are directed and run by older persons in their communities. Though highly diverse and independent, their primary goal is to not to offer social service, but self-help regarding issues and concerns facing older Americans and all of society.

As director of the Minnesota Senior Federation, I am accountable to 20,000 members and 150 affiliated organizations in the Twin Cities area of Minneapolis-St. Paul. We are the primary educational and advocacy organization of retirees in the state. For 25 years we have been involved in health care, providing objective consumer information and negotiating on behalf of seniors for improved access and quality health care. For example, we are the primary source of objective information on Medigap options in Minnesota, counseling more than 30,000 seniors annually with highly trained volunteers and professional staff. We have negotiated directly with the hospitals and physicians to create Senior Partners Care -- a program with more than 7,000 enrollees, involving 80 hospitals and 2,000 doctors across the state who are voluntarily accepting Medicare not only on

assignment (a state-mandated requirement) but as payment in full for Medicare beneficiaries who have modest assets and incomes below 200 % of poverty.

The National Council on the Aging (NCOA) is firmly committed to helping address the serious challenges faced by the Medicare Trust Fund and by Medicare beneficiaries. As a result, we have initiated a fifteen month study of the feasibility of Medicare Consumer Cooperatives (MCCs). The study is funded by the Retirement Research Foundation, a charitable foundation based in Chicago, Illinois.

In a Medicare Consumer Cooperative, beneficiaries would have the option of joining a state or regional group that would help them negotiate the marketplace of managed care and indemnity insurance options. At a minimum, MCCs would provide members with consumer information, counseling and advocacy services. Under certain circumstances, MCCs might also go one step further and actually negotiate preferential rates or benefits for their members.

The concept of the Medicare Consumer Cooperative has parallels in other sectors. Many companies have joined together to form purchasing alliances that negotiate with managed care plans on behalf of their employees and retirees. An important example of a purchasing alliance is the Federal Employee Health Benefit Program (FEHBP) which was formed by Congress in 1959. FEHBP is a health care system which covers members of Congress, the occupants of the White House, and roughly 9 million other federal employees, retirees, and their dependents. One state-sponsored plan that has also had considerable experience with Medicare beneficiaries is the California Public Employee's Retirement System (CalPERS) which administers the retirement program for California State employees. Approximately one million people -- active employees, retirees, and their dependents, are covered under this program. Despite these experiences, the benefits of purchasing cooperatives are not now available to the vast majority of Medicare beneficiaries.

MCCs could potentially yield significant benefits for consumers, managed care

organizations, insurance companies, and the federal government. For the first time, older persons would have the benefit of a sophisticated organization screening plans to ensure adequate quality, providing important consumer protection and advocacy services, and possibly negotiating benefits on their behalf. MCCs would also be an objective, independent source of information about various plans offered to beneficiaries in a given area, thus enabling consumers to make more informed decisions about which plan would best fit their individual needs. If the MCCs are also allowed to bargain on behalf of their members, older persons would also be able to get the benefits of purchasing as part of a group, i.e. lower costs or enriched benefits packages.

Managed care plans and insurance companies would also benefit from MCCs. MCCs could allow companies to reduce their marketing and enrollment costs significantly for the benefit of all involved. In addition, MCCs could also produce substantial savings for the federal government through efficiencies of group purchasing and may make it possible for Medicare to use competitive forces as an alternative to the AAPCC, thus encouraging HMOs to enroll more sick people.

Medicare Consumer Cooperatives have broad-based appeal. They are essentially a market-oriented solution that facilitates greater consumer choice and since they are based on collective action and group purchasing, can be an effective means of enhancing consumer protection in a rapidly changing market place.

Nevertheless, there are legitimate concerns and unanswered questions about how MCCs would actually operate and if they are really feasible. Some people are concerned that MCCs would lead to fragmentation of the Medicare market, making it easier for HMO's to "skim" and enroll only healthy seniors. Others question whether it is appropriate for anyone other than the federal government to bargain on behalf of beneficiaries. There are also many design questions about the appropriate scope, governance and responsibilities of an MCC.

NCOA is currently engaged in an effort to examine systematically the feasibility and merit of Medicare Consumer Cooperatives. Under the direction of Dr. James Firman, President and CEO of NCOA, and Jean Polatsek, NCOA's Director of Health Policy, we have been working with a panel of distinguished experts in health policy to consider alternative design options and to identify and address specific aspects of feasibility.

At its recent meeting, the advisory panel, of which I am a member, identified the following results that a successful Medicare Consumer Cooperative should produce:

- maximize the value for each health care dollar expended;
- assure that no harm results to those who elect not to join;
- afford increased consumer protection;
- provide better consumer education;
- protect the Federal investment in expenditures;
- ensure that the cooperative remains consumer-driven, financially sound and viable and;
- afford the maximum possible benefit to lower income beneficiaries.

NCOA staff and the distinguished expert panel are now systematically considering various design options that would enable a Medicare Consumer Cooperative to achieve these results. In addition to its ongoing consultations with the advisory panel, NCOA staff will:

- work with experts at the U.S. Health Care Financing Administration to identify and try to address their concerns and to explore issues involved in obtaining waivers or contracts necessary to implement a demonstration program of Medicare Consumer Cooperatives;
- work with representatives of managed care plans and Medigap insurance companies to learn more about their interest and potential willingness to participate in MCCs;
- work with grass-roots consumer groups of older persons, state retirement systems, large corporations and unions to examine potential consumer interest in MCCs,

and;

- analyze information and interview experts about the CalPERS, FEHBP and other purchasing alliances for employed and retired persons to determine their relevance for the MCC concept.

Once the study has been concluded, NCOA expects to develop new knowledge about the feasibility of MCCs and the potential benefits and risks of MCCs for Medicare beneficiaries, insurers, managed care plans and the Medicare program. NCOA will then disseminate widely to policy makers, policy analysts, and the public, new information about MCCs that could be very timely and relevant to future discussions on reforming Medicare. If MCCs are found to be feasible, we will explore future demonstration projects involving contracts and/or waivers from the Health Care Financing Administration.

Mr. Chairman, this concludes my statement. We have attached additional material to submit for the record. I shall be happy to respond to any questions which the Committee may wish to present. Thank you.

ATTACHMENT

The Potential of Purchasing Cooperatives

Purchasing cooperatives are one innovation that have shown promise for reforming the health care market place. Current programs which may have implications for Medicare include employer-based purchasing coalitions, the FEHBP program and CalPERS. Additionally, some large companies such as Xerox have been negotiating with a wide range of health insurers and HMOs on behalf of their employees for several years.

As of July 1993, 13 states had passed legislation to create or encourage the development of some form of purchasing cooperative designed to help small employers and their employees

purchase health insurance. Florida and California are contrasting examples of state-sponsored purchasing cooperatives for employers.

Florida offers multiple (11) community health purchasing alliances (CHPAs) open to employers with up to 50 employees. These alliances are passive, in that they are not allowed to negotiate rates with health plans. Employers are offered an array of health plans, and information about each plan. Plans which meet specified data requirements must be accepted into the alliance. A choice of at least two of the plans must be offered to employees. The alliance will publish a 'report card' on the performance of each health plan.

California offers a single, state-wide coalition (HIPC) composed of six geographic areas based upon plan service area and rating purposes.[1] Price rates and quality standards may be negotiated, and health plans may be excluded from participation in the coalition. Approximately 20 different health plans offer one standard benefits program. HIPC publishes its carriers' rates, which is thought to have increased plan quality and driven down prices on the small-group market.[2]

One state-sponsored plan that has also had considerable experience with Medicare beneficiaries is the California Public Employee's Retirement System (CalPERS). CalPERS was established in 1932 and administers the retirement program for California State employees. Approximately 1 million people -- active employees, retirees, and their dependents, are covered under this program. The health benefit offers a standard benefit package. Participating HMOs are required to provide annual cost and performance information. CalPERS requires participating health plans to meet requirements in customer service, uniform benefit design, quality and cost data, provider access, and statutory and

[1] "A Comparison of 11 State Purchasing Cooperative Initiatives." Health Care Reform Week, Special Report, September 26, 1994.

[2] Polzer, Karl. "Small Group Market Health Insurance Purchasing Cooperatives Revisited." The George Washington University, National Health Policy Forum, Issue Brief No. 653.

regulatory compliance in order to participate in their program.[3] Supplemental Medicare or Managed Medicare plan coverage is also provided to CalPERS members who are eligible for Medicare Parts A and B. While CalPERS does not negotiate preferential rates for the Medicare portion of its coverage, it is able to provide retirees with savings of 15% to 20% on supplemental or wrap-around benefits that the HMOs provide.

Another important example of a purchasing alliance is the Federal Employee Health Benefit Program (FEHBP) which was formed by Congress in 1959. FEHBP is a health care plan which covers members of Congress, the occupants of the White House, and roughly 9 million other federal employees, retirees, and their dependents. The federal government pays a large percent of the premiums, and the program offers a selection of both fee-for-service, and health maintenance organizations nation-wide. FEHBP Participants may switch plans every year. Under the plan, policies cannot be canceled or become more expensive as a result of age or an individual's health status. Retirees, former-spouses, and non-dependent children are able to continue total coverage under this plan if they pay for the full premium. Because of its purchasing power, FEHBP has been able to negotiate significant benefits (such as no lifetime caps and coverage for many experimental procedures) that are not generally available to other employees.

The concept of the MCC is simple. Medicare beneficiaries would have the option of joining a state or regional group designed to help them negotiate the marketplace of managed care and indemnity insurance options. At a minimum, MCCs would provide members with consumer information, counseling and advocacy services. Under certain circumstances, MCCs might also go one step further and actually negotiate preferential rates or benefits for their members.

Medicare Consumer Cooperatives offer several potential benefits for older persons. For

[3]Elkin, Tom J. "What Should Be the Basic Ground Rules for Plans Being Able to Participate in the Medicare Managed Care Market? Case Study: The California Public Employees' Retirement System (CalPERS)." Commissioned paper for the Institute of Medicine.

the first time, consumers would have the benefit of a sophisticated organization screening plans to ensure adequate quality, providing important consumer protection and advocacy services, and possibly negotiating benefits on their behalf. MCCs would also be an objective source of information about various plans offered to beneficiaries in a given area. This would enable consumers to make more informed decisions about which plan would best fit their individual needs. MCCs could also provide consumer protection and advocacy services such as assistance with grievances, denied claims for service and appeals.

Theoretically, MCCs could also go one step further and negotiate preferential rates or enriched benefits packages on behalf of members. Whether to allow MCCs to negotiate preferential rates or benefits is perhaps the most controversial aspect of the proposed idea. Many proponents argue that using the bargaining power of seniors is the best way to allow the marketplace to work more efficiently. Others are concerned that allowing groups of seniors to get preferential rates would fragment the Medicare risk pool and lead to further skimming by managed care plans.

Group bargaining has the potential to address what is perhaps the Medicare program's greatest flaw in purchasing HMO services: the AAPPC. Medicare currently pays plans the same rate for all enrollees, despite the fact that the average expenditure for 90% of beneficiaries is about $1400 per year, while it is about $28,000 for the remaining 10%. Studies show that Medicare risk contracts do not save the government money, primarily because plans enroll a disproportionate number of healthy people. This is particularly disturbing, because managed care has the potential to be of greatest benefit to people with complex medical needs. One reason that HMOs have been so effective for the employed population is that competition among plans leads to optimal pricing and risk-adjusting for groups, rather than an arbitrarily-set median price, which provides plans with huge incentives to avoid enrolling sick people. Properly structured, MCCs could allow for market forces to address the risk-adjustment issue which is currently the bane of the Medicare risk program.

Managed care companies and Medigap insurers could also benefit significantly from MCCs. Currently these companies typically spend between 10% and 25% of first-year premiums on marketing and enrollment costs. By being able to market to a large group of consumers, MCCs could allow companies to cut marketing and enrollment costs dramatically.

MCCs could also produce substantial savings for the federal government, while protecting the integrity of the Medicare program. For example, the efficiencies of group purchasing could be great enough to allow Medicare to reimburse MCCs at 90% or less of AAPCC. As MCCs negotiate with managed care plans, future increases in costs may be slowed. MCCs can also assist the government with its oversight role by being a local partner in detecting and reporting fraud and abuse among health care insurers and providers.

The Medicare Consumer Cooperative seems to be an idea that appeals to both liberals and conservatives. Conservatives like MCCs because they are essentially a market-oriented solutions. Liberals like MCCs because it stresses collective bargaining. Over the past several months, NCOA staff has discussed the concept of MCCs with several leading health policy analysts. NCOA has provided testimony on MCCs to the House Commerce Committee. So far, the idea has been received with enthusiasm from a broad spectrum of experts and politicians. For example, Stewart Butler, Gail Wilensky, Marilyn Moon and Judy Feder have all agreed to work with NCOA to further explore the feasibility of MCCs. Both the Majority and Minority staffs of the House Commerce Committee have asked for more information and ideas on the MCCs. Some key officials at HCFA (from both the legislative and managed care divisions) have also expressed strong interest in the MCC concept. Other HCFA officials have expressed a lot of enthusiasm for the consumer information/protection components of MCCs, but some wariness about whether MCCs should be allow to bargain on behalf of beneficiaries.

The design questions relate to what are the options for how a MCC would actually be structured and operate. Key questions include: Who would be eligible to join an MCC?

Under what circumstances? Should MCCs be allowed to bargain on behalf of members? Who would sponsor the MCC? What authority would they actually have? How would the MCCs be governed? To what extent would MCCs be involved in actual enrollment of beneficiaries in specific plans? How would the MCC provide consumer information? What role, if any, would MCCs have in consumer protection?

The feasibility questions are equally important. Key feasibility issues include: Would older people be willing to enroll in MCCs? Would appropriate groups be willing to sponsor MCCs? Are there sufficient benefits to managed care and Medigap companies to induce them to participate in MCCs? Will HCFA be willing to provide necessary waivers to finance MCCs and/or needed funds for a demonstration of MCCs? Are there legal or regulatory barriers to implementation of MCCs? Can the legitimate concerns about fragmentation of the market and skimming of healthy beneficiaries be addressed?

NCOA believes that a feasibility study is the most appropriate way to address these questions and to further develop the concept of Medicare Consumer Cooperatives. The feasibility study is a technique that Dr. James Firman, the Principal Investigator, has used successfully several times in the past to systematically develop and analyze potential innovations. It is essentially a design process. Working with experts and key stakeholder groups, project staff identify the specific needs and concerns of the stakeholders. Next, we will identify ways that MCCs might be structured to meet these needs and concerns. The next step will be to consider the most promising potential solutions from the perspective of various aspects of feasibility: market, technical, administrative, financial, legal and political feasibility. The result of the process will be identification and analysis of the design solution(s) that are most likely to meet the needs and concerns of all stakeholders. The feasibility study will provide policy makers, foundation officials and analysts with sufficient information to decide if further development or testing of MCCs makes sense, and what it would take to proceed to the next phase of development.

The feasibility process will also look at key technical concerns that some people have raised

about MCCs. Specifically, we will address concerns about the potential of MCCs to fragment the market in ways that might be deleterious to people who aren't part of MCCs. We will also look at ways to protect against skimming by HMOs and MCCs that might result in higher costs to HCFA. We believe that both of these potential problems are quite solvable, but that they deserve appropriate attention.

The following experts are working with NCOA as part of the advisory committee for this feasibility study:

Stuart M. Butler, Vice President of Domestic Policy Studies for the Heritage Foundation
LouAnn Cash, Vice President for Benefits at American Express
Richard E. Curtis, President of the Institute for Health Policy Solutions
Tom J. Elkin, Elkin Consulting
Paul Ellwood, President and CEO of the Jackson Hole Group
Judith Feder, Professor of Public Policy at Georgetown University's Institute for Health Care Research and Policy
Bruce M. Fried, Director of the Office of Managed Care at the Health Care Financing Administration
Stanley B. Jones of George Washington University's Health Insurance Reform Project
David Kendall, Senior Analyst for Health Policy at the Progressive Policy Institute
Marilyn Moon, Senior Fellow at the Health Policy Center of the Urban Institute
John Rother, Director of Legislation and Public Policy at the American Association of Retired Persons
Frederick W. Telling, Vice President for Corporate Strategic Planning and Policy at Pfizer
Bruce Vladeck, Administrator of the Health Care Financing Administration
Gail R. Wilensky, Senior Fellow at Project Hope
Peter Wyckoff, Executive Director of the Minnesota Senior Federation- Metropolitan Region

Statement
Senator Ron Wyden
Before the Senate Committee of Finance

"Market-Driven Reforms for Medicare"
May 21, 1997

Mr. Chairman, Mr. Ranking Minority Member, thank you for inviting me to testify today on a most important topic, reforming Medicare for the 21st Century

When we look at today's Medicare program we see a system that too often, in too many communities rewards waste, rewards fraud, and sanctifies inefficiency through a reimbursement protocol that ignores the key values of choice and competition which imbue the rest of American health care.

The problem is that we have a Tin Lizzie federal program trying to deliver 1965-style medicine in a 1997-informed marketplace. The result is health care that gives some seniors less than they need, and costs taxpayers and beneficiaries much more than it should.

Private care costs have been rising at a rate of just over 2 percent per capita in the last few years, while Medicare's costs are rising at three times that rate. And the cost of the Medicare program threatens to consume the federal budget.

Something's got to give.

These cash pressures pose real threats to our ability to maintain the basic mission of Medicare: the guarantee that every senior, no matter how frail, or how poor, receives a basic package of good quality health care services.

Taxpayers and Medicare beneficiaries alike have a deep and abiding interest in reforming Medicare. I hope the 105th Congress will pursue a reform agenda vigorously, and resist the siren call for off-loading our important responsibilities on a bi-partisan commission.

Fortunately, our journey to greater fiscal stability is not without roadmaps. Like many of my colleagues, I believe that Medicare's cure will include a strong dose of private sector medicine. I believe that the elements of choice, quality and competition we see in private health care can be infused into Medicare, and with good fiscal results.

Page Two

In my home state of Oregon, we've shown how 21st century medicine that relies strongly on various case management and utilization review systems can produce very good care at very high efficiency. We have the highest penetration rate of private plan managed care in the nation, and certainly one of the two or three highest rates of Medicare managed care penetration.

And our costs are low. Our Medicaid program currently is serving working poor Oregonians and traditional Medicaid populations at a cost that is ten percent per capita below the national average. We have a **negative growth rate** in nursing home beds because of a ground breaking approach to home care service development. Our Medicare population is receiving good quality care from strongly competing plans at costs ranging from 60 to 80 percent of the national average for risk contract beneficiaries.

In reforming Medicare we must capture the best elements of modern private health care. I know I share with some members of this committee a special interest in the operating policies of the Federal Employees Health Benefits Program (FEHBP).

FEHBP officers negotiate with participating plans a payment level, community-by-community, for federal workers. The system also negotiates issues like the market basket of services plans will provide, consumer protection and the content and quality of information federal workers receive regarding available plans.

There is an on-going effort to improve the quality and variety of services through these negotiations as well as keep premium costs down. Unlike Medicare, FEHBP does not assess the cost of fee-for-service medicine in an individual community, set HMO payments at that threshold and then, in effect, let all comers participate at that level. Instead, FEHBP assumes as a given that it won't pay its plans any more than a competitive reimbursement rate for coordinated care in a given community.

Plans can either take it, or leave it. And many plans accept the payment, offering federal employees in most communities a broad variety of options from which to choose.

I don't believe that using this defined payment, or contribution, is appropriate for Medicare. Medicare operates on the principle of a **defined benefit...** a comprehensive health care package guaranteed to every beneficiary rather than a **defined contribution, or payment** given to each enrollee.

> We can't just give aging Americans a check each month, and then tell them to buy whatever health care they need until their money runs out. That will put too many older, frailer and poorer seniors at risk.

Page Three

However, the Medicare system does have an alternative lever on the marketplace... its millions of enrollees. Health care policy experts as diverse as Marilyn Moon at the Urban Institute and Gail Wilensky at Project Hope have postulated that Medicare's huge beneficiary base can be as powerful a negotiating instrument as a defined contribution in an effort to move the program into an FEHBP-style competitive environment.

The Medicare Modernization and Patient Protection Act, S. 386, which I introduced earlier this year has as one of its features a provision directing development of an FEHBP-style office within Medicare to implement a number of pro-competition, and consumer protection and empowerment improvements. I think many of the smart-shopper-management characteristics of FEHBP can be implanted Medicare.

My Medicare reform legislation also reflects several other key features of the FEHBP system.Here are some examples:

- There is a strong consensus that Medicare extravagantly over-pays HMOs in some communities, based on the current system. Using the FEHBP experience as a model, Medicare should move to competitive bidding among plans in selected, high-payment communities.

- Medicare operates a creaky, slow and ineffective grievance and appeals process that would not be tolerated in most health plans, and certainly not in FEHBP plans. Streamline the appeals process.

- Use alternative providers and practitioners. Some private health plans, such as Oxford, have taken the lead on this by expanding reimbursement opportunities for the allied professions and others, giving seniors a greater variety of choices. Medicare, unfortunately, lags behind the curve.

- Improve plan information beneficiaries receive, and give them reasonable opportunity to change plans. In FEHBP, for example, plans must conform to certain standardized ways of presenting their coverage so that consumers can make kitchen-table assessments, comparing one plan against another.

  [Here's a picture of a Medicare beneficiary in Los Angeles County taking a look at a wall full of brochures of plans offered in her community. As you can see by the somewhat confused look on her face, it's a lot of information, given in a variety of ways, and almost defying interpretation and comparison. These materials aren't giving this beneficiary a great deal of help.]

- Provide qualitative reports and "report cards" on how well plans perform.

Page Four

- Finally, and perhaps most importantly, devise a new HMO payment formula that will ensure that Medicare beneficiaries in rural America enjoy the same variety and range of health plan choices present in urban America. Yes, HMOs in some counties are over-paid in the current system, but under-payments in other communities have left beneficiaries with no Medicare choice beyond traditional, fee-for-service Medicine. This can lead to inadequate care for some beneficiaries and greater financial risk for the program.

I would caution my colleagues that the FEHBP system is not a full or complete fix for Medicare's problems. Just as in risk contracting, FEHBP has problems with adverse risk selection within its portfolio of plans. I think that decreasing such risk selection and ensuring that all seniors have access to the greatest possible number of care choices must be a fundamental thrust of our Medicare reform efforts.

Also, the FEHBP system's requirements for uniformity in plan description has resulted in plans that may be too similar in scope and character, and which fail to offer the plan diversity we'd like to see in health systems whether we're talking about care for federal workers or Medicare retirees.

Mr. Chairman, I believe reforming Medicare will involve patching together a new policy quilt that stitches the current program's social contract -- the government's obligation to provide comprehensive health care to every senior citizen -- with the innovations and breakthroughs of the private health insurance market.

I hope to work closely with members of this committee on that important task.

Thank you.

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