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MEDICARE REFORM

HEARINGS

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UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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CONTENTS

APRIL 28, 1999

(CONTEXT AND EVOLUTION)

OPENING STATEMENTS

PUBLIC WITNESSES

MAY 5, 1999

(FINANCING—PARTNERSHIP OF TAXPAYERS AND BENEFICIARIES)

OPENING STATEMENTS

CONGRESSIONAL WITNESSES

AGENCY WITNESSES

PUBLIC WITNESSES

Page

MAY 27, 1999

OPENING STATEMENTS

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

MEDICARE REFORM

(CONTEXT AND EVOLUTION)

WEDNESDAY, APRIL 28, 1999

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

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

Also present: Senators Chafee, Grassley, Baucus, Rockefeller, Breaux, Conrad, Graham, Bryan, Kerrey, and Robb.

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

The CHAIRMAN. The committee will please be in order.

First, I want to thank both the members of the committee, and particularly our distinguished guests, for their interest in participating in this, the first office hearings on Medicare reform.

The purpose of today's hearing is to help frame the issues of Medicare reform within the broader context of the evolution of American medicine and the evolution of the American health care marketplace.

Since the program came into being, American medicine has gone through some very profound changes. The explosion of new medical technologies and the greater role of prescription drug therapies are but a few of the profound changes we have seen.

Medicare is a major health insurer in the U.S. and it is important to see how well the Medicare program kept up with these changes.

At the same time, the health care marketplace has changed dramatically. In 1965, the market was dominated by fee-for-service health insurance plans, while HMOs were in their infancy.

The Medicare program represented state-of-the-art coverage in 1965. Since then, the rest of the health care marketplace has changed significantly. The fee-for-service indemnity model has almost vanished from the rest of the health care market, including Medicaid.

Fee-for-service plans have largely been replaced in private health insurance by other models, such as preferred provider organizations which allow beneficiaries a lower-cost alternative.

Formerly restrictive HMOs have also developed new point-of-service options to allow beneficiaries a greater choice of providers.

This continuum of options has only recently become available within the Medicare+Choice program in certain areas, and is not reflected at all in the traditional fee-for-service program.

Compounding the problem, the Medicare benefit package has not kept pace. Private health insurance plans feature prescription drug coverage, stop-loss protection for beneficiaries. These benefits are not reflected in the Medicare program.

Employers, including the Federal Government, have moved to improve their purchasing power through enhanced competition in the health care marketplace. The Medicare program is still struggling to define its appropriate role as a major purchaser in the health care marketplace.

Today's expert panel will help move us through these thorny issues, and I look forward very much to hear what they have to say.

I want to particularly thank Senator Moynihan, who was so responsible, both for this hearing and for bringing such a distinguished panel before us. I regret that he is unable to be with us today because, as I say, he was key in organizing this hearing.

I ask all members of the committee to join in a bipartisan spirit as we engage in this most important task. With that, I would call my good friend, Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I appreciate the panel, who in some cases have come some distance. I recognize the panelists are people who know this area very well, and appreciate their additional contribution.

We have heard a lot about the troubles facing Medicare of late. Frankly, I think that's good news because, as a consequence, I think people are starting to pay more attention to the problems facing Medicare.

The actuaries tell us that Medicare simply is not sustainable in its current form and, although our day of reckoning has been postponed, the problems of Medicare will severely grow in the next 15 years.

Fifteen years, though, is not a long time, when you think about it. Since this is a hearing about the history of Medicare, I'd like to give a little history lesson of my own.

Fifteen years ago, the first Apple McIntosh was developed, the Olympics were held in Yugoslavia, and scientists identified HIV as the most probable cause of AIDS. Just over 15 years ago, Congress changed the cost-based reimbursement system to prospective payment.

A lot has changed since then. The Internet has come, Yugoslavia and the Soviet Union have gone, HIV and AIDS have exacted tremendous human and financial costs throughout the world, but Medicare is still in trouble.

It is hard to believe that these were the events of only 15 years ago, but they were. I am reminded that in just another 15 years, Americans will face the insolvency of Medicare.

Over the next several weeks, the Senate Finance Committee will hear testimony from experts on the history of the program and

issues surrounding it. We will also hear thoughts on how we might best reform it to ensure its viability 15 years from now, and beyond.

We have heard a lot of proposals, one offered by my very good friend and distinguished colleague, Senator Breaux. President Clinton has stated his intention to pose a series of reforms. I look forward to looking at them. I understand he wants to also include prescription drugs.

But history tells us something else as well. Major health care reforms are not enacted by one party or the other, only with the cooperation of both. I very much hope that, in that spirit and also listening very closely to providers and to beneficiaries alike, we are able to come up with a bipartisan Medicare reform this year.

Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

I am going to ask the rest of the panel to forego making any opening statements. One of the reasons, is Dean Roper does have to leave early and I am anxious to have his participation for as long as we can.

So, with that, we will include any statements, of course, as if read. That is true of the witnesses as well.

We will now turn to our witnesses, beginning with Dean Roper, who is an M.D., Dean of the School of Public Health at the University of North Carolina.

Dean Roper, it is, indeed, a pleasure to have you here today. Please proceed.

STATEMENT OF WILLIAM L. ROPER, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC

Dean ROPER. Thank you, sir. It is a pleasure to come before you and the other members of the committee, and I commend you for calling these hearings.

I was HCFA administrator in the late 1980s, and later I had the privilege of serving as a senior manager of one of the Nation's largest health care organizations. Those experiences have shown me that the Medicare program can be a powerfully effective avenue for providing medical care to millions of Americans, aged and disabled.

I would also say that I have great admiration for, indeed, affection, for my friends and former colleagues at the Health Care Financing Administration. But I have also learned that Medicare can be quite removed, quite separate from the larger changes occurring in the health care environment today.

Consequently, as you have said in your opening statement, Medicare continues to reflect the fragmented, open-ended, fee-for-service medical care environment that existed in 1965 when it was enacted.

I would suggest that, for Medicare to remain viable and effective, it must be allowed to take full advantage of the innovations occurring in medical care organization and delivery.

The movement towards accountable, organized and coordinated systems of care offer real advantages, advantages for aging and disabled populations especially who are living longer, but facing more complex and chronic health care conditions.

As you have noted, there have been important changes in Medicare structure and operations over the past years, PPS for hospital payment, RBRVS for physician payment, but these remain administered price systems that do not, and cannot, take advantage of the rapidly evolving market-based health care system.

Additionally, coverage for selected preventive services began in the early 1990s and has lately been expanded, reflecting the mounting evidence about the effectiveness of these services. But, as Dr. Wennberg will shortly tell you, covering services in a fee-for-service system is a long way from ensuring their provision.

Total Medicare expenditures have grown dramatically, claims administration has grown exponentially. A lot has changed about the program, but Medicare remains an open-ended, fee-for-service medical care program much like the one that existed in 1965.

Beneficiaries access care from providers on an episodic, ad-hoc basis with very few safeguards in place to assure coordination of care and active management of diseases and health outcomes. No single caregiver is responsible and accountable for the health of the individuals.

These are not the attributes of a modern-day health plan. As you know, most non-elderly Americans no longer receive health care through systems like this. Most Americans with private health insurance are served through organized medical care systems of one type or another.

Despite the public's and the media's misgivings about managed care, organized systems of care hold distinct advantages over the unmanaged fee-for-service approaches of the past. They offer the ability to follow patients across a continuum of care, to ensure that the care received is appropriate, coordinated, and comprehensive.

They are also much more responsive to consumer and purchaser demands, as witnessed by the explosion of flexible and open-ended health plans being offered in the marketplace in response to demands for greater choice. Medicare, by contrast, is simply not designed to be nimble and it cannot be a highly-responsive program.

The Medicare+Choice program enacted 2 years ago under the BBA promises to address some of these issues, but serious barriers remain in the movement towards organized health care.

The Breaux-Thomas proposal, which emerged from the work of the National Bipartisan Commission on the Future of Medicare, offers a promising set of improvements to Medicare+Choice by allowing flexibility in price and reasonable variation in benefit design. Medicare would be able to reflect some of the innovation and quality improvement that exists in the competitive private marketplace.

For these reasons, I urge the Congress to pursue policies that will be responsible in reducing government roles in administering prices and in setting standards for clinical practice.

These ideas are certainly not new. Indeed, I articulated some of them myself 12 years ago when I was at the Health Care Financing Administration in a piece that appeared in the *Wall Street Journal* entitled "Medicare's Private Option." These ideas are difficult, though, to implement within a program that has its framework based in 1960s medical practice.

In summary, I want my 82-year-old father and the millions of other Medicare beneficiaries to have access to the latest and best

in health care. This access should exist not only for innovations in technology, in drugs, and treatment, but also for innovations in the organization and delivery of care.

Thank you, Mr. Chairman, for the opportunity to appear before you.

[The prepared statement of Dean Roper appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Roper.

Now it is my pleasure to call on Herbert Pardes, M.D., vice president for Health Sciences, and Dean, College of Physicians and Surgeons at Columbia University.

Dean Pardes, we thank you for being here today. Please proceed.

STATEMENT OF HERBERT PARDES, M.D., VICE PRESIDENT FOR HEALTH SCIENCES, AND DEAN, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, NEW YORK, NY

Dean PARDES. Thank you for having me, Chairman Roth and distinguished members of the Senate Finance Committee.

America has the highest quality medical care and biomedical research in the world. Today's innovative treatments are tomorrow's routine medicines. If changes to Medicare are contemplated, we must preserve these great strengths.

Before describing some of the changes in medical care since the inception of Medicare, I want to highlight concerns I have about payment for health services. At this stage, we do not know the full impact of the Balanced Budget Act of 1997.

My colleagues and I believe we may need to consider mid-course corrections. Providers of service to Medicare beneficiaries are concerned about their ability to provide care in the present environment.

If one were to use premium support for all Medicare services, preliminary data suggests that New York patients and providers, and others, may suffer and our glorious system of medical education could be compromised. Senator Moynihan's bill, S. 210, would spread the cost of medical education across the board.

In the early 1960s, you recall the doctor's little black bag. It was little because there was little to put in it. Hospitals in the early 1960s did not discriminate between Alzheimer's and other dementias, assuming all people deteriorated in their late 60s. The prospects were hopeless, so patients with such conditions were put into disposition units with the expectation they would go to a nursing home, or perhaps would suffer death.

For coronaries, we provided pain medication and 21 days of bed rest. Add a little prayer, and you had the full prescription. In long-stay psychiatric hospitals, they were at one time 600,000 people residing there.

The prospect of being diagnosed with cancer was feared as an almost definite death sentence. Going to hospitals was a cause for great anxiety. By virtue of the limited therapeutic potential, it was not unusual that anyone going to a hospital would not come home.

Today, we recognize Alzheimer's as a separate disease. There is increasing information about genetic contributions. There is evidence that early administration of estrogen could delay the onset.

There is evidence that memory may be malleable and responsive to treatment.

Drug treatment has expanded greatly for all conditions. Patients with syphilis of the brain, who used to populate psychiatric hospitals, are unknown today because of the effective treatment with penicillin.

Manic-depressive disease can now be controlled with lithium, allowing individuals to function normally, whereas, they used to populate those same chronic State hospitals. The patient population of chronic psychiatric hospitals has fallen from close to 600,000 to less than 100,000 today.

Threatened coronaries can be prevented with rapid treatment by TPA, and the use of techniques of cleaning out clots, bypass surgery, anti-clot substances, and a host of other treatments have radically changed our approach to heart disease.

While we have a long way to go with cancer, many patients are experiencing, in some instances curative, in some instances life-extending, many treatments that relieve symptoms and improve function.

In a word, American medicine has so dramatically changed, it is almost unrecognizable compared to the early 1960s. With these new methods of treatment, sites of care are changing.

Across the United States, hospital occupancy rates have fallen, from 64.5 percent in 1990, to 58.7 percent in 1995, despite a 7 percent decrease in the potential availability of beds. There was a continuing decline in the use of hospital beds and hospital days.

More and more procedures are done in the clinics, reducing the number of hospital days. Previously, a patient with a heart attack was hospitalized for 21 days. Today, such a patient having bypass can leave in five days. It is a record of which the United States can be proud. American medicine, at its best, has no equal.

The wisdom underlying these accomplishments originates with the American Congress and the government. Medicare has been indispensable in permitting teaching hospitals and their affiliated medical schools to claim real leadership in advanced patient care, physician education, and research.

Whether you read the list of the 50 best hospitals in *U.S. News and World Report,* or learn about the latest innovative in Medicare, the chances are, that work was done in an American teaching hospital or medical school.

Teaching hospitals and medical schools fulfill valuable social missions. By virtue of the blend of their functions, patients are cared for with the highest quality expertise and settings in which new doctors can learn. Others can work with scientists to identify treatment needs and steer research toward addressing those needs.

What do we see going forward? With the completion of the human genome project, there will be new techniques for sorting out the mechanisms and figuring out the genes relevant to specific disorders.

Such increasingly specific genetic information will produce specific treatments for specific biological disturbances that cause disease. Our ability to examine the minute structure of proteins we use for treatment will enable us to maximize those parts of the

structure which give treatment and reduce those which produce side effects.

The trend of reducing the kinds of conditions for which patients are hospitalized and increasingly focusing on health care in outpatient settings will continue. As we learn more about disease, the value of educating patients with diabetes, asthma, and many other diseases as to how to care for themselves will result in more reduction of hospital stays, reduction of acute crises, replaced by more steady personal care on an outpatient basis, with more and more effective prescriptions.

I am aware of the questions that some have about technology costing more, but there are countless examples of technologies reducing costs. Lithium has saved more money than all the money ever spent on research at the NIH.

I would ask you, sir, in conclusion, number one, to continue the effort to double the NIH research budget. Number two, to ensure that the Nation's teaching hospitals thrive as they have in the past decades. As we speak, there has been an acute downturn in their financial portions. They are too valuable a resource to be put at risk.

Finally, the social goods provided by medical schools and teaching hospitals, including research, education, and delivery of care to the neediest patients, be protected.

Regardless of how Medicare is structured going forward, there has to be assurance that these social benefits can be achieved by the institutions that know how to achieve them.

The little black bag of the 1960s would have to be replaced by a very large bag today. Our ultimate intention is to have no condition for which we do not have an answer, whether it be a cure, a preventive strategy, or new treatments that alleviate pain and suffering.

[The prepared statement of Dean Pardes appears in the appendix.]

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

Our next witness is Professor Uwe Reinhardt, of Princeton. Professor Reinhardt, we are delighted to have you. Please proceed.

STATEMENT OF UWE REINHARDT, PH.D., PROFESSOR, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NJ

Professor REINHARDT. Thank you very much, Senator Roth. I am honored to appear before this committee, especially because I identify with the rural constituents of so many of its members. As a Princeton professor, of course, I prefer to be known as a humble country economist from rural New Jersey. [Laughter].

My mandate in this testimony was to reflect upon the origin and evolution of Medicare, to reflect upon the evolution of the private health care system in this country, and to reflect on ways in which Medicare can adapt itself to these changes.

Now, my written statement submitted to this committee dwells particularly on the evolution of Medicare, and I have concentrated on an interesting paradox. It is this: among policy wonks and policy makers, Medicare usually evokes such adjectives as inefficient, ob-

solete, cumbersome, moribund, and bankrupt. Those are the words that are conjured up.

If you do surveys among the American people, in any surveys I have seen for years—the most recent one, the Kaiser Family Foundation—Medicare beats any insurance product offered in this country in popularity. Any. That has always been so. I would argue, it will remain for some time.

What is the reason for this? The reason is, Medicare is the only permanent, portable insurance product available in this country. Every other country has that, we do not. People like this. Therein lies the popularity.

I mention in my paper that that is also the popularity of the VA. It is also the other really permanent thing that we have.

For all their glory, I tell my students at Princeton, private insurance contracts are a little bit like relationships with Monica Lewinsky. They have their moments, but permanence is not their characteristic. [Laughter.]

Medicare has its shortcomings, but it is important to inquire what they are. Many of these are administrative. But I have served on boards, and you have served on boards, and the rule among board members is not to micro manage. That is a rule.

Could the Congress really look in the mirror, House and Senate, and say, we have not micro managed Medicare to death? I think, with all due respect, there has been too much micro managing, too much shackling. It takes 3 years to change a Medicare rule. It is much too cumbersome a process.

So I would urge you to review the oversight of Medicare and to see whether that program should not be given the managerial flexibility that the board of Aetna gives its management, and then see what HCFA could do.

Second, if you were to propose to a private insurance company like Aetna that you are to run this business with an administrative budget less than 2 percent of total premiums, you would be laughed out of court by the private insurance industry. But you ask HCFA to do this year after year. Therein, too, you almost guarantee failure with these small administrative budgets.

Third, my colleague, Dean Roper, mentions fee-for-service as a shortcoming. That is, of course, a shortcoming. However, Medicare uses DRGs for hospitals. That is not fee-for-service, that is a highly innovative approach.

The alternative in the private sector is per diems. That is, what HMOs pay. The per diems have led the HMOs, in the end, to kick mothers out of bed 1 day after the delivery. So, those payment systems in the private sector are far from perfect, nor is capitation widely practiced or perfect. In fact, recently I read that many private products are really best considered as fee-for-service in drag. They are basically back to where they were.

So now on the evolution of the private markets, I shall submit a paper I recently wrote: "Consumer Choice Under Private Health Care Regulation." That is, of course, what managed care is, it's private sector regulation.

A central point in that paper is that the private sector has transformed in this last decade from utter, total irresponsibility, open-

ended, fee-for-service, no fee negotiated, toward something that begins, hazily, to represent responsibility, but it is not there yet.

It is nice to hear talk about coordinated care, disease management, and all of this. But much of that is just talk. There is very little managed care in America. They are managed prices. That is what we have had, not managed care.

So the question arises, go to any health care conference in America today, and speaker after speaker says, we have no idea where this private system is going, who will manage it, doctors or insurance executives. So you have something we do not really understand. We do not know quite where it is going. The question should come up, why would you adapt yourself to something you do not yet know where it is going?

So my point is, the adaptation. Certainly, there should be innovation, and certainly even proposals like premium support are certainly worth thinking about. But when something is not totally broken, you should not totally overhaul it. We have the leeway, by the economy and by demography, to think about these issues.

I am glad there are these hearings. As sad as it was, I am happy the Medicare Commission did not come out with a finished product. It is much better that we have a longer conversation on this topic.

I think, when you do, you will find that there is not as much wrong with the Medicare program as the adjectives suggest, and a lot is unknown about the private sector evolution that needs to be learned before we visit that on 33 million American people. Thank you.

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

The CHAIRMAN. Thank you, Dr. Reinhardt.

Our final witness is Professor John E. Wennberg, M.D., M.P.H., director of the Center for Evaluative and Clinical Sciences at Dartmouth.

Professor Wennberg, it is a pleasure to have you. Please proceed.

STATEMENT OF JOHN E. WENNBERG, M.D., M.P.H., DIRECTOR, CENTER FOR EVALUATIVE AND CLINICAL SCIENCES, DARTMOUTH COLLEGE, HANOVER, NH

Professor WENNBERG. Thank you, Senator Roth. It is my great pleasure to be here today.

My task is to comment on how Medicare varies from one part of the country to another, and what might be the implications for Medicare reform.

I think it is well now understood that per capita spending for Medicare varies more than two-fold on a per enrollee basis from one part of the country to another, even after one adjusts for illness and for price differences.

I think we have to ask the question, do regions that spend more have higher quality? I think if we pursue that question we have an entry to a problem that, if we pursue it, will lead from the question of value back to the question of finance. What do we get for the money we spend?

Now, the first thing we do not get, is the effective use of services that work. What we see around the country is massive under-use of immunizations, screening tests for cancer, and even the adminis-

tration of lifesaving drugs for people with heart attacks. We are not doing that correctly.

Now, none of these cost very much to do. The interesting thing is, performance is uncorrelated with Medicare spending, indeed, with the supply of physicians and resources. Our problem here is the disorganization, or not the need to spend more money.

There is a second area in medicine, however, in which we see massive over-use of services. This is epitomized by the spending on terminal patients in this country. In some parts of the country, upwards of 50 percent of Medicare enrollees will enter an ICU in the last six months of their lives. In other parts of the country, it is only 15 percent.

As you can imagine, this is associated with massive differences in per capita spending in these regions. In fact, overall spending in the last six months of life is highly correlated with overall spending, it is highly correlated with the supply of resources, and moreover, in terms of return on money, our studies find no advantage to populations living in communities with greater intensity of care patterns. In other words, life expectancy is not improved in any measurable way across the gradient here of spending of more than two-fold.

Now, we have to ask the question whether the quality of life is improved in these issues. I think there is a growing understanding in this country that the quality of life in the last six months of life is not quite what it should be. We over-treat. I am going to suggest to you that, in addressing this problem, we can generate a massive savings for reallocation to other purposes.

The third problem I want to identify and discuss with you, is the variations in surgical procedures, such as low back procedures, back operations, prostate operations, and so forth.

Here, we see a different kind of problem. We see here a problem partly of medical science. That is to say, we simply have not done the studies that clarify whether or not patients who have early-stage prostate cancer benefit in terms of life expectancy because of an aggressive, as opposed to more conservative, strategy. It is a good theory, but it simply has not been looked at.

The second problem, however, which is much more fundamental in terms of understanding geographic variations in surgical rates, is the problem of patient preferences. That is to say, surgery, in most examples, is a trade off. There are decisions to be made by the patient as to whether or not the more aggressive strategy is the one that individual patient prefers.

In our own research, which I have highlighted in my written testimony, we have seen that, when patients are informed about treatment options in the use of specific procedures such as benign prostatic hyperplasia—or enlarged prostates—or back pain, they tend to choose more conservatively than they do under the current system in which surgery is allocated.

In fact, in benchmark studies we have seen that the rate that informed patients choose for intervention in terms of surgery is at the bottom of the distribution of the rates of surgery in the United States for some of these procedures, which suggests to me that we have a large over-supply of procedures in excess of what informed patients want.

Now, the final kind of issue that the geographic variation seems to raise for this committee, is the problem of geographic equity. That is to say, why should we spend twice as much for the care of elders in one part of the country than the other?

As in the fee-for-service system, this is largely a hidden problem. Once you become a defined benefit or a price support strategy, it is going to be clear that it is better, in terms of other kinds of benefits that can be purchased for you, to live in high-cost regions than in low-cost regions. I think it is going to be increasingly a political problem.

Let me just summarize my main points, then. First, more spending does not guarantee better quality health care. Second, more money is being spent in the Medicare program than is supported by scientific evidence. Third, more spending has not improved life expectancy. Fourth, at least for some conditions, more elective surgery is being performed than informed patients want.

Finally, if this committee pays attention to these problems of quality, our study suggests that enough money will be saved to maintain the solvency of the trust fund and, in fact, perhaps provide additional benefits without additional resources for the program.

Thank you very much.

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

The CHAIRMAN. Thank you, Dr. Wennberg.

Dean Roper, as a doctor, a researcher, and a former head of HCFA, do you think HCFA could be restructured over time to focus entirely on the administration of the Medicare fee-for-service program with other functions shifted elsewhere in the executive branch?

Dean ROPER. I think that is one of the possible options to pursue. There must always be, I believe, a residual option for Medicare beneficiaries to stay in the fee-for-service system. So, it would make sense for HCFA to continue in that role.

It probably is worthwhile to have a separate organization, whether inside HCFA as we created when I was there in 1983, to manage the private options, or whether to do that entirely outside of HCFA as some have more recently suggested. I think it is a different set of processes, requiring a different set of skills, and doing it separately makes sense to me.

The CHAIRMAN. If we have time, I would ask other members of the panel to comment on these questions, but I am going to proceed with a specific question for each of you at this time.

For Dean Pardes, given the significant clinical developments you see on the horizon, do you feel that the Medicare program is ready and able to identify and incorporate the most useful developments on behalf of beneficiaries. Are we able to avoid incorporating the more questionable?

Dean PARDES. I think we can do better, Senator. But my feeling is that there is a considerable attempt to make available the most advanced clinical techniques. There is a very broad system of communication within the medical field. I share Dr. Wennberg's concern that we examine the reasons for inconsistency across the country.

But, by and large, the process by which providers become aware of advances in clinical care and then try to implement them has worked with some considerable success. Not to say that it is a perfect system, but certainly one that has had some accomplishments.

The CHAIRMAN. Professor Reinhardt I served many years on the Governmental Affairs Committee, and where I had the opportunity to examine the Federal Employees Health Benefits Program. That program is quite popular. It offers Federal workers and retirees permanent and portable coverage through the use of competing health plans.

Are you saying that the current structure of Medicare is the only form that can offer beneficiaries permanent and portable coverage?

Professor REINHARDT. I do not think the current structure is necessary, but government is necessary. I do not think it is economically or structurally feasible for a private company to engage in life cycle insurance products. It is simply actuarially impossible.

Therefore, some tasks only government can do, and only government can ultimately guarantee an American the life cycle facilities for planning that Social Security, and particularly Medicare, offer.

So you don't necessarily need the current structure of Medicare to have it, even though the guarantee is really more the government, that you will have some insurance product. But, under the FEHB, a Federal employee might pick the Oxford Health Plan, and the Oxford Health Plan might evaporate, simply through mismanagement.

So the insurance contract with a private carrier is still ephemeral. It will always be ephemeral. It is simply the government that guarantees that you will get some insurance, but no private insurance carrier can guarantee you that.

The CHAIRMAN. Professor Wennberg, is it correct to conclude that geographic variation is a shorthand way of describing wide and questionable patterns of health service? It sounds like there can be significant cost savings without hurting the quality of care seniors receive. What might be done to ensure that Medicare does not overpay, or under-pay, for care in different parts of the country?

Professor WENNBERG. That is quite a question. It surely is. I have been struggling with that myself.

In the case of the under-use of services such as immunizations, there is a fairly simple answer. The way that managed care companies do this, is they use their information systems.

They have records about patients, where they live, and they have records about doctors who are treating them. They simply send reminders. It is a postcard kind of thing, like the dentists. There is no reason why that could not be done in fee-for-service medicine right now. It just has not been done. But it is simple.

I think we could, therefore, cure, if you wish, the under-service problem when we have a very specific issue at stake by some strategic interventions. We can do that tomorrow morning. The PRO program has already shown that it can move on the problem of under-service with beta blockers. They have actually done some positive things. So that is the part that is easy.

The part that is more difficult, is the question about the intensity of care, as I mentioned, in the last 6 months of life. That is sort of a paradigmatic situation.

This has a lot to do with the "more is better" assumption, the general belief structure in this country that, "when in doubt, take it out," is what the surgeons used to say. But it is more than that now. It is, "when in doubt, do all you can with all of the resources you have got." We have an armada of resources in some parts of the country, and very few in other parts.

The irony is, as I said, that we can find no evidence of benefit for this at the population level, which means it is safe and in the public interest to look more like the practice patterns in a conservative part of the country than it is in the more liberal parts.

Now, how you move to that, that is a tough question. I think this last 6 months of life issue, this treatment of terminal care, may be the key to a good deal of debate.

Around the country, my antennae keep saying that the personal experiences of enough Americans now with those problems is such that they question the efficacy themselves. So there is beginning to be some question about this particular part of life.

Now, how you would then move to effect the resource distributions in this country, if we were back in the 1970s, it would be very easy to ask the comprehensive health planning groups to begin to deal with this. At this point in time, you do not have much structure in place to do that, and I am sorry about that.

As to the surgical interventions, you have got to learn how to inform the patients. There is no reason why we could not do that tomorrow morning either.

The CHAIRMAN. Do any others care to comment? Dr. Roper?

Dean ROPER. Not so much about that, but I would add another comment. I do not think this is a useful debate between, is government good or bad, or is the private sector good or bad. Having worked in both, my conviction is, there is an important role for both.

But we need to have an organization, whether it is HCFA or however you choose to organize it, an organization that has the capabilities, the people, the resources, et cetera, to operate the program.

I am convinced that it is simply impossible to do the things that need to be done to organize and coordinate and facilitate the careful changes that Jack Wennberg was just highlighting, and to do all of that inside the government.

Uwe mentioned the cumbersome regulatory process and all of the strictures that are applied. I think that is simply not well done inside government. Surely we need government oversight, we need your presence, and others, making sure things go well and that beneficiaries are protected, and so on. But I also believe that there is an important role for private sector structures.

The CHAIRMAN. Yes. We will go down the line. Dr. Reinhardt, then Dr. Pardes.

Professor REINHARDT. Yes. I want to stress, and I say it on page 12 of my testimony, my statements about Medicare are not an argument against reforming Medicare or offering wider choice in private sector products. Not at all. In many instances, those are easier vehicles for innovation or disease management, and that should be explored.

My point there would simply be, let us not be hasty, let us just see what the private sector can produce when it can make it work. At the moment, it really has not yet. Even managed competition does not work in the private sector yet, except in very companies.

So it is just a caution to wait a little. I am not at all in disagreement that it is very difficult to administer, through one government bureaucracy, insurance for 33 million people.

The only thing is, I have been rather, frankly, disappointed in how little has been achieved in the private sector. As we speak, premiums there are rising again much faster than under Medicare. I think we should be cautious.

The CHAIRMAN. Thank you.

Dr. Pardes?

Dean PARDES. In a look at the private and government sector, Chairman Roth, my concern with regard to the involvement of the government is that, if you do not have the government involved, will social-valuable functions be conducted and supported as they should be?

There are many things of which this Nation can be proud. I think one of the most extraordinary accomplishments has been its record in medical research and advances in what medicine can do for patients.

Whether one talks about the training of superb physicians, the offering of care to the neediest of patients and making sure that they have care which is as high quality as people who have the means, or making sure that our research goes forward, I am concerned as to whether those functions could be carried out without important government involvement. So, it is not just oversight, it is also ensuring the support of those critical social functions.

The CHAIRMAN. My time is up. Next on the list is Senator Grassley.

Senator GRASSLEY. Dr. Wennberg, a lot of members of this committee would welcome your comments about low-cost regions of the country, in a sense, providing some sort of invisible subsidy to high-cost regions, because we have dealt with that in almost every Medicare bill that we have dealt with.

One of your Dartmouth studies showed Mason City, Iowa as an example of the lowest-cost area to delivery health care in the United States. I think that was two or three years ago, one of your studies showed that. It may have not been your study, but at least it was your university.

So Iowans ask me, when they retire, they get fewer Medicare services, not only in managed care, but in traditional fee-for-service programs. Your work makes it pretty clear that that is not because they are any healthier or do not need the services.

There are voices, on the other hand, out there saying that all we need to do is to preserve Medicare as it is now, that it is just basically fine.

So my first question is, what does your work have to say to those who say that we can stand pat with the existing Medicare program?

Professor WENNBERG. A fee-for-service benefit system, you mean. Well, from the point of view of health product, the production of

health, I think you are doing as well in Mason City as they are doing in Miami.

I do not know that in great detail, but certainly from the quantities of surgery provided and the number of immunizations provided, you are going to find that your record is just as good, or as poor, depending on how we structure the bottom line on this.

Obviously, the taxes that are being paid in the low-cost regions are being transferred to the high-cost regions, to some extent. Under fee-for-service, we did not have a fundamental problem in perception, because you bought the same benefit package. If you went from Iowa to Florida, you did not notice any difference, although you might have been going to the physician more often.

But when you begin to move to some form of defined contribution, whatever that might be and that is, of course, what has happened with the current AAPC, is that people in Miami can get much richer benefit packages than people in Minneapolis, Iowa, and so forth because there is just much more money spent.

So by emulating the conservative practice patterns that exist in Iowa or elsewhere, an HMO in Miami can realize a huge surplus and convert that into benefits, or whatever else they convert it into.

There is no medical reason why an HMO in Miami cannot emulate conservative practice patterns, for example, seen in the area of the Mayo Clinic, which is a very fine system of care, but it is spending way below the national average on a per capita basis.

Now, I do not know if that addresses your question or not.

Senator GRASSLEY. It does. I think I am going to ask Dr. Reinhardt to comment as well.

Professor REINHARDT. These enormous variations have been known to us since Dr. Wennberg pioneered these studies. As a member of the Physician Payment Review Commission, we had hearings on the potential of mainly having volume performance standards by State, saying we now have a volume performance standard on Medicare for the whole country, which, theoretically, cannot even work.

But some of us thought maybe we should have it on the State, and tell, maybe, the State of Florida, here is a budget that seems reasonable. We will give you 140 percent of what Minnesota gets. See if you can make do with this.

If you bill too much against this budget, the fees go down. That is how the buyer's group in Minnesota manages a fee-for-service program under managed care in the State of Minnesota. If the budget is exceeded, the fees go down. We could have done this.

But, as Bruce Vladek points out in a very seminal paper in *Health Affairs* just recently, in many ways the Medicare program has been an income redistribution program as much as a health care program, so the politics of that were difficult. The technology of having a more even payment would have been relatively simple. Other countries have done it, and Minnesota is doing it.

Senator GRASSLEY. Dr. Roper, I understand your concerns that Medicare is behind the times in terms of innovation and responsiveness to the advances of medical care. I would like to see this program be modernized and improved as you describe in your testimony.

One area of concern to me, and I have expressed this to Chairman Roth, is how to apply some of these principles that are in rural areas, where it is very difficult to organize the delivery of care because there may be very few providers in the area.

I want to make sure that these Medicare reform hearings take into account the geographic differences that exist, because one-size-fits-all may not work for rural States like Iowa.

So I am curious to know how your vision of this program would work for rural seniors.

Dean ROPER. You are right to point out the difference in rural areas. I still believe it is possible to have organized systems of care in areas where people live far apart from each other, but you need to have individual practitioners who are accountable for the care for their patient population. That is what I am arguing for, not a particular plan design, but rather organization.

I had the privilege, when I was HCFA administrator, of appearing before this committee once and said that I was from rural Alabama. Senator Baucus told me that I did not know rural America, so I flew around Montana with him on a little airplane.

And I do fully agree with your point that rural parts of the western country are quite different from urban south Florida, or New York City, or whatever, and we need to have a program that accommodates those differences.

Senator GRASSLEY. Senator Roth, thank you.

The CHAIRMAN. All right. Thank you.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman. Thank this distinguished panel for, I think, an excellent beginning.

Yesterday, I noticed in *USA Today* that they were reviewing what happened late last year when we saw 400,000 seniors lose their HMO coverage. They were dumped. The HMO industry quickly pointed the finger at government and said it was Medicare's fault; those bureaucrats over there have made it so that the regulations are so difficult, that it forced us out of the business.

Interestingly enough, the General Accounting Office did a review and released their report yesterday. They said, no, no, no. It was not the bureaucrats at Medicare's fault, it was the HMO industry itself. They pointed out that it was their own poor planning and their profit seeking that were the real reasons behind their decisions to pull out and leave seniors in the lurch.

As for their claims that it was low payment rates and heavy regulations that caused the massive exodus, the report by the General Accounting Office found that there was little supporting evidence for those claims. In fact, it turns out that the HMOs canceled contracts in high-payment and low-payment areas.

They went on to diagnose, what were the fundamental problems. They were basically market corrections in the HMO industry itself. It kind of goes to the point, Dr. Reinhardt, that you were making, that there is real risk here and that we ought not to jump, just because we face challenges, without knowing where we are going to land.

I can tell you, I represent a rural area. There is no area more rural than North Dakota. As I look at some of these options, they just do not work in a State like mine. They just do not work. We

have got the lowest penetration of managed care of any State in the Nation. There are no options.

You tell the guy out in Bowman, North Dakota who is on Medicare that he ought to seek a competitive model, he would laugh you out of the hall. I have to go out there and be accountable in community forums, and people in my State recognize that we are headed for a cliff, that we have got hanging over the horizon here this demographic time bomb of the baby boom generation. If we dramatically increase the number of people reliant on this program, something has got to give. Something has got to give.

My question to each of these panel members would be, what do you think needs to be done to address the long-term insolvency that we face in Medicare, now, according to the best estimates, in 2015? Dr. Wennberg, what would be your advice to us?

Professor WENNBERG. Well, I think I will return to, sort of, my challenge, if I made it that way, to the committee. I think if you examine the quality problems and ask, is more better, and come to terms with that question, then you will see that you can take very reasonable health care systems, such as those located in Portland, Oregon, Utah, northern New York, Syracuse, some in the south, and use those as projections forward on what your spending will be, under the worst assumptions that were in the CBO sort of best/lousy scenario—and this was actually in our latest atlas. We provide those projections.

Basically, simply taking the spending level—and we chose Minneapolis—and projecting it forward with an increase with which the CBO had put onto it, it takes years before you cross the line of the best assumptions under the defined contribution plan that you are considering.

Senator CONRAD. All right.

Professor WENNBERG. So that tells you that this is not inevitable because of medical progress or because of that part of the equation, or patient demand.

Senator CONRAD. So, distribution within the program itself.

Professor WENNBERG. Exactly.

Senator CONRAD. Costs within the program itself differentially.

Professor WENNBERG. And against the background that we just do not see evidence that spending more on a population base is buying value.

Senator CONRAD. All right.

Dr. Roper?

Dean ROPER. I would just agree entirely with what he said, and take it further. If we want evidence-based medicine, like Jack has pioneered, to guide the practice of medicine and thereby assure the redistribution of the money in a way that allows Medicare to flourish—not just survive, but flourish—into the future, my question is, is that best served by attempting to overlay yet further and further controls on top of a program that was basically designed 35 years ago, or is it best to move incrementally—not hastily, not abruptly, not totally—in every part of the country because it will not work everywhere, but to move towards a greater reliance on the innovations in health care organization that are occurring in the private sector. That is my argument.

Senator CONRAD. Dr. Reinhardt?

Professor REINHARDT. Well, there are two parts to my answer. The first one, is I think the demographic problem has been exaggerated. We are a relatively young country, with Australia and Canada. And our population structure, in the year 2020, will be that that Germany, England, and Sweden has today.

So if you want to know, what is it like in a country with an aging baby boom, travel to Europe and have a look. They are spending a lot less money than we do as a percent of GDP on health care, and their people seem, as Jack would agree, as healthy as ours.

This suggests the point Jack made, and Bill, that we can do this much more efficiently. If physicians in Florida could learn to practice as efficiently as people in the Dakotas or in Minnesota, I think this would not be much of a problem. I am sorry, Senator Graham, but that is just the case. We could do this more cheaply.

But there is another problem. We always worry about vouchers, money, when we talk about Social Security and Medicare. But the real question is, hands to lay on sick elderly people. We are told there are only two workers per elderly in the year 2020. No matter how many vouchers you have, there are still too few hands.

So I urge in my testimony that the best Social Security reform and Medicare reform would be to increase the number of young people in this country. We can do this. [Laughter.] We can actually do it. I once gave a talk, "Making Love or Learning Spanish." Those are the two options. [Laughter.]

We either can procreate more, that is to be more grateful to mothers who bring babies into this country and support them and educate them, give them health insurance, do the things that you would do if you knew that a child is a national resource, or if you do not produce them at home, import them from Latin America, which we are doing. [Laughter.] So I think demography is destiny, and we should have a policy on that destiny.

Senator CONRAD. All right. You never know what you are going to get around here when you ask a question. [Laughter.]

The CHAIRMAN. I will have to think this over carefully. [Laughter.]

Dean PARDES. A quick, quiet poll indicated unanimity for Dr. Rienhardt's endorsement of making love. [Laughter.]

I just want to state that one can talk either in terms of polarized situations, either stay with a very so-called stagnant system or go all the way over to innovations with all the risk that is involved.

One of the things that I think has to be recognized is the extraordinary variability, and that has already come out in our conversations.

Second, I think we should take a look at places where we are making advances. If you look at the over-65 population today, and look at what proportion of them are disabled, there is a far lesser portion of disabled today over 65 than was true before. Now, there are a lot of reasons, but that is true. One of them, is because we have invested in a research enterprise which has provided foreign new treatments.

One of the things we also find, is that if people live to later and later ages, the person who dies at 85 or 90 dies with the last 6, 12, to 18 months of lower health care costs than the person who

dies younger. So, it is not as if one is simply keeping them alive for more costly expenditures later on.

But some of the points made by all the other panelists regarding attention to quality of care or trying to incentive the system, to pay attention to where the quality of care can be better and learn some various systems of the country, and also looking at the reimbursement system so that one attends to prophylaxis.

If you, right now, try to mount a program, let us say, for the treatment of diabetes, what you will find is the reimbursement mechanisms do not necessarily provide for the nutrition services, the nurse education services which have done well, maybe paid off by far in terms of less hospitalizations and less acute situations of diabetic care.

So it seems to me there is a lot that can be done with regard to efficiency, quality, more in the way of outcome research, and then using that evidence to determine what treatments we support and do not support.

The CHAIRMAN. Senator Graham, please.

Senator GRAHAM. Thank you, Mr. Chairman. I am not going to use my time to give a defense of health care in Florida, but I would like to ask what I think is the predicate question.

That is, what kind of a Medicare system do we want to have available to American beneficiaries as we move into the 21st century? As has been stated, we essentially have a mildly reformed 1965 model of Medicare today.

If you were to do a track of where Blue Cross/Blue Shield was in 1965 and where Medicare was, they would be virtually on the same dot, but Blue Cross/Blue Shield has made a number of changes in its benefit package over the intervening 35 years. Medicare has not been stagnant, but it is much closer to where it was in 1965 than most modern private health care systems.

So the question I have is, what do you think should be the principal changes in the current Medicare beneficiary package as we look towards the 21st century?

Professor WENNBERG. Would you like to start with me?

Senator GRAHAM. Yes. You happen to have the benefit of being closest to us, so you get to start.

Professor WENNBERG. Right. Well, I have all these statistics about care in Florida ready to go, but I see I do not need them. [Laughter.] But I do want to point out that, within Florida, there is tremendous variation. So, it is not just that it is all the same.

Let me say that I think the most fundamental change that we need to have happen is a cultural change. Those are the most difficult. I have to tell you that I have been studying the variations in surgical procedures for a very long time.

And I will give you a statistic. In St. Petersburg, the chances of having a radical prostatectomy are about 3.5 times higher than they are in Tampa. That is like going across the causeway.

That is associated with the practice patterns of the physicians and the advice they give, the way they frame that decision. It is not because people who live in Tampa prefer one form of treatment over another.

We need, in these cases where there are discretionary choices, to begin to inform patients in systematic ways which empower them

to choose according to their own preferences, as long as it is in the benefit package. I am not arguing that they can choose things that do not work.

But, when there is genuine choice, we find, first of all, that patients do better and feel better when they are involved in the decision. They really do.

Second, they choose more conservatively than they do under the current system. That is to say, there is a tendency for less-invasive treatments, all of which works to the benefit in terms of the overall costs.

But from the ethical perspective of what medicine is all about, we really need to understand that there is a reason, there is an ethical reason, basically, for getting patients involved in treatments, because after all it is their own fate, it is their own bodies.

Now, that is not something you can change the benefit package, necessarily, to do, although you could do one thing, I think. That is, you could begin to make it possible for physicians who spend time informing patients to achieve a benefit return for the time they spend doing that that is somewhat commensurate with the amount of time they spend if they do the operation. You have got an incentive problem.

Second, I think if you could begin to make this an issue that the Congress addresses. I was very disappointed with this whole business about the Patient's Bill of Rights. Never anywhere in the legislative proposal was there anything about informing patients about choice of treatment.

There was all this stuff about choice of plan, which was presumably necessary for the macroeconomic model to work, but when the ethical question—the variations issues in surgery really tell us that patients are being treated very differently in one place in the country or another, and we know the preferences of the patient differ on an individual basis, and we need to get information to patients. That is what I would argue for as a change in the benefit plan.

Dean ROPER. Senator, if I may. If we were designing the program today, we would not do it like it was in 1965. As you point out, the Medicare program mirrored the private sector, largely Blue Cross, model then. If we were to start today, we would surely not have the arcane Part A/Part B deductibles, co-payments structured the way they are, and so on.

So if that is what you mean by the benefit design, those things ought to be changed, including the limits on annual benefits, lifetime benefits, and so on. Clearly, the most recently discussed issue is the addition of outpatient prescription drug benefits to the program. Most all private sector plans contain that today.

However, and to come back to an earlier theme, adding all of those improvements or sweeteners to the program in a time when it does not have ways of aggregate constraint on the budget is something that you are not going to do, or I do not think can do, in a fiscally responsible way.

So the challenge is how to come up with a program that has limits that are not arbitrary and capricious, limits and the incentives to the people who manage the program to do it in a scientifically-based, rational way so that the dollars go much further than they currently do.

Senator GRAHAM. I would like to hear, if I could, Mr. Chairman, from the other two. But I would be curious as to, what have Blue Cross/Blue Shield and the other private insurers done to gain some efficiencies within their system which has allowed them to provide things like prescription medication.

Dean ROPER. I would be happy to follow up.

Senator GRAHAM. Thank you.

Professor REINHARDT. Well, that is, in fact, the central question. We do have some empirical track record. Have the managed care companies actually been able to treat the elderly more efficiently, more cheaply than the people who stayed in the old fee-for-service system?

As far as I know, I was recently at a Congressional retreat and I saw numbers that suggest, generally, the HMOs so far had benefitted from favorable risk selection. So we really do not know whether, if you took a random sample of 100,000 Medicare recipients and simply assigned them randomly to HMOs, that is the experiment we need, whether they could do this more cheaply.

I personally harbor some doubts, for the following reason. Medicare burns less than two cents of every premium dollar on administration. The rest goes to doctors and hospitals. That is a tremendous advantage it has over private products.

Second, Medicare gets huge price discounts, and the private sector would have to get those discounts that Medicare gets. And there would have to be these efficiencies. But I am not aware that HMOs, say in the State of Florida, where the APCC is fairly high, that they are thriving, nor that they do, for the same type of elderly, a much cheaper job.

That is the kind of information we need and I am not sure that any other panel member here would look you in the face and say, we know that the HMOs do this more cheaply. I am not aware of the empirical research that would say that. I am aware of the opposite.

Dean PARDES. Senator, if I could just reinforce what Dr. Reinhardt has said. I think one has to be very careful, when one gets suggestions of reduced costs with certain kinds of health care systems, and one obviously has to look at the nature of the population and how that compares to other populations, and if one cherry-picks, one obviously gets lower costs.

I think you are hearing some themes, however, which I think you may get some agreement on the panel with regard to, as to things that should be focused on. They include a focus on evidence-based medicine, an urging to try to get more consistency in the system, and attempt to focus more on prophylaxis.

But I want to reemphasize that I do not think one can just look at Medicare in isolation. There are also social functions that have to be conducted. I think if you examine the overall benefit of our Nation's research effort on what we can do in medicine, it has been extraordinary. There have been extraordinary costs saved. Who knows what we would be spending if we did not have some of those better treatments today?

So, I just want to make sure that, whatever system we come out with, Medicare, et cetera, that there is support of those major functions. For example, in the education arena, that we bring in other

payors to help share some of the burden that Medicare now assumes for medical education.

The CHAIRMAN. Senator Chafee?

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

Dr. Reinhardt, you indicated that every poll showed that the American public is very enthusiastic about Medicare. That is interesting to me, because I was surprised to learn recently that, for seniors, Medicare only covers 50 percent of their medical costs, the rest being in the deductibles, the Part B premium, or prescription drugs.

So, it is amazing that a program would be that popular. Maybe they do not realize they are paying 50 percent of the costs of their health care out of their own pocket not being covered by Medicare.

The other thing is, we have been talking about efficiency here. It is my understanding that 90 percent of the beneficiaries under Medicare have some supplemental coverage.

In other words, that is an added expense that they have, a Medigap policy. That does not make for efficiency; anybody who goes to a doctor's office, and the nurse or secretary is spending her time trying to figure out how much of this is Medigap, how much of it is Medicare.

But I would like to switch gears here a little bit. Everybody says Minnesota is great. When you are comparing Miami, we will look at Minnesota. What do they do in Minnesota that is so great? I am not holding you responsible, totally, for Minnesota. [Laughter.]

Professor REINHARDT. Well, actually, Minnesota makes the case and I want to state, I have actually generally been a defender of managed care in print and in the media, and I think managed care is here to stay, and we will have to figure out what to do, but will go better.

But Minnesota has had HMOs, I think, longer than other parts of the country, with the exception of California, so they have a tradition. I think, even under the fee-for-service program, you will find that Minnesota physicians practiced a more conservative style of medicine, which is the kind of information that Dr. Wennberg unearthed. So, it is really both. There was managed care, but there is also a much more conservative style in treating medical symptoms; would you not agree?

Professor WENNBERG. I think it is all the Norwegians up there, too. [Laughter.]

Senator CHAFEE. Well, Dr. Wennberg, you ended up your testimony indicating that, if these steps were taken, and you discussed reducing the expenditures in the last 6 months and if they practice, I guess you could call it, proper preventative medicine with different immunizations and so forth, I think you ended on a very high note, that the system would not go broke. Indeed, maybe we could have money left over to do some additional things.

Could you repeat that again? I am not trying to put you on the spot, but how do you get doctors to do the things that you say they ought to do?

Professor WENNBERG. Ah ha! Now you have put me on the spot. I can repeat. The analysis, basically, is that taking the practice variation phenomenon as a huge number of natural experiments that are going on around the country, we can understand those ex-

periments and we can be fairly firm in the statement that, if we find no benefit in community A compared to community B in terms of mortality, the questions of quality of life have to be asked, but they can be addressed.

The general conclusion is, we do not see net benefit across the spending gradient and, therefore, the lower communities become benchmarks of efficient allocation. How to achieve those allocations is complex, because it is not only a matter of the practice style, it is also the sheer quantity of resources in the market and you have to pay attention to both of those at the same time.

In other words, there is a very strong correlation between the capacity of the acute care hospital system and the probability of being in an ICU, the probability of dying in the hospital, the amount of money spent in the last 6 months of life. So you have got to deal with the capacity problem. You have also got to deal with a decision problem.

Senator CHAFEE. Right. But there are national rating organizations, are there not? For instance, I can remember Secretary Califano testifying before us here about, in one hospital in Detroit, X number of deliveries of babies would be by C-section; in another hospital down the street, it would be half of X, and no difference in the mortality or success or survivability of the baby and so forth.

Now, are there not national organizations that the first hospital is taken under surveillance there because they are doing things so vastly different?

Professor WENNBERG. Well, I think people have tried to pay attention to this. There is a program in the State of Maine which has, over the years, been effectively feeding information back to physicians that has seen some real change in behavior, but there has been no national program to do that.

I mentioned in my testimony that one way of dealing with this problem of the under-use of immunizations would be for the Health Care Financing Administration, and maybe to partner with the American Hospital Association or maybe with the AMA, to get reminders back to physicians and patients. It is just, no one has taken the accountability steps forward on these things.

Senator CHAFEE. It seems to me that this is kind of a loosely-run outfit. We point with pride that only two percent is used for the overhead. Maybe we should not be proud of 2 percent. Maybe it ought to be four percent, and get some of these things done that we have been discussing here.

Dr. Roper?

Dean ROPER. Senator, if I could follow up on your point. We have no way of holding the system accountable or individuals within the system accountable in a fee-for-service system. That is the point. I believe it is organized systems of care, largely led by physicians, who need to be given the incentives to change the way medicine is practiced along the lines that Dr. Wennberg has indicated. That is the only rational hope we have of achieving economies. That is hard to do. Ten years ago, the Congress passed legislation setting up the Agency for Health Care Policy and Research.

We had a dream then that evidence-based medicine outcomes research would yield guidelines that would transform the practice of medicine. There has been some help there, but largely that has

gone unrealized. I think that the answer, ultimately, is holding organizations accountable. That is what I am arguing for.

Senator CHAFEE. What do you mean, an organization?

Dean ROPER. Others have talked about the Mayo Clinic and their ability to manage care across a group of doctors or group of patients. Whether it is that particular model or another, I would believe private sector health care organizations can do a much better job than can HCFA with whatever oversight, two percent, four percent, or whatever, of its budget can do.

Senator CHAFEE. My time is up.

The CHAIRMAN. Your time is up. Dr. Reinhardt, briefly, if you want to comment.

Professor REINHARDT. It is just, I agree with Senator Chafee. In my testimony, I make the case that the two percent is too little, that if it were four or five, we could do some of the things management things that are not now done in the program.

Senator CHAFEE. Thank you.

The CHAIRMAN. Senator Bryan?

Senator BRYAN. Thank you very much, Mr. Chairman. And thank each of the panelists for their very thoughtful observations.

I want to pursue the elusive goal for the Rosetta Stone as to how we translate to the language of Medicare into something that provides the meaningful solutions.

We have heard repeatedly, and I think Dr. Wennberg made the point, that there is a wide disparity in terms of geographical rates and practices among physicians for the same type of medical treatment throughout the country.

Assuming that is a given, and if those of you to whom I ask this question disagree, please disabuse me of that notion, two things have specifically been suggested.

One, that we ought to structure the reimbursement for the program to provide some additional financial incentive for physicians who take—and Dr. Wennberg, if I misstate your recommendation, please correct me—and spend some additional time explaining what their options and what their choices are, your thesis being that when patients are provided information about choices, they tend to select more conservative treatment options. I think I have got that one essentially right. That was one suggestion.

The other, was some type of a reminder for your annual check-up, something I think you analogized to the experience that all of us have when we get a notice from our dentist, it is time for your six-month or annual check-up.

Dr. Reinhardt, you cautioned us. You said, we need a little more flexibility. You said we ought not to throw the baby out with the bath, that it is not as bad as, perhaps, people are saying.

So, on the one hand, we want to provide flexibility, and I gather you would argue that we should not try to micro manage it. Every time somebody comes with a suggestion as to how we ought to improve the system, we are eager to enact a new piece of legislation or direct HCFA to provide some new regulation.

Let me ask you, it seems to me that we are in somewhat of a paradox there, flexibility, yet to do something to try to change these wide variations and practice patterns in a geographical disparity. Any other suggestions that you could make specifically to

those of us who do not run the program? We simply provide the legitimate framework. Maybe that framework itself needs some specific changes, but we do not run the program. We are never going to be able to do that. We would do a poor job if we tried to do it, your suggestion, specifically.

Professor REINHARDT. For instance, for Medicare to change any rule, has to go through such a procedure that it takes about 3 years to change reimbursement. I think Medicare, for example, might have had the flexibility being given it, to say that in regions where billing per capita exceeds the national average, that fees there could be cut. An insurance company could do this, but HCFA could never do this.

Medicare had, of course, experimented with Centers of Excellence, but I am sure that is very difficult for Medicare to do because there are constituents who would complain if they lose business. So, some of this kind of flexibility, I think, could be built in.

Again, I want to come back to, when I hear this coordinated care in the private sector, other than Kaiser, that can claim to be accountable for the cost and quality of the health care of its people, I really can't think of any other private sector organization that, at the moment, does a whole lot better in terms of accountability than HCFA. HCFA could have, I believe, volume performance standards should have been State-based. That would have given HCFA a lot more clout.

But look at the issue of competitive bidding for private insurance plans. Look how every step of the way, when HCFA has tried to implement the idea of competition in America, every time the HMOs on the one hand, through the legislature, has wrecked the attempt. So far, it has not been possible for HCFA to experiment with Alan Enthoven's design. I think that is alarming and saddening.

Senator BRYAN. Dr. Pardes?

Dean PARDES. Senator Bryan, I just want to point out that I believe the ability to push for greater consistency in the way medical care is delivered around the country is very heavily related to our knowledge of what the right medical care is.

So that, as you see medical interventions becoming more specific, becoming based on evidence, being subject to more in the way of outcome research, one can say with a degree of confidence that we expect the rates for X and Y procedure in one place to be analogous to what they are in another place, which obviously argues for innovation and for incentivizing those who use evidence-based methods.

But I believe what has happened today, is we are more able to talk about insisting upon that kind of consistency than we were when it was less known. There still is a lot of variability and a lot of individuality in the treatment of any given patient by any given doctor, but that is being reduced and, therefore, offers a handle for us.

Senator BRYAN. Accepting your premise—and my time is out—that when more knowledge is obtained in terms of, what is the proper outcome, that the system will provide less variance in terms of treatment modalities, what, if anything, is our role in terms of drafting the legislation?

What should we do, if anything, to facilitate that, or is there anything? Or is this something that will just evolve on its own as this information is provided in the medical community?

Dean PARDES. I think it is worth the Congress looking at ways by which it can provide some stimulation for there being greater consistency, and also to try to incentivize that. And I am not suggesting that even the fact that there is knowledge being widely dispersed means that the consistency will be uniform.

So, I think that one could have some role, as perhaps Dr. Reinhardt suggested, for setting some parameters by which there would be an encouragement of medical people and medical systems for paying attention to what the norms are across the country, and being closer to them, or really at them.

Senator BRYAN. Is Dr. Wennberg permitted to respond? I know my time is up.

The CHAIRMAN. Please.

Professor WENNBERG. Thank you. I wanted to mention one positive suggestion. I believe that, particularly in rural areas, we know that the population density is not sufficient to support competing integrated health care systems.

We have done some papers on that. I think about one-third of the population of the United States live in such regions, where this managed competition concept that Alan Enthoven articulated simply would not work because of demography.

I think that I would encourage you to consider asking HCFA to undertake some demonstration projects for producing integrated health care systems in such areas. It is quite possible to do that.

Our own conceptualizations in Vermont and New Hampshire have approached HCFA with some ideas along that line that would put the quality issues first, and would say that our system will agree, as a point of accountability, to accomplish these goals of informing patients about choice, dealing with excess capacity, and essentially being able to manage better the process with which immunizations and so forth are given, if, in turn, HCFA, you will agree that, if we generate net savings off the projected rise in per capita costs in these regions, that we can realize those savings and reinvest them in new benefits, such as a drug benefit. I think that would work.

Dean ROPER. Can I just add one additional point, Mr. Chairman, to the point just made? HCFA strongly needs the ability to do demonstrations, to try new things, whether it is Jack's idea of a rural area, or Uwe's notion of competitive bidding for services.

Unless they are allowed to test new ideas, the program will not be able to improve. The system we have now is one with such paralysis, that it is very difficult to think outside of the box, or even to try to do something unusual or different.

Senator BRYAN. Thank you very much.

The CHAIRMAN. Next, is Senator Robb.

Senator ROBB. Thank you, Mr. Chairman. I join others in thanking this panel for a very thoughtful, and in many ways, provocative presentation. I should observe, with Dr. Reinhardt, I had occasion 10 to 15 years ago, in my period between State and Federal service, to work on another commission, and his input and testimony was always very useful and passionate. I would say it has become even

more colorful in the most recent incarnation, but I appreciate the testimony.

I am grappling with the same questions others are, and this is my first time to grapple with some of these questions on this committee as a matter of initial jurisdiction.

But, Dr. Wennberg, your discussion of the lack of benefit, at least in terms of extended life expectancy with respect to the last 6 months of life, with respect to the cost, at least, of the procedures and benefits that were available, at least caught my attention.

But there is an even more fundamental question that I have grappled with for a long time, and maybe you can clarify it for me. Because in discussing health care costs, generally, for a very long period of time I have frequently cited a statistic that related to the costs that are involved in the last 6 months.

I have had extreme difficulty in pinpointing a verifiable source with respect to exactly what percentage of, say, the total health care costs of an individual over a lifetime, or the total health care costs for the population at large, any comparative basis that is not more anecdotal than based on some evidence.

Of course, this is made a little more difficult by the fact that you have to wait until the end of life to find out, what were the last 6 months. With very few exceptions, you cannot predict that, as to when those expenses are going to occur, and track them.

But is there a reliable, empirical basis for judging comparative costs of medical services during the last six months of life that you could just cite to me, or give me some sense of where to find it?

Because every time I have gone looking for it, I found that it was citing some other study. I could never get back to an original source, and I finally decided that this might have been one of those myths that does not have the kind of empirical basis that you discussed.

Professor WENNBERG. Are you asking, what proportion of total Medicare spending is——

Senator ROBB. I am not asking really so much just in the Medicare sense, because I want to broaden it in just a minute to compare Medicare with respect to the total population.

Professor WENNBERG. Right.

Senator ROBB. But for right now, I want to pin down a place where I can go to find a reliable statistic on the expense of providing patient care during the last six months.

Professor WENNBERG. Yes. What we can give you is how much was spent, in each region, in the last six months alive. What I cannot tell you is what the proportion of the total lifetime spending that represents. It is about a third, if I remember right, on the total Medicare spending, is in the last 6 months of life.

Senator ROBB. All right. But Medicare spending, for most people, would not kick in until they are in this higher expenditure range.

Professor WENNBERG. Yes. I do not have that information on the tip of my tongue.

Senator ROBB. All right. Well, when we are looking at a comparison, right now the only plan on the table is one that has been put forward by the commission, premium support based generally on the Federal Employee Health Benefit Plans.

I think we frequently lose sight, and I have, in making comparisons between the demographics of the population to be served by the FEHB plan, which would have a normal cross-section of healthy and younger, as well as the aging and frail and those in need of greater costs, is there some sort of a fundamental way of comparing those two, i.e., Medicare-eligible costs and costs for any other broader cross-section of the population that avoids the difficulty that we have encountered in having an apples and oranges comparison, perhaps?

Professor WENNBERG. Do you have something? I have to pass on this one.

Dean ROPER. I think the general notion, Senator, is most Americans are increasingly uncomfortable with the fact that they look forward to dying in a hospital, hooked up to all sorts of devices, tubes, and whatever. That is what is driving the concern. I do not know of an empirical study, as you asked for, that isolates the amount of money spent in the last year of life. Frankly, I am not sure that would be useful, because we do not have a way of predicting when that last year begins. What would we do, stop payments during that period?

The real question, again, I believe, is who are we going to lodge the decision making with about those things; is it going to be the government and the Medicare program, is it going to be doctors and families? That kind of situation would be much more compatible with most Americans' beliefs.

Senator ROBB. Dr. Reinhardt?

Professor REINHARDT. If I could recommend, I would call Dr. Elliott Stone of the Massachusetts Data Consortium. He does not have exactly what you want, but I remember, I used to get from him the costliest cases in Massachusetts in the last year. And they were always Medicare cases that were very, very costly, and most of those patients died. He may even have exactly what you want.

Dean Pardes. And if I could add to that, Senator Robb, you might want to speak to Dr. Kenneth Manton, who is a health economist from Duke University who is focused on costs at the latter stages of, and just before, the death of an individual.

Senator ROBB. Thank you very much. My time has expired. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kerrey?

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

I am going to direct my question to Dr. Reinhardt, but only because he said something with which I disagree. I would like the other panelists, if there is time after I have asked the question—there may not be—to respond.

You said that the demographic problem is overstated and you said we should compare ourselves to Germany. The trouble is, as I see it, that is not a very apt comparison, because Germany has a much different law. We are dealing with the law here. In Germany, the law says, I believe, if you are a German citizen, and probably a legal resident as well, you are eligible for the German health care system. But that is not the way it is in the United States.

In the United States, the law says you are not only eligible, but you have a claim on other citizens' income to pay your bills if you

reach a certain age, if you have a kidney, if you are poor and promise to stay poor, if you are like me and you get blown up in a war—it is a pretty high standard of eligibility; I would not recommend you choose that course of action—or if you work for the government.

Any government agency, school, city, county, State, Federal agencies, the taxpayers pay your bills. Or if you work for the right boss and have enough income that you qualify for an income tax subsidy. The perverse system there is, the higher your income, the greater your subsidy is.

The lower your income, if your income is $15,000 a year and you are not paying income tax, you do not get any subsidy. If your income is $100,000 a year, you get a 40 percent subsidy. So, it is an interesting system. But the law does not provide people eligibility, as Germany does, based upon simply saying, if you are an American or legal resident, that is how you become eligible.

So what we have, is we have people who organize to protect their programs, veterans, seniors, advocates of the poor, though they get the short end of the stick every single time. We have 23 million Americans who are not a part of any group. They are in the workplace, but do not have insurance.

That is my estimate of the number who are more at risk as a consequence of not having children. They have no claim on anybody's income. The law does not give them a claim. They are not entitled. I am entitled to have a claim on their income because I am a disabled veteran. Anybody over the age of 65 has a claim on their income because they qualify: they are old at 65.

In fact, they have a 62-year-old claim for being old under Social Security, a $400 billion a year program. I mean, Medicare, long-term care, Medicaid, and Social Security will increase $40 billion this year. You would think we were not allocating enough of our resources.

If you look at the future trends, it is 11 percent of the budget this year. There is a limit to how much we can take. We take 20 percent of U.S. income today for Federal spending. It is actually 20.5. It is at an historic high. It has not been that high since the second World War.

There is a limit. It can only be 100 percent. We can only take 100 percent of income. So, we are at 20 percent, which I think is bumping along towards the upper limit. But we are taking 11 percent just for Medicare. It will be 28 percent when the baby boomers are fully retired.

So, if we keep Medicare as an intact program, then I believe, by the way, there is no political will to make the changes necessary to reduce those out-year costs. Any time you propose to make any changes that reduce the cost of the program, you meet opposition, whether it is allowing HCFA to be more competitive, whether it is allowing or asking beneficiaries to pay more according to their income.

I mean, I have volunteers that say, if I have $2 million worth of income, for God's sakes, I am a little uncomfortable having my secretary subsidize my health care. But, no change in the law, because that violates the spirit of what Medicare is.

One of the things I do, I reached the conclusion that Medicare cannot be fixed. There is no political will to fix it. There is the political will to have benefits, there is the political will to make it more generous, but there is no political will to do the things necessary to take this 28 percent figure—we spend 34 percent of our budget today for the Army, Air Force, Navy, Marine Corps, NIH, and everything else at the Federal level, and we are heading to zero as a consequence of being unable to say to people over the age of 65 today, or 30 years from now, that you have got to take a little less. We cannot do that because we will immediately roll out charts to show how miserable they are and how much suffering is going on in their lives.

I am willing to spend more on low-income seniors, by the way, but that description of poverty and foraging in the alley for food hardly resembles what I see when I talk to people over the age of 65.

But, anyway, I have reached the conclusion that, as far as changing the law to preserve Medicare as an intact program and solve the problem of a growing number of uninsured Americans at a time an economy grew by six percent real in the fourth quarter last year, that you cannot do it.

My conclusion is, you have got to start with a clean slate and make people eligible, as a result of being a citizen or a legal resident, then let us have an argument. We can have socialized medicine, if you want it. If you want to argue that, argue it. You want the market to do all of it? Fine. Let that argument fall.

But we are going to continue to see growing costs for this program and growing uninsured Americans who have no claim on our income and who have more illnesses and have lower health statuses as a consequence, unless we can step back a bit here and say that maybe we ought to do like the Germans did.

Professor REINHARDT. Well, Senator Kerrey, you will be shocked to hear me say that I totally agree with you. I see these problems always in two ways. First, I look at the real sector, which is the real GDP. They are people who are work, hands, human beings who create and produce the GDP. Then that GDP, once it is made, at the moment, 47 percent of the American people produce GDP; everyone else does not.

Once that GDP has been made, it is distributed to those too young to work and to those too old to work, and the rest is kept by those who made it. That is so, and nothing will ever change that. In that sense, I think, our problem in America is less than Germany's, Sweden's, or England's because we will have more GDP makers than they do, and we will be forever young.

Now, that is the real sector. How do the claims to this GDP get transferred? Then you get into the financial sector, which is Medicare, Social Security, private pension.

There I would have to agree with you, if I got a bunch of Princeton freshmen really drunk and said, at 4:00 in the morning, find out a social contract that really is unaffordable, that really is unjust, that really does not encourage or permit life cycle planning, you would probably have these freshmen come up pretty much with what we have got in America today. [Laughter.]

Senator KERREY. I agree with you.

Professor REINHARDT. That is, of course, your anger, I fully share. I despair at some of the things that we, as a Nation, have done. In Germany, people from youth on engage in life cycle planning.

When I was an apprentice in Germany, I joined a sickness fund. Then I vastly over-paid relative to my actuarial risk. But, because of doing that, I built an estate and was entitled, as my mother is now, to get health care half paid by her pension, half subsidized by the young.

We have a system where many young people who could buy insurance do not, because there is ultimately charity care. When they get to 65, they throw themselves upon the mercy of the State. It is a horrible social contract. I think it requires far more than tinkering. Even the premium support problem will not get rid of this kind of weird entitlement, redistribution upwards, and so on. So, I fully share your anger.

Dean ROPER. I will not say it as eloquently as he, but I agree, we have plenty of money in the Medicare program and plenty of money in the American health care system to deal with the problem of the uninsured, and it is a crying shame that we have not to date.

The real issue is, how do we control—and yes, it is a matter of controlling—the cost of the Medicare program over time, those 30-out years, whatever, and thereby make the resources society-wide to deal with other pressing social problems? I do not believe the current system, as it is organized, allows for that. I just do not think we will do that.

Senator KERREY. Thank you.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to sort of return to kind of a basic matter here. This has been a very tough year for me. I have been working in health care for quite a long time. And RBRVS and AHCPR, et cetera, that you referred to, Bill, were things that Dave Durenberger and I worked on. So, when I went on the Medicare Commission, I really saw an opportunity to do some really good things.

Unfortunately, the appointments and the chemistry of the commission were such that it was, in effect, stacked from the beginning. There was sort of no more revenue. The 15 percent that the President, from the surplus, put on the table was taken off in the beginning. With prescription drugs, 60 percent of those who do not have them would not get them under that plan. Some would, yes.

There are some good things in the plan, no co-insurance for preventive care, but, for the most part, it is not a good plan. It was also not a debated plan. It was a plan where there was a lot of negotiating, up until the very last moment. Things were added in to try and entice certain members.

Then people like myself, who care enormously about health care and care enormously about the disposition of Medicare and what its shape is likely to be in the future, were, therefore, put on the defensive because we were faced, numerically, with almost a predetermined position to take the Medicare problem, in terms of fiscal responsibility but not in terms of making Medicare mature with our population and looking at other factors in Medicare.

Then it has extended beyond that. I speak personally, and perhaps to my own self-detriment here. But it has been interesting, as my staff has dealt even with staff on both sides of the aisle on this committee, I have been stercotyped a bit as somebody who does not want to see any change in Medicare because I was clearly not for the Medicare Commission resolve.

That troubles me enormously. The Chairman of our committee, whom I am not only devoted to personally and we share enormous interests, ranging from Japan to all kinds of things, said at a hearing that, "Jay, we hope to get you to our side."

Now, what is my point on this? My point is, there is a railroad running on the only plan which has been put out on Medicare, and it is the Medicare Commission's plan, which is quite a bad plan.

I say that with respect, with some degree of knowledge, and with a lot of details that I will spare you from, but how a plan takes 85 percent of the counties in my State and puts them off limits because there is no managed care option.

How does a plan take GME? We all agree that GME does not have to be in Medicare, but if it is not in Medicare, there has got to be some kind of a system so that you do not see the end of all doctors trained at overseas facilities, and then finally our own, and you turn it over to the appropriations process. Appropriators are not necessarily schooled in health care and the intricacies of Medicare, or health care in general.

So I come at this with real angst because I can see a scenario, I would say to the four of you, wherein this plan, the Medicare Commission plan, will pass, that it will pass through this committee with, I would count, maybe three of four dissenting votes, that it will pass through the Senate more easily, that it could pass through the House, although the margin there is closer.

There are enough moderates that they could add on some low-income stuff, in the same way as they tried to get our votes, you add something on. Does that mean it is going to stay when the Majority is finished with it? Probably not.

But I can see that happening in the House. Then it goes to the President. Will the President veto it? He would say that he would. But Presidents, in their second terms, are interested in legacies. And would he really, because this would be called Medicare reform? There is nothing else on the table. There is nothing else.

He has not presented a plan. He is obviously engaged in other things. If he were not engaged with other things, would he have delivered a plan? I am not sure. He has talked with me about doing that, but it has not happened. We have not come forward with a plan, people like myself, because we have been on the defensive for the past year, trying to stop something, to do no harm, so to speak.

So my question to you, with what I could go on for an hour with the problems in the Medicare Commission plan, done in good faith but with a tremendous ideological stamp and with great predetermination, almost genetic coding, is it not better, as you said, Uwe, to say that this is the beginning of a very important debate and that there is a lot of information we need to have? This is an extraordinarily serious subject.

The VA health care system, which you referred to in your paper, is $27 million. That is called socialized medicine. Medicare is not

socialized medicine, but it covers 34, 35, 36, 37 million people in the declining years of their lives.

Is it not better in that we now have, with a 2.3 GDP estimate, an extension of another 7 years to the year 2015, to have hearings like this which are deeply informative and which get real debate, but not to allow this to become a series of hearings on the way to a preordained result, that is, the passage of the Medicare Commission, simply because there is nothing else on the table? When there is nothing else on the table, what is on the table being discussed has to be deemed to be the preemptive approach.

So I would simply ask that, having already overrun my time.

Dean PARDES. Senator, first of all, I just want to say for myself and for my colleagues, that we are well aware of your extraordinary leadership in health for a very long duration. It has been very much appreciated, and will be appreciated going forward. We are happy to hear you raise the questions, many of which we would raise in chorus with you.

I could not agree more that the notion of some preordained plan kind of rolling through without a real look at both side effects and unintended side effects, I think, would be catastrophic. I think it would put in jeopardy some of the best elements of American medicine. So, I would heartily endorse your calling for the appropriate scrutiny in bringing the various experts in to work on this and to put some alternatives on the table.

Professor REINHARDT. Well, you spoke very much in the way I would like to see it done, is proceed cautiously because nothing is on fire. There is a very nice paper by Beth Fuchs, formerly of the Congressional Research Service and now of Health Policy Alternatives, which she delivered at the Urban Institute two weeks ago.

I read it and I was amazed at how difficult it actually is to implement the premium support program. It is a very thoughtful, objective paper. It does not take an issue or stand, it just says, these are the things you need to do.

I would urge this committee to have her present this to you, walk you through it, and you will see, it is an idea of something that should be, of course, discussed, but it probably requires considerable modification before you could make this work. That is an excellent paper. I found it instructive and was amazed at how much more difficult it was than initially I thought a premium support program would be.

Dean ROPER. Senator, I would say the American seniors deserve your giving very thoughtful consideration to what you do in reforming the Medicare program. And for you to accomplish successful Medicare reform, it will take broad majorities and bipartisan support to really work.

That said, Medicare passed in the spring of 1965, and the prospective payment system for hospitals passed in the spring of 1983. We are at April here. You will not take final action until September, I would judge. There is adequate time to have a large-scale discussion about this. I know a lot of people, myself included, would like to be involved in that discussion with you.

Professor WENNBERG. I have to echo these comments. I see so many structural problems in the current distribution of services

that are going to impact on the feasibility of implementation of this new strategy that I just urge you to take into account.

I am talking here about the transfer payment problem, unequal suspending problem, the rural problem, and the question about experimentation. Do we want to start with one huge change or do we want to experiment?

We are a very empirical society. Unfortunately, in our legislation we tend to make categorical shifts and changes that we really cannot anticipate their full effects. I would urge caution.

Senator ROCKEFELLER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Let me just point out that this is the beginning of the hearings on this most important problem. There is no preconception as to where we will finally land or resolve this issue. I am a little surprised at the optimism of my distinguished friend from West Virginia that one plan will go through that easily.

But, in any event, I do think it is critically important that we move carefully. I urge anybody and everybody to come up with any proposal that they think will move this program ahead.

I think we face a serious question. Do we try to reform it all in one major step, or at least take a major step, or do we do it by increments? My reason for holding this series of hearings, at Senator Moynihan's urging, was to lay out the problem that faces us. I do not think, to be honest, we could have a better panel than we have had today. I just want to express my warm appreciation for all of you.

I would like to, before we leave—it is almost 12:00; Dr. Roper, I appreciate your staying—do you have any last-minute comments or suggestions you would like to make? I would welcome any further comment anyone would like to make.

Dr. Pardes?

Dean PARDES. I just want to reiterate, first of all, my appreciation for the hearing, Senator Roth, but also a concern about what appears to be a very substantial downturn in the financial fortunes of teaching hospitals and the need to attend to the impact of the Balanced Budget Amendment as we go into the out years, and endorse Senator Rockefeller's focus on the attention that we really have to protect a medical education system that has been superb and have some way of financing it.

So, I would like to recall attention to Senator Moynihan's bill, which I think is a way of doing it, and provides a shared responsibility for all the appropriate contributors.

The CHAIRMAN. Let me say, you have a very effective advocate in Senator Moynihan. I think you can be assured, he will speak loudly and forcefully on this issue.

Dean PARDES. We are very proud of him.

The CHAIRMAN. Dr. Reinhardt?

Professor REINHARDT. I would thank this committee. I am cheered by the fact that there will be this series of hearings. The commission made a good start putting something on the table, but it was very much an unfinished product that needs more general discussion.

I thank you, Mr. Chairman, for having these hearings, and thank you, personally, for inviting me.

The CHAIRMAN. I would welcome any comments on any proposal that comes up from this panel.

Dr. Roper?

Dean ROPER. I have enjoyed being with you, and I commend you for holding the hearing today, and the series that lies ahead. This is an important matter. The Medicare program is a vital one that deserves to be strengthened and improved over time.

What we are really discussing is, what can government do, what is the appropriate role for government, how can we learn from the private sector and build on things there? Those are challenging issues and deserve your careful scrutiny.

I recall, when I was HCFA administrator, I gave a talk once and a gentlemen, in the question and answer period at the end, said he was a physician who was tired of being messed with by the Medicare program. He said, Dr. Roper, what I am trying to do is tell you, get the government out of the Medicare program. [Laughter.] I said to him, sir, the government is the Medicare program. That is the issue that is before you now, and will be in the future.

The CHAIRMAN. Thank you, Dr. Roper.

Dr. Wennberg?

Professor WENNBERG. Again, I would like to also thank you for the opportunity to be here today. I deeply appreciate the attention this committee is giving to this problem. It is so fundamentally important.

If I have a last thought, it is this: do not forget the rural areas, consider experimentation, and do not do it all at once if you are not sure it is going to work. Thank you very much.

The CHAIRMAN. I appreciate that advice.

We would sort of like to have all four of you be ad hoc advisors as we proceed. We need all the expertise we can obtain, and hopefully from people of differing points of view.

I think this has been an excellent panel. I think we are off to a good start. I greatly appreciate your willingness to come and help us, not only today, but in the future. Thank you very much.

[Whereupon, at 12:00 p.m., the hearing was recessed.]

MEDICARE REFORM

(FINANCING—PARTNERSHIP OF TAXPAYERS AND BENEFICIARIES)

WEDNESDAY, MAY 5, 1999

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, Mack, Moynihan, Baucus, Rockefeller, Breaux, Conrad, Graham, Bryan, Kerrey, and Robb.

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

The CHAIRMAN. The committee will please be in order.

The purpose of today's hearing is to examine the financing of the Medicare program. The Congressional Budget Office projects that Medicare spending will reach $440 billion by year 2009. Medicare's share of the total economy will grow by almost a full percentage point, from 2.5 percent of GDP in 1999, to 3.3 percent by 2009.

Medicare financing represents, I guess you could call it, a unique partnership between taxpayers and beneficiaries. Social Security payroll taxes, general revenues, and premiums, and cost-sharing payments by beneficiaries all contribute to the financing of the program. Today, with the help of these distinguished speakers, we will examine those relationships.

Medicare financing presents policymakers with a thorny dilemma: how to provide high-quality care for one generation without creating a crushing financial burden on the next generation.

If Medicare spending rates could be slowed while continuously improving quality, all the stakeholders in Medicare would benefit. How we both improve quality and slow the cost growth rate of Medicare is a major question.

Some experts suggest extending administrative controls over what the program pays providers for specific services. Others suggest enhanced market competition between health plans seeking to keep costs down, while offering high-quality benefits.

In the end, improving quality and slowing the cost growth of a program the size and complexity of Medicare will undoubtedly take every tool the Congress can find in its tool chest.

As we struggle with these questions, we have the benefit of the assistance and expertise of some of the best minds, Pat, in the country, including the distinguished individuals who have joined us today. I want to thank you, Senator Moynihan, for your interest and your help in organizing this hearing.

I would appreciate any comments you may care to make.

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

Senator MOYNIHAN. I think I will just leave it there, sir, with just one further comment on your remark. We keep speaking of the increased cost of health care for the aged as if that were an option that we could exercise, to do it or not. I do not think that is so. Costs are going to increase.

The question is, at what rate? I think we have established over the last few years in this committee, under your leadership, the fact that the rate of increase is not out of control. It is fairly steady.

For every new practice and device that comes along, something that adds to the cost of care, something comes along that reduces it. We had that simple pill, Zantac, and some of its comparable formulations, that cut the number of operations for ulcers in American hospitals by 75 percent in 10 years.

If we have a problem right now, it is that we have too many hospital beds, some would say in some places, and all over. I think probably in Massachusetts, they are finding that we can treat people out of the hospital. This is one of the changes since Medicare began.

I was here when Medicare began. I knew what we thought we knew about medicine. What we mostly thought we knew, is that you just take people into a clean, wholesome environment and see whether they get well, and if they do not get well, bury them. There was not much else.

We were just beginning to get medicines. Penicillin was not scarce, but not abundant. It had just come on the scene. This is a wonderfully exciting time. We find pharmaceuticals clearly playing a role in medical care that they did not in 1965, and we have to adjust to that. We have a lot to learn. I look forward to hearing from our distinguished witness, sir. Thank you for having this hearing.

The CHAIRMAN. Thank you, as I said, for your assistance, Pat.

Do you want to make a statement, briefly, please?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. I will, Mr. Chairman. I want to add my words of thanks to you, Mr. Chairman, for holding this hearing, as I think it is very important. Clearly, we do face a long-term problem, and the long-term problem is, the baby boom generation, of which I am a member, because when our generation starts to retire, we are going to have a dramatic increase in the number of people who are Medicare eligible. That is going to put enormous pressure on the financing system. So, we all know we have got a problem.

We also know that that problem may be less severe than we previously thought. We looked to the re-estimates that have now been

done from 1998 to 2002, pre the Balanced Budget Act. We are down $179 billion from what the projections were for that time period that were previously made.

So, we see the growth has not increased at the rates that were previously anticipated. That is partly because of measures that were taken in the Balanced Budget Act, policy changes that were made there. It is partly because of fraud and abuse initiatives by HCFA. Those things are having a real effect.

My own conclusion from all of this, Mr. Chairman, is that we need, clearly, to reform Medicare. As Senator Moynihan so aptly pointed out, pharmaceuticals now play a role that they did not previously. That has got to be entered into the equation. But, also, I believe we are going to need more resources put into the pot, as we see this dramatic bulge in the population numbers of those who were in the baby boom generation.

I think we are going to have to put more resources into the pot. By that, I do not mean a tax increase, because I do not think that is appropriate. I do not think that is what the American people would support.

So, I think it is going to take a combination of a very serious reform of Medicare. I salute Senator Breaux and the commission for taking a serious stab at that. Then, in addition to that, to put some more resources into the pot.

With that, I want to welcome the Governor as well. We certainly look forward to your testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Kent.

While today our attention is focused on Medicare, we all are aware that it does not operate in a vacuum. Medicare operates in close interaction with the Medicaid program. I think it is pretty obvious that changes to either program can have a profound impact on the other program.

So, we are very fortunate to have with us today Governor Cellucci of Massachusetts, who I think can help us better understand this interaction.

Governor, it is a real pleasure to have you here today. Your full statement will be included as if read. Please proceed.

STATEMENT OF HON. ARGEO PAUL CELLUCCI, GOVERNOR, STATE OF MASSACHUSETTS, BOSTON, MA

Governor CELLUCCI. Thank you very much, Mr. Chairman. Chairman Roth, Senator Moynihan, Senator Conrad, and Senator Robb, I am very pleased to be here today representing the National Governors Association on an issue that is very important in our States, and certainly to our citizens. As policy makers, one of the most important responsibilities we have is to protect and improve the health and welfare of our Nation's citizens.

To this end, the Medicare and Medicaid programs have been tremendously successful. Together, these programs provide health insurance to 1 in 4 Americans, and are responsible for over one-third of the Nation's health care expenditures.

Medicare has given seniors and adults with disabilities access to mainstream medicine and has prevented many individuals from falling into poverty because of their illness or disability.

Moreover, Medicare has given American families assurances that they will not have to bear by themselves the burden of illness of their elderly or disabled parents, or other family members.

Despite Medicare's success, however, the program faces enormous challenges on two fronts. First, the gaps which have always existed in Medicare coverage for preventative care, outpatient prescription drugs, and long-term care are widening. In fact, Medicare now covers only about half of seniors' health care costs.

Second, as you are well aware, Medicare expenditures continue to rise faster than the rate of overall economic growth, and government officials project that Medicare spending will surge over the next quarter century, from 12 percent of Federal expenditures to more than 25 percent.

I am here today because the challenges facing Medicare are as important to Governors as they are to you. I specifically want to address the issue of dual-eligible beneficiaries. These are people who are eligible for Medicare and Medicaid and, in fact, receive assistance from both Medicare and Medicaid.

For many of our low-income beneficiaries, Medicaid fills the gaps in Medicare coverage and provides assistance for Medicare premiums and cost sharing expenses. Medicaid serves not only low-income Medicare beneficiaries, but some higher income individuals as well who turn to Medicaid after exhausting their own resources to pay for their care. The most evident connection between Medicare and the States is for individuals eligible for both programs.

According to the Health Care Financing Administration, 15 percent of Medicare beneficiaries are also eligible for Medicaid. These dually eligible beneficiaries, however, account for 30 percent of all Medicare spending.

Dually eligible beneficiaries are also an expensive population for the Medicaid programs. Although they account for only 16 percent of Medicaid recipients, dual eligibles account for 35 percent of Medicaid expenditures. Together, Medicare and Medicaid spending for dually eligible beneficiaries averages a staggering $20,000 per person per year, and in 1997 totaled over $110 billion.

Our concerns at the State level, first of all, are relative to cost shifting. In the years to come, the same factors that are driving up Medicare spending will place an enormous strain on State Medicaid budgets.

For dually eligible beneficiaries, States are in the unreasonable position of sharing responsibility for providing coverage without any way to affect the policies that govern Medicare and, as a result, are susceptible to tremendous cost shifting from Medicare.

For example, the 1997 Balanced Budget Act has led directly to increases in State spending for Medicare beneficiaries. In my State, the number of home health visits covered by Medicare dropped by 26 percent in the year following the introduction of the interim payment system for home health, Medicare payments decreased $130 million, and 15 agencies went out of business.

More important is the impact on the 10,000 individuals who lost their coverage for Medicare home health as a result of these changes. This was a 15 percent reduction.

These cuts have had direct impact on the demand for Medicaid- and State-funded home care services, which saw a 250 percent in-

crease in the number of clients served. It will cost the State more than $1 million a month to provide extra services that will allow 4,000 seniors to remain in their home.

Other beneficiaries will have to pay out of pocket for their care, and many are expected to go without care. Inevitably, some of these individuals will end up in nursing homes on Medicaid.

Efforts to redirect Federal payments to low-cost areas, as well as reductions in Medicare funding for the graduate medical education, are also putting pressures on State budgets as providers turn to the States to make up for the lower Medicare payments.

Teaching hospitals in Massachusetts and elsewhere have been the vanguard of important medical advances, and they continue to provide an array of specialized services to Medicare beneficiaries.

Any reduction of Federal support for medical education would compromise this important mission at the very time when teaching hospitals must respond to the pressures of an increasingly competitive marketplace and, I believe, will threaten America's superiority in health care.

As States, we view these cuts as the tip of the iceberg and are alarmed at the prospect that more extensive Medicare reform may have many times the impact on State spending that the Balanced Budget Act has had.

You must know that any time you change Medicare it affects Medicaid and other State-funded programs, typically through a combination of unfunded mandates and other forms of cost shifting.

So I ask that, as you embark on this difficult task of reforming Medicaid, I urge that you not do so at the expense of the States. I would also say that cost shifting is not our only concern. An equally severe problem for dually eligible beneficiaries is the lack of coordination among providers and the lack of accountability for health outcomes. There are many personal tragedies that illustrate the human cost of beneficiaries and their families.

Along with my testimony, I am submitting a copy of an article titled, "Saving Medicare: Why Medicaid Must Be Part of the Solution." This article, which highlights many of the problems with the current fee-for-service system, includes a story of an elderly woman who, in her daughter's words, "was bounced around like a ping pong ball" until she finally lost her independence and was confined to a nursing facility.

For the sake of all Americans, we can, and must, do better. More effective coordination of acute and long-term care services must occur if we are to serve our beneficiaries better and to prevent a decline in disability. States are in a strong position to take the lead.

Unfortunately, a number of significant obstacles have arisen to conducting effective coordinated care demonstrations. These obstacles must be removed. I must point out also that, to the extent that we integrate and coordinate these programs, the benefits of community-based services and preventative care and managed care can be applied to these Medicare recipients. That means it will cost less money.

So, in conclusion, let me say that the National Governors Association supports Medicare reform in order to ensure the long-term

solvency of the program, as well as to improve the quality of the program for all beneficiaries.

As reform measures are considered, however, they must be assessed for their impact on dual eligibles and on Medicaid and other State-funded programs. Medicare reform must not create unfunded State mandates or otherwise shift costs to the States.

Also, we need a single, integrated system managed locally. Such reform must also account for the fact that dually eligible beneficiaries, who account for 30 percent of program expenditures, have no incentive to select a health plan based on price because Medicaid programs pay their out-of-pocket costs and for services that are not covered by Medicare.

I thank you again for this opportunity to be part of this hearing, and this very important decision that has to be made for the country. I look forward to responding to any of your questions.

[The prepared statement of Governor Cellucci appears in the appendix.]

The CHAIRMAN. Well, thank you very much for your opening statement, Governor Cellucci. Let me ask you a few questions. Of course, I talked about those that are eligible for assistance under both programs. Let me ask you this. In an April 1999 report, GAO tells us that States are still encountering real difficulties enrolling qualified Medicare beneficiaries, and specified low-income Medicare beneficiaries. Why is this?

Governor CELLUCCI. Well, I think that part of the reason is that there really is a lack of integration and there is a lack of coordination. I think that there would be real benefits to integrating the care.

As I mentioned in my testimony, the case of this elderly senior woman who was, basically, her daughter said, bounced around like a ping pong ball. She lost her independence. The system is confusing and expensive. She ended up in a nursing home, which ends up obviously on Medicaid and is a very expensive form of health care.

So when the care is not coordinated, no one is responsible. We believe that this leads to cost shifting, it leads to shifting responsibility. That is why we believe what is needed is a single, integrated system managed locally.

Then we can better use community-based services, we can use managed care, we can use preventative care, seniors are involved in their care plans, and the quality of care is improved.

I can tell you, in Massachusetts, all of our Medicaid recipients are in managed care except for those who are dually eligible. Because Medicare is fee for service, we cannot put these recipients into a managed care plan.

Prior to us doing this in Massachusetts, we used to call Medicaid a budget buster because it was increasing at 15 to 17 percent per year. Because of the reforms and putting people into managed care systems, it is no longer a budget buster.

In fact, our Medicaid expenditures are growing at about 2 percent per year. Not only are they growing at that low rate of growth, we are actually expanding coverage. We applied for a waiver, received a waiver, to expand Medicaid coverage to low-income families under a program called Mass Health. We have signed up a cou-

ple hundred thousand people in the last 18 months who did not have coverage who now have coverage under the expansion of the Mass Health program.

So managed care, with the preventative care, with the coordination, really has enabled us to control the escalation of costs in our Medicaid program. And I am suggesting that, if we can integrate those who are dually eligible, an integrated program of Medicare and Medicaid, and we can put these recipients into managed care, I think, one, we can save some money, and two, I think they will get better care and they will not be faced with the confusion that they are faced with today.

The CHAIRMAN. Governor, you talk about better coordination of these programs and doing it at the local level. Could you spell out a little more what you have in mind?

Governor CELLUCCI. Well, we would like to take those who are dually eligible and we would like to put them in a managed care program. We did this, as I mentioned, with the rest of our Medicaid population.

I will just give you one example. Those AFDC recipients who, when their child would get sick with a relatively minor illness, would take their child to the emergency room of the local hospital. That is where they got their health care. It was very expensive.

Now that they are in a managed care program, they have a primary care physician that, when the child is not feeling well, they call up the doctor. Sometimes the doctor can tell them over the telephone what medicine they should be taking, or they can go into the office for a visit.

I think we have demonstrated not only in Massachusetts, but around the country, the benefits of managed care. With managed care, you are able to introduce preventative care. These are community-based programs.

Again, we think if we are able to integrate the dual eligibles—Medicare-eligible/Medicaid-eligible—into one of our managed care plans, there will be less confusion, there will be better care, and we can do it at a lower cost.

The CHAIRMAN. Let me ask you a question with respect to prescription drugs. Have you had an opportunity to review the proposal developed by Senator Breaux and Congressman Thomas to subsidize access to drug coverage through the Medicaid program for individuals with incomes up to 135 percent of poverty using 100 percent Federal funding?

Governor CELLUCCI. Yes. I think that prescription benefits are long overdue in the Medicare program. I think Senator Moynihan mentioned in his opening remarks that we are looking at a vastly different health care delivery system.

Drugs are a big part of it and they are obviously an important part of medicine. Seniors and other Medicare beneficiaries are the only group now that is paying the full cost of drugs. They do not get any discounts on price. So, I do believe that Medicare should provide catastrophic coverage. I know this is what the commission recommended.

But, again, I would urge, as you consider this, that there be no cost shifting to the States. In other words, Medicaid should not

bear a new financial responsibility here. But I do think that a combination would be good.

If you would consider this suggestion we have of this integrated system where we can put these recipients who are now in Medicare and getting Medicaid assistance as well and put them into managed care, I think that is one of the ways we can generate the savings that will help us provide this catastrophic health care coverage.

I would say, also, in my State we have stepped up to the plate. With the expansion of Mass Health, we are providing Medicaid coverage to more low-income families. We have also instituted a senior pharmacy program that is providing assistance to senior citizens with the high costs that they have with their prescriptions.

We have submitted, and hope that the legislature will approve, a catastrophic plan for drugs for our senior citizens. Certainly, if it is done at the national level, that will complement what we are doing at the State level.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Well, just to continue on this. Governor, you have been very helpful to us. I am sure you know that. At the risk of driving the Chairman berserk and looking for a nursing home or some refuge, I would like to take up this issue of managed care and its relationship to the medical schools and the teaching hospitals.

What we have seen in managed care, and it came on rather suddenly, was the rationalization of medical provision, costs and institutional arrangements. They have become a market. They have market qualities and some of the risks associated with markets, and so forth. All that has done well in keeping down costs and so forth but has left out a singularly important aspect of our medical system—our medical schools and our teaching hospitals.

You could speak with great confidence about that. You can sit there on that hill in Boston and you look down on half the great institutions in the world. There is increasing trouble.

If I were to look for one institution in the medical delivery system right now, it is the medical schools and those teaching hospitals because they do not fit into a managed care arrangement. They are public goods, as economists would say, and a profit-oriented system will just not provide for them. That is why you have governors.

But you mentioned the problems of the reduction in graduate medical education provisions in Medicare. Surely, if this continues, it is going to end up a problem for the States and States alone, is it not? Is it not the case that we have a problem here, growing by the day?

Governor CELLUCCI. Well, certainly it will be a problem for the State, because, to the extent that we have public medical schools as opposed to private medical schools, that means that the State will have to make up those dollars, if it can. Certainly it is going to have an impact on the private medical schools as well.

But I would suggest, Senator, that it is not just a problem for the States, I think it is a problem for the country. What happens, if, in fact, these medical schools are not able to stay at the vanguard of technology advances, it seems to me that our superiority

in health is threatened. I do not think there is any question that we have the best health care in the world.

I do not think there is any question that it is the medical schools and the research arms of those schools that have driven a lot of the medical advances. In a State like mine, the Department of Public Health put out a report, life expectancy in Massachusetts at the turn of the century was about 49 years. Now it is about 78 years. That is a pretty significant gain in life span for the citizens of Massachusetts and for the citizens of this country.

To the extent that we do not support these medical schools, I suspect that we will not stay on the vanguard. That means the quality of life for our citizens will not be what we all want it to be.

Senator MOYNIHAN. Could I ask you, sir, would you then agree that this needs to be a matter higher on our agenda than it has been?

Governor CELLUCCI. Absolutely.

Senator MOYNIHAN. Thank you very much, Governor. Honored to have you here.

Governor CELLUCCI. Thank you, Senator.

The CHAIRMAN. Next, we will call on Senator Robb.

Senator ROBB. Thank you, Mr. Chairman. Thank you, Governor Cellucci, for being with us. I recall, it was about 18 years ago when I was preparing to put together my first budget as a chief executive officer of the State, and the singular challenge facing us at the time was an outgoing difference between the Medicare dollars that were programmed and the Medicare dollars that were now projected.

We needed $122 million, and at that stage $122 million was still real money. We spent more time trying to resolve that difference, really, than on any other matter in terms of putting a State budget together. So, I appreciate the expertise you bring to this particular equation.

Let me just ask one question, because I see at least two other former governors, who had a chance to practice this from both sides of the table here, have arrived and they have been working on this issue from the federal perspective much longer than I have.

But, as I understand it, your principal recommendation to us is to integrate the dual eligibles into the managed care system, to make them eligible for managed care and not to do any cost shifting to the States.

Is there anything else that you would make in terms of a fundamental recommendation from the State perspective as we consider potential changes to Medicare, Medicaid, or the interaction between the two at this point?

Governor CELLUCCI. Sure. I mean, certainly the whole question of graduate medical education.

Senator ROBB. I am sorry. I was assuming that.

Governor CELLUCCI. For those States like mine that have a lot of medical schools, that is a very important factor, but, as I mentioned to Senator Moynihan, it is important, I think, for the country.

I would also suggest that, in addition to cost shifting in this integrated system, I do think, as I mentioned earlier, that Medicare re-

form has to address this whole question of drugs. This is what I hear all the time from senior citizens in Massachusetts.

Senator ROBB. I think if there is any single element of potential Medicare reform, it is the drug question. The question is, how do we pay for that change, and do we cover everyone, or do we cover those who are least likely to be able to afford them?

Governor CELLUCCI. Well, I think, one, it should be catastrophic coverage. What we found with managed care and Medicaid in Massachusetts is, because we have deductibles, because we have co-pays, that has had the effect of helping us control those costs.

I do think, as I mentioned earlier, that the seniors are the only ones who are basically paying the full price of these drugs. With these dual eligibles, we continue with this fee-for-service reimbursement system.

It seems to me that there is potential for significant savings with integration in allowing the States to use these managed care programs and these preventative care programs. I am not saying that is going to solve totally the problem of, how do you fund the drug coverage, but I think it can provide some significant savings.

I mean, we have seen it in Massachusetts, where our Medicaid budget was a budget buster and today it no longer is. I say the principal reason for that is the ability to use managed care.

Senator ROBB. Thank you, Governor Cellucci. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Robb.

Senator Breaux?

Senator BREAUX. Thank you very much, Mr. Chairman. Thanks once again for this meeting on Medicare.

Governor, thank you very much. It was a very articulate and well-thought-out statement. I take it you gave it on behalf of the NGA.

Governor CELLUCCI. Yes, I did.

Senator BREAUX. There was a lot of thought on some really important points. I am glad you responded to Senator Moynihan's question on graduate medical education. I can assure you that, in all those institutions, that Senator Moynihan has been a champion in protecting that program. I know how important it is in your State, particularly, in Massachusetts.

You raise some really good points on the dual eligibles. I mean, dual eligibles, and I know everybody understands this, are the poorest of the poor who are not paying any premiums, who are not paying any co-payments, they pay no deductibles, and most of them have some drug coverage. But, basically, all of that is coming out of the State Medicaid program.

Governor CELLUCCI. Correct.

Senator BREAUX. So your suggestion is, it is a better and more efficient way to deliver their services through managed care options other than the straight fee-for-service. Is that the essence of what you are telling us?

Governor CELLUCCI. That is it. Yes.

Senator BREAUX. And it is your opinion that, in order to help get these people into a more competitive, market-oriented system you need some legislative changes in order to accomplish that to be able to do it.

Governor CELLUCCI. That is right. The only people in our Medicaid program who are not in managed care programs are the dual eligibles, because we are not able to put them in because Medicare is the primary coverage and it is a fee-for-service system.

Senator BREAUX. And it is your testimony and belief that, if they were able to go into these new types of managed care programs, what benefits would they and the States benefit from? Why is that a good thing?

Governor CELLUCCI. It is a good thing for several reasons. One, I think it would be less confusing. We would get rid of this bouncing ping pong ball problem where responsibility is shifted.

In many instances, the fact that you are treated like a ping pong ball, you lose your independence and you just end up in a nursing home where the care is very expensive, when you might be able to stay in your home with some assistance where the care would be much less expensive.

So I think it is less confusing for the recipient. I do believe it help us control the escalation of Medicare costs, which I think is one of the principal objectives of the reform.

Senator BREAUX. Do you think the quality of services and care that they would receive would be as good or on part with what they get now?

Governor CELLUCCI. I think it would be better. You take out the confusion, you take out the bouncing around, you enable us, with managed care, to do the preventative things and the community-based programs.

We have seen in our State, with the AFDC population, that the quality of care is better now with managed care. You do not have to rush to the emergency room and see a different doctor every time your child gets sick.

You have a primary care physician who is assigned to your family. That has, I think, made a very important and significant improvement in the quality of health care for those AFDC recipients and their children.

Senator BREAUX. I appreciate that answer. The other point I would just ask, briefly. On the QIMBies and SLIMBies, one of the things we found out is a lot of these people are not involved in the programs because they either do not know about it, they have to go to the welfare office to enroll instead of doing it through Social Security, and a lot of them are really hesitant to go to the welfare office to become eligible for and qualified as a Medicare beneficiary, and the specified low income, QIMBies and SLIMBies. There are only about 50 percent that are eligible that are involved in QIMBies and only 20 percent on SLIMBies.

We said in the recommendation that those people at that level would have no premiums under Medicare, and also a prescription drug benefit program paid for entirely by the feds, not putting more burdens on you. What do you think about that?

Governor CELLUCCI. I mean, I think that is moving in the right direction. Again, I understand the question of, how do you pay for it. I think I am suggesting that, to the extent we take these dual eligibles, we can get them into managed care programs and this is integrated. It seems to me that we can help save money for Medicaid, which is 50 percent of State responsibility, but we can also

help save money for Medicare, which is 100 percent federal responsibility.

Senator BREAUX. Well, thank you very much for a very good statement.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Governor, I would like it if you could just give more examples of how States pick up shortcomings in Medicare that is a transfer from Medicare to the States under Medicaid or other ways that States pick up. If you could quantify it and just give a little more detail.

Governor CELLUCCI. Well, obviously, I mentioned in my testimony the reductions in home health. In Massachusetts, we have an Elderly Affairs Secretariat. We provide home care services on a regional basis. We think that this is a good thing to do because, to the extent that people are in their homes, it is where they want to be, they have more independence, and it is less costly.

If these senior citizens end up in nursing homes they lose some independence, and it becomes much more costly because eventually most people who go to the nursing home end up on the Medicaid budget, if not at the outset, certainly during their stay there.

So we have seen that there with the reductions in home health visits under the Medicare program. We have seen a significant increase in the demand for our State-funded home health care services. So that is one example.

A second example, is on the whole question of drug benefits. We did have a State law that required health maintenance organizations to provide unlimited prescription drug coverage to senior citizens who were enrolled.

Inadvertently, the Balanced Budget Act superseded that State law. So, we have just gone through this painful exercise of a lot of seniors who had a drug benefit now no longer get it.

We have worked with these HMOs and they have, on a temporary basis, put in some catastrophic coverage. We are working with the State legislature to expand our senior pharmacy program and to put in place a catastrophic coverage of our own.

Once again, this puts additional burdens on the State as a result of actions that are taken at the federal level. The main thrust of my appearing for the governors today is that this cannot continue to happen because the States are not in a position to handle all of this cost shifting. We are handling some of it, certainly, but if this continues, we do not have the capacity at the State level to pick it up. That is the point.

Senator BAUCUS. What about rural areas? And I mean very rural areas. In my State of Montana, for example, we do not have much managed care. Most of it, by far, is fee for service. So how do we tackle that one?

Governor CELLUCCI. Well, certainly, we have to have flexibility in the law to respond to the different needs of the States. In Massachusetts, we really do not have any areas that are very rural. We certainly have rural areas, but not with the isolation that you have in a big State like yours.

In Massachusetts, we have about 40 percent of our citizens that are in managed care programs. I think it is number one in the

country. We are not a big State, geographically. So, I understand that that is a concern.

But, again, it seems to me that there have to be ways to introduce the concept of responsibility on the beneficiary, whether that is with a deductible, whether that is through a co-payment, and it seems to me that there is more we can do, even in rural areas, in terms of preventative care, some of the things that we are able to do with these managed care programs.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

Senator Chafee has to leave. He just wanted to make a quick comment.

Senator CHAFEE. Yes. Thank you very much, Mr. Chairman. I just wanted to greet Governor Cellucci, from my section of the country where we come from. He is our next-door-neighbor, and we are all very, very proud of what he has done and the leadership he has given to Massachusetts. He has really been outstanding in all respects. So, very glad to see you, Governor.

Governor CELLUCCI. Thank you, Senator. It is good to see you, Senator.

The CHAIRMAN. I might say that pride goes beyond the immediate region. We are delighted to have him.

Senator MOYNIHAN. I would like to join in welcoming my neighbor. [Laughter.]

The CHAIRMAN. No more.

Senator Graham?

Senator GRAHAM. Well, I have three grandchildren who live in Massachusetts, if that helps. I also want to congratulate the governor for the leadership that he has provided, and particularly his very helpful comments today.

Governor CELLUCCI. Thank you.

Senator GRAHAM. Let me ask two or three questions. One, what has been your experience in getting waivers within the Medicaid system in order to be able to do some of the creative things you talked about, such as community care programs for the elderly so that you do not have to excessively institutionalize?

Governor CELLUCCI. Well, we have had success in getting the waivers, but I would say that often it takes a little bit of time. We just had one that was granted that took a couple of years.

It seems to me that, if we have a good idea at the State level and seek a waiver, we should be able to get an answer much quicker than that. In 1994, we did get that waiver to expand our Medicaid coverage to low-income families, and that program has been very successful.

We have basically reduced the uninsured population in Massachusetts from around 700,000 to less than 500,000. I believe we are the only State in the country that has seen a significant reduction in the last couple of years in the uninsured population. So, we have had success in getting the waivers, but in most instances it takes longer than it should.

Senator GRAHAM. How have you integrated your Medicaid program with those persons who were coming off of welfare? One of the concerns of particularly single parent welfare beneficiaries is

that, if they went off welfare, they would lose their children's access to Medicaid.

Governor CELLUCCI. That is one of the advantages of this expansion of our Medicaid program. One, when someone leaves welfare for work-related reasons, which has been the whole thrust of our effort in Massachusetts, as well as the national effort, and we have basically seen our welfare rolls just about cut in half.

Most have left because the income for the family has gone up because someone is working, which is a good thing. It means there is more income and a better standard of living. But we do continue with Medicaid coverage for 1 year. We have significantly increased the number of child care slots.

We found, as we went around the State talking about welfare reform, that what we heard from welfare recipients was, we really do not want to be on welfare, but we are worried about losing health care coverage and we do need day care for our children.

So, we made the continuation of health care coverage and the availability of day care part of our reform. Even after the 1 year of additional Medicaid coverage, with this new program that is available to low-income families, many of those families are then still eligible for that Medicaid coverage.

The other thing we have done, is we have provided some tax incentives for employers to continue to offer health insurance, and particularly for small companies who do not now offer health insurance, to offer it.

The hope is to get more of these people coming off of welfare who get a job to get a job that has health care coverage. But, to the extent that it does not, this expansion of Medicaid to low-income families fills in that gap and means the family continues to have health care coverage.

Senator GRAHAM. Going back to your principal issue, which is the desire to be able to place dual eligible Medicare/Medicaid into managed care, what proportion of your current dual-eligible population has elected to join an HMO?

Governor CELLUCCI. We do not have any.

Senator GRAHAM. I assume that there are opportunities for Medicare beneficiaries in Massachusetts to elect to have their Medicare delivered through a health maintenance organization.

Governor CELLUCCI. Oh, sure. Of those who are not dually eligible, we have a significant number of seniors who are enrolled in HMOs. Yes.

Senator GRAHAM. Why have those who are dually eligible not elected to use the HMO?

Governor CELLUCCI. Well, my understanding is it is because the Medicare is fee for service, and that is the primary coverage. It is just, you cannot integrate fee-for-service primary coverage with a managed care system because they are two different things. That is the point we are making here, is that we think they should be integrated so we are able to make these kinds of programs available.

The other point is, they really have no incentive. If you have fee for service with Medicare and you are eligible for Medicaid, Medicaid picks up all of your costs, all of your drug costs, all of your

costs that are not covered by Medicare. So, there is really no incentive for them to enroll in an HMO.

Senator GRAHAM. Thank you, Governor.

Governor CELLUCCI. Thank you, Senator.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Governor, in that you are representing the entire NGA, that causes me to want to ask a couple of questions, which I will do as quickly as I can.

First, I want to mention what Senator Moynihan was mentioning, and that is about the enormous array of academic health centers and teaching hospitals that you have in Massachusetts, probably second only to New York and California.

You do understand, do you not, that the Medicare Commission, on which I served, completely obliterates the funding for those hospitals in all respects and turns the funding over, $46 billion or a big amount a year, to the appropriations process in the Congress.

Now, there are two groups of Senators who more or less understand something about health care: those that sit on this committee and those that sit on the Labor and Human Resources Committee. Those who sit on the appropriations committee may or may not understand about health care.

But one of the very first things I guarantee you that they will do is to eliminate all physicians who are trained in foreign medical schools. That will impact not only inner New York, inner Boston, but much of my State. Every year, they will make the decision about whether there will be GME, DME, IME, and the rest of it.

What I can almost promise you, with the focus on Social Security and Medicare, is that there will be no all payer system, there will be no trust fund, there will be no guaranteed source of income if we follow what the Medicare Commission came out with. Massachusetts will have an economic and health care reversal the likes of which it has never seen in all of its history. I hope that that is very clear, when you speak for the governors.

Governor CELLUCCI. That is one of the reasons I am here, and I did address that in my remarks, although that was not the topic for today's discussion, as I understood it. I was here to talk about the dual-eligible situation.

Senator ROCKEFELLER. I am here to talk about more.

Governor CELLUCCI. I did take the opportunity to mention that. In fact, I suggested not only will it have an impact on health care in Massachusetts and the economy of Massachusetts, I suggested that it will have an impact on America's superiority in health care on this planet. Because if we are not going to make sure our medical schools, which are at the vanguard of technological advancement, are funded, then we will fall behind and the quality of health care for all Americans will suffer. I am very much aware of that. I have written to the Governors of several States, including New York, California, Texas, Florida, and Illinois where we have these medical schools, because it will have devastating impacts on the economics in those States, and it will have devastating impacts, I believe, on the quality of health care for all Americans.

Senator ROCKEFELLER. Well, the reason I suggest that is—and in your answer there was substantial passion, as there should have

been—what we are really talking about here is the finances of Medicare.

Yes, we are talking about dual eligibles, but it is more than that. We are talking about the clear possibility of legislation being introduced in this committee, passing this committee, passing the Senate, passing the House. The President says he will not sign it. But, on the other hand, are we sure of that, and can one be sure of that?

So the risk that one takes, whether we are discussing dual eligibles or something larger for the Governor of Massachusetts, is absolutely astounding, it seems to me, in this respect.

The second matter I would bring up, is in the Medicare Commission, in its financing, in that beneficiaries would have to pay a good deal more and the so-called premium approach would save relatively little money, about $76 billion. That is a lot of money, but it is not, obviously, in Federal terms.

In that 1 out of 4 people in the year 2025 will be on Medicare, 1 out of 8 today, is the State of Massachusetts, and are the Governors, prepared to take some of the cost shifting that will take effect if people go towards premium support and defined contribution, which are more or less the same thing in my mind?

That is, here is $5,150, go out and find an insurance company and good luck. They will not have good luck, particularly the older and sicker ones, and it will fall upon the States in some way to make this up in their emergency rooms, or however else.

So, I mean, it would be a little bit like if the Federal Government were to suddenly change the formula on Medicaid funding and put a great deal more responsibility on you, would the States and the NGA be prepared to adjust to and accept that increased funding, not only as a general proposition, but would they be able to do it on an equal basis?

Governor CELLUCCI. One of the other points I tried to make here this morning, is that it seems to me that the Federal Government cannot solve the Medicare problem by shifting costs onto the States. There just is not the capacity for the States to handle that.

But I have said, for example, that the monies that the State of Massachusetts—my recommendation to the State legislature—will receive under the tobacco settlement, I have recommended that all of those dollars be dedicated to expansion of health care in our State.

It seems to me that that is a significant amount of money that will be coming to Massachusetts. I have proposed a trust fund so that we do not spend it all, that we spend some of it but we build up the balance so we have this mechanism for many decades to come. I am prepared to dedicate that money to health care expansion.

To some extent, what you suggest is already happening. I mentioned how we have expanded the Medicaid program to low-income families. I mentioned how we instituted a senior pharmacy program to help senior citizens who do not have prescription coverage through Medicare with the cost of their prescriptions. We have expanded home health visits as a result of cut-backs in Medicare.

So, to some extent, the States are already doing what you suggest. But what I am here to say is that you cannot simply reform

Medicare by shifting all of these costs to the States, because the capacity at the State level simply is not there to pick it all up.

Senator ROCKEFELLER. I certainly agree. I would watch this very, very closely.

Governor CELLUCCI. Believe me, I am, Senator.

Senator ROCKEFELLER. Thank you, sir.

The CHAIRMAN. Well, Governor, we appreciate your being here very much today. We would ask that you continue to follow, to the extent you can, our deliberations and give us the advantage of your comments.

Governor CELLUCCI. I will. Thank you very much.

The CHAIRMAN. Thank you very much for being here.

Senator MOYNIHAN. Thank you, Governor.

The CHAIRMAN. It is now my pleasure to call forward Diane Rowland, who is executive vice president of the Kaiser Family Foundation; and H.E. Frech, who is professor of Economics at the University of California, Santa Barbara.

It is, indeed, a pleasure to welcome both of you. Your full statements will be included as if read. Please proceed, Dr. Rowland.

STATEMENT OF DIANE ROWLAND, PH.D., EXECUTIVE VICE PRESIDENT, KAISER FAMILY FOUNDATION, WASHINGTON, DC

Dr. ROWLAND. Thank you, Mr. Chairman and members of the committee. I am Diane Rowland, executive vice president of the Kaiser Family Foundation, and executive director of the Kaiser Commission on Medicaid and the Uninsured.

Today, 1 in 7 Americans receives their health care coverage from Medicare. I will focus in my remarks on these 34 million elderly and 5 million disabled beneficiaries served by the program and the challenges facing the program.

The 39 million Americans covered by Medicare are fundamentally different than our non-elderly privately-insured population. By definition, they are either aged or permanently disabled.

Twelve percent of beneficiaries are under age 65 and disabled, a population often excluded from private insurance; 11 percent are over age 85, suffering from conditions that most private insurance plans would never cover.

Second, the health needs of the population increase with age, meaning that the Medicare population is substantially less healthy than the general population. One in four of the elderly are in fair or poor health, compared to 8 percent of those in the age 25 to 44 group. Nearly one-quarter of Medicare beneficiaries have cognitive impairments, and 1 in 5 have functional impairments leading to long-term care needs.

Medicare beneficiaries also have lower incomes with which to pay for their health care needs. Forty-five percent have incomes below 200 percent of the poverty level, about $15,000 for an individual.

Most live on fixed incomes, with little ability to earn extra income. Two-thirds rely predominantly on Social Security, with an average monthly check of $745 as their major source of income.

Medicare per capita costs are, indeed, higher than those for private insurance, and that is because of the sicker population Medicare covers. Ten percent of all Medicare beneficiaries account for 75 percent of the expenditures.

Medicare spends five times more for those on the program in poor health than it does for those in excellent health: $12,000 versus $2,000. What Medicare spends on those in excellent health is about the same as what we spend under private insurance for the non-elderly population.

Despite the greater health needs of the population, Medicare coverage is also less than comprehensive. It has higher deductibles and cost sharing in private insurance. As we have heard so eloquently today, it lacks prescription drug coverage, and it has no stop-loss protection to cap the maximum amount that someone can have to pay out of pocket for covered services.

As a result, many of the elderly have supplemental insurance to complement their Medicare coverage. One of the greatest fears of our elderly population is that they will be unable to afford medical care and become a burden to their families.

They seek supplemental coverage, not to defeat the market and market forces, but to protect their families from the burden of their medical expenses. Six in 10 Medicare beneficiaries have private supplemental insurance: one-quarter purchase it directly through so-called Medigap plans, and one-third receive it as one of the benefits of their retirement, a retiree health benefit. Nine percent in 1995 enrolled in HMOs for additional protection, and that share is growing.

For the poor and the near-poor, Medicaid, as the Governor has so eloquently pointed out, plays a vital role, with additional benefits, cost sharing, and payment of the Part B premium for 5 million of Medicare's poorest, frailest, and most disabled beneficiaries.

I would note, many of these people are in nursing homes, 1.5 million, and many of them have very limited resources and limited ability to make other choices in life. But I would also point out that there are another 5 million beneficiaries on Medicare who rely solely on the program and have no supplemental coverage, the so-called Medicare-only population.

These individuals are neither wealthy nor healthy. They have tremendous health problems, yet they have to cope with paying for these bills directly out of pocket. They have worse access to care and use fewer services than other Medicare beneficiaries, mostly due to the impediments to their care that financial costs raise.

In the Medicare population, premiums, cost sharing, and lack of prescription drugs take a heavy toll on the budgets of the elderly and disabled. On average, 20 percent of their income goes to out-of-pocket spending, though that is higher for those who are sick.

Prescription drug costs, so important in the treatment options available today, especially for those with chronic illness, are a major contributor, but one-third of Medicare's beneficiaries lack drug coverage and must bear the full cost.

In evaluating the future options for Medicare, it is important to ensure that the protections that Medicare has brought to our elderly and disabled populations are strengthened, not weakened, in the future, and especially that the needs of the most vulnerable Medicare patients that I have talked about today, the low-income, the sick, and the frail, are addressed.

Efforts to reform the program should assure that future generations of elderly Americans have the affordable health care they need. Thank you very much. I would welcome your questions.

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

The CHAIRMAN. Thank you, Dr. Rowland.

We will, first, hear from Dr. Frech.

STATEMENT OF H.E. FRECH III, PH.D., PROFESSOR OF ECONOMICS, UNIVERSITY OF CALIFORNIA, SANTA BARBARA, SANTA BARBARA, CA

Dr. FRECH. My name is Ted Frech. I am a professor of Economics at the University of California, Santa Barbara. I am going to speak, from an economic point of view, in terms of the basic design of the Medicare benefit system.

So, I am going to stress how Medicare interacts with health care markets and not the more macro economic issues, and I am going to focus mostly on traditional fee-for-service Medicare because that is where there are huge neglected potentials for reform and for savings.

Now, in the long run, managed care deserves the attention it gets because eventually I think most Medicare beneficiaries will move into managed care and that will be as good for cost control and good for efficiency as it has been generally. But this movement has been much slower than for the rest of the people in this country, and it is going to be much slower for good economic reasons, and I will return to that in a minute.

But, back to the fee for service basic design. It is a very inefficient design. It was not even state of the art in the 1960's when it was enacted. It was actually copied from early 1960's Blue Cross/Blue Shield insurance which, experience shows now, is a very poor model. So, it was poorly designed from the get-go.

Now, let us think about what a good insurance design should do. It should give good incentives for cost control basically through its structure of co-payments for a fee-for-service system, and it should give good risk spreading, especially for the big risks, the catastrophic risks.

Now, the Medicare design manages to do poorly on both counts. First, in terms of the incentives, there is too little effective co-payment for most people, too little effective co-insurance deductibles and balance billing, mostly because of the private supplemental insurance, which I will get to in a minute. So the incentives are bad, in practice, for most people in Medicare. We just heard that, for the dually enrolled people, the incentives are bad.

Then in terms of risk spreading, Medicare's design is poor for two major reasons. First, the benefit structure is upside down. It covers the small risks better than the big risks.

I will point to the two most glaring problems here. One, is the limits on hospital days, which no modern insurance would have. The second, is the fact that there is no stop loss, so it is completely open ended on what the out-of-pocket responsibilities can be. That is the upside down structure.

The other part that leads to bad risk spreading on the part of Medicare, is that so many services are completely uncovered. As we

heard today, they are important services, and increasingly important services.

Going back to the efficiency issue for cost control, the worst cost control problem is the private supplemental insurance, group and individual Medigap insurance. By filling in deductibles, co-insurance, and even balance bills, in many cases, the supplemental insurance has ruined the basic cost controls that were built into Medicare in the first place.

This has been allowed to grow to enormous proportions. According to the most recent numbers I have seen, 74 percent of Medicare beneficiaries have private supplemental insurance. Another 16 percent are Medicaid cross-over enrollees, which you heard about a minute ago, leaving 90 percent of the population that has had the basic cost controls originally built into the system destroyed. This is the single biggest problem, and it is a huge extra cost to the program.

The Physician Payment Review Commission, in, I think, probably its last official report before it merged, estimated that utilization was increased 28 percent by having private supplemental insurance, on the average. That is about $1,000 per beneficiary, and it totals about 20 percent of the cost of Medicare.

This is a huge subsidy from the Medicare program to the purchase of private supplemental insurance. This subsidy is especially wrong-headed because the insurance that subsidized then destroys the cost controls that were originally put into Medicare.

Further, it has very bad distributional effects. Those getting this huge subsidy, on the whole, are much wealthier than the Medicare-only population. Another bad effect that I think has not gotten enough notice, is that this subsidy, through Medigap insurance, makes fee-for-service coverage artificially attractive.

We actually heard about that a minute ago in the context of the dually enrolled; none of them wanted to opt for an HMO because they have 100 percent coverage with no controls when they are eligible for both. Well, the same principle works for private supplemental insurance.

In my submitted testimony, I have talked about options for fixing that. I will not mention that right now, but will go on to talk about the issue of, if you need to save money in the program, raise the Part B premiums versus raising co-payments at the point of service. I want to stress that the Part B premiums are not a co-payment at the time of service, so there is no good incentive effect from raising the Part B premiums. It is just a plain tax, with nothing particular to recommend it.

Whereas, if you raise co-payments, you improve the incentives for cost control. So if you have to raise a certain amount of money by taking something out of the benefits or the package, I would recommend raising the co-payments rather than raising the Part B premiums.

Then, just very quickly, the reason managed care growth has been so slow in Medicare is we have offered the elderly the wrong kind of managed care. We have offered them tight HMOs, with no benefits for going out of plan.

For older people who have strong relationships with physicians, that is the wrong kind of managed care. We need to offer them a

broader array of managed care, especially preferred provider organizations that let them keep their longstanding relationships with their physicians.

The CHAIRMAN. Thank you, Dr. Frech.

Dr. Rowland, given the information you have collected on beneficiary out-of-pocket costs, can you tell who faces the greatest financial liability, the beneficiaries who stay in the traditional fee for service or those in Medicare+Choice?

Dr. ROWLAND. There is not very much information available today on the out-of-pocket liabilities for those in the Medicare+Choice plans. Although, when we do look at the out-of-pocket spending between fee for service and managed care for the low-income population, you find relatively comparable out-of-pocket payments, although they may get a better benefit package in the managed care plan.

The CHAIRMAN. Now, we know that sometimes a small percentage of beneficiaries have very high costs. You pointed that out in your opening statement. When we hear that average beneficiary costs are about $2,000 a year, what percentage of beneficiaries actually have costs that high, do you have any idea?

Dr. ROWLAND. I am not really sure.

The CHAIRMAN. Let me ask you, Professor Frech. A key question in considering possible reforms is the introduction of some type of a prescription drug benefit. How do other health plans structure their cost sharing for prescription drug coverage, and how might that work for Medicare? What would be your recommendation?

Dr. FRECH. Well, there are many ways they do it. They often have separate deductibles for drugs. Sometimes it is covered by an overall deductible. They often have co-insurance or co-payments. Many of them have restricted formularies, where the drug has to be one that is on the list. Many of them have better coverage for generics. It seems to me, all those tools would be open to Medicare drug prescription coverage.

The CHAIRMAN. Would you have any specific recommendations beyond that?

Dr. FRECH. Well, I am a little bit nervous about formularies. I think I like the other approaches better than the restricted formularies. The evidence I have seen on restricted formularies in Medicaid programs does not seem to be very good.

The CHAIRMAN. Let me ask you this. If the fee-for-service program were to adopt a more state-of-the-art cost sharing design, would the traditional plan be in a position to compete effectively with private health plans in a more competitive environment?

Dr. FRECH. The traditional plan, as it is structured now, you mean?

The CHAIRMAN. Yes.

Dr. FRECH. No. It is a terrible plan. It would not be able to compete with any kind of sensible, private sector plan that would have a unified deductible to cover lots of services and have a stop loss. That would be much superior to the current design which, as I said, was out of date in the 1960's.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Yes, sir. That is a fascinating observation, that we modeled Medicare on Blue Cross/Blue Shield, which was

out of date, as you say, at the time. Could you just elaborate on that? That is an important idea that has not been before us.

Dr. FRECH. Blue Cross/Blue Shield, since they were started, in Blue Cross's case, by the Hospital Association, and in Blue Shield's case, by the medical societies, they were oriented to just paying hospital bills and physician bills.

That is the origin of the core coverage of other services, which were already somewhat important in the 1960's, and obviously have become much more important, and particularly drugs. So that is the historical reason for those being focused on physicians and hospitals.

Also, since they were started by the hospitals and physicians, they were concerned about bad debts and raising demand for their own services, so they traditionally had a very shallow coverage. That is the origin of the limit on hospital days. By the early 1960's, the new commercial plans came in with what was originally called major medical—sort of like the catastrophic idea—and had a completely different approach.

They covered, typically, all services with one over-arching deductible, so it was very integrated. They did not have stop losses in the 1960's very commonly, but by the 1980's that was very common, and certainly it is very common by now. So, even within a strictly fee-for-service world with no managed care aspects, there is a much different structure in terms of risk spreading and services that were covered.

Senator MOYNIHAN. I think that is illuminating, if I may say so, that the hospitals and the doctors, with their general aversion to government involvement, produced a model of the great government involvement.

You have remarked on something here, that predicting the future of costs and such in Social Security is really pretty elemental. It is just counting people and counting amounts of money you get from them, or want to give to them. But Medicare, by contrast, is a much more difficult matter.

How do you mean that? Is it because the future of medical science is not known and not knowable?

Dr. FRECH. There are two reasons why Medicare is much harder to predict than the pension part of Social Security. One, is the technology that you just mentioned, that we may come up with some fantastic cure for poor eyesight or something that is expensive tomorrow, or all kinds of things could happen.

The other is, the future of innovation and how medical care is delivered is also very wide open. We may move in a direction of some structured PPO and HMO plan that controls costs pretty tightly, or it may stay very open ended. That, itself, gives a wide range of uncertainty.

Senator MOYNIHAN. Would you agree, just finally—and this is to the despair of the Chairman who does not disagree—but it is just that he has heard it so often he has to find it disagreeable that, with the onset of a certain rationality, cost rationality and structure that is embodied in HMOs, that the public good of the medical schools and the teaching hospitals just is not provided for in such a system and requires special attention, or else we are going to lose something of utmost value which we have taken for granted.

Dr. FRECH. Yes. As the world gets more competitive, it is not going to be covered through regular insurance mechanisms, which it has been in the past. In the past, it has been kind of cross-subsidized, people paying their regular insurance and regular medical bills. As it gets more competitive, that is not tenable. So it is going to require separate attention, and I think that makes good sense.

Senator MOYNIHAN. The kind of attention that economists—and do not let me tell you, but you tell us—will refer to as a public good that the market will not provide for.

Dr. FRECH. Yes. That is true, particularly on the research side.

Senator MOYNIHAN. Yes.

Dr. FRECH. You get an idea, and it is not appropriable, so it gets used by lots of people. That deserves separate attention.

Senator MOYNIHAN. Yes. Well, I hope we get it. I thank you, Doctor. Thank you, Dr. Rowland.

The CHAIRMAN. Thank you, Senator Moynihan.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman. I am very impressed with our two witnesses, in large part because they have actually got us talking about health-related issues. I have had the sense that so much of our discussion about Medicare begins with an accounting lesson on insolvency, not a happy beginning point.

You have helped remind us that we are fundamentally dealing with an issue of government policy aimed at maintaining the health of a significant part of our population.

Doctor Rowland, you gave some statistics about what is the status of health of the Medicare population. Since Medicare was established, what had been some of the principal changes that affect the health of that population, both in terms of changes that have occurred within the beneficiary population, such as the extended life expectancy after the age of 65, and the changes in the provider community that relate to the potential to serve the needs of that population?

Dr. ROWLAND. We clearly have seen over the history of the Medicare program a marked reduction in disparities and access to care within the elderly population between those who are poor and those who are non-poor, rural and urban residents, and minorities and the white population.

So we have seen tremendous progress with this program in going from, in 1965, one-half of the elderly population had no health insurance at all, to today where the elderly have among the best access to care in the country. They have, as the fee-for-service system has guaranteed in the past, access to the widest range of physicians.

So, unlike the Medicaid program that has always had very bad problems with getting physicians to be willing to participate in the program and had to turn to managed care in order to entice physicians into the Medicaid program, Medicare and its fee-for-service system has always given beneficiaries the widest choice of physician care.

When you talk to the elderly and you talk to the non-elderly population, Medicare, despite all the gaps in its coverage, gets higher ranked as getting choice of plan, satisfaction with the health plan, and satisfaction with the care delivered.

But I think the real progress of Medicare has been that, without it, many of the elderly would have never gained from some of the medical advances that we have had, when you just think about something as simple as cataract surgery and how many elderly Americans today have eyesight because they have had the ability to get their cataract surgery repair.

So I think the major remaining gap in the program continues to be that it does not cover the prescription drugs, which are now becoming, as medical care delivery changes, a much more important part of the Medicare benefit package, if you were looking at how to treat the full range of illness for the elderly population.

Second, Medicare has moved a lot toward covering more home health and in-home services, but we still do not provide, other than through the Medicaid program, for the full range of long-term care needs that many senior citizens have.

So we have seen improved health, improved functioning, and reduced disparities, but we still have some progress to go in making those realities there for all of the elderly and disabled population.

Senator GRAHAM. Dr. Frech, I was interested in your discussion about Medigap and how that has affected the Medicare program. What percentage of Medicare beneficiaries purchase a Medigap policy?

Dr. FRECH. It is about 74 percent, in the latest numbers I have seen.

Senator GRAHAM. And of those Medigap policies, the issues of catastrophic costs, prescription drugs, are they generally covered in the Medigap policies?

Dr. FRECH. Drugs are covered, I believe, about half of the time, or a little more than half of the time. The catastrophic care, particularly the hospital care after the very short limits that are in Medicare, that is typically covered.

Senator GRAHAM. What percentage of the non-Medicare population, which has what you would describe as a modern health care coverage program, also purchase a supplemental policy that would be analogous to Medigap?

Dr. FRECH. It is not unknown, but it is very rare. I have not seen numbers recently, but I would say on the order of 4 percent or something like that. A very small percentage.

Senator GRAHAM. So if Medicare had a structure that was more similar to that which is provided in the private health policies available to the non-Medicare population, would you suggest it would probably have a similar impact of reduction of the number of people who purchased Medigap?

Dr. FRECH. It would go a long way in that direction. Plus, it would be a good thing to do on other grounds, just giving much better coverage.

Dr. ROWLAND. Senator Graham, if I could interject, though. Of those people with what he is terming Medigap coverage, some of those are purchasing it directly, which is about one-quarter of the population, and about one-third are receiving that coverage as a retiree health benefit.

I think there is a clear difference between the policies that are purchased directly in which all of them do not include prescription

drugs, and most retiree benefits, which tend to be more generous and are awarded as a benefit of retirement.

Senator GRAHAM. So I would say from that last observation—and I happen to be one of those people, because I am a retiree from the State of Florida retirement system. I was surprised to find out that, when I get to be 65, I will be eligible for a partial payment of the Medigap policy through my State retirement system.

So one of the issues would be that, if we were to move to an expanded Medicare coverage that was more like a modern health program and therefore reduced the need for 74 percent of the people to have Medigap, we would have to look at the issue of how to integrate those previous decisions, such as my State retirement plan, which had been predicated on the permanent maintenance of the old Medicare system that requires supplemental coverage.

Maybe you could, in some written comments, discuss how we might make that integration of the old thing with a new Medicare expanded policy that would reduce the necessity for Medigap.

The CHAIRMAN. Next, is Senator Kerrey.

Senator KERREY. Thank you very much, Mr. Chairman. I appreciate, as well, the high quality of both witnesses. I would point out at the outset that, in 1997 when this committee was hearing witnesses and trying to decide what we were going to do to finally balance the budget and what we were going to do with Medicare to make a contribution to that effort, we heard many suggestions.

At the end of the day, we were only able to control the increases by giving the providers less. That has been so effective that we are now told that, from 1998 to 2002, that 5-year period, we are going to spend $200 billion less than we anticipated. That will come at the expense of significant deterioration of quality in our teaching hospitals. We will probably be, in Nebraska, closing several additional hospitals as a result.

One of the big debates that is going on right now is, do we loosen that screw a little bit in favor of quality, or do we just spend all that savings on a prescription benefit? I think one has to come into this argument right now and acknowledge that that debate is going on.

I personally favor loosening that screw a bit, because it is not going to do me much good to expand and offer a new prescription benefit if I get a deterioration of quality as a consequence of other things that I had previously done.

Let me say, and I would just ask you both, one of the problems that I have got, in general, with the current lay of the land with a variety of programs that the government has to make people eligible for health care and I am very impressed, Dr. Rowland, as you are, with how Medicare has improved the quality of life. It has increased the health care standing that people who are eligible, either through disability or through an age test.

But one of the things that I am concerned about is the inadequacy of the safety net. We had 6 percent real growth in the last quarter of 1998. We have got 4.5 percent in the first quarter of 1999.

But we are creating another 150,000 per month of Americans who do not have access to health insurance, which means they are going to be less healthy. I mean, there is a direct correlation be-

tween a person's capacity to pay, either themselves or through a third party, and their health status.

So we have a lot of Americans out there who are working that have no legal claim on anybody's income to pay for their health insurance or to pay for their health care spending. It seems to me, as I look at Medicare, even with the good news that we have got of decreased cost, it is still going to double up in 8 years.

When you look at the choices you have to make to get that done, nobody wants to do anything, or a minority want to do anything, other than take more money out from the providers, which I indicated earlier, I think at some point is fool's gold.

I am wrestling in my own mind with an idea that says, perhaps it is time for us to rewrite the contract and change the law, and change the law that governs the way people become eligible.

I am eligible. When I go get a prosthesis made at my prosthetist, every taxpayer in America shares that cost because I am service-connected disabled. That is a pretty high threshold to become eligible. I would not recommend it for most people, but it is how I became eligible.

Medicare people are eligible for payment because the law says, if you reach an age, Medicaid-eligibles, if they promise to stay poor, we will pay the bills. Every government employee and everybody with an income tax deduction—over half of all spending is direct tax expenditures today, and it is growing.

I am just wondering if, in your own thinking, as both citizens and as policy makers, do you think it is time for us to rewrite the contract and say, the way you become eligible, under federal law, is if you are an American or legal resident, and then let us have the debate about whether or not you are going to have a full market system, or socialized medicine, or whatever option you have. It is probably going to be somewhere in between.

But it seems to me, if we are going to have good trade policies, good education policies, and good immigration policies, you cannot have a growing share of people who are in the work force without health insurance. It was fine for me 30 years ago, fine for me even 25 years ago when my babies were born.

I could self-insure the cost of a delivery because it was a relatively low cost. We have got half of the babies in Nebraska being born and paid for by Medicaid just because of the cost of delivering and the risk associated with not being able to get those bills paid.

So I wonder if, in your own thinking, you have evaluated whether or not it is time for us to rewrite this contract, establish under law that eligibility occurs as a result of being an American and legal resident, and then let the debate begin about how we are going to do it rather than continuing with this differentiated system of eligibility that covers one organ, the kidney, and everybody else has to become eligible as a consequence of meeting some other preexisting test that we have established under law.

Dr. ROWLAND. Well, clearly, I think having 43 million Americans without health insurance is really a major problem. When I look at Medicare, we have 40 million people on Medicare, 40 million people on Medicaid, and 40 million uninsured. So, we have three 40 million issues that we are dealing with.

I think any way that one can improve and expand coverage to the American population so that we do not have people going without care is essential and important.

Senator KERREY. The red light is going to flip on here. Let me just ask you to reconsider that answer. The 40 million people under Medicaid and the 40 million people under Medicare are eligible because of a law. It did not happen by accident. The law specifies how you become eligible for those programs.

Congress is not going to come up with a new program to say, you are going to be eligible if you are uninsured. We are going to see a growing number of uninsured people. Then every now and then we will have a new program for kids, where we try to do something about it.

My question is whether or not we should back off this a bit and just rewrite the contract, folding Medicare, Medicaid, the VA, and the income tax deduction into a single program so that you can do life planning, so you can begin to consider what kind of expenditures you want to make.

Dr. FRECH. I think the uninsured is a big problem, a bigger problem than Medicare, in my opinion. But the track record of Medicare in designing such an awkward system and then sticking with it for so long makes me a little bit nervous about just wrapping it all into one, particularly if it ends up having the politics and the political economy that Medicare has had. That does not auger so well.

Senator KERREY. Well, sir, I would tell you, I have 240,000 beneficiaries in Nebraska. They have many complaints about Medicare, but, on balance, they love the program. They are not coming to me and saying, gee, Senator, why don't you get rid of that program because I do not like the way it provides me legal and guaranteed access to be able to get health care.

Dr. FRECH. Sure. It is great for them.

The CHAIRMAN. Senator Bryan.

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

Dr. Frech, a question to you, if I may. I think you just shared with us that 74 percent of Medicare beneficiaries avail themselves of a Medigap policy.

Dr. FRECH. Yes.

Senator BRYAN. You may recall that, some years ago, one of the problems that we faced was in the marketing of those Medigap policies. Our experience in Nevada was that the marketing was so successful, that many beneficiaries were buying two, three, or even four Medigap policies unnecessarily.

The Congressional response was to streamline the options that were available to make them less confusing to Medicare beneficiaries. Can you share with us whether or not we were successful in that objective? Are there abuses? Are people buying more than they need in terms of redundant or duplicative Medigap policies?

Dr. FRECH. My understanding is that, basically, you were successful. There has been a big improvement. There are less redundant policies and there are less policies out there that are really almost worthless. There used to be some like that.

There is a down side of what you did, though.

Senator BRYAN. Please share that with us. We would not want to leave feeling we had done too much good. [Laughter.] Sober us

up with a little bit of what we did that created the unintended consequences.

Dr. FRECH. That is just what I was going to do. One of the things that you did and that was required, was that Part B co-insurance be covered by all of the plans that are allowed to be private Medigap. That is very destructive of cost control. If there would have been anything I would have done, I would have prohibited Part B co-insurance from being covered rather than required it.

So that part was negative. But, on the whole, and particularly in reducing fraud and redundant, silly policies, I think that has really been pretty successful.

Senator BRYAN. We actually had circumstances where I think some beneficiaries had actually like 9 or 10 Medigap policies. They were so frightened that there was some gap that may not be covered, and some entrepreneurial salesman-type said, look, this protects you, and the abuse was quite substantial in our State. I am sure that was reflected across the country.

Dr. Rowland, just kind of a question and an observation. We have heard through a lot of testimony that the Chairman has arranged, through an array of very distinguished and able witnesses, that Medicare, based upon a 1965 private insurance model, is kind of an old system, does not really get the job done, and that prescription costs have risen enormously.

In 1965, it was kind of a marginal, almost a de minimis part of one's health insurance coverage. Today, and I think we all recognize and accept it, the cost of prescription medications are staggering. Many elderly beneficiaries of Medicare take three, four, and five medications that cost hundreds of dollars a month.

I am always struck by the tremendous support that the Medicare population feels towards this program. I think I shared with the committee an experience I had five or six years ago when we were debating a broader health care program, and I was at a senior complex.

A woman got up and was quite impassioned. She said, please, Senator, keep the government out of our health care. I was bold, and perhaps I should not have but I hope I was gentle enough, and said, tell me, are you on Medicare? She said, I am, and I love it. So, the disconnect is so obvious.

What is the great attraction there? I mean, it is clearly a wonderful program. Fewer than half of the people over 65 or older in 1965 had any health insurance at all. So my question does not suggest a denigration of Medicare, but it is almost a mystical feeling that people have about this program. It is just incredible, with all of its shortcomings.

Dr. ROWLAND. Well, I think it is a number of things. I think, one, it is a known quantity that they get at age 65, so that they do not have to worry when they are 63 or 64 whether they are going to have health insurance in another year or two. They get it at age 65 and it is an entitlement, they have it forever.

So it is not like those of us in the work place that are not sure who is going to be insuring our firm next year, whether our firm is going to be offering insurance, or whether we are going to be able to afford it. Most people know that, when they turn 65, they have Medicare and it is there as a benefit.

So, in that way, it is like Social Security to them; it is part of their retirement package and it is part of their ongoing ability to meet their health care needs.

Second, I think there is a huge concern within the elderly population of not being a drain on their children and their grandchildren.

I think Medicare has, for many, been a lifesaver. It has been the program that means, when they need to go to the hospital, they can go to the hospital and they do not have to worry about having a pre-admission deposit, or about whether their insurance is going to cover it or not.

So I think that the program's popularity is because it is providing a basic and very stable means of coverage. Most Americans, I do not think, know a lot about whether it is a fee-for-service, antiquated system or a modern, up-to-date system.

What they want to know is, when they get sick or their family member gets sick, can they go to the doctor they need to go to and can they go to the hospital they need to go to.

That has been a very real part of the Medicare experience for most elderly Americans, and their families all know about it, as we all do as we struggle with our parents to help them through their medical needs.

Senator BRYAN. It is interesting, because we see more criticism back here as witnesses testify about its shortcomings and acknowledge it than you do out there. The biggest criticism that you hear out in the States, I think, oftentimes, is that the difference in terms of the Medicare options that are available in the urban areas than that in the rural. In other words, 60 miles from a major population center, the Medicare choices are much more limited.

Those are people who are focused on, at least in a State like Nevada where driving long distances is not something that is an atypical experience, why can the folks in Fernley not have the same options that the folks in Reno seem to be getting 30 miles away? I thank you very much.

Dr. ROWLAND. We also do a number of public opinion surveys. In all of those surveys, even the non-elderly rank Medicare above private insurance. I think part of that is its basic nature.

Senator BRYAN. Thank you very much.

The CHAIRMAN. Thank you, Senator Bryan.

Next, we have Senator Grassley.

Senator GRASSLEY. I am going to ask just one question and submit two for answer in writing.

Dr. Frech, this comes from your testimony where you discuss the need for drastic and punitive regulation or price controls to be imposed on fee for service. I guess I asked the question because my impression from most of the providers that I meet is that Medicare already imposes a tremendous amount of price controls and regulations. So, explain what you mean by that. I assume you mean in addition to anything we already have.

Dr. FRECH. Actually, in context, what I was saying was that fee-for-service was going to continue to be dominant for many years, unless we had this kind of drastic regulation. I was not calling for it. I was not recommending it. But I was saying, that is what it would take to really, with the current structure and other ways, to

drive people out of fee for service. It would take something really rough. I was not recommending it.

Senator GRASSLEY. All right. Well, then that answers my question. Thank you for the clarification. I will submit a couple of questions for answer in writing.

[The questions appear in the appendix.]

The CHAIRMAN. Senator Mack?

Senator MACK. In the interest of going to the next panel, I will forego my 10-minute opening statement.

The CHAIRMAN. Well, thank you very much. We appreciate your being here.

Senator MOYNIHAN. Very much.

The CHAIRMAN. Your testimony has been very illuminating.

Next, I will call Richard Foster, who is Chief Actuary, Health Care Financing Administration; and the Honorable Dan L. Crippen, who is Director, Congressional Budget Office.

Gentlemen, please proceed. We will start with you, Mr. Foster. Your full statements, of course, will be included as if read.

STATEMENT OF RICHARD FOSTER, FSA, CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. FOSTER. Thank you. Chairman Roth, Senator Moynihan, distinguished members, thank you for inviting me to testify today about the financial outlook for the Medicare program. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the Nation's second-largest social insurance program.

I will briefly summarize the financial outlook for Medicare as presented in the 1999 annual reports of the board of trustees to Congress. My written testimony, as well as the reports themselves, have substantial additional detail.

You all know Medicare has two parts: hospital insurance, Part A, and supplementary medical insurance, Part B. Part A is financed by a portion of the FICA and SECA payroll taxes. In contrast, Part B is financed, about 25 percent, by monthly premiums paid by beneficiaries, with the remaining 75 percent coming from general revenues.

Let us take a brief look at the short-range financial outlook for the hospital insurance trust fund, Part A, of Medicare. We have a chart that shows income to the program, expenditures, and trust fund assets.

During 1993 through 1997, the hospital insurance expenditures were increasing at a faster rate than income to the program. That resulted in deficits in 1995 through 1997 totaling more than $17 billion, and that situation, of course, helped directly lead to the Balanced Budget Act of 1997 to correct the situation.

The Medicare provisions in the Balanced Budget Act substantially slowed the expenditure growth rate during 1998 to 2002, as you can see in the chart. In fact, we ran a surplus in 1998 for the first time in 4 years.

We estimate, under the trustees' intermediate assumptions, that these modest surpluses will continue through about 2005 or 2006, but we would return to deficits thereafter. The assets of the trust fund could cover those deficits, but only through about 2015, before the assets would be depleted.

Now, this represents a significant improvement from the outlook even compared to a year ago, and I would be happy to discuss the reasons for that improvement in the questions.

Let us look at the long-range financial outlook for the hospital insurance program. In the long range, we express tax income to the program as well as expenditures as a percentage of taxable payroll. It is easier to understand that way.

You can see that, in the past, the income rate rose in steps over time as Congress adjusted the payroll tax rates. But notice the minimal growth in income rates for hospital insurance in the future, because the HI payroll tax rate is scheduled in the Social Security Act, and is not scheduled to change at any time in the future under present law.

The cost rates for hospital insurance. You can see the marked reduction, in large part attributable to the Balanced Budget Act. But notice that, after about 2002, the cost rate would then accelerate again and even grow more quickly once the baby boom generation begins to retire, starting in about the year 2010.

Notice also that the cost rate after the baby boom has, shall we say, moved on, does not come back down again. It stays up at the higher level.

Senator MOYNIHAN. Moved on where, sir?

Mr. FOSTER. Passed on. No longer with us, sir. I still have not found a polite way of saying that.

Notice that the gap in the early years between income and outgo is relatively modest and could be addressed without too much difficulty, but by the end of the projection period we had a situation where scheduled taxes would be sufficient to cover only about one-half of projected expenditures.

Let us take a quick look at Part B of Medicare, supplementary medical insurance. Again, we will look at the short range projection, income, expenditures, and assets. It is a lot like what we saw for hospital insurance, but with two notable exceptions.

First, the income and expenditure curves are nearly indistinguishable in the future. That is because, every year, my office reestablishes the monthly premium rate for beneficiaries and the matching general revenue contribution to equal the next year's estimated expenditures. So we refinance the program every year, with the result that it is automatically in financial balance.

The other difference of HI is, we can maintain a much lower level of trust fund assets as a contingency reserve because we refinance every year; less can go wrong in a year than can go wrong in several years.

So what is the problem with Part B? The problem is, basically, that expenditure growth rates remain a concern. Expenditures grew by 41 percent over the last 5 years. That is about 9 percent faster than the economy overall. Now, that is a significant improvement compared to many prior periods, but it is still a significant concern.

Let me conclude by saying that we have clearly had a significant improvement in the financial outlook for both hospital insurance and supplementary medical insurance. However, there is still a substantial financial imbalance for Part A and the rate of growth in expenditures for Part B remains a concern.

I thank you for this opportunity to testify and I pledge the Office of the Actuary's full continuing assistance to the efforts by the administration and the Congress to determine effective solutions to the remaining problems facing Medicare.

Senator MOYNIHAN. Even when we have moved on? [Laughter.]

Mr. FOSTER. As long as I can, sir. As long as I can.

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

The CHAIRMAN. Dr. Crippen?

STATEMENT OF HON. DAN L. CRIPPEN, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. CRIPPEN. Thank you, Mr. Chairman. Senator Moynihan, it is good to have you back, sir. I want to say at the outset that our baseline deals with the next 10 years. That is about as far as we know a lot of detailed cost estimates and other things.

While we do longer-term projections of budget implications, we mostly rely on the good work of Rick and his fellow actuaries when it comes to going out further than 10 years. So most of our analysis is limited to 10 years. When we do more, we rely on Rick and his associates.

Growth in Medicare spending has slowed remarkably in 1998 and 1999. Spending during the first half of the current fiscal year is actually $2.6 billion less than during the comparable six-month period in 1998.

That slowdown is unprecedented and contributes to the favorable near-term outlook for the Federal budget. But we expect the budget to face mounting pressures in the long term from both demographic changes and rising health care costs, as reflected in Rick's report.

The Medicare program (as other witnesses have said today and as you know) pays for the health care of 39 million elderly or disabled people in the United States at the moment. This year, spending for those 39 million will top $200 billion. That amount makes Medicare the second-largest entitlement program, consuming about 12 percent of the Federal budget.

Historically, Medicare spending has grown substantially faster than both the economy and the spending of other major programs. Despite the recent slowdowns—which, as I said, are unprecedented—CBO believes that Medicare spending will continue to increase faster than the resources that finance it.

As we know from painful past history, spending on Medicare benefits grew at double-digit rates during the 1980's. It slowed somewhat during the early 1990's but still rose at an average rate of almost 10 percent a year between 1993 and 1997.

In 1998, however, the growth of Medicare spending did slow sharply, after increasing by more than 8 percent in 1997. Outlays for benefits in 1998 rose by just 1.5 percent. Medicare spending has actually declined, as I said, during the first 6 months of this year.

We believe the slowdown in Medicare spending that began in 1998 is related to three factors. First, the Balanced Budget Act of

1997 reduced payment rates for many Medicare services and restrained the update factors for payments through 2002.

Second, widely publicized efforts to clamp down on fraud and abuse have improved providers' compliance with Medicare payment rules. We have heard from other witnesses about what is euphemistically called reverse creep, or down-coding, in some of the DRG coding and other things.

Third, the average time for processing Medicare claims rose dramatically in 1998. We surmise (although we are not certain) that the increase resulted from two things: the need to make sure that the computers run after midnight of December 31 this year, and the need to program the changes from the Balanced Budget Act into these computers. Thus, the average time for processing claims has stretched out.

As I think I said in earlier testimony here, Mr. Chairman, although it makes sense, it is still surprising to think that a one-week delay in payments actually reduces costs in that year by two full percentage points. It does not take a lot of delay to diminish a lot of Medicare spending. (Obviously, that is a one-time delay.

Those factors notwithstanding, we expect outlays for benefits to grow by more than 8 percent a year over the next decade. If that trend holds, Medicare will consume about 20 percent of the Federal budget by 2009, and, as other witnesses have said, total outlays will almost double.

In future decades, the Federal budget will face mounting pressures as the baby-boom generation begins to draw benefits from both Medicare and Social Security. A larger elderly population will also have growing needs for long-term care, resulting in higher Medicaid spending.

The substantial financial cushion that results from surpluses in the near term will eventually disappear, even if the surpluses are all saved—something we have all commented on before.

The major factors in the rapid expansion of Medicare and Social Security in the coming decades are simply growth and enrollment. Between 2010 and 2030, the elderly population will grow by 3 percent a year, rising from 39 million people to 69 million people. So we have a virtual, or almost virtual, doubling of that population in 20 years. Because of increased longevity, the proportion of the population over age 75 will rise as well.

Medicare costs are likely to grow faster than program enrollment, however. The cost per beneficiary of providing health care services has risen dramatically since the program began in 1965. It is expected to keep growing rapidly. That growth reflects advances in medical technology, as Senator Moynihan said earlier, that will raise health care costs, as well as continued increases in beneficiaries' use of services.

Medicare has not changed appreciably since its creation and remains largely a fee-for-service program, whereas health care for most of the working population has been converted to some type of managed care, frequently with more generous benefits than Medicare currently has.

If Medicare is not reformed, changing demographics and rising health care costs will place greater demands on both the budget and the economy. Currently, Medicare, Medicaid, and Social Secu-

rity together account for about one-third of Federal spending and 8 percent of our total economy (GDP).

By 2030, when the last of the baby boomers will have reached age 65, those programs will account for two-thirds of Federal spending and 15 percent of GDP. The largest area of that growth is Medicare.

The projection for Medicare spending based on the forecast of the Medicare trustees assumes that growth and spending per beneficiary will gradually decline to be more in line with growth and higher earnings, even without a significant policy change.

Consequently, after 2020, Medicare spending is expected to grow as a share of GDP only to the extent that Medicare beneficiaries grow as a share of the population. That is reflected in Rick's report.

That assumption, however, could be unrealistic. If spending per beneficiary does not slow, Medicare's share of GDP will be significantly higher than even the estimates I just gave you.

In conclusion, a great deal of uncertainty surrounds these budget projections beyond the next few years. As I have said in other forums, Mr. Chairman, the longer we project into the future, the less we are doing so on fact and the more on assumption. These conclusions are driven almost entirely by assumptions.

What is clear, however, is that Medicare must prepare for the unprecedented demands that the baby-boom generation will soon impose on it. The Nation should expect to devote more of its income to health care in the coming decades.

The ability to pay for goods and services, including health care services, grows as the economy grows. Policies that enhance economic growth, even those outside the Medicare program, will make it easier to meet the needs of the retired population.

Finally, Mr. Chairman, some people have stated the policy options for Medicare succinctly, but I believe somewhat incompletely, as being only two choices: raising taxes or cutting benefits.

However, at least part of the solution might be found in using medical resources more efficiently. For example, hospitals now use only half of their available beds. Shedding some of that excess capacity could help reduce costs. Similarly, estimates suggest that there are too many physicians in certain fields.

The wide variation in practice patterns across the country suggests room for improvement in either health outcomes or cost. The millions of hospitalizations for ambulatory-sensitive conditions such as diabetes and asthma, which could be prevented with proper care, are clearly a situation in which health could be improved and costs reduced simultaneously.

There are other opportunities to increase the efficiency of the health care system. Rather than belabor the point today, I simply want to state that there is a third way that has the possibility of improving health while reducing costs or providing additional benefits. Moving toward that goal requires adopting proposals to fundamentally restructure the Medicare program. Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you, Dr. Crippen.

Let me ask you, Mr. Foster. Could you give us an idea of the magnitude of fiscal effort necessary to save the Medicare trust fund beyond the year 2020? Could you include in your answer as an example how long the President's proposal to transfer—I think that is something around $690 billion—would have to save the trust fund? How long?

Mr. FOSTER. Certainly. I would be happy to. Let us talk about the President's proposal, first, for just a moment. Under this proposal, specified amounts would be transferred from the general fund to the Treasury to the hospital insurance trust fund in each year, 2000 through 2014. As you mentioned, the total amount is in the ball park of $690 billion.

If this proposal were enacted, we estimate that that would extend the lifetime of the hospital insurance trust fund from 2015 under present law, to 2027 for a gain of about 12 years. So that would be the impact of the President's proposal.

You also asked what it would take, generally, how much in benefit reductions or tax increases, to get through about 2020 for the hospital insurance trust fund. If you start with the trustees' test of what we refer to as short range financial adequacy, the trustees recommend that assets be maintained at the level of annual expenditures, or 100 percent of annual expenditures.

So in the short range, over the next 10 years, if you wanted to keep the HI trust fund assets, or first get them back up to 100 percent and then keep them there through 2008, that would require about a $65 billion reduction in expenditures, or about a $75 billion increase in tax revenues, or some combination. On a relative basis, that is about a 4 percent reduction in expenditures, or about a 5 percent increase in taxes.

Now, what happens thereafter? You said 2020, not 2008. The baby boomers show up. It gets harder. So the amounts required increase steadily in the future as the baby boomers shows up and become beneficiaries.

Through 2014, for example, through the period for which the President's proposal would provide additional revenue, you would have to have, if you did this through additional taxes, an additional $235 billion to stay at this target trust fund level that the trustees recommend. That is about an 8 percent increase compared to present law. If you went through 2020, as in your original question, it would take about $670 billion, which is about a 13 percent increase.

These dollar amounts are fairly hard to interpret over longer periods, so I would recommend you focus more on the 8 percent and the 13 percent.

The CHAIRMAN. Dr. Crippen, do you have any comment?

Dr. CRIPPEN. As I said before, most of our longer-term projections are based on Rick's good work. We do not really do anything on our own beyond the 10-year baseline.

The CHAIRMAN. Let me ask you to comment—and Mr. Foster, feel free to join in as well—on the amount of time we have to make changes to the Medicare program so that its solvency is secured for the baby boom generation.

Dr. CRIPPEN. Well, at least in terms of the demographics, we know that over the next decade the elderly population—and thus

enrollment in Medicare—will only grow by about 1 percent a year. But between 2010 and 2030, it will grow by 3 percent a year. That is when the baby boom will hit in a major way for Social Security and Medicare.

So in some sense you have that long if your goal is to have something fixed before the baby boomers retire. But, as we all know, the longer you wait to do something, the more dramatic the change has to be, particularly in these long-term programs. This is a classic case of the sooner, the better. The longer you wait, the more dramatic the tax increases, the benefit cuts, the changes, the reforms will have to be. Whatever you choose to do, it will have to be more precipitous.

The CHAIRMAN. Mr. Foster, do you have any comment?

Mr. FOSTER. I would agree with that. I would also echo the theme that sooner is better than later. We have the situation now, under the Balanced Budget Act, where the hospital insurance trust fund is running modest surpluses for the next several years. That is quite a turnaround from the situation only a year ago where we expected to run modest deficits. That is what helped extend the trust fund to 2015.

If something bad happens—a recession, health care costs returning to faster growth—it is not unthinkable we could go back to the small deficits and accelerate that depletion date. The trustees' pessimistic projection shows a 2007 depletion date. So, the faster we act, the better.

Also, the faster we act, the more time we have to sort of get everybody involved—providers, beneficiaries, taxpayers—a chance to adjust their expectation, as necessary. Senator Moynihan well remembers the 1983 Social Security amendments where, for example, the increase in the normal retirement age was enacted with 20 years' warning, and then on a very gradual basis thereafter. It is good to give people warning and not to pull the rug out from under them.

The CHAIRMAN. Dr. Crippen, could you discuss, with Medicare, what is sometimes referred to as a taxpayer premium? That is the amount taxpayers pay now to support general revenue transfers to the Part B trust fund and the growth that this premium could experience in the long run?

Dr. CRIPPEN. The Part B premium, as currently structured, is 25 percent of total Part B costs. So its growth depends critically on how much the Part B total, grows on a per capita basis.

Thus, if health care spending and inflation grow faster than the rest of the budget or the economy, you will have premiums increasing faster than other sources of income. Most likely, for the elderly and particularly those on fixed income, the increases would have an even greater impact.

In the Medicare program at large, as the Medicare Commission developed its proposal, tax contributions from current workers cover about 88 percent or 89 percent of program costs, and beneficiaries pay something like 11 percent or 12 percent. That is the current split, roughly, in very gross numbers of how much taxpayers, or current workers, are subsidizing the Medicare program.

The CHAIRMAN. Any comment?

Mr. FOSTER. I do not have anything to add, sir.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Well, Mr. Chairman, this has been important and refreshing testimony. When you do not know the answer, you say so. More often than not, you do know the answer.

I would make a comment to Mr. Foster. We do have a problem. I wish HCFA would tell us more about why there is so little public knowledge about projected changes in these systems, why there is so little confidence. It is just like the Social Security Administration. Why do the majority of non-retired adults think they are not going to get Social Security?

If you tell Americans, I believe, that the age of eligibility for Social Security and Medicare is going to go up to 67 years in another 12 years' time, they will be furious. That information never got out. But I wish the organizations would get more information for us.

I would just say to you, Dr. Crippen, you said that the alternatives of raising taxes or cutting benefits, that there is a third alternate of more efficient use. You mentioned that we now use only about half of our available hospital beds. That is not inefficient use, that is an advance in medicine.

Dr. CRIPPEN. Oh, I agree.

Senator MOYNIHAN. Yes.

Dr. CRIPPEN. But those are also overhead costs that are being carried (not that you could get rid of 50 percent of costs).

Senator MOYNIHAN. But if you were running an automobile plant, you would have gotten rid of the press, or whatever. It is a little harder. You could rent them out, or something.

Dr. CRIPPEN. Indeed. Many hospitals are trying to convert to other forms of services that will be able to use those facilities.

Senator MOYNIHAN. Yes. On the idea that there are too many physicians, particularly specialists currently in practice. I would like to hear some counsel from physicians on this matter. If medical science is going to keep moving, you are going to have more specialists all the time. Can you have too many of something so rare and new? What is the metric for too many? Go and solve that for us, will you, Dr. Crippen? [Laughter.]

Dr. CRIPPEN. Yes. What is the right measure?

Senator MOYNIHAN. Yes. Think about it a bit, will you not?

Dr. CRIPPEN. Yes.

Senator MOYNIHAN. Would you sort of give us something in writing? Do not spend the weekend on it. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Moynihan.

I am going to call Senator Mack. We have a vote, so we may sneak away. Gentlemen, we appreciate your most helpful testimony. Of course, we will continue to call on you.

Senator MACK. Well, possibly before I move on, I might be able to get my question in. And by that, I mean go vote, not the great move on. [Laughter.]

The CHAIRMAN. I was not sure.

Senator MACK. I really only have one question to raise, Dr. Crippen. And Mr. Foster, if you want to comment, that would be fine, too. You report that growth in Medicare spending has slowed, but spending will continue to increase faster than the resources that finance it. The situation we are in today, home health agencies

going out of business, nursing home companies moving towards bankruptcy, teaching hospitals claiming huge losses this year.

Where I am going with this is, what do we need to know, or how do we better predict, before we attempt to either restore the funds or make cuts someplace else, what did we miss the last time? Help me with that. How do we avoid making the mistake we made the last time?

Dr. CRIPPEN. The biggest thing we all missed, I think, is the impact of the very public crackdown on fraud and abuse. Not that there was necessarily rampant fraud and abuse in the system, but that people became much more reticent and careful about what they were coding and how they were coding it. The contractors are doing a better job before they say "this is a clean claim."

We did not anticipate that happening, because we did not necessarily expect it concurrently with the BBA cuts, the Y2K computer reprogramming, and other things. What we had was a confluence of events, not just policy changes, that caused spending to be as low as it is, at least temporarily.

Senator MACK. Let me ask you this question. Do those explanations answer the issue of what is happening to home health agencies and nursing home companies?

Dr. CRIPPEN. Only in part, because some of them reacted somewhat irrationally, if you will, to the new policies and the way they were administered. They did not adapt very quickly.

As I think you will recall, we had growth in home health care of 35 percent one year, and an average of 20 percent over several years. It was clearly an intention of the Congress to reduce that rapid expansion of costs, whether it was a rapid expansion of services or not. You had that effect, so it was a desired outcome in that sense. As a result, you are going to see some capacity go away.

Now, whether it was too much or too little, I do not know. But certainly we think some of these cost reductions are, in a pure outlay sense, going to return quite quickly. Your question suggests that we do not know what the aftermath will be when that happens, but this is a very temporary phenomenon, we are quite certain.

Senator MACK. Mr. Foster, maybe you want to respond to that.

Mr. FOSTER. I would just add, Senator, that you could think of your question in a slightly different way. Let us take ourselves back to 1997 and suppose that at that point in time we knew how the economy would do, we knew that inflation would be low, we knew that we would do the fraud and abuse more effectively.

Suppose we knew all the things we knew today back them. Then the question is, would you have felt like doing something different for the Balanced Budget Act? Could you have done far less, for example?

The answer to that is, basically, no. If you go back to 1997, under the conditions we thought we would have or the conditions that turned out to come true, we had a very serious financing problem for the hospital insurance trust fund. It took fairly substantial solutions to address that problem.

So, even if we knew back then what we know today, we still would have had to have something very much like the Balanced Budget Act in order to keep the hospital insurance trust fund from

going broke in the relatively near future. Could we have done it somewhat less? Maybe a little bit, but not lots.

Senator MACK. Well, I thank you both. Again, there is a vote on and I need to go cast that vote. So, the hearing is adjourned. Thank you very much.

[Whereupon, at 12:17 p.m., the hearing was recessed.]

MEDICARE REFORM

(KEY ISSUES—PREMIUMS, BENEFITS, SUBSIDIES FOR GRADUATE MEDICAL EDUCATION, DISPROPORTIONATE SHARE HOSPITALS, AND RURAL HEALTH CARE INFRASTRUCTURE)

WEDNESDAY, MAY 12, 1999

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

The hearing was convened, pursuant to notice, at 10:08 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, Nickles, Baucus, Rockefeller, Breaux, Conrad, Graham, Bryan, and Kerrey.

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

The CHAIRMAN. The committee will please come to order.

I have an opening statement and then I will be very pleased to call on Senator Baucus. We, I think, will have a vote no later than 10:30, so we want to proceed as rapidly as possible.

Now, the purpose of today's hearing is, of course, to continue our examination of the key differences between Medicare and other public and private health insurance programs.

These comparisons help us form a picture of what will be required to modernize the Medicare program. It is increasingly clear that we face challenges and decisions regarding every facet of the program.

Medicare is a critical program for the well-being and financial security of the Nation's aged and disabled citizens. However, testimony to date suggests that the Medicare program has become excessively centralized and bureaucratic in its management.

The benefit package is simultaneously insufficient in some areas and excessive in others. There are inadequate plan choices for beneficiaries. Finally, there are virtually no structural competitive incentives for cost control, or crucial benefit and quality improvements.

Reforming Medicare involves real ideological differences that cannot be ignored. Despite its importance, this committee must build a consensus on essential and enduring reform.

As we struggle with these questions, we have the benefit and assistance of experts and distinguished individuals who have joined us today. We welcome you and appreciate your being here today.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

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

I want to thank our distinguished panel for their willingness to work hard and prepare for this hearing and give us their thoughts.

In this series of hearings on Medicare reform we have had an opportunity to discuss the history and evolution of Medicare, as well as the changing demographics and health care needs of beneficiaries.

Today, we address aspects of the program related to special payments, support programs that are public goods, such as graduate medical education, health care for the poor, the uninsured, inadequate access to care in rural areas.

Graduate medical education payments have allowed academic health centers to establish residency in fellowship training programs that are second to none. Many of medicine's greatest advances have been developed at academic health centers that rely on GME payments to support their research and patient care missions.

With the number of uninsured Americans now exceeding 43 million, disproportionate share payments have become a critical source of revenue for hospitals and physicians that provide care to the poor and uninsured.

In addition to GME and DSH payments, we will have an opportunity to hear testimony about the needs of rural areas in the Medicare program. I have introduced legislation that addresses these needs, and I am especially looking forward to today's testimony.

As we proceed with the debate on reform proposals, we must remember the importance of the public good programs that are currently supported by the Medicare program. If we believe that these programs are important—and I believe that they are—then we must ensure their viability throughout this reform process.

Just yesterday, I spoke with a constituent who is a chief executive officer of a major hospital in my State. He told alarming stories about the negative impact of the Balanced Budget Act on his hospital. The unexpected consequences of the Balanced Budget Act should serve as a red flag, warning us as we move ahead.

Do we need to ensure the solvency of the Medicare program? Absolutely. Should we consider market strategies to improve the efficiency of health care delivery in Medicare? Of course. Can we afford further unexpected consequences for providers and beneficiaries who rely on GME, DSH, and rural health programs in the current system? I do not believe we can.

Mr. Chairman, I very much hope that today's testimony will allow us to move ahead with appropriate foresight to protect these important programs. I expect that the expertise and insight of our panelists would very much help us.

Thank you.

The CHAIRMAN. Thank you. I would like to proceed with our first panel, because of the lateness of the hour and the interruption we know will come.

On our first panel, we are very pleased to welcome four experts. Dr. Harry P. Cain II, of Blue Cross and Blue Shield; Tony Hammond, of the Institute for Health Policy Solutions; Christine Ferguson of the Rhode Island Department of Human Services. Nice to welcome you back. And Dr. Paul Ginsburg, of the Center for Studying Health System Change.

All of your statements will, of course, be included as if read. We would ask that you keep them to five minutes.

Dr. Cain?

STATEMENT OF HARRY P. CAIN II, PH.D., EXECUTIVE VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION, CHICAGO, IL

Dr. CAIN. Mr. Chairman, thank you. I am Harry Cain. I am personally honored by the invitation to come here and speak. I should emphasize that I am not speaking as an official of the Blue Cross/Blue Shield Association, but rather as a long-term observer of the Washington world.

In my view, this committee has two basic problems in trying to reform Medicare and bring it into the 21st century in a healthy way. One of the problems is philosophical, the other, structural.

The philosophical problem is the one that I discuss in the article that is attached to my testimony. I will say a couple of things about it. If you would turn to the next-to-final page in that article, what you will find is a chart and an exhibit which tries to portray two very different views of the health care world: what I call the public-Kaiser view, and the private-Kaiser view.

Here on the chart, I have chosen a few of the examples in that exhibit just to illustrate the distinction between the two points of view.

I will only make one other comment about it. It is clearly a caricature of two different views of the world. I do not mean, for example, to suggest that public Kaisers are not interested in efficiency and effectiveness, and I do not mean to imply that privatizers are not interested in equity. What I am trying to do, is to highlight the driving motivations for both schools of thought.

Medicare is perhaps the prototypical public-Kaiser program in this government. To change it, to make it more accommodating to the 21st century, is going to run against nearly everything the public-Kaiser philosophy holds dear. So, that philosophical challenge, which probably is not a surprise, is a huge one.

Turning for a moment, now, to the structural problem, what I argue in the testimony is that the decision making process for changing Medicare is a major problem. To try to bring that home, I contrast Medicare and the Federal Employees Health Benefits Program.

It seems to me to be a fair comparison because both programs are authorized by Federal statute, both of them involve the Congress and the executive branch, both of them effectively create entitlements for the beneficiaries served.

But one of them has created a structure, somewhat by accident, that has allowed it to remain very current with what is happening in the health care industry. It is very well-positioned to move into the 21st century.

Medicare, on the other hand, because of its structure—which I certainly do not have to describe to this committee—has an enormous problem coming to the same kinds of conclusions or decisions, and I tried in the testimony to spell out what they are.

So what I argue is, you are going to have to change the structure of Medicare in order to make it the kind of program that you are after, and I wish you well.

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

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

Next, I will call on Mr. Hammond.

STATEMENT OF P. ANTHONY HAMMOND, A.S.A. SENIOR ACTUARY, INSTITUTE FOR HEALTH POLICY SOLUTIONS, WASHINGTON, DC

Mr. HAMMOND. Thank you, Mr. Chairman.

My name is Tony Hammond. I am a senior actuarial fellow with the Institute for Health Policy Solutions. I am also an independent actuarial consultant. I have been chief actuary of Blue Cross/Blue Shield plans and a multi-State HMO, and I was also a vice president of Empire Blue Cross/Blue Shield in charge of individual and small group, including senior care products and child health programs.

My testimony is concerning, mostly, the difference between what private insurers and conventional insurers might offer through their conventional employer-sponsored plans versus what Medicare offers.

Now, if you took a very big perspective and looked down on this from above, you would see that mostly Medicare and most employer-sponsored plans cover pretty much the same benefits. At least 80 percent of what you are looking at is all the same. The difference starts showing up when you look at certain details.

It is those details that, when you start talking to seniors who are switching from their employer-sponsored plan to Medicare, or to Medicare with supplemental, or some Medicare risk plan, it is those details that are going to be surprising to the beneficiaries when they change.

The first, and most obvious, I do not think is any surprise, the lack of a drug benefit under Medicare, but there are other, less obvious, differences. I think you guys have looked at the drug benefit enough that I do not need to go into a whole lot of detail here on what that is.

But I will mention one thing. If you look at most employer-sponsored plans, over 90 percent of employers, whether you are talking about conventional fee-for-service, HMO, or PPO, or any of the other alphabet soup that you are looking at, they all pretty much have drug plans associated with them, certainly far above the majority.

When you then go on to Medicare, when someone switches from their employer plan to Medicare, they then go from a plan that more than likely had drug coverage to one that now, even if you have a supplemental plan, often does not cover the full amount of your benefits and your drug benefits. Even if it does cover some of that, maybe $500, $1,000, with some kind of cost sharing, whatever, for someone who really needs those benefits, that is not much.

The next thing that you might notice, is that for someone who has a conventional fee-for-service plan for someone who has a PPO plan, for someone who is using out-of-network benefits under their point-of-service plan, they generally have combined deductibles.

You have got one deductible, you get your $100, your $250, your $300. Then they might pay 20 percent of any benefits after that deductible is paid. Then they reach a certain limit, and they do not have to pay anything more.

Normally, we call this an out-of-pocket limit. You spend $1,000, you spend $1,500. Generally, that is when people start really going into the hospital and who are really sick that they start reaching those levels. That is the 25 percent of people that incur the 75-80 percent of the cost.

Those are the people that, once they reach that point, then they do not pay anything more. Medicare does not really do that. They have certain limits and, for the most part, your true cost for someone who has a catastrophe is virtually unlimited under Medicare. Obviously, there is a limit. That is just that you can only do so much. But there is not an out-of-pocket limit that says you are going to pay $1,000 and that is it.

Now, when you are talking about how many plans have the co-insurance that I was mentioning, where you provide your deductible and you then have a co-insurance. Over 80 percent of conventional plans and most of the plans that have, like, PPO or the out-of-network portion of a point-of-service, most of them have something that looks like a deductible, and then co-insurance. But, again, they also have these out-of-pocket limits.

Now, some HMOs may have out-of-pocket limits too, but when you are paying $5 every time you go to the doctor, it is going to take you a while to hit a $1,000 limit. So, it really is less above point when you are talking about HMOs.

One other major difference that someone switching from their employer coverage to Medicare coverage might notice, is not all conventional or PPO-type plans may cover 365 days of hospital coverage, but most of them do.

While in some ways this may be more psychological or appearances than reality, when someone sees, wait a minute, my plan covers 90 days and my old plan covered 365 days, what is the difference here? It will be rare, granted, that people might have a period of illness that goes over 90 days such as Medicare covers, but it still happens. When it happens, those are the people that most need their coverage.

So you are looking at Medicare coverage, which now says, well, we will cover 90 days and we have a flat deductible for that. But I used to get 365 days, so we are not quite having the same benefit. Those are probably the major differences. There are some others that are mentioned in my written testimony that you may want to take a look at.

Thank you.

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

The CHAIRMAN. Thank you, Mr. Hammond.

Now, Ms. Ferguson. It is a pleasure to have you here.

STATEMENT OF CHRISTINE C. FERGUSON, DIRECTOR OF THE RHODE ISLAND DEPARTMENT OF HUMAN SERVICES, PROVIDENCE, RI

Ms. FERGUSON. Thank you, Mr. Chairman.

It has been four years since I saw the backs of your heads. [Laughter.]

The CHAIRMAN. My best side.

Ms. FERGUSON. That has given me a very different perspective of the world, one of which is that five minutes up there is a lot slower than 5 minutes down here.

So I am going to hit the highlights of the written testimony and then discuss a little bit more philosophical issue, if I have some time.

At the end of the written testimony that you have from me, you have three recommendations. One, is to reexamine the implementation of the home health care changes in the Balanced Budget amendment.

The reason that we put that in, is because the impact of those changes, at least in our State and I know it is true in others, is that there are home health care agencies that are going out of business.

And, while that may be a good thing or a bad thing, I am not sure which, what is happening is that access for Medicaid beneficiaries who are entitled to home health care services is being cut off at the same time, with no changes in Medicaid.

So there is an interaction there that you need to be alert to and aware of. I would urge you to, at the minimum, repeal the 15 percent cut that goes into effect if HCFA does not come up with the prospective payment system, or the equivalent of a prospective payment system, for home health so at least we can try to stabilize this.

From our perspective, it is costing us money. We are going to have to go in and raise rates and do a series of other things to keep a supply at least at a minimum. Otherwise, we are at something like 70 percent occupancy of nursing homes. That other 30 percent is going to be filled with these folks on Medicaid, not having had anything to do with Medicare. So, it is something that I would urge you to look at.

The second thing is, you have a list of technical revisions to the Social Security Act to streamline programs for the dually eligible. Those are folks who are eligible for both Medicare and Medicaid. I know that Governor Cellucci addressed this in his testimony last week, but I want to reemphasize it.

In Medicare, in 1997, $62 billion, or 30 percent of spending, was spent on elderly individuals who were eligible for both Medicare and Medicaid. That is 30 percent of total spending and 15 percent of the beneficiaries eligible for Medicare.

At the same time, in the Medicaid program, those same people were $58 billion worth of expenditures nationwide, 35 percent of all expenditures in Medicaid, 16 percent of the beneficiaries in Medicaid. That does not count SLMBies, QIMBies, Q–1s, Q–2s, and whatever else you did the last time around.

Because of that, because of the extensive percentages, there are some things that we could be doing on an incremental basis regard-

less of what happens with Medicare reform at the State level to help manage the care and quality outcomes, as well as the cost.

I think that the staff has that, actually. It was done by a coalition of New England States and grantees from the Robert Wood Johnson Foundation, and a couple of other groups. I think staff has that. It has not been officially introduced as a bill.

The third recommendation, is to provide clear HCFA authority to allow States to participate in your recently-enacted Medicare Coordinated Care demonstration projects. What that is, is the same idea. I think you entered into it with the concept of having a private sector HMO or managed care entities performing that work.

We would like to be able to at least go into some sort of a demonstration that would allow a State that was interested in doing both to do the same thing. Because what you will do when you get the HMOs into this mix, is you will then have not only Medicare and Medicaid cost shifting to each other, but you will have the private sector cost shifting to both of those programs.

What ends up happening, is everybody points like this, and the beneficiary is sitting in the middle trying to get the services that they need, and we are all fighting about who is going to pay.

To give you a blatant example, at the risk of sending CBO estimates for your proposals through the roof, what I could do, and actually at one point considered doing, was to take the 30 percent cost folks, the 15 percent of the population on Medicaid that is also eligible for Medicare who do not enroll in HMOs and who HMOs do not seek out because they are more costly, I could aggressively go after all of those folks, enroll them in HMOs, and then assign a case worker to them to ensure that those HMOs were covering every single thing that those folks were entitled to, aggressively, and then managing my care of those folks through the Medicaid program to only cover the gaps.

If we were to do that, it would potentially break the back of the private sector involvement in this program. That is how intertwined the Medicare and Medicaid issues are.

I have a series of examples of some of things in my testimony. From a philosophical perspective, one of the biggest problems, and it is highlighted on this chart, is highest value does not include health outcomes.

When that is included, when you look at it from the perspective of, the highest value is the health outcome, the issue is, can we get Medicare, Medicaid, all of the other programs, all of the committees of jurisdiction, HCFA, OMB, our legislature, and our budget officers to understand that the outcome we are seeking is a better health outcome, better health status, in a cost-effective way?

Because, absent that, we can all do our jobs beautifully and perfectly, fit within all of the requirements that we have to fit within, do everything we are supposed to do, and the end result is, we will have worse health, not improvement, for the beneficiaries, and higher cost. But everybody will have done their job perfectly.

The CHAIRMAN. With not very good results. Thank you, Ms. Ferguson. It is a pleasure to have you back. I do not like your message, but that is all right. [Laughter.] Just kidding.

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

The CHAIRMAN. Dr. Ginsburg?

STATEMENT OF PAUL B. GINSBURG, PH.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, DC

Dr. GINSBURG. Thank you.

My organization, the Center for Studying Health System Change, performs research to inform decision makers about how the organization of health care is changing and its impact on people. It does not make policy recommendation. It is funded entirely by the Robert Wood Johnson Foundation.

When the Medicare program was designed and implemented in the 1960's, many aspects of it were modeled after the leading private insurance plans. But the two have diverged over time. Medicare, which has had the market power to pay providers on the basis of administered prices, developed sophisticated mechanisms to determine payment rates for different classes of providers.

Some elements of the administered pricing systems were oriented towards influencing the delivery of care. For example, the encouragement of shorter hospital stays. These payment policies have been fairly successful, especially in limiting payments per unit of service.

Private insurers, which have had much less market power, developed mechanisms to purchase service competitively through limiting provider panels. Although most payment initiatives have focused on discounts from fee-for-service rates, capitation—paying a fixed amount per enrollee—is being used a substantial amount, especially for primary care physician services.

Private insurers have done much more than Medicare in the use of administrative mechanisms to influence how care is delivered. For example, private insurers routinely require authorization for hospital admissions and for major procedures.

Managed care plans often require enrollees to see a primary care physician for referral to a specialist. None of these tools are used extensively in Medicare. Managed care now is in a period of widespread experimentation with respect to influencing delivery of care.

The most innovative plans identify persons with certain chronic diseases, such as diabetes, and prescribe a regiment of preventive services, education, and self-care. Often referred to as disease managements, these secondary prevention activities have also been applied to asthma and congestive heart failure.

But other plans have not gone beyond the standard utilization control systems that I described before. Medicare has done less in the areas of selective contracting with providers and administrative tools for care management for two key reasons. First, government programs operate according to different rules than private enterprises, limiting flexibility and making changes more slowly.

Second, in many areas of the country, Medicare beneficiaries have few, if any, alternatives to the traditional Medicare program.

The inability of beneficiaries unhappy with administration in this program and unable to go elsewhere if they are unhappy leaves the traditional plan with the responsibility to attempt to meet the needs of all beneficiaries.

Congress can pursue two courses to bring additional care management activities into the Medicare program. One, is to encourage greater enrollment in private health plans. Congress took steps in this direction in 1982, and again in 1997. Proponents of premium support proposals seek to further encourage enrollment in private plans.

The other, is to take steps to make it easier for the traditional Medicare program to incorporate innovations in care managements. The National Academy of Social Insurance panel that I chaired developed a series of recommendations to encourage and facilitate innovation in the traditional Medicare program.

Many on our panel favored private health plans, but were also interested in improving the traditional program because it will serve large numbers of beneficiaries for many years, even under the most optimistic assumptions about the growth in private health plans.

In sum, the Medicare structure has led to valuable innovations in provider payments, but much less in the way of innovations in care management. The program needs to innovate in order to contain costs and to pursue opportunities to improve the quality of care for beneficiaries. Additional enrollments in private plans and more innovation in the traditional Medicare program are both viable options to accomplish this important goal.

Thank you.

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

The CHAIRMAN. Thank you, Dr. Ginsburg.

Incidentally, I know I have several questions and probably will not get an opportunity to ask all of them. So I will keep the record open until 7:00 this evening for those who want to submit written questions, and I would ask that you respond quickly.

Dr. Cain, if we went to the FEHBP model, one of the competitive options would be traditional Medicare run by HCFA. Do you think that is a good idea?

Dr. CAIN. No. It is a very good idea to have fee-for-service options available to the Medicare beneficiaries all over the country. But to have HCFA or any other federal agency run the program, I think, would not be very sensible, for about three reasons.

One, if HCFA ran as it does today and continued with its current regulatory authorities, it would be an unfair competitor. Second, if it were shorn of its authorities, it would be a very poor competitor because it would have the very unwieldy decision process which I describe in my testimony.

But, third, even if you could get by both of those problems, I think HCFA would discover that, in order to remain competitive in the future, it would have to do what private players do, which is to discriminate among hospitals and physicians and to decide that some are preferred and some are not, which private actors do all the time.

But, for a federal agency to get into the business of deciding, who are the good guys and who are the bad guys, I believe, would be an inappropriate federal role. We all want our government to be at least an impartial ruler of the world.

The CHAIRMAN. Thank you, Dr. Cain.

Mr. Hammond, if we should consider a drug benefit for Medicare, are there aspects of the benefit design that could be used to help finance a drug benefit in a cost-efficient manner?

Mr. HAMMOND. Yes. Yes, there are. The first thing you have to keep in mind, is there is a phenomenon called induced demand, which, when you are looking at it directly, means that if I offer a new benefit to someone under an insurance plan, there is going to be more utilization under that benefit than there would be if it was not being paid for by someone else.

There is also an indirect aspect of it, which is that, when I offer a drug benefit, for example, to a plan that did not have it before, I am going to get probably more utilization under the other benefits provided by the plan.

So when you are looking at this, you not only have to do things to account for the increased cost of just adding the drug benefit, but if you do not do things to account for the increased cost in the other benefits, too, the sum is going to exceed the sum of the two pieces.

So you have to actually go further than just cutting the cost for the drug benefit. You have to look at ways to also reduce for induced demand. There are ways to do that. The simplest way would be, I am only going to cover a certain dollar amount. That would limit your costs.

There actually is some drug benefit under Medicare today. It is very slight. It only covers very specific benefits. But you could go in and say, well, certain high-cost drugs, or certain high-cost medical conditions, or things like that, we might cover the drugs for. You can put very high cost sharing.

For example, a $1,000 deductible, or something like that, and only cover half of the cost up to that point, or do not even cover the cost until you get to that point.

So you could, in effect, phase in a drug coverage, so to speak, and see what is going to happen, see what kind of utilization and cost you get because, except for retiree health plans, we do not really have a good idea of what drug utilization and cost is going to be for the elderly population because no one has been covering that or providing full benefits except in some of the retiree populations, which some people could argue is a little bit biased compared to what we would see when you cover the entire population.

But, to answer your question, in short, yes, there are ways to do it. Use some form of cost sharing or some form of limits on the benefit.

The CHAIRMAN. Thank you.

Ms. Ferguson, in an April 1999 report, the GAO tells us that States are still encountering real difficulties enrolling qualified Medicare beneficiaries and specified low-income Medicare beneficiaries. Why is this?

Ms. FERGUSON. I cannot speak nationwide. But I can tell you that, in Rhode Island, one of the things that we see is that the resource test that has to be applied affects abilities of elderly folks to enroll.

It was also one of the things that affected children, not being able to enroll in child health programs in the Medicaid program, was the resource test. A lot of elderly people might have a stash

of $10,000 or $20,000 that they cannot disregard, that is not disregarded in determining eligibility. So, that is one of the problems.

There are probably also some issues regarding applications. We still have an application. It took me 4 years to change our child health application from 28 to 4 pages. We still have an application that asks elderly women if they are pregnant.

The CHAIRMAN. Why can those not be changed faster? Do they have to be approved, or what?

Ms. FERGUSON. No. If you go back and do a review of the literature of all of the management gurus, Drucker, Peter Sengey at MIT, James Champy, all of those folks, what the common theme is, is that you have to have a clear outcome, clear goal, that you are trying to achieve, a clear vision, for those private sector companies that operate well.

Clearly, their first goal is profit. Their second goal, is whatever it takes to make that profit using the company's resources and the service they are trying to provide, TQM, all of those techniques.

The problem is, over the years, Medicare, Medicaid, all of these programs have not articulated clearly what the goals are. So you have some people thinking that the goal of the program is to keep people off.

I think if you went throughout the country, you would find that there are more folks on the budgetary side of the house who would say that the goal is to prevent people from getting on the program.

There are others who would say that the goal is to improve the health status of a particular population, in this case, the elderly. There are others who would say that the goal is to simply contain the costs for those things that we are now eligible for.

So what you have in a bureaucracy at both the federal and State level, are people who have conflicting goals. No attempt has been made to force those folks to look at it from any other perspective than the goal that they think they have. It may be 30 years old.

So one of the things we did in Rhode Island from the beginning was to try to begin to separate out all of these programs by populations served and to focus on what the outcome was. We found that we were actually able to control costs, manage programs, and get better health outcomes all at the same time without any major, major changes.

But it took, as I said, four years to get the application down because, again, going back to all of the management gurus and what works in the private sector, you have to have your line staff on board and they have to understand what the goals are and buy into them.

Until that happens, until they feel secure that they are not going to be punished because they have a quality error or because they have an error on the application with regard to disregards, they are not going to make that change, regardless of what the Governor says, or the director says, or the secretary says, or their supervisor says. The bottom line is, they want to make sure that they are doing their job the way they perceive their job is to be done.

This sounds very simplistic. I was very reluctant to even talk about it here. Having sat behind you, I understand how simplistic this is, and the fact that you want solutions that will make changes right away.

But, if we are trying to replicate what is going on in the private sector in government to some extent, we have to take those management techniques and begin to apply them. You can do that without costing any money, but it takes time. That is usually what we do not have very much of.

The CHAIRMAN. Of course, in Congress, we think four years is fast. Thank you, Ms. Ferguson.

My time is up and there is a vote on. I guess we will have to recess the committee so we can vote in the next 4 years. The committee is in recess.

[Whereupon, at 10:48 a.m., the hearing was recessed.]

AFTER RECESS

The CHAIRMAN. The committee will please be in order.

Dr. Ginsburg, the Bipartisan Commission chairman's proposal provided HCFA with broad, new authority to modernize its operations. However, these broad, new powers were only available within the context of a premium support model, and HCFA would be expected to compete in a premium-based system.

Do you agree or disagree with the linking of new powers for HCFA to participation in a competitive system like premium support?

Dr. GINSBURG. For the most part, I disagree with that. I believe that many of the potential innovations in care management for HCFA and Medicare, I believe, should go on whether we have a premium support system or a continuation of our Medicare+Choice system.

In a sense, if, say, HCFA can engage a contractor in an area to perform disease management for diabetics that volunteer for this system, I do not see that we should hold back on pursuing that because of issues about competition, the nature of competition with private plans.

I think the one exception that I could see is that authorities which are strictly to get lower prices as opposed to innovate or use package prices, I can see some hesitancy about giving HCFA unbridled authority to, say, use a competitive bidding system for a particular service as opposed to contracting for a bundled service, which I would see more of an innovation in care management.

The CHAIRMAN. My time is up. I think, Senator Grassley, you are next.

Senator GRASSLEY. I thank you very much.

My first question is going to be to Dr. Cain. But I wanted to comment just on something Ms. Ferguson said. That is about home health care. You mentioned that, if we do not have a prospective payment system ready by late 2000, there will be a further 15 percent automatic cut. You are right on that.

In order for PPS to be ready, HCFA needs the information from the OASIS survey. The Aging Committee I chair will hold a hearing on the problems that HCFA is having with OASIS. That will be on, I think, May 24.

I hope it will help make sure that PPS is ready on time, because I agree fully with what you said about the necessity of that working or not being able to withstand those further cuts.

I will start with you. Obviously, you gave very thought-provoking testimony, and very few witnesses before this committee get done before their 5 minutes are up like you did.

But, from your written testimony, very thorough. I agree that the Federal Employee Health Benefit Program represents a radically privatized end of the spectrum. I am not sure of that. I think the end of the spectrum was pre-1965, when seniors were on their own.

I would like to describe the federal employee program as really a mix of both approaches. It is true that it does rely upon consumer choice among private plans, but I think the range of choices is pretty narrow, and kept so by the Federal Government. In fact, OPM dictates minimum benefits that plans must provide, and provides enrollees with standardized, comparative information.

My point is, there is a major federal role there and no one is saying that there should be less of a federal role in a reformed Medicare program.

So my question is, is the federal employee plan not already pretty close to being a middle ground between two extremes, and should that not tell us it is worth considering importing at least some of its features into Medicare?

Dr. CAIN. I think so, Senator Grassley. The FEHBP and OPM, the agency that administers it, I would not argue, are perfect by any means. We all could find some ways we would think to improve it. But, compared to Medicare, it has major advantages.

And, as I indicated earlier, because the FEHBP is a federal program, it is not a private program, it does have to grapple with all the same kinds of issues that Medicare does. In my view, it is just set up to handle them more easily. But I think that you could characterize it as a middle ground, which is very worth pursuing.

Senator GRASSLEY. All right.

I would go to Dr. Ginsburg. In your testimony, you refer to Congress' under-investment in the administrative budget of Medicare, the operational costs. I have heard similar comments from other witnesses who have been before this committee.

So I would like to have you comment on how we should determine the budget for the administrative costs of running the Medicare program. In addition, could you comment on how those additional funds would be used?

Dr. GINSBURG. Sure. I think the goal would be to develop a decision making structure in the Congress where the spending for administrative activities was dealt with at the same time as the projected spending for the benefits, so that if there were administrative activities that had the potential to reduce spending on benefits such as by reducing fraud or by achieving more efficient delivery, that in a sense those extra administrative dollars were not competing with NIH grants and could be, say, scored as not costing the government anything because we are saving more in the way of benefit payments than we are spending for administration.

So I think it is linking the two aspects of the program together in one decision making process that is the goal.

Senator GRASSLEY. All right.

Ms. FERGUSON. Senator Grassley?

Senator GRASSLEY. Yes.

Ms. FERGUSON. Can I just add to that? This is a problem at the local level as well, at the Medicaid level. We have a $1 billion—which is small for other States, but for our State is very large—insurance company, basically, that operates on much-reduced administrative costs than the private sector would. An example of where that becomes a problem is, we can go through and look at high utilization of emergency rooms.

If we had the staff, the Medicare program could do something very similar. You could go through the data and look at where high utilization of emergency rooms were on an individual basis, and then go and talk with that beneficiary about why that emergency room use is happening. It has been our experience that frequently it is because their doctor died. When we can hook them up with another primary care doctor, their emergency room visits go down to zero.

So those are the kinds of things that none of us at the State or Federal level are doing right now because all of our work is in verifying, and accounting, and trying to work and do budgets year-round. We do not focus on those other things which are longer term investments, but which pay off in spades in terms of management.

Senator GRASSLEY. I am going to submit one more question for answering in writing, and I would like to have all of you respond to that.

Thank you, sir.

[The question appears in the appendix.]

The CHAIRMAN. Thank you, Senator Grassley.

Next, we have Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I am not really quite sure what I want to ask here. But I had the CEO of an extremely large—I guess I will do this to you, Paul—insurance company in my office the other day, and I had just finished reading what he had posted in the business section about enormous profits, and the reason for those profits. In other words, he was speaking to the business community.

He said, we are able to do this because of a variety of things. He said, we also pulled out of a number of Medicare programs. We pulled out of those plans because they were not profitable. He said, we were also able to—and I forget what the phrasing was—sort of control the costs, or reduce the amount of, or whatever it was, prescription drugs.

Then in our conversation I said, but you are one big insurance company. So there must be, as there are in so many other things, kind of cross-subsidization. He said, no, that is not what we do. Every profit center has to pay for itself. It has to make money on its own.

That raised an interesting question to me in terms of the effects of plans and how they make decisions, and what kind of decisions they are forced to not make. Then I come back, as I always do, to rural America. In our State, I think there are 42 or our 55 countries that are completely unserved by any plan whatsoever.

When I asked him, does this not mean that those counties really have nothing that they can look forward to in the way of managed care—and this is quite beyond the point of the Medicare Commis-

sion wanting to see managed care go from 50 to 75 percent of all beneficiaries by the year 2020, 2025, whatever it is.

So then you can imagine what happens for fee for service, the costs, and what they would have to do to premiums and benefits to survive, if that came about. I do not think that will come about, but it might.

But I would like to get you to reflect, and anybody else, too, to reflect just on the sort of philosophical dilemma of what he put to me. On the one hand, what he said to the business community, profits were up 33 percent over the previous quarter. So, it was pretty hefty. I mean, I would have said it to the business community, too.

On the other hand, part of the reason was that they were cutting off Medicare beneficiaries. I would like to hear sort of the philosophical approach to that that any of you might have.

Dr. GINSBURG. Sure. One thing I can say is, even though we have national companies in health insurance, they do business market by market. A particular company may find that it is in a very good position in some markets relative to its competitors, if it is larger.

In the state the insurance industry has been in in recent years where, on the whole, they have actually done very poorly in the last four years, they have responded to that by withdrawing from the markets that they are not doing well in and they do not see the potential of doing better in the future. Actually, all types of insurance have their own cycles. We call this an underwriting cycle.

Now, the problem in health insurance, though, is it is one thing if a company pulls out of the property and casualty insurance markets in an area because what other companies offer is very similar. But, in health insurance, there is this potential that some of your enrollees are going to have to change physicians and be very disruptive to them.

So, in a sense, it can be overly shortsighted on the part of a company to go in and out of markets, and I think this is a problem for the beneficiaries if there is rapid entry and exit. It just is not consistent with what they want, which is stability.

Now, the other part of your question you are asking about, will private plans ever come to these counties in West Virginia——

Senator ROCKEFELLER. And elsewhere.

Dr. GINSBURG. And elsewhere. I think the main reason that you do not find them there, is that the costs in the Medicare program of the fee-for-service program are very low in those areas, probably because of the very limited medical resources.

Private managed care plans, which have an orientation towards managing care somewhat in the same way in different areas, find that there is probably a much less expensive standard of care being delivered in these rural areas than they are used to providing, so they just do not see an opportunity there.

Senator ROCKEFELLER. But it is a fee-for-service standard of care.

Dr. GINSBURG. That is right.

Senator ROCKEFELLER. So, again, that gets into the balance. If managed care participation increases very substantially and the sicker and the poorer and the older reside more and more in the fee for service, what you are also describing then puts even more pressure on fee for service, does it not, in those rural, non-competi-

tive counties in terms of either premium increases or benefit cuts? It is almost mathematically inevitable, it would seem to me.

Dr. GINSBURG. Well, I think, in the current system, if these rural areas are left with sicker and certainly older people, then the AAPCC will reflect that. If they are left with just sicker people, then the mechanism would not reflect that and that would really limit the prospects of a managed care plan going into those areas.

Senator ROCKEFELLER. Mr. Chairman, I apologize for going over my time.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to talk about a subject that I heard a couple of you talk about while I was watching the discussion on television. That is the fact that Medicare has been a slow-to-change institution in terms of its basic coverage, that we have not moved nearly as far from the mid-1960's models as has the typical private insurance company.

What are the decision making processes within the private insurance sector that has allowed it to stay more contemporary with its patients' needs that might be instructive as to how Medicare could modify its change mechanisms to do likewise?

Dr. GINSBURG. Sure. Well, in private insurance, most of it is employment-based. If employers tell insurers, we want a new benefit and we are willing to pay for it, then insurers scramble to be able to deliver those benefits quickly.

So I think what has evolved in the benefit structure in private insurance over the years is just changing demands by employers. There was no drug coverage in private insurance in the 1960's. Then, when its value became more apparent as drugs became a greater part of medical care spending, the benefits were offered. It cost the companies more to pay this.

In Medicare, the mechanism has been that the benefit structure is set by Congress. Throughout all the years when the Federal budget was in large deficit, it was always, oh, we cannot contemplate this change because it would be too expensive.

Ms. FERGUSON. I think, Senator Graham, also, one of the issues is that the Medicare agency is moving from a fee-for-service mentality, the 1930's Blue Cross/Blue Shield that everybody knew—in Rhode Island, we still know it—to a purchasing mentality.

When you make that shift, you are producing on behalf of a group of beneficiaries. That is very different than in the old fee-for-service world, trying to figure out how to control costs. You are not purchasing on behalf of beneficiaries, you are really trying to control the flow of claims coming in.

That shift is profound. It is the shift that a lot of Medicaid agencies still have not made. It gets to some of the issues that Senator Rockefeller addressed. We tend to think of things in black and white.

If we are going to contract out and buy health insurance for people, then we buy the whole thing. We buy an insurance company taking on the risk that we used to have, as well as the benefit structure for the beneficiaries. We had terrible problems in Rhode

Island initially with Medicaid managed care because we looked at it that way.

What we shifted to was saying, when an actuary comes in and tells us that X benefit is going to cost $1 billion and we do not think our experience in fee-for-service shows that, what we say to them is, we will take back the risk on that piece, but you will still manage it for us. So we are no longer buying risk from them, we are only buying management from them.

What has happened in benefit decision after benefits decision, is that it did not cost anything. When you go into a rural area as a private sector company and your goal is to make a profit, and you are making a profit on the delivery of the benefits, the management of the care, and your ability to manage the risk, those are the things that you are looking at, if you can, as an on-the-ground entity or at the Federal level somehow share some portion of the risk and the rates are adequate, then you have an opportunity to experiment with some things that use some of the private sector management techniques and benefit structure techniques, but do not require them to take a huge risk. Because why should they? Our rates probably are not adequate in a lot of places in the country, including Rhode Island, on the Medicare side.

It does not make any sense for them to get into it. It does not make any sense for them to charge private sector businesses more to cost shift over. But we can work with them to manage risk and manage benefit structures.

We do not tend to look at it that way. We tend to look at it, either you are buying everything or you are buying nothing. You are either buying risk and benefits, or you are buying fee for service, and that is it. There is nothing in between.

But what we are seeing, is that there are some things in between and they are very interesting, and they lead to some really interesting findings that may help your cost estimates in the long run.

Senator GRAHAM. Yes, Doctor?

Dr. CAIN. Senator Graham, the way I would respond to your question, is you do not have to just look at entirely private sector models. That is the advantage of the government employees' program, because it is similarly a publicly organized and run program.

But it has managed to remain very current with industry. Why, or how? I would say it has a lot to do with, what is the decision making role of the Congress and the executive branch in the two programs. In the federal employees' program, the Congress very seldom gets very involved in the kinds of issues that come before the Senate Finance Committee, which turns out to be a huge advantage.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Graham.

I would call, next, on Senator Kerrey, then Senator Bryan.

Senator Kerrey?

Senator KERREY. Thank you, Mr. Chairman.

Christine, I am going to ask you the question since you have been on this side of the bar as well. It is nice to see you back with the committee, at least momentarily.

You heard Mr. Hammond earlier describe the differences between Medicare and private insurance. One of the reasons people

like me are drawn to using an FEHBP and premium support model is those differences: prescription drug coverage, combined hospitalization, and medical deductibles, which is a very important part of the proposal we had, consistent co-insurance policies, explicit out-of-pocket limitations, 90 versus 365 days a year of hospitalization coverage. I mean, you can see why people are drawn to trying to use the FEHBP model.

You have got a lot of experience with the dual eligible, and that is the other end of the spectrum. It is very difficult to make that work in a market environment, just because the substantial cost per patient is there. It is hard to underwrite that if we do not have a large risk pool that reduces the unit cost in some fashion.

What I am wrestling with myself, though, is we seem to have two courses of action that we can take. One, is to try to make the Medicare program better, which I am fully committed to do, especially the problems in rural areas that both Senators Grassley and Rockefeller talked about. Medicare is an enormously important part of the Nebraska health care system, especially in rural communities.

We need to try to improve it, which is probably the course we are going to take in the next few years. We recognize that there is a growing share of taxes that are being used to pay for people's health care anyway.

We already have an individual mandate. I am mandated to pay taxes for somebody else's health care. I do not become eligible unless I meet some special category under law—age, disability, poverty, veteran status, work for the right employer, work for the government—and then I have got a claim, under the law, on other people's incomes to make me eligible.

In my own mind, although I do not have it figured out, by any means. I keep coming back to the idea that we would be better off making every American eligible as a result of being a citizen or a legal resident, putting everybody in the same system, using the premium support model.

I mean, I like the premium support system. That would require some pretty wrenching change in the way we think about health care, but at least we would have an American system. We think of ourselves as part of an American system.

But every time I think about this, I worry about the potential impact upon the lower income and sicker citizens. I am wondering if you can give me your own thoughts about whether or not that kind of thinking could be done in a way that would work for the dual-eligible population.

Ms. FERGUSON. Well, I think that one of the issues is the premise that low-income, sick people are too costly. I know that that sounds like what you are talking about. But when we went into Medicaid managed care—oh. Sorry.

Senator KERREY. You do not need to apologize. I am the one that is interrupting you. But we have six million dual eligible, and they cost about $110 billion a year.

Ms. FERGUSON. Right.

Senator KERREY. That is where I come up with, from where I sit, it looks expensive.

Ms. FERGUSON. It is expensive because it is not managed. When I say managed, I do not mean managed from a cost perspective, I mean, managed from a health perspective. I used to think this when we were having all of our very interesting discussions about health reform the last time around. But I could not prove it, and CBO certainly did not believe it.

What we have done in Rhode Island, is to test out a whole series of premises that we used in health reform, medical necessity definitions, the cost of poor people versus the cost of commercial people. We have gone through and tested a lot of that stuff out.

What we are finding is, it is not that expensive, it is not more expensive, and, in fact, the longer they are in, the better health status they have. They do not have children unless they are ready to have children. There is a whole series of things, which I will send you.

But if you take that experience and you move back to the dual eligible experience and you look at some of the examples that I gave in the written testimony, what we have, is two systems—three, when you start to include the Medicare HMOs—all maximizing the reimbursement streams.

The reimbursement streams do not talk to each other, so we end up spending a whole lot of money on people who, number one, do not want it spent on them. They want their care managed and integrated in a way that they cannot manage themselves with all of those three entities involved.

So, even though it looks like it would be an expensive proposition, in fact, I think what you would find is that you could actually reduce costs substantially if you combined the management, not all of the funding streams. You do not even have to do that.

What we are thinking about doing in Rhode Island, is attaching a case manager with each of the dual eligibles, which is, after all, 30 percent of our case load—if I had the staff, I would do it right away—and having that person work with them on the funding streams, and then also have a medical case manager that might be a primary care doctor, or it might be somebody we contract out with who would work with them on the medical side.

My premise is that the end result of that is going to be that the continuum of care will be better used, we will not be so focused on the institutional side, whether it is nursing homes or hospitals.

Today, when you make a cut in Medicare and you save money in Medicare, we end up paying it at the State level in Medicaid, and so do you. Those cost interactions do not get reflected in the budget directly, and they often do not get reflected in your cost estimates.

But when you go back and you look at the rates of inflation in Medicaid and you actually track the data—which, by the way, we tried to get the Medicare data so that we could do a cross match with Medicaid. One of the things that happened in the midst of that was that the administration thought that it had to change the way it did business, so that that particular portion of HCFA would have to earn money. So we were not able to get the data right away. But when you look at that data cross match, that is where all the money is, and the care can be managed much more effectively than it is.

I am sorry, Mr. Chairman.

The CHAIRMAN. We are running out of time, so I would ask everyone to be as brief as they can in their questions and answers. We will have, as I mentioned earlier, written questions as well.

Now we have Senator Bryan, then Senator Baucus and Senator Chafee.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Cain, I would like to ask your view of the degree to which, in rural areas, there is a way to provide for competition and choice of plans. As you may know, recently in the last several months, 120 rural counties have discontinued managed care plans. It just did not work. That affected about 56,000 beneficiaries, and I think there were 15,000 with just no option whatsoever.

How do we do it? Is there a way to have competition and choice of plans in rural areas?

Dr. CAIN. Senator Baucus, that clearly is not a simple question. I would make a couple of comments on it. One, is in my view, the Medicare problem that we have had recently, HMOs pulling out of many places, can be traced back very heavily to the way the Medicare HMOs are paid.

If you stand back from it very far, it does not make a lot of sense. Individual companies figure out whether or not they can survive in some areas, and often decide they cannot. So, I would argue that you have to come at the way Medicare pays for managed care in rural areas.

The other thing to offer, however, is it is very hard to establish managed care in rural areas.

Senator BAUCUS. Risk pools are so small, for one thing.

Dr. CAIN. Interestingly enough, the Federal Employees Health Program solves that problem by making available at least five or six choices to everybody in the country, including many hundreds of thousands in rural areas. The choices available are not heavily managed care plans, but those people do have many choices and the care provided tends to hold up pretty well.

Senator BAUCUS. So does that mean the only solution is a national plan?

Dr. CAIN. Again, I would not have one of anything. I would have choices.

Senator BAUCUS. But the question is how you provide for those choices. As I have mentioned, 120 counties in the last several months have discontinued managed care plans. They just did not work. They were too expensive, inadequate coverage. That is the main problem that a lot of us in rural parts of America have with the movement toward management care. Also, low reimbursement rates for managed care Medicare patients.

Dr. CAIN. Well, if Medicare were going to offer fee-for-service options all over the country and put out an RFP to the private sector and had several demands in it, one of the demands would be that you have to be able to provide care across the country, including in every rural area. It is feasible to do that. I just would not choose only one carrier to provide those services.

Senator BAUCUS. Do you think that requirement would be advisable and appropriate?

Dr. CAIN. Sure.

Senator BAUCUS. Dr. Ginsburg?

Dr. GINSBURG. I think that, in rural areas, we have to talk about the potential of managed care to deliver care in a very different way from fee for service. I mean, I think one way to go would be to provide Medicare with the authority and wherewithal to introduce some of the innovations in care management that are appropriate for rural areas that can work without a lot of competition. I think the other way to do it, is to—I am not sure. I have a lot of concerns about a competition between a national plan and locally-based plans.

My sense of the Federal Employees Health Benefit Program is that we have distortions there, that we find in expensive cities, for health care, that there is a disproportionate number of federal employees in the national plan because it is rated based on the average in the whole country.

In the lower-cost areas, you have a disproportionate number in local managed care plans. I am not sure whether we would be happy with that phenomenon in the Medicare program. It is something we would have to think through. We are moving slightly in that way.

In 1982, when Medicare set up its risk contracting with HMOs, the payment for HMOs was based on the Medicare fee-for-service experience in the county, actually. We are moving away from that, I think, to the benefit of rural areas. I can see some real distortions in the market, having a national plan competing with locally-rated plans.

Senator BAUCUS. Thank you very much. Appreciate it.

The CHAIRMAN. Senator Chafee, and then Senator Breaux.

Senator CHAFEE. Thank you, Mr. Chairman.

Ms. Ferguson, why is it that the Medicaid beneficiaries would suffer from the fallout of the reduced access to home health services?

Ms. FERGUSON. Because home health care had been primarily paid for by Medicare and Medicaid, and some private-pay as well.

Senator CHAFEE. Now, I understand that we cut Medicare under the BBA.

Ms. FERGUSON. A home health agency basically uses all of those funding streams to support each patient that they have. So, you basically have cost shifting going on between funding streams. So when you yank one funding stream, not only cut it but also limit the ability of a beneficiary to access it, you did two things: you cut back on what the benefit looked like and you cut back on the rates.

So the combination of those two things is that, for a company that is operating, say, in the southern part of the State or the northern part of the State, you have got a group that is funded by all of those funding streams. Now, a quarter of the funding gets cut, and they are no longer able to provide the visits under Medicare, and Medicaid ends up coming in and taking up the slack.

Senator CHAFEE. Now, you said something about, there is a 30-percent vacancy in your nursing homes, if I understood it correctly.

Ms. FERGUSON. It is something in that neighborhood.

Senator CHAFEE. Are you suggesting that, as a result of inability to get home health care, that they are going into the nursing homes?

Ms. FERGUSON. Absolutely.

Senator CHAFEE. Well, that is a loser.

Ms. FERGUSON. On an anecdotal basis, we know that that is happening.

Senator CHAFEE. Well, now, the difference in cost is substantial.

Ms. FERGUSON. Substantial.

Senator CHAFEE. So, truly, it is a loser, this cutback in the home health care benefit.

Ms. FERGUSON. Absolutely. I think you will see that reflected over the course of the next couple of years in the rate of increase in Medicaid.

Now, those States that do not have as many nursing home beds, that is not going to happen because there is no available placement. There, I think you are going to see some increased hospitalization, which we are also seeing: dehydration, diabetics not under control, a whole series of reasons for that.

Senator CHAFEE. Then on top of all this comes, as I understand it, what, a 15-percent additional cut?

Ms. FERGUSON. Yes. My understanding is that people do not really believe that HCFA is going to be able to come up with an adequate payment methodology by the time frame that they have placed on themselves, or you have placed on them. The 15-percent cut is probably going to go into effect.

Senator CHAFEE. Wow. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman, for continuing these hearings, which are most important, and for the panel's testimony and their assistance.

We have this huge problem with this wonderful system that we have, in the sense that we found out in the commission that Medicare only covers about 53 percent of the cost of an average senior, and means 47 percent is not covered. The average senior under this program spends over $2,000 a year out of pocket to buy things that Medicare does not cover.

The trustees tell us that, in addition, if no changes are made, that the premiums that beneficiaries pay under the current system are going to double by the year 2007. If that is not bad news enough, it is all going broke by the year 2015.

So for those who sit around and discuss why we should not do anything, it is not a reasonable alternative. To do nothing is to invite total chaos and disaster for a system that serves 40 million Americans. So, I certainly appreciate your recommendations and your suggestions.

I am sorry my good friend, Jay Rockefeller, is not here because we have engaged in these discussions for a year.

But I would like to ask Dr. Cain. One of the criticisms of what the commission recommended in the premium support model was that, well, it is a voucher system. If there is any criticism you could make against what we reported, it is not that.

I mean, what we did was based how we pay on this new proposal on what the Federal Employees Health Benefit Program pays, which is 75 percent of the cost of the plan. The federal employee picks the plan. The government pays 75 percent and the person pays 25 percent. We suggested that, under our proposal, that the Federal Government would pay 88 percent and the beneficiary 12 percent, which is about the ratio we have now.

Can you give me any kind of a comment as to whether what we had recommended in any way constitutes a voucher?

Dr. CAIN. Senator Breaux, I do not know how one would define a voucher. I think what you have just described is essentially accurate. In the federal employees' program, the government will pay up to 75 percent, depending on the plan chosen.

Senator BREAUX. I think it is about 72 percent, on average, is what they pay.

Dr. CAIN. That is a very important feature. It really improves consumer behavior.

But, unless one would define what the federal employees have as a voucher, I do not believe that the same would apply here.

Senator BREAUX. All right. I agree. I mean, it is not a voucher. A voucher is when you give a person X amount of money and say, go buy a health plan. I mean, good luck. That is not what we recommend by any stretch of the imagination.

Let me ask Mr. Hammond. You had a typical employer-sponsored health insurance plan and had a number of cost sharing features in a typical plan. We had recommended in the commission a combined deductible of $400 instead of the $100 deductible for Part B, and the $768 current deductible for the hospital Part A, and also a 10-percent co-insurance for home health care and lab services, and also stop-loss plans so no one would have to pay more than a certain amount in a year.

There are other things that you could add to sort of rationalize cost sharing for the beneficiaries in a fee-for-service plan. What do you think about some of these suggested changes that we had as far as cost sharing?

Mr. HAMMOND. I think it is totally consistent with what I said before about putting on an out-of-pocket limit, putting on some of the cost sharing, particularly the aggregate deductible that goes across.

I often hear it described as, you have got a balloon here, and wherever you start pushing on it, it is going to pop out somewhere else.

The only way you can really deflate the balloon is to put on some kind of cost sharing provisions. It does not mean those costs are not incurred, it means that the beneficiaries themselves would end up paying for them.

But what it does do, is it gets at the fee-for-service side of controlling utilization. The purpose of having any cost sharing benefit is to avoid the low medical cost/high administrative cost services from running through your insurance program.

And, to the extent that you can do that, some higher cost sharing up front with a cap on it later on will help control costs. So that, if I have to go to the doctor, and I know I have got to pay $50 if I take my kid to the doctor, I am not going to be running in there

if they have just got a cold. If they have got a fever, maybe I will go. But if I only pay $5 every time I go in, then I am going to start acting differently.

Senator BREAUX. Let me ask one final question. I am concerned that the administration, in developing their recommendation on Medicare—and anybody can take a shot at this—is going to come back with—hopefully not—what I would suggest is same old, same old.

In mean, in the sense that we are all guilty of this. We fixed Medicare in BBA 1997 by cutting providers' reimbursements. Then the next year we came back and put the money back in. The next year, we make more cuts. Then the next year, we come and put money back in. This is the year we are putting it back in from last year, while at the same time the administration is proposing $20 billion more of provider cuts to Medicare programs which affect beneficiaries.

So it is a cycle. You can just write it out. You know what is going to happen: 1 year we cut, the next year we put it back because of all of the complaints. The next year we cut again, and the next year we get all the complaints and we put a little bit of it back. It is a vicious cycle that is leading us off of a cliff.

My question is not that. My concern is about the administration coming back saying, well, let us just do some more demonstration programs. That is what Congress does when we do not want to bite the bullet; let us think about it, let us have a few demonstration programs.

If you look at what has happened to demonstration programs, in places like Baltimore it failed, in Denver it failed, it is not doing well in Phoenix and Kansas City and is going to fail there, too. It fails because nobody wants it in their backyard. It is the NIMBY symbol: not in my backyard.

Can demonstration programs be made to work? Their history is nothing but failure. If we come back with more demonstration programs, I will tell you what is going to happen: it is not going to work. We are going to come back, and the next Congress is going to be debating the same thing this Congress debated.

Any comments on why demonstration programs have had such a history of failure?

Dr. GINSBURG. I think, Senator, you have really explained the reason.

Senator BREAUX. You do not disagree with me. I thought so.

Dr. GINSBURG. It is actually one thing to have a demonstration. Some of the successful demonstrations are when an organization approaches HCFA or the government and says, we would like to try something and it looks like it has possibilities, so everyone wins. But the most important demonstrations for policy change have to involve the home markets. There, they are going to be losers, and you really pointed out why it does not happen.

My perspective, from watching this for many years, is that policy moves forward when we enact legislation and take chances and fix it later, and perhaps phase it in slowly. It is not the best way to do the job, but it seems to be the only one that works.

Mr. HAMMOND. Could I add a brief comment to that?

Senator BREAUX. Yes.

Mr. HAMMOND. This is exactly the reason why health insurance companies and other insurance companies hire actuaries, because they cannot afford to go out with a product in one little area, or another area. So they basically hire us to tell them what is going to happen when you do something. You go out, and then you have to live with it for a while.

Ms. FERGUSON. And I would simply add that you probably want to think about doing a combination, because I think that Dr. Ginsburg is correct. In those places where they come to HCFA and say, we think we have got something that would work, it is worth investing in.

I will tell you that the dual eligible project, as well as if you took a city State like Rhode Island and tried to do some of this where we have laid some of the ground work, I think you would have the possibility of proving a lot.

There are some demonstration projects that have led to significant change. In our case, Medicaid managed care has been a boon for our populations. That is not true in other places, but what we have done has been extraordinary.

Senator BREAUX. Under Medicare+Choice?

Ms. FERGUSON. No, on the Medicaid side. We can do the same kind of thing with Medicare if there is a linkage between Medicaid and Medicare because of the way that the population demographics are in our State.

Senator BREAUX. Thank you.

The CHAIRMAN. I want to thank the panel for their participation. It has been excellent. We will probably have a number of written questions. In any event, we will continue to consult with you. Thank you very much.

It is now my pleasure to welcome the witnesses for our second panel. The first, will be Murray M. Ross, doctor of philosophy. Dr. Ross is the executive director of the Medicare Payment Advisory Commission here in Washington.

He will be followed by Dr. Keith Mueller, the director of the Nebraska Center for Rural Health Research at the University of Nebraska.

Then Dr. John W. Rowe, the president and CEO of the Mt. Sinai-New York University Medical Center and Health System in New York City, will testify.

Then we will conclude with the testimony of Dr. David Blumenthal, the executive director of the Commonwealth Fund Task Force on Academic Health Centers, and the director of the Institute for Health Policy at Massachusetts General Hospital in Boston.

Gentlemen, it is a pleasure to welcome you. I would ask you to limit your testimony to 5 minutes. Your full statement will be included as if read.

We will be happy to begin with you, Dr. Ross.

STATEMENT OF MURRAY N. ROSS, PH.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC

Dr. ROSS. Thank you, Mr. Chairman. Good morning. I am Murray Ross, executive director of the Medicare Payment Advisory

Commission, and I am happy to be here with this hearing focusing on differences between private health plans and Medicare.

My assignment for this hearing was to look at Medicare's so-called special payments that are not directly linked to patient care for beneficiaries. As I was preparing the testimony, I realized this is not an easy exercise because there are a number of different classes that one might look at.

First, there is a set of payments that are commonly asserted to be for things other than patient care but which may, in fact, cover patient care. An example of this would be Medicare's payments for direct medical education. I will come back to all of these in a moment.

Second, there are other payments that are linked directly to patient care services in the way we pay them out, but which, in fact, cover some services unrelated to patient care. Something in this category might be Medicare's payments for the cost of indirect medical education that gets attached to payments for inpatient hospital stays.

Finally, there are a number of situations where Medicare pays more than the average costs of care for its beneficiaries. Examples here include disproportionate share payments to hospitals, certain provisions for payments to rural hospitals and other providers, and the payment floors that are applied in the Medicare+Choice program.

Let me, briefly, go through each of these sort of classes that I have talked about, and then talk a little bit about how they might fare as one thinks about restructuring Medicare.

Medicare's graduate medical education payments reflect salaries and benefits for residents, supervising physicians, office costs, and other overhead. Many observers have viewed these as subsidies to hospitals and ultimately residents that are unrelated to the costs of care for Medicare beneficiaries.

But economic theory suggests that, in fact, the training costs are borne by residents who receive lower salaries. If this is correct, then the direct costs we actually observe are for patient care. This is an idea that our commission has been discussion at length recently as it prepares for its August report on graduate medical education, so you will hear more from us in the future on it.

In addition to the GME payments, Medicare also increases operating payments to hospitals to compensate them for factors that raise their costs but which cannot be separately identified as a cost of teaching.

These factors might include having a more severe case mix, the presence of special capabilities such as trauma units or burn centers, unsponsored clinical research, and, of course, higher quality of care related to developing or being early adopters of new therapeutic techniques and diagnostic techniques.

To the extent they reflect a more severe case mix, Medicare's indirect medical education payments clearly represent payments for patient care. To the extent they compensate for other factors, such as either a different product produced by teaching hospitals or financing social missions other than patient care, policy makers can ask whether Medicare's payment formula in current law is appropriate.

Again, I would note that our commission is looking at a couple of different options here to try and get at whether you can better measure the more severe case mix in teaching hospitals.

As I mentioned, there are a number of Medicare payment policies intended to maintain access to care and foster choices among different providers in types of private health plans: the DSH payments to certain hospitals, the provisions for special payments to hospitals and other providers in rural areas, and the floor payments.

These policies may be justified in a number of ways. DSH payments compensate hospitals that provide above-average amounts of care to low-income patients. Special payments to rural providers and the floor payments under the Medicare+Choice program have a slightly different rationale.

Basically, they stem from the fact that, in thinly populated areas, providers cannot exploit economies of scale and, thus, have higher-than-average costs. If Medicare paid only the costs of an average efficient provider, its rates might not be sufficient for low-volume providers.

How might the activities supported by Medicare's special payments fare in an environment that relied more on market forces? It is not possible to provide a definitive answer, but I think analysis suggests that the less closely tied payments are to patient care, the more vulnerable are the activities they support. If the Congress wants to continue supporting these activities, it may need to explore new mechanisms for doing so.

With respect to payments to teaching hospitals, I think the answer hinges, in part, on whether beneficiaries can observe and value the differences in what those hospitals provide.

Just as we observe consumers willing to pay for higher quality in a wide variety of other markets, from automobiles to college educations, we can reasonably suppose that Medicare beneficiaries would choose plans that contracted with teaching hospitals. Whether that would provide the same level of support that we have under current law, of course, is hard to tell.

With regard to disproportionate share payments, it is likely that support would decline under a more market-oriented program. In the past, hospitals could upset the cost of uncompensated care by charging some payors more. But, as health care markets have become increasingly competitive, plans have resisted from paying the costs of any but their enrollees. Making Medicare more competitive would reinforce that trend.

Finally, support for providers and health plans in rural areas would depend, in large measure, on what the program looked like. On the one hand, policymakers, the Congress, could provide greater support for beneficiaries living in areas where low volumes meant high average costs, just as we do for beneficiaries living in areas now where costs are higher for other reasons, such as high wages.

On the other hand, policy makers could choose not to recognize the higher costs attributable solely to low volumes. In that case, market forces would encourage providers to increase volumes by expanding service areas. That would likely reduce premiums for beneficiaries, but require them to incur greater travel costs in exchange. I will stop there.

Thank you.

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

The CHAIRMAN. Thank you, Dr. Ross.

Dr. Mueller?

STATEMENT OF KEITH MUELLER, PH.D., DIRECTOR, NEBRASKA CENTER FOR RURAL HEALTH RESEARCH, UNIVERSITY OF NEBRASKA, OMAHA, NE

Dr. MUELLER. Thank you, Mr. Chairman.

My comments today draw on research and analysis that has been conducted by the Nebraska Center for Rural Health Research and the health panel of the Rural Policy Research Institute, or RUPRI.

The Medicare program is based on a promise to our Nation's elderly population that they will have access to health care services. Services must be available before any insurance benefit makes them financially accessible. This committee and members of Congress have acted to affirm the principle of access by using Medicare payments to help assure availability of services.

Any dialogue about the future of Medicare payment policies must recognize that spending on behalf of rural beneficiaries today is low, payment to rural providers is low, and Medicare payment will heavily influence the fiscal health of rural providers.

Without adequate Medicare payment, the rural health care infrastructure, particularly in small-town rural America, cannot survive. There are supporting numbers in the written testimony.

Medicare's commitment to access is met by investing in rural health systems through payment policies. This approach is sensible for two reasons. First, it links investments to services being demanded by the beneficiaries. Second, it links provider revenue to services rendered. Further, this approach allows Medicare policies to define the specific providers who warrant the additional payments.

The following are examples reflecting Medicare investment in rural health care delivery: sole community hospitals that provide access to essential hospital services; rural health clinics that provide access to primary care; federally-qualified clinics, including community and migrant health centers that are the safety net providers; Medicare-dependent hospitals, institutions with more than 60 percent of inpatient revenue coming from Medicare; physicians practicing in rural and under-served areas; critical access hospitals; and telemedicine services.

These payments help assure that primary care, emergency care, and short-term hospital stays are available in close proximity to the beneficiaries needing them. With that in mind, this committee may want to impose a rural test on Medicare payment policies as they are enacted, and afterwards, as they are implemented.

How will changes in Medicare payment policies affect rural health care delivery systems, especially in those communities where rural providers are most financially vulnerable? The rural test would help monitor changes currently unfolding in the payment streams that include premiums paid to Medicare+Choice plans, hospital inpatient and outpatient payment, skilled nursing and home health payments, bad debt, and disproportionate share, and transfer payments.

The RUPRI health panel, and others, are monitoring impacts of these changes on rural health care delivery systems, and thus far the trends seem negative, with impacts not yet fully realized.

If this committee and/or others decide that, for reasons of general Medicare policy change, the current system for rural providers needs to be replaced with a different strategy of investment in rural health care delivery systems, I would suggest you use these guidelines to be sure that different approaches retain the achievements of present payment policies.

One, the investment support of all essential appropriate services for rural beneficiaries. Two, that the investments are sustainable and thereby secure over time for the providers. Three, that investments have a positive impact on services for all rural residents.

Finally, Mr. Chairman and members of the committee, I offer two frameworks for use in monitoring current Medicare policies in considering any changes.

The first, is a set of criteria used by the RUPRI health panel in our work, and there are three. One, what is the impact on rural consumers, in this specific case, Medicare beneficiaries? In our work on Medicare policies, this includes out-of-pocket payment, benefits available, and availability of choice.

Two, what is the impact on the rural infrastructure? Specifically included are availability of rural health services, effects on efforts to coordinate or integrate those services, and rural involvement in decisions about what the health care system will look like in rural communities. Our third criteria, is what is the impact on the local rural economy?

The second framework is a more subjective one and includes a series of principles I offered to the Bipartisan Commission on the Future of Medicare a few months ago.

Medicare policies must: (1) Help sustain the rural health care delivery infrastructure; (2) Help sustain the safety net in rural and under-served areas; (3) Contribute to the overall quality of life in rural communities; and (4) Include comparable opportunities that improve Medicare benefits and choices for rural, as well as urban, beneficiaries.

Thank you again for this opportunity to speak to rural interests in Medicare policy. I would welcome any requests to work with this committee and your staff as you continue to improve the Medicare program.

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

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

Now it is my pleasure to call on Dr. Rowe.

STATEMENT OF JOHN W. ROWE, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, MT. SINAI-NEW YORK UNIVERSITY MEDICAL CENTER AND HEALTH SYSTEM, NEW YORK, NY

Dr. ROWE. Thank you, Senator Roth, Senator Graham. I serve as the president and CEO of the Mt. Sinai-NYU Medical Center, which is one of the Nation's largest academic health science centers, and also as president of the Mt. Sinai School of Medicine.

I am a geriatrician and I serve as a member of the Medicare Payment Advisory Commission, which Dr. Ross serves as executive director of.

Four years ago this week, I testified before this committee as it began consideration of changes in Medicare. I ended my testimony, as I would like to begin in this time, with a recommendation that you honor the first principle of medicine: *Primum Non-Nocere,* which Senator Moynihan liked. I think he is an aficionado of Latin. I am sorry he is not here today. Above all, do no harm. I think, for the most part, the provisions of the Balanced Budget Act reflected this principle.

But, in recent months, it has become clear that, in a few critical areas, there have been some unintended consequences of the Balanced Budget Act that need to be corrected.

Just as the treatments prescribed by the best of doctors can have unintended adverse effects, so too can the best legislation. Just as I was taught in medical school that it is best to stop the offending treatment sooner rather than later, I am here to urge you to make some critical changes.

Senator Roth, you said 2 years ago on the Senate floor that your intent was to slow Medicare's rate of spending growth rather than to achieve reductions in Medicare spending. But absolute reductions in Medicare spending have, unexpectedly, indeed, been the result of the Balanced Budget Act.

For the six months ending March 31, Medicare spending was $2.6 billion less than was spent in a similar period of a similar year, according to the Treasury Department.

The Center for Health Economics and Informatics has identified several unexpected fiscal BBA effects. The first, was that the BBA actually reduces Medicare spending on hospital services by $17 billion more than CBO's initial estimate.

These estimates are never absolutely accurate; sometimes they are under, sometimes they are over. In this case, the estimate was somewhat under, we believe. The finding of higher than expected Medicare savings from hospital-based acute care services is certainly in line with the recent Treasury report.

The second finding, was that the BBA actually cut Medicare payments to major teaching hospitals and would reduce the aggregate bottom-line margin of major teaching hospitals to a negative level, the only group of hospitals to be so affected.

In addition to the update and capital cuts, which have a significant effect on all hospitals, cuts that have a disproportionate effect on major teaching hospitals include the IME cut, the outpatient cut, the PPS cut, and the DSH cut. I will comment on each of these, very quickly.

The IME cut is a 29 percent reduction. The IME adjustment pays for the higher costs associated in teaching hospitals resulting from the teaching missions such as a higher acuity level of patients treated by the hospitals, development and testing of new technologies and treatment protocols, cost of maintaining expensive services such as emergency rooms, ICUs, et cetera.

The outpatient cut represents a conversion from cost-based reimbursement to a PPS. The major reason teaching hospitals bear a disproportionate impact from this cut, is that HCFA did not include

an IME or DSH adjustment to the cut and these hospitals tend to serve the highest share of patients with co-morbidities and severe acuity.

The PPS-exempt cut threatens service delivery from the point of view of, it is a national 75 percentile cap on cost-based payments for discharge for three services: psychology, rehabilitation, and long term care.

Because the variation in the cost does not reflect differences in efficiency but in actual costs, the TEFRA caps are having the unintended effect of crippling important, high-acuity services.

Finally, the DSH cut. This is a reduction in payments for hospitals that serve a disproportionate share of indigent patients. There is typically a high degree of overlap between these institutions in major teaching hospitals.

Thus, I would recommend for your consideration that you: (1) Halt the phased 29 percent reduction in IME payments; this would cost approximately $3 billion over 5 years; (2) repeal the phased reduction in DSH payments, which would cost only—you can only say only in the U.S. Senate with this—$600 million over 5 years; (3) provide IME and DSH adjustments to new outpatient PPS. This would allocate roughly $90 million a year; (4) repeal the TEFRA cap provision, which would cost about $700 million over 5 years. Lastly, provide direct payments of Medicare DSH funds to DSH hospitals on behalf of Medicare managed care enrollees.

I believe that these changes would go far to mitigating the disproportionate effect on one class of hospitals that has been the result of the Balanced Budget Act.

Regarding IME and DSH, some have said only Medicare pays for these things, as if that statement indicted the Medicare program. I believe it is an indictment of the rest of the payor community. If Medicare stops paying for these public goods, you will find senior citizens and others losing access to teaching hospitals and hospitals in their urban and rural communities.

Thank you very much.

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

The CHAIRMAN. Thank you, Dr. Rowe.

Dr. Blumenthal?

STATEMENT OF DAVID BLUMENTHAL, M.D., M.P.P., EXECUTIVE DIRECTOR, THE COMMONWEALTH FUND TASK FORCE ON ACADEMIC HEALTH CENTERS, AND DIRECTOR, INSTITUTE FOR HEALTH POLICY AT MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MA

Dr. BLUMENTHAL. Thank you, Mr. Chairman and members of the committee. My name is David Blumenthal. I am executive director of the Commonwealth Fund Task Force on Academic Health Centers, and also the director of the Institute of Health Policy at Massachusetts General Hospital and Partners Health System in Boston.

I greatly appreciate the opportunity to appear before you today. I am going to focus my remarks on graduate medical education provisions of the Medicare program.

The first thing I would like to do is point out, as others have, that the very term "graduate medical education" is really a mis-

nomer for these provisions, and a confusing one. These provisions are really, historically, about paying for the extra costs of academic health centers and teaching hospitals.

The question before the committee, with respect to these extra costs, is whether, and how, the Medicare program should continue to pay for them, and whether and how we, as a society, should continue to pay for them.

On the question of whether, I think it is, first, important to be clear on what the sources of these extra costs are. There are really two basic sources. One, is the extra-patient care costs that derive from the nature of the services and the case mix of patients that are treated in teaching hospitals and academic health centers. Dr. Ross and Dr. Rowe have both made reference to those.

The Commonwealth Task Force believes that there are, in fact, major differences in the case mix between patients cared for in teaching hospitals and academic health centers and other institutions, and that there are also good studies showing differences in quality of care as well, and technical quality of care.

Differences in the value of services received and in the cost of patients care for are legitimate patient care costs of the Medicare program, and arguably should be paid for by the Medicare program.

There is another contributor to the cost of teaching hospitals, and those are the cost of the so-called public goods, things that have value and deserve financing, but cannot be priced and sold in private markets.

These include things like the cost of clinical research, the cost of indigent care, the preservation of access to certain rare and highly specialized services, and innovation on an ongoing basis in patient care. These things go on in academic health centers and deserve public support.

Now, in the past, society has chosen to pay for a significant portion of these by allowing academic health centers to charge higher prices and subsidize the cost of these goods by transferring money from patient care services into the support of these public goods.

To the extent that these extra costs of teaching hospitals do, in fact, represent public goods, they are legitimate expenses for the Federal Government. They may also be legitimate expenses for the Medicare program, to the extent that Medicare beneficiaries benefit along with the rest of society from these services.

One may even argue that, given the higher costs and the disease burden of Medicare beneficiaries, that they benefit more than many other populations from the production of these public goods.

These are legitimate expenditures of the Medicare program if we as a society continue to pay for these as we have historically, out of patient care costs, allowing academic health centers to collect more money and cross subsidize these goods.

The Commonwealth Task Force has proposed an alternative way of financing both the quality and case mix-related expenditures and the public goods related expenditures that teaching hospitals incur. That is the creation of an academic health services trust fund.

This could be financed in a variety of ways. It could be financed out of appropriations, or could be financed out of an all-payor contribution which legitimately should include contributions from the Medicare program as one of the Nation's major payors.

The key thing about the financing of these services, of these extra costs of teaching hospitals, is that they be stable, secure, and predictable over time. Those are the criteria that I think the committee ought to apply in considering alternatives to the current system.

Let me make one final point before I close. The premium support approach would be a radical change and provide a radically new premise for financing the extra costs of teaching hospitals.

It is not at all clear how premium supports would assure support for the additional case mix or the added quality of care that teaching hospitals provide and that are legitimate extra costs of these programs.

I think, until we have better measures of quality and better measures of case mix, the adoption of a premium support model would place in jeopardy some of the provision of these extra costs.

Mr. Chairman, members of the committee, thank you very much for the opportunity to appear before you and share my thoughts. I would be glad to answer any questions you may have.

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

The CHAIRMAN. I wonder, Dr. Rowe, would you care to comment on the testimony of Dr. Blumenthal as to alternate methods of payment?

Dr. ROWE. I would accept David and the Commonwealth's view of establishing, and I think Senator Moynihan has discussed this as well, an academic trust fund that is separate from Medicare as a reasonable provision.

Our concern has always been that it be stable, secure, and predictable and that, if it becomes subject to annual debates with respect to appropriations, that it is not the kind of stable, secure, predictable financing that is needed to maintain the capacity of the academic infrastructure. So, that is really the major issue, from my point of view. I would otherwise support it.

I would also say that I would agree with David and Murray's comments with respect to the fact that the DRG system does not fully capture the costs associated with many of the patients seen in teaching hospitals. I know this is of interest to some people on the committee, and I will take a second, if I can, to respond.

All three of us have said that there have been measurable costs in teaching hospitals that are not measured fully by the DRG system, which you would think, superficially, should have done that. The reason is, people's illnesses vary even though their diagnoses may be the same.

I could give you an example, Senator, of a man who is 75 years old and has a history of a heart attack, diabetes, and hypertension. That is common, 75 years old, hypertension, heart attack, diabetes. You cannot tell me whether he is in a nursing home or in the Supreme Court of the United States with those diagnoses because there is a big difference in illness.

It is some of that unmeasured difference, that lack of adequate risk adjustment, which is covered with these IME payments. So, they are really not graduate medical education payments. It is a bad term.

The CHAIRMAN. Dr. Ross, do you have any comment?

Dr. ROSS. Let me just comment that, again, in raising these issues, there are a number of avenues that the Medicare Payment Advisory Commission is pursuing in developing our report that is due up here in August, and we will bring those to you at that time.

The CHAIRMAN. Let me turn back to you, Dr. Blumenthal. While it is clear that the social goal is worthy, some people believe Medicare payments for GME may be poorly distributed relative to the genuine health care the work force needs for the future.

How would you envision adding accountability to GME programs to ensure that the future health care needs of society are truly addressed? How could we implement standards for GME programs that would assure payments are more appropriate for the future work force needs than they appear to be today?

Dr. BLUMENTHAL. Well, that is a very important question. I think the task force is actively addressing that issue, so let me just speculate a little bit. These represent my own views, not necessarily those of the task force.

There are clearly needs for redistribution within our work force as to the specialty of the physicians and some of the other health professionals we are producing. I think the task force would support the idea that more primary care physicians ought to be trained and that the payments to teaching institutions ought to reflect that priority. In fact, they do already. Not always very successfully, but there is already policy in place to that effect.

The other thing that I think we have not done a good job of is training residents, young physicians, for the changes in the health care system. We need to provide more outpatient alternatives and more experience in managed care settings. I think that the Medicare program has, and should, continue to push in that direction.

The question of, once we actually allowed the extra costs of teaching hospitals, if we could, into different buckets, the bucket for the case mix, a bucket for quality, a bucket for teaching, a bucket for research, and I do not know if that would be possible. It would be technically very difficult.

But if you could identify a teaching component, then the opportunity would arise to look in some way at the quality of alternative teaching settings and the content of education and to use the teaching payments in some way to emphasize quality, as well as distribution and the nature of the personnel.

The CHAIRMAN. Anyone else care to comment? Dr. Rowe?

Dr. ROWE. No, sir.

The CHAIRMAN. Dr. Ross?

Dr. ROSS. No, sir.

The CHAIRMAN. Let me ask you a question, Dr. Mueller. Your testimony outlines a number of guidelines and criteria to consider when addressing rural health care policies. Could you elaborate, please, on these concepts and identify challenges faced under current payment policies, as well as considerations for reform?

Dr. MUELLER. Yes. The criteria tend to focus around two major areas of concern, the beneficiaries and the delivery systems. Let me take those in order, with some illustration.

If you look at Medicare beneficiaries and any suggestions to change the way in which Medicare is financed so that you might create a different premium structure for beneficiaries to which gov-

ernment contributes, or you might try to emphasize the Medicare+Choice options in the Balanced Budget Act, it is important to recognize, what will the financial burden be on the beneficiaries in a rural area? So if you tried to go with a national average rate, for example, what will that do in rural areas?

It might pull up the contribution that beneficiaries have to make because, as I said at the beginning of the testimony, historically, payments are lower, cost to the beneficiary is lower in a rural area if they are paying a percent of the premium, because the overall expense is lower.

If you average rural in with national in setting a premium to which the beneficiary contributes, that would increase the out-of-pocket expense for the rural Medicare beneficiary.

If you look at the institution side, or provider side, I think what is really important in rural areas—and I will play off of Dr. Rowe's testimony for a moment—is to think about the multiple payment streams that affect the same providers.

Dr. Rowe's example was the case of teaching hospitals. There are examples in my testimony in the supporting documents that RUPRI has developed that apply to rural hospitals, where the same institution is home health, nursing, hospice, inpatient and outpatient in the community.

If you adopt policies like we did in the Balanced Budget Act that affect all of those payment streams, no one payment stream may look critical, but combine them and it does.

Analysis by Ernst & Young, for example, shows that there is a second group of hospitals that will have a negative margin at the end of the day when the BBA is fully implemented, and it is the small rural hospitals that will have that.

So any change in payment structure needs to be examined from sort of the bottom up, beneficiary up, to see, what is the effect on the beneficiary, the providers up to see, what is the total effect on rural providers.

The CHAIRMAN. Well, the hour is late. I appreciate you gentlemen being here today. Again, I am sorry it was so late, but we had votes and it could not be avoided.

There will be written questions and we would appreciate your answering them. Thank you very much for being here.

The committee is in recess.

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

[Whereupon, at 12:29 p.m., the hearing was recessed.]

MEDICARE REFORM

(PERSPECTIVES)

WEDNESDAY, MAY 26, 1999

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

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Hatch, Gramm, Lott, Jeffords, Mack, Thompson, Moynihan, Baucus, Rockefeller, Breaux, Conrad, Graham, Bryan, Kerrey, and Robb.

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

The CHAIRMAN. The committee will please be in order.

This is our fourth hearing on Medicare reform, which of course is a very, very critical program for the financial security and well being of our Nation's aged and disabled citizens.

I believe that Medicare has significantly improved the health and quality of life for these Americans. However, testimony taken by this committee in recent weeks has made it clear that the Medicare program has lagged behind improvements occurring in the private sector and needs significant modernization.

There is disagreement on how best to achieve a more efficient, higher quality Medicare program. Some are more confident in approaches that rely on the marketplace, others are more confident in approaches that rely on the government.

Today, we are privileged to have two very distinguished legislators appear before us. Through their work as chairmen of the Bipartisan Commission on Medicare Reform, Senator John Breaux and Congressman Bill Thomas have, in my judgment, materially influenced the Medicare reform debate.

Their ideas about a premium support system have captured the imagination of many who are wrestling with the deep issues about how to secure and improve the Medicare program for the next generation. It is a generation that will look very different from today's retirees in terms of education, income, employment experience, and familiarity with both choosing and navigating through different health plan models. This will be particularly true of women, many of whom have spent a lifetime of working outside the home, as well as raising a family.

I am very pleased that Senator Breaux and Congressman Thomas have agreed to come and share their ideas and perspectives. We are also very interested in the views of the administration, and we had invited Secretary Shalala to also testify this week. Unfortunately, the administration is not prepared to testify on these matters until they have released their plan.

I strongly prefer that the committee have sufficient time to consider the administration's plan prior to a committee mark-up on Medicare. Hopefully, we will have that opportunity soon.

Finally, I also want to thank the other distinguished experts who have agreed to share their perspectives on Medicare reform with this committee.

Senator Moynihan?

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

Senator MOYNIHAN. Yes, sir. I would simply hope that we do, as you suggest, move forward without waiting for the administration. I mean, we have had five years of this now and that is enough. This is the first of our hearings in which we will hear actual proposals.

So, we are honored to have our colleague and friend from across the way, Chairman Thomas, joining John Breaux, and Bob Kerrey, who took part in that large and important undertaking. I look forward to hearing more about it.

The CHAIRMAN. Thank you, Senator Moynihan.

We will now call upon our distinguished colleagues. Traditionally, it is our practice not to pose questions to other members of Congress. But Senator Breaux and Representative Thomas are really invited here as chairmen or leaders of the commission. They have indicated their willingness to answer questions, and we will open the panel for that purpose.

So we will begin with our good friend and colleague, Senator Breaux.

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

Senator BREAUX. Thank you very much, Chairman Roth and Senator Moynihan, for your comments. I thank you, Mr. Chairman, for your leadership, number one, in even having these hearings. It takes a great deal of courage even to have hearings on the subject of Medicare.

The real test of courage for all of us, however, is whether we can follow through with the hearings and actually get something done.

I have a prepared statement and ask that it be made part of the record.

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

Senator BREAUX. I want to acknowledge my colleague this morning, Bill Thomas, who served with me as a statutory chairman of the Bipartisan Commission. I want to publicly congratulate him for his efforts and his contributions, and particularly for the indications that I have read that he is planning to bring forth a Medicare reform recommendation to the full House. That takes a great deal

of political courage, and I commend him for it, and his willingness to work in a bipartisan fashion to make it work.

I want to acknowledge the fact that three members of our committee served on the commission for over a year, working on this very subject every week, almost every day: Senator Jay Rockefeller and Phil Gramm, who served with us on the commission. While we did not always agree, they made valued contributions to our effort.

I want to particularly recognize colleague Bob Kerrey, who labored long and hard to try and bring together what we needed in order to get a super, super majority to make an official recommendation. Bob's contributions and efforts continue today in this effort with us to try and bring forth a package that can really accomplish what we are trying to do.

It is interesting to note that we had 17 members on the commission. We had a majority that recommended this plan. We had 10 of the 17 that agreed on this plan. That is more than a simple majority. In fact, it is a super majority. But it was not the super, super majority of 11 out of 17 that had to agree to make a recommendation.

The conventional wisdom, Mr. Chairman and my colleagues, is that you cannot reform Medicare this year because next year is an election year. Then, of course, you cannot do it next year, because next year is the election year.

If you follow that logic, you can never reform Medicare because it is either an election year next year or you, in fact, are in the election cycle itself. If you follow that conventional wisdom, we would never get anything done in this area.

Mr. Chairman, I think it is time to disregard conventional wisdom into the trash can of political obsolescence. The question is, why should we be bold and try and do something about it?

Well, the first chart tells us why, and you have it before you. First of all, Medicare is not as good as it should be, nor as good as it can be. I think it is a popular misconception that it is a wonderful program. It has done wonderful things. But, in 1999, it is not as good as it should be, nor as good as it can be.

Number one, beneficiaries pay over $2,000 a year, on average, out of pocket for things that Medicare does not cover. Medicare barely covers half of what the average beneficiary needs as far as health care. It covers about 53 percent. That means 47 percent. An average of over $2,000 a year comes out of their pocket because this great program does not cover it.

In addition to that, we all know what it does not cover in terms of services. It does not cover prescription drugs, it does not cover long-term health care, it does not cover dental, it does not cover eyeglasses, all the things they have to pay for out of their pocket.

In addition to that, the actuaries tell us that if we do not do anything by the year 2007, right around the corner, the premiums they pay for this program are going to double. If that is not bad enough, add all of this up and the final note is that actuaries tell us that, by the end of the year 2015, it is going to be bankrupt.

So you have a program that is not nearly as good as it should be and it is going to be bankrupt by the year 2015. And that is assuming a 2.8 percent inflation growth, which is not very likely to happen, so it could be even sooner than that.

Every year, Congress, in the past, Mr. Chairman, has basically addressed this problem the same old, same old way: SOS approach. We cut benefits and payments to providers, doctors, and hospitals. The last Balanced Budget cut it $115 billion. The President's budget recommends we cut it another $20 billion. SOS. Same old, same old.

We cut it 1 year, and the next year we come back and put it back in. Every one of us right now is being besieged by everybody who provides services saying, you cut us too much; give us back some of the money.

So we are going to probably give them back some of the money, then next year we will come back and cut it again, followed by the next year when we put it back in again. You just cannot continue to do that and have a program that is going to make sense.

Now, some Democrats, quite frankly, will argue, well, let us not do anything. We can blame the Republicans for the failure. Republicans, sometimes, some of them, say, do not do anything about reforming it. Just blame the Democrats for mismanaging it. That is the blame game. Nothing gets done. We argue about failure and whose fault it is as opposed to arguing about success and who did it, which is a much more legitimate argument.

The President told us as recently as this week, and Senator Kerrey was in the meeting, that we should try and pass Medicare reform this Congress, that we are all better off if we do it.

He said we need to try, and that he would have a detailed plan available, Mr. Chairman, after the recess when we return. I think that is good news. I congratulate him for doing it. I congratulate him for rejecting the "do nothing and blame others" approach to Medicare. That is old politics and it does not work.

My colleague will go into more details about what we have. The second chart indicates the essence of the plan, which is based on what all of you have, and everybody behind you has as Federal employees, the Federal Employees Health Benefits Plan.

It guarantees an entitlement for benefits that are at least as good as the current Medicare fee-for-service program. It guarantees statutorily that the Federal Government will pay 88 percent of the cost of the average plan, the beneficiary will pay 12 percent, which is about what they pay now.

We made some major changes in providing prescription drugs for low-income seniors up to 135 percent of poverty, which would get a drug package free of charge and no premiums at all that they would have to pay. That is very progressive. We reform Medigap policies that say that every one of them has to offer prescription drugs in order to lower the prices. I personally am willing to do more than that.

We worked very hard, Bill Thomas, Bob Kerrey, and I at the very last to try and see if we could not come up with additional subsidies for the fee-for-service plan. But, by and large, they said that we would save $800 billion by the year 2030 with this ap-

proach. That is real savings, it improves the program, and it gets us away from the SOS, same old, same old type of an approach.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

Now, Congressman Thomas, we look forward to your comments.

STATEMENT OF HON. WILLIAM M. THOMAS, A U.S. REPRESENTATIVE FROM CALIFORNIA

Representative THOMAS. Mr. Chairman, thank you very much. I would ask unanimous consent that my written testimony be made a part of the record.

The CHAIRMAN. Without objection.

[The prepared statement of Representative Thomas appears in the appendix.]

Representative THOMAS. It is a privilege coming before the Chairman and the Ranking Member of this committee, especially since those of us who deal with committees and subcommittees have to deal with jurisdictional limits.

I am rather envious of this committee's jurisdiction regarding Medicare versus the cooperative structure that has been present, but not always historically, but I am pleased to say, most recently in the House.

Out of my recent experiences, there are a couple of points that I would like to make. One, I do not think people appreciate how extraordinarily difficult change is in a politically charged environment, especially fundamental programs, no matter how much they might need change.

The second factor is that this experience has been, personally, very rewarding in terms of creating what I believe to be some long-lasting bipartisan relationships which will overcome those political difficulties.

I just have to tell you that I knew Senator Breaux in his former life as a member of the House. We had worked together then, and it was a renewed pleasure to work together with him on the commission.

I did not share a House experience with the Senator from Nebraska. I had observed him more from afar. But, working with him and other Senators on this project, it really did allow us to build a relationship which I believe will produce a quality product.

On the House side, the bipartisanship has been there. In fact, the nucleus on the House side for the 1997 changes in Medicare was forged when the gentleman for Maryland, Ben Cardin, and I sat down and wrote a basic preventive care and wellness package, long overdue for seniors, which required us to actually spend money because of budget rules.

But that forged then, I think, the nucleus on the House side to begin to talk about other changes that we were able to make in 1997. Certainly not the kind of fundamental change that I think we now, most of us, agree needs to be addressed.

The current system, I guess, is fine, if you do not care that seniors are not allowed to get health coverage as we know it today, especially as members of Congress and the Senate get it, as most Americans get it, especially in the area of an integrated health care program dealing with prescription drugs.

And I guess today's system is fine if you really do not care about seniors in major portions of the country that do not have the kind of choices that they ought to have, notwithstanding our attempts to modify payment structures of the bureaucratic administered price system that we currently have.

I guess, most frustratingly, the current system is fine if you do not care if seniors do not get new and innovative programs of delivery and technology when they should get it, as soon as it is available, rather than waiting years for the political process to determine, as the Senator rightly corrected, all of the stars are in alignment for changes in Medicare. That is the wrong way to go about not only ensuring health care for seniors, but making sure it is there for seniors who are not seniors today.

So, basically, I would like to say, and it has not been said enough, that our proposal is more a change in our approach to change than anything else. This idea of using a negotiated plan structure is clearly not new. In fact, it was the preferred choice of most of the experts that we brought before the commission to offer new ideas in changing Medicare.

I might, for the record, indicate that the American Academy of Actuaries, in a news release today, indicated that, in a poll that they took, nearly two-thirds of Americans favor Medicare changes to give individuals a fixed amount of money to purchase their own private health insurance, basically the premium support model.

More significantly, Generation X respondents, those under age 35, responded 70 percent favorably. Those that we keep worrying about looming on the horizon, the soon-to-be seniors, the baby boomers, supported the restructuring of Medicare to a system of premium supports by 71 percent. It is an idea, in our opinion, that is overdue.

The bipartisanship, I am pleased to say, continues on the House side, notwithstanding some folks' efforts to wait until after the next election to deal with policy change in Medicare.

I have a letter which I would like to place in the record, although it is a work in progress. It is a letter to the Speaker of the House and the Minority Leader from eight members of the Minority on the House side urging that both the Speaker and the Minority Leader bring up Medicare reform embodied in the proposal that was offered by the commission, although they say in the letter, as you will read, the report that was offered is not perfect. They wanted to focus on additional subsidies for prescription drugs and are concerned about, or have serious reservations, as the letter says, about raising the eligibility age for Medicare.

I would hasten to add, if you do not think eight signatures is very important in a bipartisan effort, my party is currently governing on the over side of the Capitol with a five-vote majority, and the Speaker would think eight would be a luxury. It is a significant number.

[The letter appears in the appendix.]

Representative THOMAS. The key to what we want to do, is provide a structure that offers solutions. We can go through in any particular area that you would like to talk about how this system might bring about change.

But one of the really positive things about the commission's journey—notwithstanding the fact that we did not get the 11, although clearly in the testimony of 12 of the commissioners, they thought a market-based structure was the most appropriate—offers a solution not just to reforming the seniors' health program, but I think also a structure that might be available for those Americans that we are all concerned about who, although not seniors, currently do not have health insurance.

So, with that, Mr. Chairman, I would like to thank you and the committee for your willingness to go ahead and begin to investigate these options. The bipartisanship that was evidenced in the commission is alive and well on this committee, since there were five Senators, four of them on this committee, and three of them supported the model. We are building a bipartisan coalition on the House side; you already have one, and of that, I am envious as well.

I thank you very much.

The CHAIRMAN. Thank you, Senator Thomas.

Representative THOMAS. Well, thank you for that. [Laughter.]

The CHAIRMAN. Congressman Thomas. I just downgraded you.

Representative THOMAS. In defense of the other House.

The CHAIRMAN. It is a pleasure to have you here.

Let me say, Senator Kerrey has to go to the floor to offer an amendment. So, with the indulgence of everyone here, I would like to yield two minutes to you right now.

Senator KERREY. Yes, sir. I will not ask any questions, but I just want to state for the record, Mr. Chairman, and I appreciate your allowing me to do it, that I do join with both Senator Breaux and Congressman Thomas in this effort and appreciate their courage and willingness to take the lead on this thing. I hope that we can get a mark-up. I hope we can, in the Senate, move a piece of legislation modeled on the premium support plan.

I like it. I would not argue that premium support is necessarily going to save money, because we just do not know. There are other changes in there that offer considerable savings. I like it because it modernizes the system along the lines of where customers are already going. HCFA already has lots of private insurance that it is managing already. This is not a new concept.

But I like it. Further, Mr. Chairman, the question I was going to ask, is that I see this as a way to not only solve the growing share of our budget that is being allocated to mandatory programs, decreasing the amount of money we have got for discretionary spending, but I see it as a way for us to solve another problem, which is a very inadequate safety net for health care for Americans today.

We have a growing number of uninsured, and I believe premium support can be a way to solve the problem of uninsured Americans who are working, paying taxes, and subsidizing others.

So, I appreciate very much, Mr. Chairman, your holding this hearing, and appreciate the testimony of Senator Breaux, Congressman Thomas, and others who will follow them as well.

The CHAIRMAN. Thank you, Senator Kerrey.

We will now open it up to questions of our panel.

Senator Breaux, in your opening comments you said your plan would pay for prescription drug coverage for beneficiaries through 135 percent of poverty. Then you indicated perhaps something more. Why stop there?

Senator BREAUX. What we attempted to do, Mr. Chairman, was to improve prescription drugs for seniors. About 65 percent of the beneficiaries already have access to prescription drugs through Medigap insurance and other ways of getting it.

But we need to do more than that. What we said, were two things. Number one, that everyone up to 135 percent of poverty would get their Medicare with prescription drugs free of charge, and also they would pay no premiums for the 12 percent.

That cost about $61 billion over 10 years; $31 billion for the drugs and $30 billion for the premium subsidy. That takes care of a large number of seniors which we are helping who need the most help, have the greatest need.

The second thing we did was say, all right, you have about 11 Medigap plans now that people have to buy to cover things that Medicare does not cover. Notably, it is prescription drugs. But only three of the plans offer prescription drug insurance.

So we said that if you offer a Medigap plan, you have to offer prescription drugs, requiring them all to do it. If everybody did it, it would lower the cost of purchasing prescription drug insurance. Those are the two basic things that we said.

But I think that also it is legitimate to consider even doing more for that, doing more for people in the traditional fee for service. Having prescription drugs is part of the general fee for service in a new and reformed HCFA, not one that is price controlled. If you could do that, you could consider adding some assistance, a subsidy, to those people as well.

We had talked and debated, and Bill and Bob Kerrey know this very well, of something up to maybe 25 percent additional subsidy. But that was not recommended because we could not get sufficient votes to do it. But that is something that we should explore.

Representative THOMAS. Might I respond, briefly?

The CHAIRMAN. Yes, Congressman Thomas.

Representative THOMAS. In hearings that we had before the Health Subcommittee over on the House side, there was virtually unanimous agreement that when you began subsidizing above 175, and especially 200 percent of poverty, you begin driving out dollar for dollar private dollars. So, your question focused on the 135 percent.

When we discussed the most economical way of delivering prescription drugs to the most needy, the low income, we decided that the current structure that is already in place for those who are below 135, especially 100 percent of poverty, would be a structure that could deliver this program at a much cheaper rate than inventing a new one. So we redirected, up to 135 percent of poverty.

As the chairman indicated, we were willing to discuss additional assistance between that 135 and somewhere, when you begin driving out dollar for dollar private dollars.

I will underscore the letter of my colleagues on the other side of the aisle who want to work with us in the House. They said, "The proposal embodied by the Breaux-Thomas report is not perfect. We

believe it should also include support for drug coverage and that the support should go beyond the 135 percent above poverty threshold established by the authors."

Obviously, if we are going to have a harmonious and cooperative working relationship, we are going to have to sit down and talk with them about a subsidy beyond the 135 percent, what might be appropriate, where it would be applied, and the structure.

So, we will be engaging in examining the potential for support of a prescription drug, high-option, integrated program with our colleagues on the other side. Hopefully, that will bear some fruit so that your question will be answered in the product that we deliver.

The CHAIRMAN. Let me turn to the Medicare board. Your plan would set up a new board, as I understand it. Why not let HCFA administer the premium support system? Either one can answer.

Senator BREAUX. Well, I think both of us could comment. I think the concept is that we are looking at a new delivery system, a new philosophy, moving away from micro managing and price fixing everything we do, which is what HCFA has attempted to do since they have been around.

The new Medicare board would operate much like the Office of Personnel Management does under the Federal Employees Health Plan, which basically solicits from other private companies their submissions to ensure the 40 million beneficiaries.

So the reason is, the new Medicare board is not micro managing, price controlling, and price fixing everything we do. We cannot continue to do that. So the new Medicare board was created. I think we suggested seven, appointed by the President, confirmed by the Senate, which would basically run this new-style program like the Office of Personnel Management.

Two reasons I can think of we did not let HCFA do it, is because HCFA will still have a fee-for-service plan which they will run. They will continue to fix prices. If someone wants to go into that program, if that is the best, they can still do it. The second reason, is this is a new philosophy so a new board is essential in order to run the program.

Representative THOMAS. I would only say, briefly, Mr. Chairman, that part of the reforms that we have tried to bring about in the Balanced Budget Act of 1997, having HCFA reorganized to try to integrate the managed care part was not nearly sufficient. There needs to be a reculturalization as well. We have embarked on that in a kind of not-so-successful way.

I would like to submit for the record a letter that I sent to the administrator of HCFA on May 21, reviewing the recent draft of the proposed Medicare and You handbook. This is our second effort to try to provide an educational program for seniors about their choices in Medicare, the long-overdue information and educational program.

But in the three pages, and I will only give you a couple of examples, we find that the reculturalization has been less than successful, especially when you compare it with other programs that spell out options and satisfactory or quality comparisons, most notably the Office of Personnel Management, especially in not dwelling on the obvious. For example, I indicate to them that "one final exam-

ple of wasted space is the listing of phone numbers one can call to get additional information."

In addition to numerous references to phone numbers spread throughout the text, a full seven pages are devoted to nothing but describing government phone numbers where seniors can get more information. Yet, approximately 75 percent of this material refers seniors to the same 1–800 Medicare number. This could easily be condensed into two pages at most, and three additional pages for more information.

I might indicate that there was a six-month running battle to get them to realize that adding the "E" on the 1–800–MEDICARE did not make any difference when seniors dialed, but they would understand that it was for Medicare. That is the kind of bureaucratic inertia that we do not need to overcome. A Medicare board would solve that problem.

The CHAIRMAN. My time is almost up, so I would ask you to be very brief in your answers, if you could.

Could you give the committee a bit more detail on how your plan could serve beneficiaries in the rural areas where, at present, the traditional fee-for-service program is the only plan choice available?

Senator BREAUX. Well, one of the things that was raised in the discussion, and Senator Rockefeller raised it many times, is a question about, what happens in a rural area, which many of us represent, where you do not have a lot of competition? The only thing you have is fee for service. That is a legitimate concern.

What we said in our recommendation is, if you live in a rural area and the only program you have is traditional Medicare fee for service, that in no circumstances could the cost of your fee for service be more than the national weighted average for fee-for-service plans around the country in order to protect rural areas. We do not want all of the older, sicker people in a rural area to remain in fee for service with no other choice and have their prices go up substantially.

So we said that, if you live in a rural area, that the beneficiary who lived in that area with no private plans to be offered would be limited to 12 percent of the fee-for-service premium or 12 percent of the national weighted average, whichever is lower.

So, they get the benefits statutorily of having the lowest 12 percent, whether it is for the national average, or if their plan and their State or area is lower, they get the lowest one. They are protected.

Representative THOMAS. Just very briefly, also, in terms of the managed care, we are all frustrated with the so-called AAPCC payment structure, artificial administered prices county by county, which create not only great discrepancies between States, but within a State, and sometimes not easily explained between counties in a State.

What this provides is an opportunity to negotiate a real-world price which I believe, especially in those counties on the margin now who will have to wait years for the blended price, to administratively provide a price that would work, an opportunity to negotiate a price which, in fact, would deliver service and over the long haul actually produce the cheaper price because beneficiaries could choose a structure which was a zero cost premium.

The CHAIRMAN. Finally, let me ask you, are there reform options you could support, short of premium support, but would not preclude future action in that direction?

Senator BREAUX. I think the real danger, Mr. Chairman, is trying to micro manage reform in the sense that, let us add a little bit here. You really have to do a whole package, because if you just do a little bit in one area it causes something else in another area to go haywire.

For instance, just say, well, we are going to fix Medicare by offering free prescription drugs. That does not fix it. I mean, that is easy to do. We all would love to say, free prescription drugs for everybody and we reform Medicare. Well, it really has not.

I mean, there are other things to look at. This is not the only idea in the world by any stretch of the imagination. We spent over a year looking at all of these options and came up with the fact of, let us model it after something that already works.

That is what you have, I have, and all of these people behind you have. It works. It brings in competition, it has kept down prices, and it has offered us more choices. That is one of the reasons why we picked something. We did not reinvent the wheel here. This is a proven type of concept that works very well.

Representative THOMAS. Just very briefly. The old structure, which was originally established for a lot of reasons, does not make any sense any more. Between hospitals paid under one fund, other-than-hospital physicians, skilled nursing facilities and others paid in another fund, and that we can continue to try to patch it together.

But what we need to do is provide a payment structure and a delivery structure that reflects today's health care market. As I said at the beginning, Mr. Chairman, our proposal is more a change in our approach to change than anything else. That is what Medicare needs, a structure that will allow for change in the future, not, as the chairman is fond of saying, same old, same old.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you.

Mr. Chairman, you probably got a copy of this. This week, the Merck Pharmaceutical Company, which puts out that wonderful annual Merck manual, sent us a copy of the original, first manual. Here it is, all 70 pages, full of tests for tuberculosis and guaranteeing the efficacy of Merck cocaine as against Bayer heroin. If cocaine did not work, opium would. There is opium to be had here, too.

A hundred years go by, and you get this extraordinary document. I mean, the amount of medicine that has been acquired in the century, there cannot be an equivalent in learning after so long a period. Three thousand years got us to where we could diagnose most things, but could not do anything about them. Now we can.

You have described it very well, and the proposals you have made. Chairman Thomas spoke of the health care market. Senator Breaux spoke of, we have to move away from price fixing. This is the rationalization that has come into medicine in the last half century since Medicare began.

The one thing, however, which markets will not provide, and this is classic economics, is the public good. In this case, the medical

schools and the teaching hospitals. The world is full of public goods that benefit everybody and no one has any incentive to pay for them. That is one of the reasons you have government, actually, from White Houses, to George Washington University Medical School.

One of the great issues is, how do we continue to provide for the medical schools and teaching hospitals that have been so extraordinarily creative in this period of Medicare, and the pharmaceutical companies which have brought pharmaceuticals to a role in medicine they did not have 50 years ago? Could either of you discuss how you are thinking about this?

Senator BREAUX. Well, very briefly, Senator Moynihan—I know Bill is going to want to comment on this—the committee looked at how we paid for graduate medical education, which you are the resident expert in.

What Congress decided years ago, is we pay for it out of Medicare because graduate medical education is in the national interest. Here is a program that pays hospitals. We should pay teaching hospitals more to teach the medical professionals in their institute out of Medicare. I think we just picked Medicare because it was a large amount of money that was available to do something that was important.

We initially recommended in the commission, that does not really make a lot of sense. Let us just recognize that we should teach doctors in this country and say that it is going to be a guaranteed entitlement, that Congress will look at it and appropriate the money for the program.

That was our original recommendation. After talking to some members of Congress who had strong feelings about this, I am willing to negotiate on this and try and figure out, what is the best way to do it? If it is Medicare, so be it. If it is something else that we can guarantee, let us do it that way. It is important. I recognize it is important. We should pay for it. The question is, what is the best way to do it? I will tell you, I am just as open for your suggestions and anyone else's as I possibly can be.

Senator MOYNIHAN. Thank you very much.

Mr. Chairman?

Representative THOMAS. Yes. I want to underscore that medical education is a public good and that, because it is, we really ought to look at a broader revenue base in support of it. The idea of attaching it to a Part A hospital fund may have made sense when hospitals were the cornerstone, in fact, almost the be-all of the health care structure. They are not anymore. The current system is not sustainable. Notwithstanding the desire to want to protect, which I share with you, we might be able to preserve and protect—in fact, enhance—if we look at a broader revenue base.

Fully 25 percent of the pediatricians trained in this country today are trained in hospitals that do not get the kind of medical education support that other hospitals get, because they are children's hospitals. That does not make a lot of sense. They do not get Medicare money.

So what we tried to do, under the guidance of Senator, Doctor Frist, is to open up the dialogue, perilous as it may be, that perhaps we need to find a better way—as sure a way, but a better

way—of funding medical education, because it is a public good that deserves a broader revenue base.

Senator MOYNIHAN. I could not ask more. Let us just keep this debate going. Thank you very much, both.

Representative THOMAS. Could I just briefly comment on your prescription drug question?

Senator MOYNIHAN. Yes.

Representative THOMAS. Because not only is that book already out of date, by the end of the year it will be amazingly out of date, given the kinds of drugs, more than 200 this year, that are coming on line far more rapidly than anyone even anticipated, fully 50 percent of those drugs designed to help seniors.

Government should not, in my opinion—and in this instance, cannot—regulate the need to mix and match and provide to seniors the prescription drugs that are available. For that reason alone, we should examine this model which would integrate prescription drugs into seniors' health care in a way that no other model that currently has been presented can do.

Senator MOYNIHAN. I thank you very much. I just would like to make the point that we probably need a broader base for graduate medical education, Medicare, and other programs. Your point is, too, that at the end of the year, that is why we will have a new edition next year.

Representative THOMAS. Exactly.

Senator MOYNIHAN. They have not got cocaine back, but it goes on. [Laughter.]

The CHAIRMAN. Next on my list is Senator Breaux. Do you want to ask yourself any questions, or of Congressman Thomas? [Laughter.]

Senator BREAUX. No. I probably could not answer them.

The CHAIRMAN. That comes as no surprise.

Senator BREAUX. Thank you. [Laughter.] It is because I ask good questions.

The CHAIRMAN. I think, next, is Senator Jeffords.

Senator JEFFORDS. I do not want to pursue the questions lengthily. I am also deeply interested in the medical education problems, as well as the prescription drug problems, which I think we all are. I do not know whether you have any enlightenment as to what your suggestions are. I have not read your report as to how we could broaden the base for medical education. I think that would be my question.

Senator BREAUX. Jim, I think what we had suggested originally is that, well, look, let us recognize it is a national obligation, let us appropriate the money for it, make it an entitlement so that there is a guaranteed flow of the money. I mean, the argument is, we fund NIH and we have been doing it very well lately, and it is through an appropriations process.

Could we not look at that as a means of doing graduate medical education? Could you take it a step further and make it an entitlement? Some would argue against that, but some would say that is the right thing to do. But take it out of the general pot of money, out of income tax revenues, instead of just taking it out of Medicare.

We did it because the money was there back in 1965, but I argue that that does not make the greatest amount of sense in 1999. Let us take it out of a larger pot of money and make sure they get it. I mean, there are a lot of ways to do that.

Representative THOMAS. Let me say also that the debate that, we just want to stay below the radar screen, leave us alone, we like the current structure, is, in my opinion, not sustainable. We have already seen an attempt in the 1997 legislation to argue that certain kinds of health delivery do not utilize the teaching hospitals as much as they should and, therefore, there should be a pass-through of money that otherwise would have been spent that these folks are not spending. That is what happens when you get in and try to jury-rig a system that needs to be rethought.

The other thing that I am amazed with is, just as the Senator from New York, and I, and virtually everyone else, believes that medical education is a public good, one of the greatest benefits this society has provided to its citizens.

To say that you cannot take the combination of academic institutions and medical institutions and create a lobbying structure—I mean, one of the reasons the defense industry oftentimes has been successful with particular weapons systems it that they build a piece of it in virtually every State, even possibly every county, to create a constituency that wants to support it. Well, you have a ready-built constituency out there in academic institutions and in medical institutions.

Were they to have what I believe should be the courage of their convictions presented publicly, you could not only get the money that you are getting now out of this structure, you could get more.

It is just an opportunity that is there, and our job is to convince these folks that, once they begin communicating with us in a way that we fully understand and appreciate their benefits, that flying above the radar, visible, with all of your support in array is a far better way to fund this system than to try to stay below the radar in a system that is not adequately funding.

Senator JEFFORDS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Next, we have Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Let me just ask a couple of questions and make a philosophical statement.

On the GME question, you went back to a tactic which was used a great deal: I am willing to negotiate, we are willing to talk. Nevertheless, what we are discussing here is what the Medicare Commission plan was. You both said, and others have said, that you want to drive it through Congress. So I have to deal with the Medicare Commission, not this sort of willingness to negotiate.

The fact was, on GME, what the Medicare Commission suggested was that it be completely left up to the appropriations process on a year-by-year, annual basis, which would, first, eliminate all doctors trained in foreign countries, which are fundamental to us, to New York, Louisiana, and many other places as well. That is what you said. That is what was written down, that it was left up to the appropriations process on a year-by-year basis.

Now, when you say, I am willing to negotiate, that says two things to me. One says, well, we have got to keep this thing alive. Then it also makes me ask the question, are you talking about what you are talking about, and that is what we did, or are you talking about just sort of keeping the ball in the air so that you can adjust?

As another way of saying that, you talk about guaranteed benefits. John and Bill, as you know perfectly well, I was on the commission. Every time we met I asked, what are the benefits, what are the benefits? There was always talk about, we are going to have hospital physicians and other services, et cetera, but there was never anything listed. There still is nothing listed.

Now, you may have something that you are drawing up in the way of legislation. Neither I nor my staff have seen that. So I have to go on the assumption that there are no guaranteed benefits. You said that they will get the same benefits as they do in Medicare today.

Well, we never saw those. We asked, we asked, we asked. We never, ever saw those. I do not know how we discuss something like this without having a standardized, guaranteed benefit package. A 10-percent variation. We talked about that. Well, what does that come to?

I guess another thing I would want to say, is I never really understood why it was that the majority of the commission so clearly wanted to leave the 15 percent lock-down on Medicare money out. I think that has something to do with the paucity of the prescription drug proposal.

I really cannot imagine doing Medicare, both in terms of solvency and in terms of relevancy, in terms of health care, without a prescription drug benefit. We cannot do a prescription drug benefit without the 15 percent lock-down on that surplus.

And I never understood why it was the Medicare Commission sort of completely took that off of the table, unless that is also up for negotiation, in which case I am glad to hear that, but then again, I have to deal with what it was that we voted on, which was the "final product," which is what you said that you want to put through Congress.

So I guess, John and Bill, what I want to say is, number one, I enormously respect the effort that you both made. I know, John, you better than I know Bill, so I can talk more directly to you on this, because we sit side by side on all committees that we serve on. You really wanted this thing to work.

The problem was, when you say, we do not want the same old, same old, I agree with that. I do not want that. But I also, representing, as we all do, seniors across this country—and the whole FEHPB thing is a whole other series of questions.

I mean, the differences between FEHPB and the Medicare Commission report are just overwhelming, the nature of FEHPB, how it is performed, what it is meant to do, income, knowledge, education, and all of the rest of it. It is very, very, very different.

But when you reform Medicare you just do not have this feeling that anybody who does not want to do what the Medicare Commission suggested, which is highly unclear to me, that they are somehow stuck in the sand and they do not want to do anything, same

old, same old. I have been around here 15 years and have done a lot of things in health care which are very much un-same old, same old. I am not in that category.

But when you are driving a plan which has so little specificity to it, as a Senator, I am obligated at least to be cautious, to be respectful of you both in your work but to be cautious, that what we are doing is, in fact, for the general benefit of the Medicare population in terms of solvency and in terms of health care relevancy.

I just fundamentally, totally, sincerely, honestly, unpolitically believe that. I do not think there is an effort to politicize Medicare, on either side. I am certainly not a part of it. I do not think either of you are.

But when we do something in Medicare, we really have to make sure, spending $207 billion as we did last year, that we do what is right, what is good, and, frankly, what is also understandable for the senior population in reference to catastrophic health care.

Now, I apologize for that. Mr. Chairman, if either of the witnesses want to respond, or if you will allow them to, I would be, obviously, happy.

The CHAIRMAN. Well, I would ask that the comments be brief because we do have a long ways to go.

Representative THOMAS. Mr. Chairman, in regard to the graduate medical education, I do have to take exception to the Senator's statement that what the commission proposed was an annual appropriation.

On page 4 of the document which was voted on by the commission where it refers to Medicare special payments and premium support system, it says very plainly that, "Since the Part A and Part B trust funds would be combined in the traditionally separate funding sources of payroll taxes and general revenues would be blurred, Congress should provide a separate mechanism for continued funding of direct medical education through either a mandatory entitlement or a multi-year discretionary appropriation program.

On the other hand, indirect medical education presents a unique problem, since it is difficult to identify the actual statistical difference in costs between teaching and non-teaching hospitals.

Therefore, for now, Congress should continue to fund the indirect medical education from the trust fund as an adjustment to hospital payments. That was what the commission proposed, either an entitlement or a multi-year discretionary appropriation program, and that is what we advocate today.

Senator ROCKEFELLER. I stand uncorrected.

Senator BREAUX. Mr. Chairman, let me comment on the benefit package. On the language we voted on in the document, I would make two points.

Number one, says as follows: "The standard benefit package in the new proposal specified in law would consist of all services covered under the existing Medicare statute.

As under current law, private plans could establish their own rules on how the benefits would be provided. Board approval would be required for all benefit design offerings and changes, but all plans would be required to offer, at a minimum, the same benefit package beneficiaries are entitled to under current law."

I cannot be much clearer. I could not write it any clearer. The same benefits that they get under current Medicare law, at least.

The second point, I would say, is it is important to separate now the commission, which no longer exists. We are talking about now a new recommendation which will have some things that are different from what the commission voted on. That is what we are trying to reach, some type of an agreement on graduate medical education. How we handle prescription drugs. Those are going to be different from what the commission recommended. That is what we are saying.

The CHAIRMAN. Thank you.

Next, we have Senator Bryan, then Senator Robb.

Senator Bryan. Thank you very much, Mr. Chairman. Thanks to each of you for the important contributions you have made in your recommendations in this debate which sometimes engenders more heat than light, as we know.

Senator Breaux, you anticipated the question that I was going to ask with respect to the benefit package. We do hear out there that, under the proposal that you have advanced, there is going to be uncertainty.

Now, the language that you read seems to me to be pretty precise. That is an assurance that the current benefit structure, at least in terms of the services offered, if I am understanding you, remain. That is the minimum, the base level, that is provided.

What is the basis of this concern that has been voiced out there? Obviously, for some people, I suspect, they do not want to make any change at all. But what is the basis? Your argument seems to be that there is no basis in fact for that, John.

Senator BREAUX. I think I would say, Senator, that whenever you begin talking about changes, two areas are always foremost in most people's minds: whether you had a defined benefit or defined contribution package.

What we are saying is, you have a guarantee on our proposal that the Federal Government would pay 88 percent of the national weighted average, you would pay 12 percent of a package that is at least as good as what you currently get under Medicare.

Now, the Medicare board's function is to make sure that everybody meets that requirement. If they do not, they could not bid. They can vary on how it is delivered. I do not think we can go down and say that every plan has to be exactly the same number of hours and minutes in a hospital bed, or the exact number of aspirins or Tylenol that they are going to pay for. But have the area that they are going to cover be at least as good as what is currently available under Medicare.

I do not think Congress can spell out the minute details of each one, but make sure that the plan that is offered is at least as good as that which is being offered under the current Medicare. That is what we are saying, that is what we are trying to reach.

That says that some plans will vary how the services are delivered, just like we have under our fee for service under the Federal plan. Different plans offer different variations, but all cover the same basics. That is what we are trying to accomplish.

Senator BRYAN. Well, as you know, much concern has been raised about the impact in rural America. Let me say at the outset

that I agree with the observation that Chairman Thomas made, that it makes no sense to have the Part A and Part B.

I think we all have an understanding that Medicare, as enacted in 1965, which probably at that time paralleled the private sector offerings, that it is a different world today and that, clearly, Medicare has a number of deficiencies. One that is most frequently called to our attention as we travel around our State is the absence of the prescription coverage, which is what you are trying to deal with.

We provided a couple of years ago a number of choices out there. That sounds fine. I am for that; I think most of us support that. But, in point of fact, in rural Nevada, those choices are illusory. Ours is a State that has a highly concentrated urban population. But 30 miles from those major population centers, the only real option that they have is fee for service.

What does your plan or proposal do that changes that? In effect, for those people out there, they are not talking to me about, gee, thank you for the choices you provide. They are very frustrated that they live 30 miles from Reno and they do not have the choices that their neighbor 30 miles in the west.

As the two of you know, that is just a stop to the grocery store. We are not talking about 400 or 500 miles away. There are those more remote areas as well. But there is just not really any choice out there.

Senator BREAUX. Well, I think it is clear that if you are in a very rural area where there are no hospitals, almost nothing works. I mean, fee for service does not work, private insurance does not work. That is another, larger problem for society.

But what we have said, in answer number four we tried to address this and explain what we have done in the questions that you have in front of you. It says, "What would happen to beneficiaries who live in areas where there are no private plans?" Well, first of all, every one of those seniors would have access to Medicare fee for service. That would continue. Every one of them would have access to fee for service.

The answer is, the beneficiaries premium for those who live in those areas with no other private plans being offered, the premium would be limited to 12 percent of the fee-for-service premium in their area, or 12 percent of the national weighted average nationally, whichever is lower, to guarantee them that they would have fee for service, yes, and that it would not be so expensive that they could not afford it.

It would be 12 percent of the national weighted average, or 12 percent of their local plan, whichever is the lower. That, I think, is a very major guarantee that people in rural areas would still be protected by Medicare fee for service.

Representative THOMAS. Might I respond, briefly?

Senator BRYAN. Sure.

Representative THOMAS. Since for more than a decade my eastern boundary was, in fact, the State boundary between Nevada and California and there was not a whole lot of difference, there were not any people on either side of the border out in the Enio County area.

What we really have in our area, Senator, is frontier medicine. It is not rural medicine. There are hundreds of miles between locales. There is just not a lot of opportunity, not just for seniors, but for regular health care delivery.

The one advantage other than the point that the Senator made that I see that this would provide would be the point that Senator Rockefeller mentioned, the 10 percent variation. One of the things we are hopeful for is that there will be a degree of innovation. We do see some opportunity in our area in the telemedicine area and in other areas that allow for remote evaluation.

It seems to me that a Medicare board, reviewing proposals with a degree of leeway for change, rather than waiting for Congress to legislatively change, could promote over the next decade changes that will create a movement toward different kinds of health care deliveries.

That is not a firm promise or guarantee, but I think you will agree, the opportunity for change brought about by this model gives us a better chance for providing decent health care for rural Americans than the current system, waiting for a political debate and a vote of Congress to change the system.

Senator BRYAN. My time is up. Thank you very much, Mr. Chairman. Thank our two witnesses.

The CHAIRMAN. The Majority Leader is here, so, with the indulgence of the panel, I will call upon him, next.

Senator LOTT. Thank you, Mr. Chairman. I will be brief because I know there are a number of other Senators who have been here longer that wish to make comments.

But I wanted to make a particular effort to be here to thank the members of the Bipartisan Commission for their work. The chairmen that are here, Senator Breaux, put a lot of time and ideas and innovation into the process that the commission considered. He made it truly bipartisan, and I appreciate his effort.

And Congressman Thomas, my old friend from the House. As usual, he knows the subject and he has hung right in there. The two of you have worked together very closely, and that is the way commissions are supposed to work. So, I thank you.

Also, the members of this committee, Senator Gramm, Senator Kerrey, were involved and they have shown courage in this instance, as in other instances, in votes we have had in the past. I note that commission member Deborah Steelman is here, too. So, I want to thank all of you for the good work that you have done.

Also, I must say, Mr. Chairman, that you and your Ranking Member, Senator Moynihan, have also shown a history in this committee of working together, being bipartisan, and showing courage. I was very proud of this committee and, in fact, the Senate, when we voted three tough votes in 1997 that would have made a real difference: the means testing of Part B premiums, proposing a $5 co-payment for home health care, and matching the Medicare eligibility age to Social Security's age.

We stepped up to the plate, we cast the tough votes, we got it done. But, for reasons that I guess are understandable, we could not get the support we wanted and needed from the administration and we could not get it moved in the House of Representatives. I

hope we will show that kind of courage again. We will try to come together on a package.

Some people look at me and say, well, what are you going to do with it? Are you really going to try to do something? Well, it begins here in the Finance Committee. If we can come together in the Finance Committee in a bipartisan package in the area of what the commission did and move that out, then it would be a marker for everybody else to consider, the President, the administration, the House of Representatives, and we could then see, what are the chances of really addressing this problem?

It needs to be done. Medicare is over 30 years old. Not many of us drive a 30-year-old car. It is time we look at Medicare and upgrade this car, get a little better model. And I think this commission has given us some direction.

The future of Medicare is the kind of system, a premium support system in which Medicare helps seniors by high-quality health insurance rather than directly dealing with providers on behalf of seniors.

I think we need to look at the innovation, the choice that the committee came up with, the way the commission dealt with the question of prescription drugs. It may have to be modified one way or another. But I think you have given us real direction, and I appreciate your effort and look forward to being able to work with you in the future. I thank the Chairman and the Ranking Member for having this hearing, and I hope we can get something done in this area. I yield the floor.

The CHAIRMAN. I would just say to the Leader that it is the intent of the Chairman, and I believe the Ranking Member, that we once again come forward with a bipartisan approach.

Senator MOYNIHAN. It surely is.

The CHAIRMAN. I think that is doable, and we should work very hard to make it a reality.

So it is now my pleasure to call upon Senator Robb.

Senator ROBB. Thank you, Mr. Chairman. I join the distinguished Majority Leader in thanking the chairman and vice chairman of this commission. This is the kind of thankless task that requires strong will and perseverance simply to come to a conclusion.

You are guaranteed going in that no conclusion that you reach is going to be ideal and, indeed, improved by every group that might have an interest in it, which is understandable.

But I think you have done an important service simply in putting the time in and putting something on the table. The old adage about "something beats nothing," at least for a place to start, is ever present.

Several of the questions that I was going to pursue have been addressed already, so let me ask a little broader question that still concerns me as someone both new to this committee and new to grappling with this issue in more detail.

I look at it in two ways. Number one, the modernization question which the Majority Leader and others have addressed. Second, the whole question of financial solvency, in the long run. I must confess to you that, as soon as the announcement was made, the solvency, as we figure it, had been extended for a number of years.

It occurred to me that we might, in using military terminology, "take our packs off" and decide we can kick this particular challenge down the road. I appreciate the fact that there are many that want to move forward in trying to find some long-term structural reform.

But to get back to the solvency question, I continue to worry about the big picture, if you will. You have already addressed the question of graduate medical education and the fact that that is taken out, under the current proposal, from under the Medicare plan and put in the general authorization/appropriations process.

That saves money if you look at the smaller picture, but it does not save money if you look at the big picture. Shifting funding between Part A and Part B does the same thing. Other provisions, that if you take certain responsibilities out of a particular committee jurisdiction and put them in somebody else's, then you have more money to spend on other priorities.

That is really my concern here, is that, in terms of looking at the long-term financial solvency, that we are not always pulling all of the disparate pieces of medical care or medical funding for the elderly together, to include Medicaid and its impact.

That is a fairly broad, general question. But can you attempt to reassure me that this has been taken into consideration or that the savings that appear on paper are not somewhat illusory if you are concerned about the big picture and paying for all of the programs for which we clearly have responsibility toward those who are the beneficiaries of these programs?

Representative THOMAS. That is an excellent question, Senator, and one that the commission grappled with, and that we will continue to grapple with. The first statement that I think needs to be made should not shock anyone. That is, we are going to spend more money on this program in future years.

The question is, is the money going to be spent in a way that the taxpayer believes they are getting value for dollar? We, as in essence the trustees, are getting the best health care purchase for those seniors.

As we looked at the old Part A, Part B, hospital and then other services, what has happened since 1965 is that more and more of the costs of health care are over in the other services. What we have as surrogates for long-term care—which is an issue that we did not address in the commission and which the Congress has to address—skilled nursing facilities and home health care, are the fastest-growing portions of Medicare.

Now, the difficulty in talking about solvency is that, historically, it has only been viewed in the Part A, dedicated payroll trust fund, when almost 50 cents of the dollar is currently coming out of the general fund and projected growth in the kinds of services funded by these two structures means that ultimately more money will be coming out of the general fund than would be in the trust fund. So, solvency is not a test that makes a lot of sense.

One of the things the commission did was focus on the portion of the general fund that was going to be consumed by Medicare, and to what extent did we want to talk about creating a Governor, or at least an early warning system, about that amount.

But, clearly, by combining Part A and Part B, by creating a single deductible and removing the discrepancies between those two pieces, we at least have a clear picture of what our financial obligations are, notwithstanding the fact that the old three-legged stool that funds it, the dedicated trust fund, the general fund, and the beneficiaries' premiums, are all still going to be part of the mix. Our job is to understand that mix and to create a system that best spends that mix.

We thought that going to a negotiated, integrated medical delivery system for a standard plan, which is your basic benefits as they will be enhanced over the future years, and a high-option plan which incorporates prescription drugs, gives us an ability to provide a health care package to seniors that could be monitored and adjusted between any one of those three areas of funding in a far more responsible way, where Congress becomes the policy board and the day-to-day structural decisions would be made by the Medicare board.

It is still going to be a very difficult problem. It is going to be a growing expense to society, but society ought to determine where the money comes from. By making it clear, we think we have a better chance of producing a debate in the future that will be less political and more based on policy because the program itself would be integrated.

Senator BREAUX. Let me make just one quick comment on the savings.

The CHAIRMAN. I do want to say, we are running out of time. So, I would ask that everybody try to be as concise as possible.

Senator BREAUX. The commission analysis showed, Chuck, that the premium support would slow the growth of Medicare spending. The estimated savings were roughly in line with those used by CBO in their debate and testimony on various reform proposals.

They said that was between 1 and 1.5 percent per year reductions in the annual growth. Over time, this results in huge savings, $800 billion in the year 2030 alone, a year, because of the movement towards premium support. Those are huge savings.

Senator ROBB. Thank you, Mr. Chairman.

The CHAIRMAN. Next, I will call on Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

He has left, but I want to compliment Senator Lott for the statement that he made. I think his expression of the desire to move forward on this issue and to do so on a bipartisan basis and to challenge the committee to live up to the sort of standards that we set in 1997 were very constructive comments and, I am certain, have sent a clearly understood signal to all of us.

I would like to ask a question about Medigap. Some of the most interesting statistics that we have had in the hearings in the last few weeks, to me, have been the fact that, whereas less than 5 percent of the general population, including those of us who are covered by the Federal Employees plan, feel it necessary to purchase supplemental insurance, that almost 75 percent of the Medicare population do.

What that says to me, is it is a commentary on the deficiencies in the basic benefit package and it is a comment on the fact that people recognize and are willing to pay out of their pocket for a

modern structure, albeit one that is sort of X + Y = a modern structure.

My question is, did the commission look at that interplay between the 75 percent of Medicare beneficiaries who were purchasing Medigap and the possibility of integrating those into a single, modern benefit package?

We would feel it very unusual, as members of the Federal Employees package, if we had to send one check off to Blue Cross/Blue Shield and another check off to insurance company X and have different kinds of coverage, deductibles, et cetera, from two different packages. But that is exactly what three out of four Medicare beneficiaries have to deal with.

Senator BREAUX. Well, I would just make a brief comment; I know Bill wants to get in on this.

I mean, you are exactly right. The average beneficiary pays over $2,000 a year out of their pocket for things that Medicare does not cover. Medigap insurance is part of those payments.

I think, and I think all of us who supported this concept believe, that through premium support and competition the plans will start covering more than is currently covered under Medicare.

Because of competition, it is going to force them to offer better benefits and more benefits, in order to get the business, and through the competition system. We statutorily say that the plans have to offer at least the same benefits as traditional Medicare, but they can offer more, and they will in order to get the business.

The only other thing we did on Medigap was to say that they all have to offer prescription drugs, which they do not do now, and thereby lower the cost if someone wants to still buy it. Hopefully, they will not have to because the new policies being offered will cover the things that are needed by the seniors in this country.

Representative THOMAS. Senator, you hit on an excellent example of the problem we have with the current system. The advantage, as Senator Breaux said, would be that the Medicare and the integrated model would provide the standard benefits and then a high option that would provide prescription drugs, like most of us understand it. But Medigap is a legislated insurance package; it is told what it provides.

In the 10 plans, interestingly enough, the A plan, which is the bare bones, provides you the ability, if you are risk averse, to avoid co-pays and deductibles, the very thing that leads a number of experts in front of the commission to say that people over consume because they do not have the moderating factor of a co-pay.

Yet, you have got to go up to the high end, the 7th, 8th, 9th, and 10th models. The J model, for example, which finally gives you prescription drugs, costs $2,400 a year.

If we could require all of those plans to have prescription drugs, and in the first plan, or A plan, only prescription drugs, you would find that, at least in today's market, if that change were made, seniors could spend between $700 and $900 and get a prescription drug plan.

But it still would not be integrated in terms of the health care delivery structure. It is still piecemeal and add-on, plus, plus, as you indicated. That is why, to really get it integrated, you move to the Medicare model of premium support.

I guess that concerns me in a couple of ways. One, the fact is that 80 percent of the Medicare beneficiaries are still in fee for service. That number has not changed very much. In fact, in some areas, with the withdrawal of managed care entities, it has gone up.

If you start, as you did, from your statement that the baseline would be the current Medicare package of benefits, then fee for service is going to be locked into where it is today and we could assume that 75 percent of 80 percent are going to continue to have to buy a Medigap policy to get a modern benefit structure.

Would it not be better to start from the first step that we are dealing with a health program here, not essentially an accounting/financial plan, and let us figure out what is the most logical health plan, including benefit structure? I think that means integrating Medigap into base Medicare and then figuring out how we are going to allocate the costs.

Senator BREAUX. I agree with you. I think that is what we are trying to accomplish. When they offer the plans, they are going to offer some of the things that are now covered by Medigap to make it the most attractive plan. People will buy the most attractive plan at the best price, and it hopefully will cover a lot of things. Now people have to buy Medigap insurance in order to have coverage.

Representative THOMAS. I would say that the Senator is perhaps even bolder than we are, because there are folks who want certain things. We are trying to create a choice structure. If we could take a clean sheet of paper and reinvent the senior health care structure today and impose it, a number of changes could be made.

But what we have to do is create a system in which people voluntarily choose what we believe to be a program that offers better benefits, and we believe, in the long run, they will because the numbers do show that they are migrating.

The statistics on the poll, which I thought was very interesting, the baby boomers and Generation X overwhelmingly supported. As more and more seniors retire, this model will look more like the health care that they got when they were working rather than the old separate structure, which seniors remember as their health care structure when they were working.

The CHAIRMAN. Senator Gramm?

Senator GRAMM. Thank you, Mr. Chairman. First of all, let me say that it was a great privilege for me to serve as a member of the Medicare Commission. I want to congratulate our co-chairmen for the excellent job they did. I was proud to be able to vote for the final package. I hope that we can refine that package in this committee and adopt it on a bipartisan basis and make it the law of the land.

I want to take my time, since I spent months and months with our two witnesses today and I have figured out what answers they would give if I could figure out good questions to ask, let me just try to address three issues that have been raised.

First of all, I am a strong proponent of the premium support system. I think it has a very strong argument to make. It puts each of us in a position to say to those who question how good it is, we can simply say, would you like to have as good of insurance as the Chairman of the Senate Finance Committee has?

I would submit that there might have been, during the oil boom, some people in my State who would have said no. But those days are long past. I think 99.9 percent of the people would say yes, and others would have been confused about the question.

Second, in terms of GME, let me make clear what the concern is. There are two States in the union that have more medical schools and more medical training than Texas does: California and New York. It is close. I have got many medical schools, and no politician in my State could be reelected that was hostile to graduate medical education, nor should they.

But here is my problem about GME. First of all, GME is funded by a payroll tax that does not tax rents or profits and, thereby, it is taxing only about 80 percent of the production by the country.

Second, it is clear to me, at least, in looking back historically at why we funded graduate medical education here, is because we were running big surpluses in these accounts. This was a vital public need. It was strongly supported on a bipartisan basis and it was a convenient place to fund it.

The problem is now that the trust fund is broke, and now trying to fund both graduate medical education and fund disproportionate share, which is basically an indigent care program, the idea of making Medicare pay for those things rather than the general taxpayers is, I do not think, sustainable.

The second problem, is that because it is an entitlement, it is on automatic pilot, and we are now producing, by general consensus, more physicians than we need, more specialists than we need, and as many people on this committee are aware, we are now paying some graduate schools in health education not to train doctors.

I mean, we are basically back in the old soil bank program, where we have an automatic pilot program paying people to train doctors. Yet, we have had for about three or four years, is it not, Bill, a program whereby we are paying people not to train doctors.

So what I want to do is come up with a funding source. But I want to also review the programs to be sure we are funding at a level that meets the market demand.

A final point on this. I hear people talk about great fear about appropriated accounts. But look at what has happened to the National Institutes of Health under appropriated accounts. I personally do not believe that the political base for the National Institutes of Health is stronger than the political base for graduate medical education.

So, quite frankly, I understand concerns people have, but I do not agree with the concerns. I think that there is a strong base in Congress to fund graduate medical education. To me, it is something we ought to debate how we do it. The old system, I do not see how we sustain it. As people go to more competitive medicine, there is no money for graduate medical education anyway, so it is being eliminated right before our eyes.

A final point about drug benefits. Everybody would like for there to be drug benefits. Everybody knows that people go to the hospital and we fund conspicuous consumption, for lack of a better name. But yet, when they leave the hospital, they often take half of their prescription drugs because they cannot afford it.

Now, obviously something is crazy with that system. I would say, I am willing to submit any drug benefit system that, one, is rational, it has co-payments. And I remind people that, when the government pays 100 percent of your pharmaceuticals, people are spending $711 a year, on average, on pharmaceuticals. When it pays none, they are spending about $350. Now, you can guess why.

So the key point is, however, the purpose of this whole effort is to save Medicare, which means saving money. If we are going to add a drug benefit, we have got to save enough money to save Medicare and to fund the drug benefit. If we can do that, I am for it.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

First of all, I think that you folks deserve a lot of credit for putting up with all of the attacks that you get. I, for one, want to applaud you for actually making such a proposal. The proposal might not be perfect, but at least it is a very important starting point. We are off to a race with the work that you have done.

It is a lot harder to put a proposal forward than to sit back and find fault. I notice that a number of my colleagues have found time to propose a new prescription drug benefit without broader Medicare reform.

So my first question, is whether any of the other commission members ever proposed an alternative plan to your plan. If so, I did not ever hear about it.

Senator BREAUX. Senator Grassley, I would just point out that there were discussions within the commission about how to handle prescription drugs. What we have, as you know, a free drug program of up to 135 percent of poverty, and some changes in the Medigap policy to offer drugs. The short answer, is yes.

Senator GRASSLEY. Were there any other comprehensive plans put before your committee? That is my main point. The point is, you cannot hardly have a new benefit like this without having some overall reform, it seems to me.

Senator BREAUX. There was nothing that was offered like some of the current legislative efforts that are ongoing that have been introduced by some of our colleagues in the House. None of that was proposed.

There were arguments that we ought to have prescription drugs made part of the regular fee for service and subsidize it up to, say, 25 percent. But there was no overall offering like we have in some of the legislative packages.

Senator GRASSLEY. All right. It seems that this discussion of premium support has a lot of the critics of your proposal now, all of a sudden, very concerned about rural health issues.

For those for whom this is a new interest, I welcome them because obviously we do have a lot of problems out there. Yes, I agree that we need to give careful scrutiny to the effects of premium support on rural America. But, while we are at it, it seems to me, we ought to take a look at how Medicare is treating rural areas right now.

This is not a success story, as many members of this committee have very eloquently stated today, and every other time we have a meeting on Medicare, and rightly so.

On the other hand, rural federal employees seem to be happy with their insurance. So my question is, if it is completely impossible for premium support to work in rural areas, then why is it possible for federal employees' plans to work in rural areas today? As far as I know, they are working very well.

Senator BREAUX. I would just make a short comment. It does work well. It is a different type of population, of course, but it works. There is competition. I know that Senator Rockefeller and I have talked about this issue a lot because of his rural State. But there are about 23 different FEHPB plans available in West Virginia. It is a different population, no question about that. But it does work in those areas that are very rural in nature.

The other point is, no matter how rural your area is, you will always have access to traditional Medicare fee for service at a rate and a payment level that is the lower of the national weighted average in the whole country. So, you are protected if you have nothing offered other than traditional Medicare fee for service.

Representative THOMAS. I would just tell the Senator that, as he well knows, no one is more responsible for raising the current Medicare+Choice or risk plan basic rate than he in making sure that the absolutely ridiculous amounts, for example, in your State, of a county getting $220 a month, is now at least up to about $380.

But what frustrates me about all of the difficulty that we went through in bringing about change and now blending those county payments between national and county, is that we are still looking, in my State and yours, at a decade of blending before we get a structure that possibly could support a premium support model.

In this arrangement, you get to negotiate on real labor costs, not imputed labor costs, against other real plans willing to offer that benefit package and not an arbitrary model created by bureaucrats.

In that sense, I think, we have a better possibility—still difficult, but a better possibility—of bringing choice to rural areas.

Senator GRASSLEY. I would like each of you to comment, if you would, on Dr. Vladeck's assertion that it is very hard to make long-term projections, so then consequentially we should not attempt to reform Medicare substantially anytime soon.

My question is, is it really that hard to forecast the Nation's demographics? What is the cost of simply waiting to see what happens, and then react to what has already happened?

Senator BREAUX. Well, of course it is hard. That does not mean we should not try and do it. I mean, these are difficult problems. That is why we are here. We just cannot say, well, it is pretty difficult to project what the future is going to look like, so we are not going to do anything. We do it all the time in Social Security, we have to do it in Medicare. Actuaries can give us the make-up of the future generation of Medicare beneficiaries.

What is uncontested, is the fact that it is going broke. In 2015, it is going to be in bankruptcy and the premiums are going to double by the year 2007. I do not think there is any disagreement with that. So the short response to do nothing is not an answer. We will be without a program if we do not do something to reform it.

Representative THOMAS. In fairness to Dr. Vladeck, I think you do have to understand that, if you are just looking at demographics, it works on a plan like Social Security, which is a dollar amount applied to an age profile.

When Alan Greenspan was in front of the commission, he indicated that, back in the early 1980's, in looking at Social Security, it was offered to that commission that they could look at Medicare as well. As he said, they politely declined.

The examination not only of the demographics of who is going to be the population, but what is going to be health care as defined at that time and what are going to be the costs, are far more difficult to determine.

The key point that I think I would like to leave you with, is that the old system, which was slower in changing and in which perhaps a government-modified structure could keep up with the changes, is no longer possible.

The idea of a premium support model is change brought about in a way that change can occur more easily in the future. That is really what the fundamental point is, allow for change in a responsible, meaningful way rather than the current way of making changes in the program.

The CHAIRMAN. Senator Hatch?

Senator HATCH. Well, I want to compliment both of you for the work that you have done here and those who have worked with you on the commission. It has been a really tough job.

One of the issues we face under the current Medicare system is with respect to the ability of the Health Care Financing Administration to make rational and efficient decisions concerning coverage for new and innovative medical products and procedures. Clearly, the experience regarding these so-called coverage decisions has been poor, and this has been a major problem for the Medicare program as well.

Now, medical technology is changing so rapidly, with improved products and procedures that will clearly enhance and save lives. Yet, these products are not getting to the beneficiaries in a timely fashion because Medicare does not pay for them.

I am not aware that you had any specific recommendation on this issue from your work on the Medicare Commission, but I would appreciate any thoughts you may have as to how we should address these various problems.

Representative THOMAS. Senator, just several weeks ago in the Health Subcommittee of the Ways and Means Committee, we held a hearing on coverage and appeals process. It is interesting to note that, while there is some concern about non-seniors and their ability to get an appeals process in today's managed care world, that in the Medicare world it is twice as bad, up to 700 to 900 days in working through the appeals process.

Senator HATCH. Now, that is pathetic.

Representative THOMAS. One of the things that I made sure, was to examine the areas that the commission did not specifically address—we could not be that encyclopedic in examining the problems of Medicare; we wanted to put a basic reform structure in place—was that I believe shortly we will be moving legislation in

a bipartisan way that covers changes in the coverage and appeals process, both at the national level and at the local level.

I do want to make sure that I compliment Nancy Ann Min DeParle, the current administrator, because when we brought to her attention that the coverage process was, in fact, illegal, it was a closed-door process, she immediately canceled that process and is going through the building of a new, more open process. But, clearly, coverage and appeals in a bureaucratic, administered price structure is always difficult.

One of our goals was, as we streamlined the process, as the Medicare board negotiated with different plans, it was the plans competing with each other that will bring about the innovation far faster than a bureaucratic structure approving a new model, sometimes months, sometimes years after it is developed.

Senator HATCH. I think she deserves some credit as well. I am glad to see that.

One aspect of reforming Medicare was, to what extent should the Congress get involved in the details over Medicare benefit and coverage issues? One of the witnesses from a previous hearing made the analogy that Medicare can be viewed as a giant insurance company overseen by two boards of directors, the Senate Finance Committee and the House Ways and Means Committee. I thought this was a very perceptive comment, and I tend to agree.

But, in some respects, I think Congress does micro manage Medicare. But, in our defense, we do so because we hear so many complaints about the Health Care Financing Administration's management of the program.

Now, I am not so sure that micro managing is a good policy. I am just not sure how to fix it. Should Congress be less specific or more specific when passing Medicare policy?

Should Congress give the Health Care Financing Administration broader authority and flexibility in implementing statutory laws? Should Congress designate a new agency, in part, to run the program as provided for under the Breaux-Thomas proposal?

Quite frankly, I hear as many complaints about the Health Care Financing Administration as I have about the IRS, and that is saying something. So, maybe we need to reform the Health Care Financing Administration first before we reform Medicare. Do you agree or disagree with that?

Senator BREAUX. Senator Hatch, the comparison you make is well thought. Medicare has about 132,000 pages of regulations, the IRS has about 45,000. We thought that that was a bureaucracy? I mean, Medicare is 132,000 pages of regulations, in minute detail, saying what is paid for, what is not paid for, how much we pay for everything that is ever provided.

How many times have you had people come to your office, and all of us, saying, we want you to introduce a bill to make sure Medicare covers this or that, or that they pay more for this or that? We are truly micro managing a bureaucracy that is engaged in price fixing everything that we sell as health care. That cannot continue to work.

No other system has this in this country in the area of health care except Medicare. It is deficient. If we do not change the whole

system, we will continue to do the same thing. That is why our package is fundamental reform.

We give tools to modernize HCFA, but we also give a whole new alternative where the marketplace and competition that the Medicare board would oversee can solve these problems in the marketplace as opposed to doing it before the Finance Committee every month.

Senator HATCH. Well, as you know, I am concerned also. Go ahead, Bill. I did not mean to interrupt.

Representative THOMAS. I just wanted to tell you, Senator, that there are excellent professional people at HCFA.

Senator HATCH. I agree with that.

Representative THOMAS. They are asked to do an impossible job today, given the rapidity of change and the degree of change. Ten thousand administered prices in 3,000 counties, you cannot get right.

I thought the lowest point of the 1997 debates was when we were in conference and we spent six hours, as members of the House and the Senate, debating whether the oxygen reimbursement should be reduced by 10 percent or 20 percent. That should be a supply item determined to be used by medical professionals, when appropriate, charged to some structure that pays for that sort of thing.

Senator HATCH. There you go being practical again. It is a terrible thing. [Laughter.]

Representative THOMAS. But your question goes to the heart of change. How do we do it? Trying to put more people in, get more dedicated people, give them more money to administer more prices that are changing faster is not, in my opinion—and I assume in yours—a solution. What we are offering is a new way that we think could help.

Senator HATCH. Well, thank you both. I appreciate both of you.

The CHAIRMAN. Senator Baucus, please.

Senator BAUCUS. Thank you, Mr. Chairman.

I want to congratulate, and do congratulate, both of you. You have worked very, very hard. You have advanced the debate very significantly. I think all of us who think a bit about this problem recognize the good work that you have done. I mean, it is very good and I commend you for it.

As we work through this, I would hope that we also pay attention to quality assurance. My sense is that, as important as it is to restructure Medicare, including managed care plans, because of the demographic changes, that perhaps we are losing some sight of the quality side.

Senator Graham touched on this and suggested maybe looking a little more at beneficiaries' satisfaction as well as quality assurance, as opposed to so much emphasis on cost. To a large degree around here, policy is budget driven. We have balanced budgets, and we appreciate that. But I think too often we do not pay enough attention on the policy side and what, really, we are trying to do here in addition to the economics.

I have two questions and I will just ask them both. What thoughts do you have as we work through this as to how to provide for incentives for more quality assurance, a system that includes

process measures as well as patient satisfaction? I think we should spend a little more time on that.

The second question really gets to a fundamental problem, where 10 percent of the beneficiaries consume 80 percent of the costs of the program. So the real question is, how do we devise a system where managed care plans, et cetera, compete for the sickest and the most expensive beneficiaries? That is the heart of the problem here, at least in one respect. In traditional fee for service, if a plan is left with a lot of these people, I am just wondering whether a premium support system will work.

The 12 percent guarantee for fee for service. I understand and I appreciate your effort there to help provide some satisfaction in rural communities. A question arises, though, but what happens when a managed care plan comes in, then leaves? Beneficiaries' premiums will go up and down, theoretically, and will be quite unsatisfactory and dissatisfying to a lot of folks.

That has happened in my State. A mental health managed care plan came into Montana, and all kinds of problems arose and they have now withdrawn. In my State, there are no managed care plans for seniors. There just are not.

So if you could just talk a little bit about both of those, I would appreciate it.

Senator BREAUX. Let me try the quality thing first, maybe, because it is obviously very important. If you have a new plan that does not have quality, you do not really have anything.

The reason why the Medicare board is established in our proposal is to provide information to the beneficiaries on the plan, to give them comparisons of which plans have worked and which ones have not, to oversee the quality of the plans that are being offered, to prevent plans being offered that only try and cherry pick healthy seniors, not letting them bid if they are going to only have a plan that is devised to go after healthy seniors.

So the whole purpose of the Medicare board is not to fix prices, but to ensure that the information on how the plans work is made available, to ensure that the plans meet financial criteria when they are offered, to make sure that they do not cherry pick the healthy as opposed to the unhealthy, and to make sure that seniors can make this selection with the number of choices that will be available to them. So, that is the role of the Medicare board.

Through competition, you are going to improve the quality of the product, because if you have a poor-quality product, people are not going to choose it. It is just that simple. If you have a good-quality product, with a good history behind it, they are going to go to that plan. That is what the board would function as, as to guarantee the quality.

Representative THOMAS. I would just say, briefly, that the problem for seniors is also the problem for most of Americans in the health care area because, through no fault of their own, we developed a system which did not require them to become knowledgeable. They simply ask, does my insurance cover it?

So the question of education of consumers is a really important one, especially for seniors. There are a lot of models in the private sector that are assisting in education. We have begun to develop those.

But the question of quality is also the ability to measure; you can at least determine on a relative basis. There are other committees on the Senate side that are wrestling with collecting data to allow us to measure quality.

We are doing that on the House side as well. It is a question of confidentiality, the ability to provide statistics. That collection of data can be used far more beneficially than we currently use it to assist seniors in making choices.

In addition, the question of 80 percent near the end of life, I am very pleased to say that the changes that we made in the 1997 bill, which we will have to continue to develop in the area, for example, of hospice treatment for seniors, is a growing area.

The whole question of geriatrics is a new and involving health care delivery area and we have to continue to work, not only with decisions that we make as societies, but as individuals in terms of the relative quality versus quantity of life. That decision is not going to be made in a committee hearing, or even on the floors of Congress. It is being made today by people in the society discussing the medical technology choice versus the quality of life. That is going to be a continually changing debate.

But the development of hospices, the providing of information, and the assistance in making decisions, I think even in the last 5 years, has changed significantly. Over the next decade, we will try to make sure that seniors who want to make a choice, heavy technology or no technology at all, is available to them.

Senator BAUCUS. Well, I appreciate that. I would hope that we would, in addition to your plan, frankly, look at other plans, other ideas, and the way other countries deal with this question. We do not have much time to solve this. We do have a little time, but not much time. I urge you and the great work you have done, as well as others of us who are working on this, to address that.

I am also a little concerned about too much choice. In this Information Age, so many of us are bombarded with so much information and so many choices. There is going to come a time when people start to tune out with respect to trying to choose and decide what is better, this, and that. I think that also has to be addressed.

Representative THOMAS. Could I respond, briefly? You mentioned another item on your list, and that was what you do between plans where choice is made. One of the tools that we desperately need and we are trying to develop is a risk adjustment mechanism so that people can make choice with a comfort level that, whichever choice they make, we are able to adjust it so that there is not the cherry picking, as the Senator mentioned, or that if you make a mistake you have an opportunity, in a timely fashion, to correct it. But that your comfort level, through education, is there and that the plans can sustain providing it because there has been an adjustment based upon risk. That tool is crucially needed and we are trying to develop it.

Senator BAUCUS. I appreciate that. I thank the Senator for turning the light out for a couple of minutes there.

The CHAIRMAN. Well, gentlemen, I want to thank both of you for the excellence of your testimony. I think it shows without question the strength of your leadership in this matter. I may never let Sen-

ators again be asked questions, because it is almost 12:00. But, we appreciation your contribution.

Representative THOMAS. Mr. Chairman, I want to take back this bell. We do not have it in the House.

The CHAIRMAN. No way can you have it!

Representative THOMAS. And some folks do not watch the lights. The bell is a good idea, and I am going to steal it.

Senator BAUCUS. We have got a five-minute rule which we go by.

The CHAIRMAN. We must proceed. Thank you.

Our second panel will consist of experts who both support and oppose the premium support model, as well as others who have explored a range of Medicare modernization options.

Two of the panelists were members of the National Bipartisan Commission, attorney Deborah Steelman of Steelman Health Strategies, and former Health Care Financing Administration administrator, Bruce Vladeck.

The other panel members include Dr. William Scanlon from the GAO, who will describe for the committee the range of reform options; Dr. Dan Crippen, Director of CBO, who will discuss the budget implications of various reform options. David Kendall, of the Progressive Policy Institute and Dr. Ken Thorpe, professor of Health Policy at Tulane, will both add their perspectives to the discussion.

Gentlemen, your full statements, of course, will be included as if read. We will start, if we may, with Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman. I am happy to be here today as an observer of these various proposals, and am pleased to respond to your invitation to summarize the array of options that have been proposed to reform Medicare.

While there has been a multiplicity of these options that have been both proposed and discussed, and they reflect a diversity of approaches to solutions, there is clearly growing consensus, as we have heard, on the problems.

The current Medicare program, without improvements, is ill-suited to serve the future generations of seniors and eligible disabled Americans. Today's Medicare benefit package contains gaps in coverage and the program's incentives and mechanisms for cost control are not adequate to keep spending sustainable in the coming years.

As you can see from the figure at the front of the room, and as well as on page 4 of our written statement, the reforms that have been proposed and discussed align themselves along two dimensions. One, expansion of the Medicare benefit package, and second, financing and other structural changes aimed at better control of costs.

In considering benefit package reforms, we need to ask the fundamental question, what should Medicare pay for? We have, and we expect to continue to have, a system where the cost of health services are shared between beneficiaries and the program.

The two commonly discussed benefit expansions are prescription drugs and some form of catastrophic or stop-loss coverage for ex-

traordinary, out-of-pocket costs. We recognize the importance of prescription drugs, in particular, because today, relative to 1965, they have become a much more important portion of medical care.

We also recognize the substantial burden that they and other service costs can be for beneficiaries with serious illnesses. Yet, considering benefit modifications raises many questions about the potential costs, the options for targeting coverage to selected services or beneficiaries, the opportunity for cost savings through substitution of services, and the potential displacement of existing non-Medicare coverage.

Critical to the consideration of modifying benefits, but even more essential because of the unsustainability of Medicare expenditure growth, are reform options to modify how services are purchased and financed.

A substantial number of such reforms have been proposed and discussed. The underlying objective of them all is to alter incentives currently in place to make beneficiaries more cost conscious and providers more efficient.

A useful way to organize a discussion of these reforms is to array them in essentially three groups: fee-for-service modernizations, Medicare+Choice modernization, and a premium support system fashioned after the Federal Employees Health Benefits Program.

We have listed many of the major options in each group on the second chart that is in the front of the room, as well as on page 6 of our written statement. There are too many options and too many variances of options to discuss in any detail here today. I would like to make a limited number of observations, however.

First, you will note we have divided this chart into two rows, pending reforms and potential reforms. The pending reforms encompass some of the elements of the Balanced Budget Act that are currently being implemented. As we discuss reform, it is important not to overlook the significance of the reforms of the Balanced Budget Act as initial steps in modernizing Medicare.

Second, there are two themes that transcend many of the reforms. One involves moving away from paying for each item or service to purchasing packages of services, and the other, to rely less on administrative pricing or rate setting and more on supplier-provided prices.

Obvious examples of the former include the Home Health Prospective Payment System based on episodes of care rather than paying per visit, or the encouragement of enrollment in Medicare+Choice where a single payment will cover all needed services.

Purchasing a package of services does encourage providers to be more efficient and employ only necessary resources. It, however, imposes a considerable burden on the program to ensure that it knows what the packets contain and that it has received value for its dollar.

Provider-supplied prices can be more beneficial than administered prices if providers have incentives to truly restrain their offered prices. That will occur only when the system is structured so that providers compete to serve Medicare beneficiaries and their costs are part of that competition.

The last observation I would make about these reform options is that the premium support system incorporates many of the elements of fee-for-service or Medicare+Choice modernizations. To have a viable, self-sustaining public fee-for-service plan, it will need to be modernized to set prices sufficiently and to manage utilization.

To maintain equitable and efficient plan participation and competition, we need to be able to do a very good job of risk adjusting rates. We also need very good information about plans' performance so that competition is based heavily on quality.

In conclusion, I would note that with the BBA introducing several significant reforms into the program already, we have a natural laboratory which is providing us some sobering observations about the difficulty of undertaking reform.

For one thing, we are learning very well that specifying the details of reform is extremely challenging and hugely important. We are also discovering that the implementation of reforms also leads to disruptions for beneficiaries and providers.

We are appreciating the vital importance of comprehensive and valid information about those disruptions, to understand that they involve desired changes in the historical status quo, or some unintended consequences of reform that we would like to undo.

Given that such insights are not immediately available, we also appreciate the need for prudence and deliberation in refining the reforms already enacted.

Mr. Chairman, thank you very much. I would be happy to answer any questions that you or members of the committee have.

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

The CHAIRMAN. Thank you, Dr. Scanlon.

Next, we will call on Dr. Thorpe.

STATEMENT OF KENNETH E. THORPE, PH.D., VANSELOW PROFESSOR AND DIRECTOR, INSTITUTE OF HEALTH SERVICES RESEARCH, TULANE UNIVERSITY, NEW ORLEANS, LA

Dr. THORPE. Thank you, Mr. Chairman, members of the committee. I am pleased to be here today to share my views on Medicare reform.

My testimony will focus on two sets of issues. First, a little bit about the savings necessary to ensure the future of Medicare, and focus on four specific recommendations to strengthen the program.

The provisions of the Balanced Budget Act, combined with reactions in the provider community, have slowed substantially the growth in Medicare spending. Table 1 of my written testimony displays the relevant figures and highlights the fact that federal Medicare spending per beneficiary is expected to grow 2.5 percentage points slower than private health insurance over the next three years, and 1.5 percentage points slower than private health insurance over the next 10 years.

Yet, despite these trends, Medicare will rise as a share of the budget and as a share of GDP in the foreseeable future. We have heard a lot about potential future reforms this morning. I think, as Dr. Scanlon mentioned, perhaps the most important future reform

that we need to keep our eyes on is the full implementation of the Balanced Budget Act.

None of the scenarios that I talked about in terms of the 10- or 20-year projections will come to fruition unless we continue to focus our efforts on implementing the remaining provisions incorporated in the BBA.

These include several prospective payment systems for post-acute care benefits, a risk adjuster for Medicare+Choice plans, and the implementation of the competitive bidding demonstrations, as recommended by the Competitive Pricing Advisory Committee. Future savings in the program are largely contingent on the successful implementation of these provisions.

Though the BBA resulted in several critical changes in the program, several areas of additional reform are required. The first concerns the movement towards the use of competitive bidding in the Medicare+Choice program. Competitive bidding offers several advantages compared to the current system. First, premiums and service would be based on a plan service area rather than on a county-by-county determination currently made by Medicare+Choice plans.

Second, it would establish a process similar to that using the Federal Employees Health Benefits Program. In the FEHB, community-rated managed care plans establish their premiums in each service area independent and separate from the premium-setting process employed by the national plans, such as the Blue Cross standard option. A separate bidding process for the Medicare+Choice plans is similar to the current FEHB program.

Three, competitive bidding could result in slower growth than the projected growth in private health insurance, and I underscore, could. The extent will depend on several key and unspecified design choices. Whether competitive bidding would have saved more than the Balanced Budget Act, however, I think is quite debatable.

The second area to focus on, is modernizing the traditional Medicare program. I think at least four changes are needed. One, is that we need to look seriously to combine deductible, look at an out-of-pocket cap, perhaps set at $5,000 to $6,000 per year, and third, and perhaps most importantly, a modest outpatient prescription drug benefit phased in over a 5- to 10-year period, starting with the lowest income beneficiaries not currently eligible for Medicaid.

These changes in the program could be financed through several means. One, is by out-year savings beyond 2002. The projected growth in Federal Medicare spending between 2002 and 2009 is expected to rise at 6.1 percent per beneficiary, compared to 4.7 percent per beneficiary between 1999 and 2002.

These changes could be made and, in part, be financed by reducing the out-year growth to 5.5 percent per beneficiary. This rate of growth is similar to the growth in total Medicare spending today. Some of these savings could also be devoted to assuring the long-term viability of the program past the year 2015.

A second area where savings could be generated could be through competitive bidding in the Medicare+Choice program I talked about. A third area I think we need to put on the table, is prescription drugs in both the Medicare+Choice program as well as the fee-for-service program with contributions from beneficiaries.

I know this committee has passed an income-related premium. I think we should look at that again in the context of providing a Medicare prescription benefit package phased in over several years.

I think the issue is going to be at what income to start the contributions and when to phase out the general revenue subsidy of the program. The program should also probably be indexed to make sure that the savings do not deteriorate over time.

A final area I think that would be important to look at, is that a lot of the discussion today is focused on the insurance part of the Medicare program.

However, Medicare is much more complicated than that. It is not only an insurance program, it provides social goods for graduate medical education, it provides care to the poor through the disproportionate share adjustment, and it provides for long-term care services.

Reform is needed across the board, and I think we need to spend careful attention focusing on the long-term care provisions of the program, really the area where, when you look at the demographic changes expected over the next 30 years, the biggest demand for services is likely going to happen in the program.

On that front, I think it would be wise to rethink the way that we fund long-term care services, both through Medicare and Medicaid, as well as the way that we deliver services to those programs.

I thank you for the opportunity, and would be happy to address any questions you may have.

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

The CHAIRMAN. Thank you.

Next, we will call on Dr. Crippen.

STATEMENT OF DAN L. CRIPPEN, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. CRIPPEN. Thank you, Mr. Chairman. I thought I was going to get to bat clean-up. It is something I never got to do as a Little Leaguer because I could not hit. Anyway, I am now back in the lineup, where I belong.

One of my colleagues at the Congressional Budget Office (CBO) has this irritating habit of looking at a nasty piece of work, Mr. Chairman, and declaring that it is really an opportunity. Then he smiles. But that is true for us today. Genuine reform of Medicare can free us of the mentality we often apply to government programs, that we have only two options—raising taxes or cutting benefits.

We may eventually have to do some of both but not exclusively, probably not predominantly, and maybe not at all, at least in the short run. There is plenty of room for improvement before we get to those two old options.

It is not simply a matter of money. We have an opportunity to significantly improve the health care of our elderly and create a system that will survive for the next generation.

You have heard this morning of several options for reform. I do not propose to expand on the list so much as to suggest criteria by which you might judge these reform alternatives. In so doing, I pro-

pose to return to some "first principles" that I believe will suggest those criteria.

One of the manifestations of the genius that is the United States is its success in developing systems that efficiently collect and respond to very diverse individual preferences and choices. That role of our economy, embodied in our private sector, is obvious.

But our political system, our unique form of representative democracy, also officially collects individual preferences for public activities. The health care delivery system is one place where the private sector and government meet, and it is not always a friendly encounter. Nonetheless, with reform, Medicare can have the best of both of those worlds.

But any reform must keep in mind several things. First, the status quo is untenable. Many of the witnesses today have spoken about that. Second, the size of the economy is important. The ability to pay for goods and services, including health care services, grows as the economy expands. Policies that enhance economic growth will make it easier to meet the needs of the elderly population, particularly in the future.

Third, improving efficiency will augment reform and expansion. Fourth, we have to keep in mind that the changes to Medicare will have profound effects on the private system of health care delivery in this country.

Fifth, the key to improving Medicare lies in the payment system. Sixth, plans and providers must bear some financial risk. For competitive systems to be viable, Medicare's payment methods must adequately compensate participating plans and providers while giving them incentives to control costs.

Seventh, financial exposure is also an important component in the decisions by individuals to utilize medical services, something members of your Committee have reminded us of this morning.

Finally, Medicare's traditional fee-for-service plan will be a major part of the program for the foreseeable future. Consequently, efforts to reform Medicare cannot ignore it.

These principles suggest several avenues of analysis, some of which Dr. Scanlon has already covered. I want to make a couple of observations, however, about both Medicare+Choice and fee-for-service, observations that I intend to be illustrative and not exclusive.

In Medicare+Choice, the need for competition has already been commented on. In establishing the system under the Balanced Budget Act of 1997 (BBA), the Congress wanted to make Medicare's managed care sector more competitive. But the BBA left in place the administered pricing system that sets Medicare payments to those plans. Consequently, Medicare+Choice has no meaningful price competition among plans.

Changing to a premium support or bidding system could expand competition to include price as well as benefits and quality of service, and in so doing, Medicare could capture some of the savings from the plans' more efficient health management as well as expand coverage.

One area, Mr. Chairman, I am going to dwell on for a minute or so is how we analyze and compensate for risk. One of the things

Dr. Scanlon and others have addressed is risk adjusters, something this committee is quite familiar with.

It takes a very large pool, probably in excess of 100,000 beneficiaries, for a plan to have anything approaching an average risk. Very few health plans have enrollment of that magnitude. Therefore, the pools of many plans have overall levels of risk that are either above or below average, and their risk profiles may well change from year to year. Nonetheless, the government's payments to Medicare+Choice plans do not adequately recognize that phenomenon. Plans with low enrollment, such as those in rural areas, are especially vulnerable to financial losses from the unexpected use of expensive services by a few seriously ill people, because such plans have too few enrollees with below-average costs to balance out those with higher-than-average expenses.

Eliminating all such risk would be undesirable, since financial risk promotes more efficient practices, but the system of payments could compensate for those differences in risk.

There are at least two ways to change the payment structure to adjust for such risk. One, of course, is using the risk adjusters that you are familiar with. The second, however, is one that we have not discussed a great deal heretofore: adjusting the financial risk in the pools by carrying out payments for certain high-cost procedures or providing various forms of reinsurance.

The second option, which has been discussed by the Medicare Payment Advisory Commission and, in fact, was developed by a couple of its members, suggests that some kind of partial capitation may be possible. Partial capitation could be introduced by blending a capitated rate and a fee-for-service rate, supplementing payments for cases that are outliers, providing stop-loss protection on aggregate costs at the plan level, or carving out selected high-cost services, such as we do now, for instance with end-stage renal disease. Most of those approaches would reduce the capitation rate across the board, imposing a kind of premium on plans in return for insurance against excessive risk, a form of insurance in which the risk pool would be all Medicare enrollees in managed care.

Regarding fee-for-service Medicare, Mr. Chairman, the other panelists have already discussed a number of reform possibilities, the primary one of which is expanding prospective payments. In terms of the policies affecting enrollees, we have included a number of options included in our volume this year on maintaining budgetary discipline, some of which show how you can improve the program in a budget-neutral way.

But let me conclude where I began: there is plenty of room for improvement. Suppose, Mr. Chairman, that rather than the current payments for, say, a liver transplant, we solicit bids that are evaluated on the basis of both price and outcomes. The list of all bidders and their outcomes and prices would be widely available. The price Medicare would pay for liver transplants would be the average of, say, the top 10 bids.

Beneficiaries could go to a facility of their choosing for a transplant but would know where the best outcomes were produced and what price Medicare would pay. We could, with that approach, improve health, lower costs, invite specialization of medical centers, improve the risk profile of plans with smaller beneficiary pools, and

arm beneficiaries with important information related to their health.

That is why the task before us is, indeed, an opportunity, Mr. Chairman. We can do better than the current system. Thank you.

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

The CHAIRMAN. Thank you, Dr. Crippen.

Dr. Vladeck, please.

STATEMENT OF BRUCE M. VLADECK, PH.D., MT. SINAI SCHOOL OF MEDICINE, FORMER HCFA ADMINISTRATOR, NEW YORK, NY

Dr. VLADECK. Thank you very much, Mr. Chairman. I am pleased to have the opportunity to be back here before this committee. It is just two years ago since I had the privilege of working with many members of the committee on the Balanced Budget Act, and I think with each passing month, as we learn more and more about the effects of that legislation, we need to try to understand what it was we accomplished and what some of the implications are.

I am not going to use my very brief remarks here this morning to rehash some of the arguments that we had in the Bipartisan Commission. Senator Rockefeller had more than enough opportunity to participate in them and watch them himself, I cannot imagine he would want to do it again.

But I thought what I would do is just suggest a few facts, both about the Balanced Budget Act and about health insurance, and about what is actually happening in the health care system today of a kind that may not have gotten adequate attention during our deliberations. Of course, I would be happy to respond to any questions.

The first thing to be said, is we need to recognize what it is we accomplished. Medicare, from a financial point of view, is in the best shape it has been in at least a generation as a result of the Balanced Budget Act.

The long-term actuarial deficit in the program, which is still there, is the smallest it has been in more than 20 years. This suggests to me the power of the kinds of changes we have already made in the Medicare program to solve some of its financial problems.

It also suggests, as Dr. Crippen has suggested, the power of macro economic forecast forces, which we seem not to be terribly good at forecasting these days, to take very serious problems and make them look very differently over a reasonably short period of time.

The second point is that this remarkable transformation from just two years ago, in the long-term financial projections for the Medicare program and indeed for the state of the economy as a whole, were undertaken largely through a set of measures that Senator Breaux would apparently describe as "same old, same old." But we have been doing this with the program for close to 30 years. We have kept the program functioning and improving for close to 30 years.

While I certainly would not suggest mindlessly extending provisions of the Balanced Budget Act past 2002, the historical record is that we will not be denied alternatives to make still further changes in the program to improve its financial performance or its economic well-being over time.

There are clearly a number of technical changes that need to be made in the legislation. I list some of them in my testimony. You do anything this big and this complicated, you are not going to get everything right.

But I hope you will resist, please, the sort of wholesale give-backs in terms of provider payments for changes made in the Balanced Budget Act—some of those reasons, I will get to in a moment—but I think that would literally be to snatch defeat from the jaws of victory.

Two other points. Not only has Medicare's financial situation changed, but that of the Federal Government has changed. You all recall that, when we completed the Balanced Budget Act, when the President signed, CBO estimated that, as a result, the federal budget would come to a break-even basis during the year 2000 and we would be on a surplus basis in fiscal 2001.

Because of this economy and because of the changes in the Balanced Budget Act, we are in much better shape than we even though we would be less than two years ago.

Given the extent to which Medicare's savings have contributed not only to the improved financial projections for Medicare, but also to the improved state of the federal budget as a whole, I think it is only appropriate to begin talking about reinvesting some of those changes which are called the surplus, or other things, in the needs of beneficiaries, and particularly in addressing the need that you have heard about so much today for a prescription drug benefit.

Very quickly, in the interest of time, let me just suggest that my problems with some of the rhetoric that we have been hearing about reform are very much colored by the fact that we have had private health insurance plans participating in the Medicare program for the last 30 some-odd years, and we have a lot of empirical data about the performance of private health insurance in the private sector as well.

What we know is, beneficiaries who can freely enter and freely leave private health insurance plans are reasonably satisfied with them. What we know, is that their quality appears to be roughly comparable to that of fee-for-service, though not as good in caring for chronically ill or seriously ill people. We have not seen any great innovation in benefit design from the participation of private plans, and we have not saved a nickel.

In fact, if you look at the performance of private health insurance premiums or FEHBP premiums compared to Medicare, over a reasonably long period of time to give you a chance to adjust for the very cyclical nature of pricing in private health insurance, then Medicare has performed at least as well under its existing structure as the so-called competitive market private health insurance would give us. That raises questions for me about the motives of people who are promoting premium support. In the interest of time, I will not go into that, but they are in my statement.

Let me just conclude by saying that, from where I sit on a day-to-day basis in the private sector in New York, this whole conversation has a somewhat unreal character to it because, as we try to operate a health system in a community in which 1 in 4 of our non-elderly adults is uninsured, in which Medicaid has largely eliminated subsidies for uncompensated care, in which our major problem with the private health insurers is not that they pay us too little, but they do not pay their bills at all, either because they default or because their computer systems are not adequate to it.

Medicare is the only system, the only part of the system, that is keeping the health care delivery system in New York City and the other major cities of the United States afloat at the moment.

What we are hearing is, in the name of modernization, we should throw out the one part of the system that is least broken to follow the model of those parts of the system that, at least on a day-to-day operational level, are collapsing in front of our eyes.

I thank you very much for the opportunity to be here. I would be happy to respond to any questions.

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

The CHAIRMAN. Thank you.

Ms. Steelman?

STATEMENT OF DEBORAH STEELMAN, PRESIDENT, STEELMAN HEALTH STRATEGIES, WASHINGTON, DC

Ms. STEELMAN. Chairman Roth, I would like to thank you for your leadership on this issue for many, many years, and for your plaudits to the commission for our work. I voted for the plan. I have to say that, if it is a good plan, it is only because we stood on the shoulders of giants; you were the one who originally proposed the FEHBP model for Medicare. We took that as our more serious basis for our work.

As a Republican, I would like to say that I think the work of this commission was very important because it established two key points: that we believe in the entitlement for seniors, that we believe in Medicare as the most important program for seniors, that we believe the best way to pay homage to the people who created this program, which is of tremendous benefit to seniors and to their families, is to make sure that it lasts for all future generations, for myself, for my children.

We studied many different ways to do it. Chuck Grassley asked if other people had issued proposals. No other commissioner put forward a whole proposal, but we looked at a lot of different things, including Senator Baucus' view that we should look at other nations' systems. We had people in from Canada and Germany. We looked at an awful lot of different things.

We did come to this model for two reasons. It seemed to be the best answer to the puzzle we face, which is, how do you improve the benefits, how do you reduce the growth rate of the program, how do you make the program run better, and how do you do it all at the same time?

This is something FEHBP has done for many years. Its growth rate is at about a point lower than Medicare's over the long haul. Its benefit package is routinely and easily updated over the years

and its system of choice is not difficult for federal employees and their families to accommodate and to get what they want. We thought that was the best model to go from.

But we then said, it is not the same population, it is not the same program. It is an employer-based model, not an individual model. It is a homogeneous, more working-age model. People have different incomes, much higher incomes. How do we take that model and apply it to the guarantees that are necessary in Medicare?

Reform cannot go anywhere if it does not increase the confidence beneficiaries have in the program. So our second reason was, we felt that this model actually strengthened the nature of the entitlement, strengthened the nature of the guarantees across the board.

If you take a look at the entitlement today, I do not find it particularly good. I do not find it a real model. If you suffer a stroke and you hit your $1,500 therapy cap, how good an entitlement is Medicare to you today if you still cannot talk? If you have had a transplant and you have had 3 years of immuno-suppressant drugs and then, poof, they are gone, how good an entitlement is that?

These are questions, and there are hundreds more like that, that no federal employee has to worry about. Your benefit packages are whole, you have stop-loss coverage, you do not have certain days in the hospital you are allowed, or certain SNF coverages you are allowed. It is a real health plan.

So we tried to take the FEHBP model and apply it to the unique population, that is the Medicare population. Certainly, I cannot improve on the observations that were made by Chairman Breaux and Chairman Thomas. Their bipartisanship was really wonderful to see, both here and throughout the commission.

So I would just like to use up my remaining time to address some of the questions that were asked earlier this morning.

Senator Graham, you mentioned Medigap, and why do we not just incorporate it. I particularly have spent a lot of time on that question because, if you take what beneficiaries spend on Medicare and what they spend on Medigap, surely we could provide a better product combining those resources.

It was with that in mind that we came to the notion of the standard option and the high-option plan because one of the lessons we learned from catastrophic, unfortunately, is that mandates are not going to work in a reform of this nature. Seniors simply have to be able to keep what they have, whether it is Medicare, Medigap, whatever.

How can we make a product that really brings them into a comprehensive world, into a full, real benefit package like you have as a federal employee, without disrupting what they may already want or desire?

We did take a look at, is there any way to improve Medigap itself, or is there any way to bring those things inside in a way that beneficiaries will not be disrupted. In terms of bringing it inside Medigap's 10 different plans, if you are talking about bringing the most comprehensive plan, Plan J, into the program, then you are talking about a drug benefit that probably costs a little bit less than the one Senator Kennedy has proposed, but is really a significant magnitude of cost, $12–15 billion a year.

So is there a way to offer a drug benefit like that that is better? We felt it was better, in a high-option plan, where the stop loss is across the board, not just on a drug piece, where it can be integrated with other delivery mechanisms, where you are not stacking the coverage like you do in Medigap to buy all of the deductible and all of this so that it could be offered more cheaply.

So we did take a look at how to deal with Medigap and we came up with a two-part recommendation: let us reform it now for those beneficiaries who want to stay in that world, but let us give an option of a comprehensive package.

We also took a look at the size of Medicare and how that would operate in the marketplace, and how we would make sure that the competitiveness existed. Clearly, we had to give a lot of powers to the board on that. But, looking at the FEHBP model again, we were comforted because, when beneficiaries have some say in this program, which they do not now, when they can put their own resources or their employers' resources to bear, they do not all choose managed care. Seventy percent of FEHBP enrollees are in fee-for-service, Blue Cross/Blue Shield or some other fee-for-service option. Only 30 percent are in HMOs.

We were trying to create a market in which, unlike the Medicare+Choice market which is price administered, you did, in fact, have an ability to have many more choices and to have more than one national fee-for-service plan.

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

The CHAIRMAN. Thank you, Ms. Steelman.

Mr. Kendall?

STATEMENT OF DAVID B. KENDALL, SENIOR ANALYST, HEALTH PRIORITIES PROJECT, PROGRESSIVE POLICY INSTITUTE, WASHINGTON, DC

Mr. KENDALL. Thank you, Mr. Chairman. It is an honor to be here as well, and also with this very illustrious panel.

I want to speak today to the broad themes that underpin the Breaux-Thomas proposal: opportunity, responsibility, and community. The opportunity for older and disabled Americans to have good health care benefits, the responsibility for those beneficiaries to choose the coverage that best suits them, and the community commitment to those who cannot take care of themselves.

But just quickly, just because it bears repeating, the problems that we are trying to address are that the fact that we have about 40 to 45 percent of the Medicare beneficiaries without adequate drug coverage, early in the next century, rising health care costs in Medicare, as well as the costs of Social Security and Medicaid, will drain away funding for research, roads, defense, and other public responsibilities.

Finally, the past efforts to reform Medicare have been very volatile. Medicare catastrophic was repealed, and the Republican attempts to limit the Medicare spending with a fixed contribution was also a dramatic failure. So the challenge, really, is to improve benefits, lower the overall spending costs of Medicare, and do it without creating a political firestorm.

The Breaux-Thomas proposal offers a road map for solving these major problems, based on the ideas of opportunity, responsibility, and community. These ideas are the same ideas that new progressives are using in the United States and elsewhere in the world to create a third-way politics.

It is an attempt to move away from a reflexive defense of government bureaucracy and a destructive bid to simply dismantle it. The third way, seeks to replace centralized bureaucracy with public institutions that enable people to solve their own problems.

The Breaux-Thomas proposal would do this by using the federal employees' system as a model, of course. It would guarantee workers have a minimal contribution, as well as the choice. Like the OPM, the Medicare board would have the ability to oversee the competition and prevent health plans from cherry picking healthy employees.

So how does this work in the Breaux-Thomas proposal? The kind of coverage that we need in Medicare right now obviously includes Medicare benefits for drugs, as well as other innovations.

Now, let me just focus on how innovations would occur, because I believe that, if the Medicare program had been like the premium support system 30 years ago, we would have had today coverage for drugs.

That is because, as drugs have evolved, the reduced costs for taking care of people in hospitals, through drugs for asthma, diabetes, and heart disease, that would create a competitive incentive for people to include those plans as they were trying to get new customers in the marketplace.

The combination of a guarantee for benefits, the existing Medicare benefits plus an incentive to have an innovative program distinguishes the Breaux-Thomas proposal from the 1995 GOP effort to set a defined contribution for Medicare.

Well, that proposal also would have been encouraged innovation. It would have let existing benefits erode if premium and prices went up faster than the dollar amounts set in law by the bill.

Second, Medicare beneficiaries should have the responsibility to choose the coverage that best suits them. Today, as we know, the decisions about price are made by Medicare legislators and regulators, by fiats here in this room and elsewhere.

Alternatively, the Federal employees' system uses competition to determine prices, and those choices by people in the marketplace, in aggregate, would set the overall spending level.

Of course, the important thing to recognize is that some people will choose to spend more, perhaps, or some people might choose to spend less. That means that we have to face up to the fact that this is going to be a different set of choices than Medicare beneficiaries have had to make before.

But it does not necessarily follow that they will get worse care, although they will be sort of priced out of the marketplace. In fact, although it may sound counter-intuitive, higher-quality care can often be lower cost. The Mayo Clinic in Rochester, Minnesota practices cost-effective medicine by doing it right the first time.

The cost of patient care in Rochester, Minnesota has been tracked at 22 percent below the national average. Now, there are

a lot of reasons for that beyond just their competitive system, but it is important to note that.

Finally, the Medicare program should have more responsibility for those people who cannot help themselves. The Medicare board would help do that by preventing cherry picking, as I mentioned earlier. We would have to get more financing for low-income beneficiaries to basically compress the price between the high cost and low-cost plans in an area so that the price that they would face would reflect their means.

Third, I want to just say that the Breaux-Thomas proposal would be better off if it had an additional feature, which is voluntary purchasing cooperatives or Medicare consumer coalitions, which is an idea promoted by the National Council on Aging.

These would give Medicare beneficiaries the same kind of opportunity for getting market clout as large employers use to demand lower prices and quality in today's health care marketplace.

So, a lot can be said about the Breaux-Thomas proposal, and I would like to go on. But I think the important thing to note is, regardless of whether you adopt the Breaux-Thomas proposal in whole this year, or parts of it, the more important thing is to send the signal that there will be a change in the Medicare program that needs to happen, and the debate needs to start today.

So, I look forward to your work in the future. Thank you.

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

The CHAIRMAN. Thank you, Mr. Kendall.

Dr. Scanlon, could you review the key differences between modernization of the current program and the premium support plan? Is it not true that many of the modernization reforms are incorporated in premium support?

Dr. SCANLON. Yes, Mr. Chairman. They are. One of the key aspects of modernizizing the current program, both Medicare+Choice and fee-for-service, is to try and move away from the administered pricing system that we have where we both try to price individual services and try to price the package of services that a plan is going to provide, and to move more towards market-based principles, where plans and providers will be submitting prices and be concerned about sort of keeping those prices low because of competition.

It is also key in that we want to make consumers more aware of the costs of their use of services. That is something that is true in both some of the proposals to modernize fee-for-service, as well as in the premium support model.

The difference between the two is really, in large part, the comprehensiveness of premium support; the idea that we would bring the entire Medicare beneficiary population into this system, we would create a public plan that is self-financing, is, from a beneficiary's perspective, competing like other plans.

There are questions we have to ask about what that exactly means because, as we have talked about today, there are going to be areas of the country where only the public plan is going to exist. It is very important that it is viable sort of in those areas, because it is the safety net for beneficiaries in many areas.

The CHAIRMAN. Thank you.

Dr. Crippen, could you elaborate on some of the Medicare-related budget discipline proposals that we might consider acting on?

Dr. CRIPPEN. Mr. Chairman, yes. I will not take a great deal of time because there are further explications in the volume that we released in April, *Maintaining Budgetary Discipline: Spending and Revenue Options.* I cite just two of them at the moment as examples of things that we can do inside a reform plan focusing on the current fee-for-service program.

For example, the current copayments in the existing Medicare program do not work very well, for a number of reasons. First, they are quite complex, and many recipients do not understand them.

Second, a benefit such as home health care, in which they might have a significant behavioral impaction utilization of services, they do not apply to but they do apply to hospitalization, in which they may have very little behavioral impact because hospitalization is not generally a voluntary activity.

The whole series of copayments in the existing Medicare system could certainly be restructured into a unified cost-sharing system, and in so doing, you might well introduce, as other members of this panel have said today, the desirable benefit of having some catastrophic or stop-loss protection on the upper end.

Again, you can make that change, when all is said and done, in a budget-neutral way, if that is your preference—there is plenty of room. But in the process, you would also enhance the incentives offered by the cost-sharing system inside Medicare.

Another example of a potentially beneficial program change that others have cited today is medigap reform. It would appear that Medicare spends a fair amount of money in part because medigap policies blunt incentives for decreased utilization of services. By changing medigap policies, as the commission recommended, you may well save money in Medicare, which could be deployed to finance other benefits such as a pharmaceutical benefit.

So there are many ways to think about changing the existing system. Of course, no one, even on this panel, would say that it is perfect. But some of the options for reform could be revenue- or budget-neutral, and then some of them could actually save money, which you could then use to enhance benefits.

The CHAIRMAN. Thank you.

Dr. Vladeck, you seem to suggest that there is no pressing need for Medicare reform at this time, except for the addition of some new programs. Is it your judgment that the program is sound enough financially that we need make no structural reforms?

Dr. VLADECK. Well, again, it is a little bit difficult to argue that the program is on entirely sound financial terms when our capacity to project the movement of health care costs or health care prices from one year to the next appears to be as poor as it is now.

But that would also suggest that our experience over just the last two years, again, suggests that the long-term well-being of Medicare is tied as much to the overall performance of the economy as it is to anything else, and we do not seem to be doing a very good job of understanding.

When I went to school, we could not have the current level of unemployment and inflation existing simultaneously. It was not possible. So I suspect it would be better to understand some of these

longer term macro economic trends a little better before we did anything that created any jeopardy for current, let alone future, beneficiaries.

The CHAIRMAN. Ms. Steelman, the suggestion has been made that all HCFA needs is enhanced authority similar to that employed by private organizations. Can you elaborate on some of the differences between private sector organizations using such mechanisms and empowering HCFA to utilize such authority?

Ms. STEELMAN. The difference between government and the private sector are profound. Government has to operate on an entirely different time frame in terms of its regulatory and legal process. Sometimes we can have a bill that will correct problems in two years, sometimes it takes four years. The private sector gets to move much more quickly than that.

But I think probably the most significant difference is that Medicare is a monopoly. It is a huge presence in the marketplace. Hospital revenues, I think, are between—depending on the hospital—60 or 70 percent Medicare-derived. The footprint Medicare leaves is absolutely enormous.

The private sector, in a more pluralistic fashion, can innovate, can change, without having the devastating effects on the rest of the marketplace. I think this is what, again, has been proven in FEHBP. Over time, FEHBP simply issues a call letter that has a cumulative effect that is innovated in terms of the benefit package and has served beneficiaries' needs very well.

In Medicare, we have stopped innovation. Cost sharing is virtually impossible to change. Some of the benefits have been virtually impossible to change. Drug coverage is the most obvious, where you enacted, then unfortunately had to repeal.

Government simply cannot function in the same way as the private sector. So to say that we simply need to give them the tools of the private sector is to suggest that they can use them in the same way. I do not believe they can.

What the premium support proposal tries to do is bring the private sector tools to bear and then focus the government's power on what it has proved it can do very well, not micro manage the prices so much, but oversee the plans and the structure of the system, which is appropriate use of government's power, and certainly an appropriate use of this committee's time as opposed to that horrific story of six hours spent on oxygen reimbursement.

The CHAIRMAN. Thank you.

Dr. Thorpe, what mechanisms would you recommend to get the Medicare program to the slower growth rate you discussed in your testimony?

Dr. THORPE. I focus on two or three areas past 2002. I was talking about a half a percentage point or so slower rate of growth. I would look at, first of all, extending certain provisions of the BBA. I think, as Bruce mentioned, not all, but certain ones of those make some sense.

Second, I think we need to have another look more broadly at how we pay fee-for-service providers under the program. We have made a number of big changes in the BBA with respect to post-acute care benefits and how we reimburse for hospital outpatient services, in particular.

I think we need to revisit that in the future, to think more broadly about broader bundling of services under a prospective payment blanket and, indeed, using many of the tools the private sector does when they negotiate capitated contracts with hospitals or physician groups, and so on. In situations like that where the hospitals, then, and physician groups, will then negotiate for supplies and inputs to provide services.

So I think we can do some innovative thinking about more rational payment for health care services, even within the context of the fee-for-service system. Paying on an episode basis would be an example. I think that there are substantial savings to be had there.

A second area that I talked a little bit about, is that I think, on the one hand, if we are going to phase in a modest outpatient drug benefit in the Medicare program, which to me, in terms of modernizing the package and dealing with the state of science and how medicine is progressing, is absolutely essential. We keep comparing Medicare to FEHBP, but the huge differences between those programs are just so obvious, and the scope of benefits that are provided between those two, that we need to do that.

But I think, at the same time, beneficiaries, on an income-related basis, should probably contribute towards the overall Medicare benefit package. I think we need to relook at that and put that, at least, on the table.

So, those would be three areas, the extenders, thinking more broadly and innovatively about how we pay for episodes of care, and putting back on the table an income-related premium to pay for some of these new benefits.

The CHAIRMAN. Mr. Kendall, would you expand on your ideas on the new relationship between the Congress and the Medicare program under a premium support system?

Mr. KENDALL. Reform of Medicare will be as much a reform for beneficiaries as it is for members of Congress. The problem is, there is no trust right now between the legislative branch and the administrative branch. It is a fight every year to determine what the prices are going to be and how to make sure that HCFA is doing exactly what you want them to do.

Changing that is going to have a huge effect on how members of Congress work. But just to say that it is not possible is, I think, not giving credit to administrators. We give the Federal Reserve the ability to set interest rates. No one dares question Alan Greenspan's words. In fact, we hang on his every word.

Why can we not get the same kind of relationship with HCFA? Well, it has to start with the idea that we are going to give them some responsibility. It is almost as if you have had a child, and you have to send them off into the world and begin to let them act responsibility.

So, in certain areas, we need to give them that flexibility to do the kinds of things that Dr. Thorpe is talking about, and others, to let them innovate and have some responsibility to do that. The accountability comes through the ability for members of Congress to see the results. That is how we can begin to change that culture.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I just want to ask two questions, then sort of do a one-minute rumination.

First, to Bruce Vladeck. I come from a rural State, and you and Debbie Steelman will faint when you hear that statement from me for the first time in your entire life. But when I say that 42 of the 55 counties in my State have no plan, or, conversely, that, I do not know, 75 to 81 percent of all counties in America have no plan, I then, in all honesty and good faith, have to deal with the statement that Senator Breaux made earlier about, well, what do you do in a situation like that?

He said, well, there is always fee-for-service. Yes, but is fee-for-service not going to be much reduced if you have many more plans, which is the purpose of the commission plan, is going to be much more reduced, much more expensive, have the sicker and other people who are chronically ill. The answer is, but they will not have to pay more than 12 percent. I have not really ever quite been able to figure out the math of that.

Dr. VLADECK. Well, Senator, I have not seen the latest version that Senator Breaux and Mr. Thomas described this morning. But, as I understand it, as opposed to beneficiaries in non-rural areas, under their proposal, even if the dynamics of a premium support model drove up the fee-for-service premium as much as, say, the HCFA actuary predicted, rural beneficiaries would still not have to pay more than 12 percent of either the average price of all plans or the average price of fee-for-service, whichever was lower.

Now, that would protect rural beneficiaries who were in the fee-for-service market. As I have told Senator Breaux and Mr. Thomas on many occasions, and would say again today, if they would only extend that protection to all Medicare beneficiaries, then I could support their proposal.

But the fact of the matter is, the best economic analyses we have, which are not as sophisticated as we would like because we still do not have a specific proposal, are that, in order to stay in fee-for-service in New York City, to take a purely random example, beneficiaries would pay premiums 15 to 30 percent more than they would under current law. Then the doubling that Senator Breaux talked about is going to happen. And New York is not unique in that regard.

Moreover, as we analyze their proposal, beneficiaries in New York who are now in managed care plans would have their benefits reduced relative to current law under their proposal.

So, I am all for protecting rural Medicare beneficiaries. I think it is vitally important. I believe, throughout the history of the Medicare program, this committee, in particular, has played an essential role in protecting the interests of rural beneficiaries. All I would suggest is that, in doing so, the committee ought to give very serious consideration protecting urban beneficiaries at least to the same degree.

Senator ROCKEFELLER. Debbie Steelman. I was always baffled by the unwillingness to take the so-called 15 percent lock-down of the surplus, which was based, I think, on an annual 2.3 percent GDP growth, which is reasonable, that was, I think, what, $650 billion, $700 billion, $750 billion over a period of some years.

Understanding that Medicare makes an enormous footprint, as you indicated, therefore, why would one not take the opportunity to do that? We are going to do that for Social Security. Republicans and Democrats seem to have agreed on that. Where there is a different, is that Republicans do not want to do that on Medicare.

That baffles me because, if one is talking about not just trying to make Medicare fiscally solvent in which that 15 percent would play an enormous part, but also make Medicare more relevant in terms of health care from 1965 to the year 2000 and beyond. It would seem to me, that 15 percent would be enormously helpful.

Ms. STEELMAN. Two questions, one dealing with Republicans and one dealing with the commission. It is my understanding that the budget resolution does create a specific Medicare reserve fund and, in terms of any long-term restructuring that comes forward from the Senate, that that would absolutely qualify for surplus usage. They want to see whether there is a reform to do it. So, I think in terms of Republicans, that is in the budget resolution.

In terms of the commission and the 15 percent question, I think we were always baffled by the fact that that was what ended up denying us the 12 votes. Laura Tyson and Stuart Altman agreed with the concept of premium support, and we really came down to just two issues. The first, was how much of a high-option plan, in terms of its stop-loss and drug coverage, should be subsidized by the taxpayer. The second, was the use of the 15 percent.

I think both of those questions were eminently workable. I was very pleased to hear Senator Breaux and Chairman Thomas this morning talk about the fact that those, particularly on the drug question, are, in fact, under discussion.

The 15 percent is simply just not a very straightforward way to do it. And I do not think it is as straightforward as what the commission, in fact, did. What we said was, we are going to have a new government guarantee. That guarantee is an 88/12 percent share of the standard option plan. That is the same beneficiary tax per share as is under current law, and that share would be funded over time.

There is no similar guarantee in current law. As we have already seen, we are under-spending what the BBA allowed by $19 billion. So, I do not know where you believe that the guarantee is better today than it would be under this. We said, there shall be this government guarantee of this percent of the premium. To me, that is a very politically powerful number. Just take a look a the 25 percent that is still the beneficiary premium under current law. That is a very difficult number to move.

Now, we did say that, to the extent that you unify the trust funds, to the extent you are committed to this growth rate, to the extent that nobody knows exactly what this growth rate will be, therefore, it is not a voucher, we are not saying we are going to index it to GEP or index it to any other non-relevant factor, we are going to pay what health care costs in a system that we think is the most efficient way to get it, a FEHBP model, a commercial market model, someplace where competition is better than, as Len Nichols put it, trying to set 10,000 prices in 3,000 counties.

We are going to pay what that yields. Now, how are we going to finance what that yields? When I am 66, when I am eligible for re-

tirement under Social Security, 65 under Medicare, my children will be 25 and 26 years old. They will be in their first house, maybe, if they are lucky. They will be buying their own health insurance. They will not have had a lifetime to build up assets.

I am very concerned about that taxpayer burden. I know that that generation will have to make the decision as to how to fund this program. Anything I do today to handicap that generation's and that economy's ability to fund this program is wrong-headed.

As Bruce has said, and we have all said many times before, we do not know what this economy is going to be like in 30 years. We do not know what it will be like in 10 years.

So we have to set in place a stable and predictable system where beneficiaries and taxpayers can have an honest discussion about financing, very different than the one from today where we simply create Part A solvency by transferring general fund revenues.

The question is going to be, how much general revenues fund this program and what does that mean for other government and public priorities like transportation, education, and other health care needs outside Medicare? That is a public dialogue question that we need to illuminate with a very bright light so that decision can be made.

In the commission, we gave a different solvency definition. We said, the definition of solvency should be the exposure of the general fund. That is what we should debate.

We said, to the extent that it is above 40 percent in any given year, that we would suggest the trustees say, that is a place where we need to stop and make a national decision. So we guaranteed a percent of premium and we guaranteed a national debate that will occur on financing.

I think that is, in fact, much more straightforward than simply a shift of one IOU to a different system that does, I admit, make a direct call on general revenues without public debate later, when, in fact, our public may not be happy with that decision. So I think our commitment was real and the difference over the 15 percent was tactical, at best.

Senator ROCKEFELLER. Can I just make my 30-second statement?

The CHAIRMAN. Thirty seconds.

Senator ROCKEFELLER. I think that Debbie said it best when she said it makes a footprint. I have always said that about Medicare. What Medicare does now, the rest of health care is going to be doing one way or another 2 or 3 years from now just because it is such a big thing. That is a little less true than it used to be 4 or 5 years ago.

But I think two things have to be said. One of the things that I felt saddest about with the commission, and I care enormously about health care, I care enormously about trying to do the right thing, I care enormously about trying to modernize, to improve, whether that is RBRVS, MVPS, ACPR, whatever it is. I want to see those things happen.

But what I do not want to have happen is for us, in a climate which is somehow fairly politically charged, as our commission was—I mean, it was. I had to go farther to the left than I wanted to in order to prevent certain things from happening. In other words, I had to overstate here because of what was being said over

here. I do not think that is a healthy position for a Senator or for any public policy person to be in.

We have a presidential election coming up. The President said he is going to present a plan. He has said that before, and we have not had it. Maybe we will get it. Maybe it will be good, maybe it will not be. I have no idea. He has still got Kosovo on his mind, he still will then.

I am just floating the idea that I think that Bruce might agree with. That is, is there an absolute compulsion that we reform Medicaid, putting in cement something this year or next year, right in the teeth of a presidential election which is going to be one of the most hotly-contested ever, with Medicare held hostage by one side or the other?

Or should we let the good work of the commission, that is, in getting a lot of heat generated, and a lot of light generated, and a lot of discussion generated to let that sort of flow out across the country, let that be debated in OpEd pieces among not just health care specialists like you all are, but also, gradually, including the people, including, in fact, even seniors so we do not have a repetition of catastrophic? It is really unfair to put on seniors what they do not understand. At this point, I do not think they have any idea of what the commission or any of us are talking about. I know that, because I had 15 hearings in West Virginia on this subject.

So, I just raise the question of, one, do no harm. You said, Mr. Kendall, send a signal. I think the commission has sent a signal that we are not satisfied with the way things are now, that things have to change.

But whether that means that we should move right now in this sort of sense of, if we do not have legislation, we will not be legislators, we will not be worth anything, we will show that we cannot lead, that we are in danger of doing some harm in a variety of ways.

I think it makes more sense to get the presidential election out of the way, then turn our attention to Medicare reform. That is the end of my statement.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I start this discussion by assuming that we are dealing with health care policy first, and financial policy as a derivative.

I am not satisfied with one of the starting points that John and Bill outlined, which is that we are going to start by saying that the standard of the benefit package is going to be the status quo. The status quo is demonstrably unacceptable. The people have said it is unacceptable because three out of four have elected to supplement that package, with an average cost, someone said, of $2,000 a year.

It is unacceptable because 25 percent of the people, assumedly those who cannot afford to buy Medigap, are being denied a modern coverage package. It is unacceptable because we are shifting costs dramatically to the States.

I do not know what percentage of that 25 percent who do not buy Medigap or Medicaid is, which means that the cost is being picked up on a cost-shared basis between the Federal Government and the State.

Representing a State with 19 percent of its population over the age of 65, where are about 65 to 70 percent of our Medicaid budget is being spent on that over-65 population, I am acutely aware of what those consequences are.

But, even in at a more humane level, we are denying to our Medicare beneficiary population, or large components of it, what we know is the best state of health care coverage.

I have had an opportunity to spend some time with Dr. Rowe of Mt. Sinai. The breakthroughs that are occurring in geriatric medicine demonstrate that not only will appropriate early intervention strategies extend life, add to the quality of life, but will actually reduce the lifetime medical costs.

If you can buy proper treatment, keep a woman, for instance, from losing their calcium level to the point that they are very susceptible to hip fractures and those kinds of aging issues, there are enormous economic cost savings by avoiding them, and we know how to avoid them. But our current Medicare program is largely devoid of those kinds of issues. Every one that is added, it is like fighting World War II to get it into the program.

With that bit of editorialization, I am now going to turn to history. As I understand the history, when Medicare was being developed, people did the logical thing. That is, they said, well, what is the kind of coverage that is currently being made available?

They looked around at what Aetna was doing, what Blue Cross/Blue Shield was doing, and they picked out a set of benefits that essentially modeled what the benefits that were being offered in the private sector in the mid-1960's were, and said, we will make these the Medicare benefits. That was a pretty sensible thing to do.

The problem is, we have been stuck in 1965 now for almost 35 years. So, it seems to me that, rather than legislate that we are going to continue to be stuck in 1965, that we ought to almost do today what we did 35 years ago.

That is to say, what is a modern package of benefits today based on what we know best serves people, and let us make that the beginning point of our discussion of what Medicare should be into the 21st century. Once we have done that, then let us ask the question of how to pay for it.

As I look at the arithmetic, and you are the experts, but someone has said that the average Medicare beneficiary spends about $6,000 a year on health care. We know that ranges from 70 percent of the people who are spending a third of that number, and about 10 percent who are spending four or five times that number. So, there is wide distribution within the $6,000 average, but just to use that $6,000 number.

The Federal Government pays $5,400 of that, because $600 is the Part B payment by the beneficiary. But in addition to that $600, 75 percent of the beneficiaries are paying another $2,000 for Medigap.

If they are paying 20 percent of the cost of services, that would be another $1,500, on average. I do not know what the average copays and deductibles are. But when you add all of those things up, the average senior is paying about as much out of his or her pocket as the Federal Government is paying out of its pocket.

So we have an expensive program that is an antiquated program, a very complicated and confusing program. I think we ought to start by saying, let us get into the 21st century and then figure out how to allocate costs.

Now, Ms. Steelman, you indicated that you thought that the premium support model would drive us towards a modern plan, which would mean that the premium support, even though it is only mandated to do what the current Medicare does, would find that the economics would be sufficient to move us from a system where the Federal Government is spending $5,400 to a system that has a real cost of about $11,000, if you add up all the things that the beneficiary is paying.

Now, I am surprised that there is that much capacity for reform within that $5,400, and the recent experience with the MedicarePlus and the retrenchment of managed care providers from the program do not give me a lot of encouragement that we can leave the current program in the law and assume that this external economics is going to make everything right.

Ms. STEELMAN. Which of the 18 questions would you like me to answer? Those are all great questions.

Let me just say that, as a legislator, you have a fundamental choice to make, which is, do you want beneficiaries to have the option of what they have today or not?

Senator GRAHAM. No, I do not want them to have the option of what they have today, because what they have today is lousy, out-of-date, and misserves their interests.

Ms. STEELMAN. If you do not want them to have the options they have today, then I think we are looking at an awful lot of turmoil in people's lives. There are at least 30 percent of beneficiaries that have employer-sponsored wrap-arounds.

The trend line there is negative in terms of percent, but positive in terms of actual enrollees. There are more seniors tomorrow that will have wrap-arounds than have them today.

Those wrap-arounds tend to fit very nicely with the Medicare benefit package. Am I going to defend it? Am I going to say it is efficient? Am I going to say it is the thing I would design if I did it? No.

But to suggest that they are not going to have that option available to them is to say that the benefits you worked for your whole life, you now do not get because we would rather do it through one big plan here.

If it were not for the tax problem, that might be all right. But how are you going to take that money? Are you going to have an employer-mandated to require them, or are you going to make the employer pay the Federal Government the taxes?

Is it better to simply say, we are going to create one comprehensive benefit package which will be standard Medicare, plus drugs, plus a stop-loss that is across the board, not just on drugs, with the ability to innovate over time at at least a 10-percent actuarial value per year, which is the FEHBP model we looked at, and then allow employers and employees to get together and say, well, gosh, does it not make more sense to buy this comprehensive plan and I, the employer, will help contribute toward that? Is there not a more efficient way to do it?

I think, in the commission, we were very respectful of what people have. Medicaid offers seniors benefits beyond what a major medical policy is, so the transition from a Medicaid senior to a full Medicare senior is enormous.

I think we felt that the most urgent need for action is to enable a comprehensive option for people who cannot afford Medigap. So, even before premium support comes into effect, we said, let us at least get a lot of those seniors drug coverage through Medicaid, up to $6 million. Let us at least subsidize that.

But let us focus on how to give them the high-option, comprehensive plan, too, that would have preventative, that would have drugs, that would have everything. So we felt that this was the best way to get to a 21st century benefit package without the kind of turmoil that a Federal mandate would cause.

Perhaps we were also too respectful of the tight margins. Perhaps our plan is more incremental than it should be. But I would say that you are the first person to suggest that, and I am going to use it in the future.

Senator GRAHAM. Well, I guess it is a legitimate question, and I think you are a very good advocate that the incrementalism that you built into your plan will get us to where we all, I think, feel we need to get. I am less sanguine about that based on my observation of the actual history of the recent action.

Ms. STEELMAN. Well, the Plus Choice market is an administered pricing system, and we knocked prices back considerably last year. So when you change things like that, interestingly enough, the market does respond.

One of the reasons that we went to market pricing here is to try to make sure that the benefits are stabilized. It is standard economics. If the price varies, the benefits are stable. If the benefits vary, the price is stable. Medicare+Choice has it exactly backwards: you make the price controlled, the benefits are going to vary. So, we think in the new system that you would actually find stable benefits and a price that is competitive.

Senator GRAHAM. I wish we had passed, in 1997, a proposal that a number of us, including myself, had strongly supported. That is, to use a competitive process to set the prices in Medicare+Choice as opposed to this goofy system that we currently use. If we had done so, I think Medicare+Choice might have had a different record and we would have learned some more.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, I want to thank the panel for their patience. We appreciate very much your contribution today.

We will leave the option to submit questions until 7:00 tonight. We would appreciate written answers from you. But your testimony has been extraordinarily helpful, and we will continue to count on it in the future.

Thank you very much.

[Whereupon, at 1:07 p.m., the hearing was concluded.]

MEDICARE REFORM

THURSDAY, MAY 27, 1999

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

The hearing was convened, pursuant to notice, at 10:12 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr., (chairman the committee) presiding.

Also present: Senators Moynihan, Baucus, Rockefeller, Breaux, Graham, Bryan, and Kerrey.

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

The CHAIRMAN. The committee will please be in order.

This is the fifth in our series of hearings on Medicare reform. I will ask that my opening statement be included as if read, and any other statements will be similarly treated.

[The prepared statement of Chairman Roth appears in the appendix.]

The CHAIRMAN. Our first panel this morning will continue discussing perspectives on Medicare reform. We welcome the first panel and ask them to come forward.

We are very pleased to have Gail Wilensky of Project HOPE, who is also chair of MedPAC and a former administrator of HCFA. Also on the panel, and we are delighted to have her, is Marilyn Moon of the Urban Institute, one of the two public members of the Medicare Board of Trustees.

Stuart Butler of the Heritage Foundation is also with us here today. Adding the States' perspective will be Ray Scheppach of the National Governors Association. The beneficiaries' perspective will be presented by Esther Canja, a representative of the American Association of Retired Persons. We are delighted to have you.

Martha Phillips of the Concord Coalition will discuss long-term fiscal responsibility. It is a pleasure to welcome you.

We will begin with Dr. Wilensky.

STATEMENT OF GAIL WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD

Dr. WILENSKY. Thank you, Mr. Chairman and members of the committee. Thank you for inviting me here to testify. As you have mentioned, I am both a John M. Olin Senior Fellow at Project HOPE and chair of the Medicare Payment Advisory Commission,

and a former administrator of the Health Care Financing Administration.

I am here, however, to share with you my views as a health policy analyst and someone who has been observing Medicare and Medicare reform for a number of years, and not in any official capacity.

I want to summarize the four points I make in my testimony for you. The first, is to emphasize, as I know you have been hearing before, that there is a continuing need for reform. Part of it is financial. Do not be fooled by the recent five years' additional solvency in the Part A trust fund that has been reported.

It is our best estimate, the trustees' best estimate, as of now, but it is based on very small, razor-thin surpluses in each of several years, and if expenditures increase only a little or revenue declines only a little, we will lose that additional five-year period. In any case, the problem remains, the financial pressures on Part B, et cetera.

Second, and at least as important, the current benefit structure is unfair. It does not include a number of benefits that are normally part of the insurance package, and Medicare pays very different amounts for people in different parts of the country.

The second point I want to make is that, while you know from previous testimony that I have given before this committee, I am a supporter of the premium support or the Federal Employees Health Care model as a vehicle of reform.

But I would like to emphasize the point, since I know some of the committee members are not a supporter of this type of reform, that many of the most vexing problems that we will have to face in premium support we will have to face in any case because they are part of any system that includes fee-for-service Medicare and a series of Medicare replacement programs.

That includes difficult issues like risk adjustment, educating seniors so they know the health plan options available in their area, monitoring plans to make sure they provide quality health care, et cetera.

The third point I would like to make is that, in reforming Medicare, either through a premium support program or any other type of program, will require a number of changes and, therefore, it is very desirable that you start now in making those changes.

It will allow you more time for transition, it will allow you to experiment with different ways to solve some of these vexing issues, and, frankly, it will allow you to recoup from some errors in case you make them along the way. It would be unlikely if you do not find better ways as you start out in the process.

The other point to make in this conjunction is that, while it is appropriate to worry about the fragile and vulnerable seniors that we have now among us and will continue to have in the future, and while it is appropriate to be concerned about some of today's seniors, many of whom are low-income and many of whom have not been used to having health care plan choices, we should not confuse today's seniors with tomorrow's seniors.

Tomorrow's seniors will have had very different experiences in terms of the kind of health care plans they have grown up with,

with choosing among health care plans, with more education, and frequently with more income and assets.

It is especially true of the women. Most of the women whc will be retiring in the next 10 years, or the baby boomers, will have had substantial workforce experience and, therefore, a lot of additional involvement in choosing among health plans, and also probably more income and assets.

Finally, I would like to just mention some of the institutional requirements that I believe a premium support model would require. In the first place, I strongly support the notion that has been raised by the Bipartisan Commission of having a Medicare board, a Medicare board that would negotiate and provide oversight to the health care plans.

I say that with no disrespect to the Health Care Financing Administration, but, rather, recognizing the different functions that this board will need to consider and to participate in.

I believe it would be appropriate to set up a different institutional structure to move some of the individuals who have been involved in the Medicare+Choice program over to that program, but also to include other people with relevant experience from the Federal Employees Health Benefit Program or CALPERS, the retirement plan in California, and particularly to have a new institutional leadership for the Medicare board.

Finally, while I believe we will have a fee-for-service program as part of our future, and I would very much like to see the Health Care Financing Administration be able to take on the role of running such a publicly administered plan—if, in fact, the Congress decides a publicly administered plan is the way to go—I worry about HCFA's ability to do so.

I worry, in part, because HCFA has seemed to have great difficulty adopting some of the normal ways that health care plans have used to try to bring costs under control and to provide better health care to its members.

Frankly, I worry because I see very micro proscriptive activities by the Congress in trying to control each and every move of the Health Care Financing Administration.

So, I plead with you to try to think about extending to the Health Care Financing Administration some greater flexibility in the future if you expect them to be able to run a modernized fee-for-service Medicare component to the program.

As much as I support a premium support system, I do believe that we should have a modernized fee-for-service component as part of the plan offerings. if HCFA is to be involved, you will need to give them a little more headway.

Thank you very much.

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

The CHAIRMAN. Thank you, Dr. Wilensky.

Dr. Moon?

STATEMENT OF MARILYN MOON, PH.D., SENIOR FELLOW, URBAN INSTITUTE, WASHINGTON, DC

Dr. MOON. Thank you. It is a great privilege to be here this morning and I appreciate the opportunity to address the Finance Committee.

My remarks will also come as policy analyst and not in my role as a public trustee, where most of my emphasis here is on the numbers. I want to talk today a little bit about some of the roles that Medicare plays that are very important, that go beyond the issue of having the most efficient possible private insurance system or public insurance system.

That is, while I think it is very important to have as a goal savings for the Medicare program and that is going to need to be an important emphasis over time, there are other things as well that may sometimes caution against moving just on the basis of seeking more efficiency.

First, I would suggest that the evidence is not totally clear that the private sector always does better than Medicare, as it sometimes said. When we looked back over the last 27 years, from 1970 to 1997, we found that actually Medicare had done better in terms of its rates of growth cumulatively over time. It is not at all clear, I believe, what the future will hold.

Both Medicare and the private sector, over time, have emphasized that getting discounts from providers and some modest changes in the way that the structure of payments are made in order to improve efficiency, the whole challenge of coordinating care and finding improvements in the way that care is delivered, is going to be a challenge for both the private sector and, I believe, should be also a role for the public sector as well.

I also think that, while there are modest savings that could be achieved from competition among private plans, there are some important caveats, that moving too far in the direction of private plans may cause some problems.

In that regard, I think that it is important to focus on some of the other goals of the Medicare program. In particular, for example, if we focused in a private system, or a privatized system, or a partially privatized system on price competition, that is going to lead to some effects that are going to be harmful to a number of beneficiaries, the beneficiaries that the program was initially designed to protect, that is, the most vulnerable, low-income beneficiaries, people with substantial health care problems who have always had trouble getting insurance in the private sector.

Shifting among plans, for example, is not necessarily a good thing. Over time, what happens is that the important emphasis on shifting among plans is going to be most useful for the healthy and the wealthy; the healthy who can afford to shift in terms of not losing doctors that they care about at a particularly point in time during a course of treatment, and the wealthy in terms of folks who will be able to supplement or afford more expensive plans. Shifting also has disadvantages in some cases because disruption of care can lead to higher costs over time.

But more important are some of the roles of social insurance that Medicare has traditionally played and that we would have to make a lot of adjustment to have the private sector deal with.

The private sector is not intended to, and should not be expected to, meet social goals. Its role is to provide a good product that satisfies its own consumers, and do so efficiently.

In that sense, I think it has certainly had some advantages, but it does not necessarily have in mind then, or does not react, to the kinds of social goals that we have.

For example, one of the important principles of Medicare has always been its universality, the fact that the benefits are there for everyone. And, although Medicare has some problems in adjusting to that across the United States and in other ways, it has done a very good job of absorbing the sickest of the population.

In fact, eligibility as a disabled person comes about because you have health care problems and not, as often is the case in the private insurance sector, that you are scorned if you have health care problems.

Also, importantly, is the issue of the pooling of risks that occurs in the Medicare program and for which, if we move to move privatization, we have to worry about how to adjust for private plans that may have, for example, a very healthy mix of the population which, on average, has tended to be the case.

It is not fair for a system to pay more on behalf of the healthy than the sick, or disproportionately more in terms of the needs of the individuals that are being served.

Risk adjustors that seek to do this are a long way from solving the problem. My concern is that traditional Medicare would be at a substantial disadvantage, and even innovative private plans that might like to, for example, specialize in high-risk populations, might find themselves at an enormous disadvantage without good risk adjustors.

Third, the role of government has always been important in protecting beneficiaries against some of the arbitrariness that might otherwise exist. One of the advantages of private insurance is it can be arbitrary. It can move quickly and flexibly, but that is also sometimes a disadvantage. I think there is a case where sometimes you do not want the most efficient health care system.

Now, I have been fairly critical of a private approach, so what would I suggest instead? What I suggest, is that we emphasize, instead of looking only at the structural issue facing Medicare, we look at the needs of the delivery system.

We certainly do not want to eliminate private plans. We certainly do not want to not have private plans. But I think there needs to be a focus on the particular role of traditional Medicare and private plans as a supplement to that. We need to invest in the kinds of things that are necessary to understand how to deliver care well in the United States, both for the elderly and disabled, but that will also have spill-over to the rest of the population.

If done in a proprietary way, it is quite appropriate that private plans would view those as their own innovations that they do not necessarily want to share with others in a competitive environment.

Medicare, on the other hand, just as we do with public research on medicine through the National Institutes of Health, can be a source of innovation and information that can be shared broadly

with other private plans and other public providers, and I think that is a critical and important role.

I, therefore, conclude that it is difficult to assume that Medicare can be in a level playing field kind of situation with private plans. It should not be because it has a role to play as the default option, as the option of last resort for a lot of people who are sick and afraid of changing for a very long time.

I agree with Gail that, in the future, we will see some improvements in the status of elderly persons, but it is going to take a very long time. An individual who is 65 today and does not have much experience with managed care will likely still be on that program for another 20 to 25 years, if that person is fortunate.

So, as a consequence, I think that we need to focus very must on the role of the traditional Medicare program and not expect it to be just one of many players. That does not eliminate the role for private plans, but it means that we need to have a special emphasis on the traditional Medicare program.

Thank you.

[The prepared statement for Dr. Moon appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Moon.

Dr. Bulter, please.

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT, DOMESTIC AND ECONOMIC POLICY STUDIES, HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you Mr. Chairman. I know you have already heard from Senator Breaux and Mr.. Thomas, and I believe the plan developed by the majority of members on the Medicare Commission that they chaired is a sound approach to Medicare reform and should be the basis of legislation.

Their premium support proposal would maintain the elderly's entitlement to a core set of Medicare benefits, yet would introduce long-term incentives to beneficiaries to make cost-conscious decisions. In my written testimony, I note ways in which this mechanism can be adapted to secure other objectives as well.

I devote most of my written testimony, however, to the governance issues involved in reform. As the majority of the commission concluded, Medicare reform will require fundamental changes in the way the program is managed and organized.

In making these changes, Congress can learn much by comparing the very different ways in which Medicare and the FEHBP are run. I should add that, while HCFA has many shortcomings as an agency, it would be beyond the capability of any agency to carry out the functions HCFA has been given.

With this in mind, I make three governance recommendations in my written testimony. First, Congress should create a benefits board. This board would propose changes each year in the Medicare benefits package, and board proposals would be subject to an up or down vote in Congress, without amendment, much like the procedure used in the Base Closing Commission. This innovation would address the problem itself, the process will remain heavily politicized and slow to change.

That problem explains why the benefits package is constantly out of date in Medicare and it is why we have to talk today about try-

ing to add a drug benefit to Medicare, even though drug coverage is a routine feature of virtually all private or FEHBP plans.

The first task for such a benefits board should be to determine the best way to introduce a drug benefit into the traditional fee-for-service segment of Medicare. Congress could instruct the board to develop a drug benefit within a specified budget.

The board might propose changes in the benefits package to achieve Congress' objectives. The plan would then be sent to Congress for an up or down vote without amendment. Should it fail to win approval, the board would develop a modified version until agreement could be reached.

My second recommendation is that Congress should create a Medicare board to manage the market for competing plans, as the Medicare Commission and as Dr. Wilensky have proposed, and take this role away from HCFA.

HCFA cannot, and should not, combine the role of managing a market for competing plans with the role of developing and marketing the fee-for-service plan, which is one of the competing plans. It is an inherent conflict of interest.

Moreover, HCFA evidently cannot carry out its consumer information functions effectively. It is significant that, while HCFA spent millions of dollars in a futile attempt to produce a consumer's handbook for Medicare.

Washington Consumers' Check Book completed the same task for the FEHBP, with more complicated differences in benefits to explain, and did so through the efforts of just one analyst working for two months with only clerical assistance.

The Medicare board, which should be separate from HCFA, would carry out functions similar to those of OPM within the FEHBP. Using the OPM model, the board would negotiate benefits, service areas, and prices with plans instead of the current approach of regulation and price formulas.

I should add here that I believe that this negotiation approach would be a crucial instrument in protecting the interests of the elderly, not just setting prices. It allows sensible decisions to be made on a case-by-case basis with individuals plans. That has certainly been the case in the FEHBP.

My final recommendation is that Congress should, as the majority of the commission proposed, give HCFA the flexibility it needs to enable the fee-for-service program to compete aggressively with managed care plans. This means that Congress should not micro manage the agency in ways that it does today.

In effect, Congress should give HCFA the same ability to compete that States and local governments routinely give in-house public agencies when they are subject to competitive bids from the private sector for a whole range of services.

Well, to put it another way, Congress should give HCFA the same kind of flexibility and entrepreneurial opportunities that school districts give teachers and principals when they create charter schools. Needless to say, HCFA should not be given these increased powers to compete if it also remains in charge of writing the rules of competition.

Mr. Chairman, it is unfortunate that the Medicare Commission was not able to secure the super majority necessary to formally re-

port out its recommendations. But that simply means Congress should not take up where the commission left off and move forward with a proposal shaped by the Chairman.

Thank you.

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

The CHAIRMAN. Thank you, Dr. Butler.

Mr. Scheppach?

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION, WASHINGTON, DC

Mr. SCHEPPACH. Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today on behalf of the Nation's governors. I would like to submit my full statement for the record, but will summarize its key points.

The CHAIRMAN. All full statements will be included as if read.

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

Mr. SCHEPPACH. The two main priorities for States in Medicare reform are increasing administrative flexibility to better coordinate Medicare and Medicaid, primarily the dual eligibles, and to prevent changes in Medicare from cost shifting tc Medicaid and other State-funded programs.

With respect to the coordination, there are significant statutory and administrative obstacles to effectively coordinating care for the 5.4 million individuals eligible for both Medicare and Medicaid, the so-called dual eligibles.

These barriers must be addressed so that interested States can make demonstration projects broadly available to low-income beneficiaries.

The authority to test new approaches should be clarified through explicit legislation authorization or creation of substantial waiver authority similar to the waiver options that exist currently for Medicaid. Included in my testimony today is some draft language prepared by the National Association of State Medicaid Directors that essentially would do this.

With respect to QMBs, SLMBs, and qualified individuals, since 1988 the Federal Government has increasingly passed on to the States the responsibility to cover cost-sharing responsibilities for many low-income Medicare beneficiaries.

The Nation's governors are committed to providing the highest quality of services to seniors, however, for QMBs, SLMBs, and qualified individuals, Congress should recognize that the strength and responsibility of the Medicaid program is providing services, not in cutting checks for a few dollars per month.

Allowing Social Security or some other federal agency to provide assistance to these beneficiaries would streamline a cumbersome system and ensure greater participation in the program. The bottom line is, it would be much more efficient for the Federal Government to both fund and administer these particular benefits.

Beyond these changes, governors ask that you remember the interrelationship of the two problems and consider the potential implications for Medicaid before proposing changes to Medicare.

There are several legislative proposals that have emerged from the Medicare Commission's work that contain serious potential cost shifts to States. NGA does not have a policy with respect to the proposal, however, we have a number of concerns.

In terms of changing eligibility from 65 to 67, the creation of a two-year window in which seniors would have no access to Medicare will force States to be the only source of health care for the dual eligibles.

The governor of Massachusetts, Governor Cellucci, who testified before the committee on this topic three weeks ago, said that this provision alone would increase Medicaid costs by $66 million in his State alone.

The proposal to increase cost sharing for home health services has been promoted as a way to contain the rapid growth in home health. Governors are worried about this cost shift as well, not only because of the projections, but because they are currently dealing with a significant cost shift crisis created by the Balanced Budget Act of 1997.

Many of the price and coverage limitations there were predicated on the concern over the growth in home health care, and States are now spending hundreds of millions trying to compensate for these changes.

Again, in Massachusetts alone, Medicaid and State-funded home health programs saw a 250 percent increase, a cost of about $12 million, as a result of those particular changes

Premium support. The cornerstone of the reform proposal generated by the Medicare Commission is what is called a premium support model. While we have not taken a position on a proposal, we urge you to keep in mind the dual eligibles that have practically no experience in the managed care market and have absolutely no fiscal incentive to economize.

The 5.4 million dual eligibles currently have no out-of-pocket expenditures and no reason to be prudent. This group represents about 15 percent of the beneficiaries of both the Medicare and Medicaid programs, but they also represent between 30 and 35 percent of the expenditures of the two programs. If you added just the State and federal cost for thee dual eligibles, they represent about $120 billion.

It is also unclear whether the Medicaid cost sharing obligations would be for the dual eligibles who select a plan for which the beneficiary premium exceeds the federal voucher amount.

Dual eligibles are not only the poorest of the Medicare beneficiaries, but they have the highest medical needs. Therefore, this demographic group is simultaneously the most expensive for care and the least able to finance the care without Medicaid support.

Unless this proposal also includes risk adjustors to account for the functional status and institutional placement, it could have a monumental fiscal impact on the Medicaid program.

Mr. Chairman, that completes my comments.

The CHAIRMAN. Thank you.

Ms. Canja?

STATEMENT OF ESTHER CANJA, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS, PORT CHARLOTTE, FL

Ms. CANJA. Thank you, sir. Mr. Chairman and members of the committee, I am Tess Canja, president-elect of AARP. Thank you for the opportunity to share AARP's prospective on the future of Medicare.

Medicare has served our Nation well. It has provided millions of older and disabled Americans with access to affordable health care and kept older people out of poverty.

Medicare is the health insurance coverage for older and disabled Americans. It is also as much a part of retirement planning for younger Americans as Social Security, pensions, and savings.

Medicare now faces some challenges, among them being prepared for the enormous baby boom generation, keeping pace with advances in benefits and delivery of care, and long-term financial solvency.

While Medicare could benefit from some of the advances in today's health care market, AARP believes very strongly that the fundamental principal of Medicare will never be outdated, that it is a program that provides access to affordable, dependable, quality health care to those who, throughout their lives, paid into it.

To this end, there are several tenets that have successfully guided Medicare and must be part of any reform effort, including: a defined set of benefits including prescription drugs; an adequate government contribution that keeps up with the benefit package; protection from burdensome out-of-pocket costs; eligibility at age 65 for all who qualify regardless of their income or health status; effective administration; and adequate and stable financing.

My written statement elaborates on the importance of these principles. The success of any changes to Medicare depends on three things. One, a thorough analysis of all the issues. Two, a dialogue with those who have a stake in the program. Three, a good understanding by beneficiaries and policy makers of what proposed changes mean in policy and human terms.

Mr. Chairman, your continuing hearings are making an important contribution toward this. Senator Breaux's premium support plan and other proposals that will emerge provide opportunities for examining different reform options and for stimulating debate.

Genuine debate is critical to building public understanding and support for reform. AARP believes that it would be a serious mistake for anyone to hinder debate, or for Congress to rush to judgment on any reform option.

If legislation is pushed through too quickly before the effect on beneficiaries and the program is known, and before there is an emerging public judgment, AARP would be compelled to alert our members of the dangers in such legislation and why we could not support it.

At this stage, AARP has reserved judgment on the Breaux plan to encourage debate and because many of the critical details have not yet been spelled out. My written statement identifies key questions that need to be answered so all of us understand the impact of premium support on beneficiaries and on the program.

Mr. Chairman, AARP is committed to making Medicare stronger. We look forward to working with the committee and the Congress to advance the debate over Medicare reform and to carefully explore the best options for securing its future.

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

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

The CHAIRMAN. Thank you, Ms. Canja.

Now, Ms. Phillips, please.

STATEMENT OF MARTHA H. PHILLIPS, CONCORD COALITION, WASHINGTON, DC

Ms. PHILLIPS. Thank you for inviting me to testify today on behalf of the Concord Coalition, a grass roots bipartisan organization concerned with fiscal responsibility, generational equity, and long-term economic growth.

At least, the federal budget, after three decades, is approaching balance, not counting Social Security. However, a balanced budget is temporary, at best. Even if we do not get caught by war or recession, the baby boomers will catch us because the cost of Medicare, Social Security, and other senior benefits will skyrocket.

You have heard these statistics so many times, they have lost their shock value. Instead of having 450,000 new Medicare enrollees like we had in 1997, by 2022 we will have a staggering 1.63 million new enrollees just in that one year alone lining up to get on the rolls.

It is not just more retirees, it is that the people who are already old are going to be living longer. We are going to go from having 12 percent of our population in retirement status to 20 percent.

At the same time that the number of retirees are almost doubling, the number of working-age taxpayers is going to remain static. Any time you have a new, young worker entering the workforce from high school or college, at the same time you are going to have somebody turning 65 or older leaving for retirement.

That is only part of the Medicare's problem. The other part is the growing cost per beneficiary. The official projections show that this is going to slow down to only 6 percent a year, but that is a lot faster than the economy grows.

As a result, Medicare costs per capita will drive Medicare from less than 3 percent of GDP today to 5 percent by 2020, 7 percent by 2040, and these are optimistic estimates and do not include Social Security, Medicaid, prescription drug benefits, long-term care, and other factors.

Will taxpayers be able, or willing, to support this future burden? It is doubtful. Excluding interest, seniors already claim half of federal expenditures. Now, whether that is fair or not is arguable. But how much more than half will future taxpayers be willing to devote to their elders? That is where we are headed with the current program.

Will a magic elixir be found that doubles productivity and boosts annual economic growth rates to 6 percent over the long term? Not likely. Can Medicare costs be managed by repeating tweakings with provider cutbacks, greater reliance on managed care, vigilance against waste and fraud? No, again.

The Concord Coalition believes fiscal responsibility requires strenuous efforts, and make them soon, to bring promised future Medicare benefits into line with identifiable future resources.

There are really only two responsible courses of action: either raise the revenues to meet the anticipated costs, and this means looking beyond payroll tax which is already the largest tax for most working-age Americans, or reducing the benefits to a program level that can be supported by the taxes that we now dedicate to Medicare, or a little of each. Either course is responsible, neither course is easy.

What is both irresponsible and easy, is to continue to promise benefits, and even promise larger benefits, and refuse to raise the revenues to pay for them. What is particularly reprehensible is to block or delay responsible bipartisan efforts to reform the program so that the issue can be used as a political wedge.

Concord believes that generational responsibility means that each generation should, as much as it can, prepay the cost of its own retirement package. That will be all the more important when you have a large retired generation, the boomers, followed by a smaller working-age population, the baby busters. We also believe it is reasonable to consider increasing the Medicare eligibility age.

We think generational responsibility also means that no group of citizens should be immune from helping to solve this problem simply because they have made it across a chronological age threshold, especially when many of them are doing better financially than the younger people whose taxes are supporting their benefits.

We have supported means testing as a fair and equitable way of trimming back the cost of the program. When Bill Gates retires, why should a single mother earning less-than-average wages pay for his health insurance? Why should he not pay his own premium?

In 1990, which is the last year that we have data for, 16 percent of Medicare benefits went to people with incomes of $50,000 or more in 1990. Most of them could better have afforded to pay their full premiums for Part A and B combined than working families with several children could afford to fork over a hefty chunk of their paycheck to support elderly benefits.

Concord generally supports moving Medicare to an FEHBP-type premium supported system, but we wonder whether a flat premium is the best approach. We think those who can pay full premium should be asked to do so, and others should be charged less on a sliding scale.

Concord believes the universal guarantee that Medicare offers should not be free health insurance no matter what, but rather access to health insurance at a price commensurate with beneficiaries' ability to pay.

It is important that Medicare be addressed soon. Changes require long lead times, as other panelists have pointed out. It is estimated that moving to a premium support system could require a decade or longer to be up and running smoothly.

Entitlement programs are commitments between people and their governments. People base their behavior and make their plans based on current provisions, so we need to give people a long lead time to plan and adjust to changes, and that means starting soon.

Finally, it is important to remember that Medicare is only one of these supports for seniors, along with Social Security and Medicaid. If you use up all of the resources to solve one problem, those resources cannot be used to solve the other problems.

Keep in mind the triple whammy of Social Security, Medicare Part A, Medicare Part B. Today, the Social Security surplus is just about enough to pay for the cash shortfall of Part A, plus the general revenue infusion that goes into Part B.

By 2035, the combined cash shortfall for all three programs, Social Security, Part A, Part B, measured in today's dollars, adjusted for inflation, will be $670 billion annually, each year, on the course that the trustees tell us that these programs are tracking on.

By 2070, the annual costs, if one can make any projections that far out, is officially projected to be $1.3 trillion, year in, year out, in inflation-adjusted dollars. That is unsustainable, that is irresponsible, but that is where the commitments already built into Social Security and Medicare will take us if we do not change the programs.

Some advocate expanding Medicare's commitment to include prescription drugs and long-term care. Concord believes it would be generationally unfair and economically damaging to even consider such expansions unless ways were found not only to pay for the new benefits, but also to bring the current commitments into line with identifiable future resources.

Thank you.

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

The CHAIRMAN. Thank you, Ms. Phillips.

Dr. Wilensky, you noted that we are designing a Medicare program for the future and that the beneficiary population in the future could present a very different profile from today.

Could you elaborate on this, especially changes relating to women?

Dr. WILENSKY. This is an issue that has been raised many times. Before the committee it was raised, also in the retreat that the Finance Committee had recently. You need to be aware of the current Medicare population.

There are many people who have not had experience with managed care who are choosing health care plans, as Marilyn Moon, Judy Feder, and others have testified before you. These populations are lower income. Not poor relative to the rest of the population, but lower income.

But I think it is equally important that we remember the future generation of Medicare. The baby boomers and the people who will be retiring in the next 10 years are, for the most part, better educated, with greater income, have had choices among health care plans, have experienced managed care, and particularly the women's experiences have been very different.

Most of the women who will be retiring starting in the next 10 years have had substantial periods in the labor force. That means that their acquaintanceship with health care plans and choices is very different.

So, while I suspect you will have to do something to protect some or all of existing seniors, grandfathering or grandfathering them in,

or those over a certain age, or those who are frail, I think it is equally important not to design Medicare for the 21st century based on today's seniors.

The CHAIRMAN. Now, a couple of witnesses have raised concern about whether beneficiaries with cognitive disorders, such as Alzheimer's disease, could be served properly under a Medicare program that involved widespread health plan choices.

Do you share this concern about whether their needs can be met? I would ask you, Dr. Wilensky, and Dr. Moon, perhaps, to comment, and anyone else on the panel.

Dr. WILENSKY. Clearly, people who are cognitively impaired with Alzheimer's, dementia, or anything else need some protections. Presumably, these same individuals need protections now in terms of how they carry on their daily lives, which doctors they see, how they receive their health care.

So, in no way do I want to demean or belittle the needs of this population, but I do not think it is something that is uniquely of concern to a program of premium support, or any other program. They need to have protection. Presumably, now, at least, they have some.

If we were to move to a full premium support program, there clearly would need to be assurances that individuals that are cognitively impaired have both ways to have support in terms of making their choice, and presumably that would be an allowance for making a different choice throughout the year if there was, in fact, some indication that this was providing particular hardships.

Again, it is, fortunately, a relatively small part of the program and I think we ought not to design Medicare for the 21st century because we know that these individuals exist, rather to provide some meaningful protection.

The CHAIRMAN. Dr. Moon?

Dr. MOON. While it is still a minority, certainly, of the population, over 20 percent of all Medicare beneficiaries have severe mental health problems, Alzheimer's disease, dementia, and a large number of the young disabled population have severe mental illness.

Those are some of the people that are of particular concern. I think there are other groups that are also of concern. I agree with Gail that there are other problems that these folks face no matter what the organization is.

One of my concerns about a choice world is the importance of making that choice. It is a very large decision that you would make every year and it is a decision in which you would be looking at private plans who would have a great deal of flexibility in terms of the controls and restrictions that they put on use of care.

Those controls and restrictions very few people understand when they look at plan pamphlets even today, and I suspect it is going to be a big challenge for the Medicare population. I am much less sanguine about the ability to adjust for this problem now, and even for a considerable period of time.

I think that, if individuals are going to have choice, there is a lot of careful management of the rules that have to be done. Ironically, what that does is undermine to some extent the flexibility that private plans would have to do their own innovations in terms

of management of cost. So, there is a balance there that I think would have to be worried about to a considerable degree.

The CHAIRMAN. Ms. Canja, the questions that AARP raised in the written statement will, I think, be very helpful to us as we think about Medicare reform. You have given obviously a great deal of attention to the idea of a Medicare board.

First, what would be your recommendation about how to make such a board accountable, while also insulating it from undue political pressure?

Ms. CANJA. Well, you have really hit on one of the key concerns, and that is the accountability. So, really, there have to be representatives of all of the stakeholders, along with independent experts.

I think we have to be very careful about what the role of the board is and what the parameters are to make sure that Medicare does not change so much beyond the wishes of Congress and of the public and that there is accountability so that those changes can be controlled in some way.

We have to realize that this is not just a board of 20 or 30 members, this is really going to be a super HCFA. They are going to have control over the entire administration of the program. So, it has to be a board that is capable of handling that type of responsibility. But I think that there has got to be, before we even can agree to the concept of a Medicare board, we have to know what the role is and what the parameters are gong to be.

The CHAIRMAN. Let me turn to you, Dr. Butler. What lessons can be learned from the FEHBP experience on how to best inform beneficiaries about their choices among plans and benefits?

Dr. BUTLER. I think there are a number of lessons that can be learned. I think, in general, it is fair to say that, if you look at the track record and the satisfaction of those that are under the FEHBP compared with Medicare, it is markedly greater.

But I would say that there may be three broad lessons that can be learned. The first, is that it is possible to give people understandable information on choices that they can make.

As I have emphasized, you see what has happened within the FEHBP in terms of simpler information, easy-to-read information that is routinely available to every member of Congress and to staff, and you compare that with the great difficulty that HCFA seems to have in doing the same kind of thing.

So I think it is very important, first of all, to recognize that, merely because HCFA says it is difficult to do this task, it should not be taken as the final word on the matter.

I think, second, the FEHBP shows that you do not have to be a medical expert to make decisions when you get information. The fact is, if you look at how people actually make decisions in the FEHBP, not including very elderly people, they do not only look at the information that they get from the government or consumer organizations, but they also rely on other organizations with which they are affiliated.

For example, the National Association of Retired Federal Employees is constantly informing and recommending plans to more elderly federal workers and retirees. I would envision that, under

a more choice plan in Medicare, that AARP and other organizations would play this kind of role.

So, I think it is important that there are other ways of providing additional information, and that is what happens within the FEHBP.

The third thing I would say, is that the power of the Office of Personnel Management within FEHBP to negotiate with individual plans and to require them to provide information on their plans in a very simple, understandable way, in booklets and so forth, as well as looking at building in protections to ensure that marketing practices of individual plans do not confuse individuals.

That is another aspect of FEHBP that I think should be looked at carefully as a way of dealing with the understandable concerns of wide choices within a reformed Medicare program.

So, I would say those are the three broad lessons that come out of the FEHBP, and I think they are very strong lessons.

The CHAIRMAN. Let me ask you a question, Ms. Phillips. I was interested in your observations on the baby boomer generation and generational responsibility. Would you elaborate on what the generational relationship will be after about 2010?

Ms. PHILLIPS. After about 2030, actually, all of the baby boom generation will have moved into retirement status. This will be happening between, roughly, 2008 or 2010 and 2030. There really will be so many retirees at that time, not just the boomers but the people who are older than the boomers, who will still be around to a large extent.

The people of working age are not as numerous. It is true that we have got more young people now in the public school system in the millennial generation, age newborn through 18, than there were boomers. But, as a percentage of the population, they are smaller.

So what will the relationship be? Under our current programs, we are still set up for a pay-as-you-go relationship. The young people who are working, or middle aged people who are working, will be responsible for paying for the programs of the people who are retired.

The people who are retired may say, well, we paid in when we were working so we deserve these benefits. But the monies they paid paid for their parents' or grandparents' benefits.

Today, to be elderly no longer means being poor. There are some elderly people who do not have enough money but, by and large, the elderly, thanks to these programs, thanks to the economy and good times, are today, and in the future are likely to be, better off.

If there is any group that should be singled out for special treatment by the Federal Government, it is children. They are the people who are our future citizens, our investment in our future economy, our future workforce.

For every dollar that the Federal Government spends on children, it spends $9 on seniors. Even if you put in State and local expenditures for education and Medicaid, it is still 3 to 1. Generational responsibility means taking those things into account.

The CHAIRMAN. My time is up, but I would like to ask you, Mr. Scheppach, one question.

Senator MOYNIHAN. Mr. Chairman, you represent the Republican side. [Laughter.] I think you should have equal time.

The CHAIRMAN. Well, is that unanimous? [Laughter.]

Let me ask, if Congress were to create an outpatient drug benefit for the Medicare program, what issues would be important for us to address from the perspective of the Medicaid program?

Mr. SCHEPPACH. Well, I think, as always, it is basically, how does it fit with Medicaid? Different States have different drug benefits currently, so you have got a lot of differentials there. Of course, they do it essentially for the dual-eligible population.

So the question for you is, how much further up that income stream are you going to go, who is going to pay for it, and who is going to administer it? I think the States are now gaining some experience with administering it, but our sense is that we would prefer the Federal Government to administer any particular drug program.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, just for purposes of our committee itself and our guests and all, these acronyms really can get out of control. The FEHBP. When I hear it, is that a subsidiary of British Petroleum?

Dr. BUTLER. Which is now, of course, a subsidiary, I believe, of American Oil. [Laughter.]

Senator MOYNIHAN. That is right. Dr. Butler would know that. The Federal Employees Health Benefit Program. It adds a little time, but it's worth it; you know what you are talking about.

I would like to be, as a Medicare recipient and a Social Security recipient, a little grumpy and dissatisfied, as all seem to be once the government starts looking after you. Do not pay too much heed to that, Dr. Butler.

I am concerned about this preoccupation with that baby boom cohort. It really is a demographic irregularity that has been causing us all sorts of trouble for 60 years now, or 45. It is not clear to me that it is the future, but rather than it is, in fact, a one-time event.

In the early 1970s, when we still had the President's Science Advisory Committee, PSAC, as it was called—sorry about that. President Eisenhower had set it up. I was a member. Under the chairmanship of James S. Coleman, University of Chicago, we took a look at this phenomenon.

At that time, it seemed that campuses were out of control and would, of course, stay out of control. Once something has happened, you always project it will continue. Crime and disorder in cities was a fixed condition that would not go away.

From 1890 to 1960, the number of persons 14 to 24 grew at a rate, I think, of 8 million persons a decade. Then in the 1960s, the size of that cohort increased by the same amount that it had done in the previous 70 years. Then the following decade, it would revert to the historic pattern.

We said, you are just seeing an irregularity. I was able to write an article for the Public Interest called "Peace," saying, "Campus disorders are over." They are a function of that demographic group.

The demographers refer to those people as barbarians. They attack the society and, if society has enough defenders, they absorb the barbarians. If not, the barbarians overthrow them. This is true of barbarians, as well. You have to teach people to be a barbarian. You are not just born one. You are socialized to one role or the other.

So, it does not follow that we are going to have this crisis indefinitely. It may just be the same crisis, where we had to get federal aid to education when these children were in grade school.

We had to get to federalize national guards to put down campus revolts when they were in college, and we will have to pay a lot when they are in nursing homes. But it was a one-time event. Anybody have any comment on that? Ms. Phillips, you were very helpful in your concern for generational equality. This cohort has extracted an awful lot from this society.

Ms. PHILLIPS. And they want more.

Senator MOYNIHAN. And they want more. Well, of course we want more; think of all the difficulties of our adolescence. But with children, the disparity is almost 9 to 1, did you not say, in federal aid dollars spent?

Ms. PHILLIPS. The baby boom generation is, I think, probably a one-time, unique occurrence and it is very easy for the Concord Coalition and a lot of people who are trying to dramatize the population impact on our programs for the elderly to use the boomers' retirement as shorthand. But, actually, it is merely signalling a very rapid onset of something that would happen anyway, which is the aging of our population.

Senator MOYNIHAN. Longer lives.

Ms. PHILLIPS. We are going from a population pyramid to something much more like a population column, where you are going to have roughly the same number of people in each of those 5-year-old cohorts, going all the way up not only just to 80, 85, but 85 to 90, 90 to 95, as people live longer. We have seen this in nations around the world.

We are lucky. We are only headed toward a situation with our birth rates and immigration rates where we are looking at two working-age people for every retiree in the future instead of the 3 to 1 that we have now. There are nations in the world, industrialized nations, that are looking at 1 to 1.

Senator MOYNIHAN. There is going to be 1 to 1.

Ms. PHILLIPS. That is going to really be quite a strain. So, we know this strain is coming. It is just coming very suddenly and rapidly because the boomers are making it happen so quickly.

Somebody once gave me the mental picture of, do not think about the problem like a python that swallowed a pig, think about it as the python that swallowed the telephone pole. I mean, it is permanent.

Senator MOYNIHAN. Thank you, Mr. Chairman. Thank you, Ms. Phillips.

The CHAIRMAN. Next, is Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I might say, Senator Moynihan, we are glad you are back. It was dull when you were gone.

Dr. Wilensky, I was pleased that your first four points was the fact that we needed to think about what kind of a Medicare program we wanted to have for the 21st century. I agree, my opinion is the first question.

I believe the current Medicare system has been inappropriately characterized as being stale, dated, unresponsive, because, in fact, what we have done is we have set up a system in which we have a Medicare system, and then 75 percent of the Medicare beneficiaries buy a Medigap policy to fill some of those gaps, another 15 percent are covered by Medicaid, which fills many of those gaps, and it is actually only about 1 out of 10 of the Medicare population who has to rely on Medicare alone for their coverage.

Dr. WILENSKY. That is correct.

Senator GRAHAM. The question that I am interested in is whether we would be better off trying to bring the services that are currently being purchased voluntarily through Medigap policies and which make Medicare a more modern and appropriate system, whether we should try to incorporate those into an integrated Medicare program.

We know that the average Medicare beneficiary is paying about $2,000 a year now to purchase that Medigap policy, so that amount of dollars are in the system today. Would they be better in the system if they were integrated into Medicare or if the current separate, voluntary purchase were maintained?

I would like your comments on the consequences of the current pattern as opposed to an integrated pattern on issues like health care services, efficiency of administration, total cost of programs, and the issue that you focused on, the experience that the next generation is going to bring where they had been used to an integrated health care model, to now be dealing with a fractured health care system.

Dr. WILENSKY. I think the present two-tiered insurance-type structure that we have for people in traditional Medicare, where you have traditional Medicare and a private Medigap policy, is a particularly bad idea. It would be much better to have traditional Medicare, whatever it looked like, and Medicare replacement programs that people were to choose from.

So, I fundamentally agree that altering the benefit design and having catastrophic coverage and some kind of a prescription drug ought to be in the Medicare reform plan.

The only issue that I think is important, is this is not the only problem with the current Medicare program, but I do think, one, redesign of the benefit package to make it more like existing private plans is a sensible strategy. There will, of course, be some very important redistribution of income issues that get raised.

If you were to bring into Medicare as we now know it some of these other benefits, that means wage, tax, and taxpayer financing of most of it. Right now, you have those supplemental benefits being paid for by seniors to some extent, by employers, maybe indirectly by those seniors in terms of the wages that they had.

So it is not a small issue about how you make that change, but it is not the only problem with the existing Medicare program. It is certainly one of the 1960 remnant pieces of Medicare, but so is a lot of the administrative structure of Medicare.

Senator GRAHAM. I wonder if anyone else would like to comment on, what are the attributes of the current dual system and what would be the consequences of trying to integrate them into a single benefits package?

Dr. BUTLER. Let me discuss that for a moment. I think that the fact that we have all of these benefits, which most people would think of being the sort of thing you should routinely expect in any good health plan, are kind of out there as a satellite to Medicare, I think, underscores the general problem we have in this country of allowing the Medicare benefit package to evolve over time and improve over time. We are now, today, these days talking about a drug benefit; a few years ago, it was catastrophic, and so on. It is sort of one thing after another.

That is why I think it is extremely important to reevaluate the method we use to try to improve the drug benefit or the basic benefits package, and it is why I suggested that maybe we ought to think about this very differently in terms of some other method of doing this.

I suggested a benefits board much like the Base Closing Board as a way of trying to constantly upgrade the benefits package and submit that to Congress rather than having what we have today, which is just titanic struggles over trying to do what most people would think would be such an obvious element of a basic package in this country.

Dr. MOON. I would just add that I do not think that we are going to have prescription drugs in the private Medigap market very much longer that are affordable to most beneficiaries. Most beneficiaries now who buy Medigap insurance pay higher rates as they age.

If they want to purchase prescription drugs, they usually have to pay more than the cost of the full benefit if they were to get it in order to get prescription drug coverage. So, left as a voluntary benefit, it is an ideal risk selection mechanism and it creates a lot of problems in terms of the efficiency of the program.

So I think, when thinking about redesigning the benefits, one of the key things in a core benefit package is that you do not want to have benefits that can then be used to manipulate the program to segregate the healthy and the sick.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman.

Thank all the panelists. It is kind of, as they say, deja vu all over again. I know for Senator Kerrey and I, since I think four of the panelists have previously testified before the Medicare Commission, and here we are again. So, we thank you for being with us as well.

Dr. Moon, you have an apparent concern that you expressed that a premium support type of program would provide too many choices for seniors that would not be very efficient for them to make those choices.

I do not understand how we square that with the situation under Medicare fee-for-service today, where a beneficiary has to choose not just a plan, but has to choose which doctor they want to go to, they can pick any one they want, they can pick any hospital they

want to go to, they can pick any one they want. They can pick any nursing home they want to go to and they have to make a decision.

They have to decide on home health care and which one is the best. I do not see how those choices, which are difficult choices, either they make them by themselves or their children help them make it, or some association helps them make it. I mean, they have a lot of choices today which are difficult choices.

Choices under premium support would be difficult choices. I would argue it would be a lot simpler than having to choose every doctor, every hospital, every nursing home, every home health care facility that you want to go to. What is the difference?

Dr. MOON. I think the difference, for many people, is that they have a difficult time thinking about choosing a whole system of health care as a one-a-year choice. Individuals who need health care services at one particular point in time, certainly among the current elderly population, are used to going to their physician that they trust and asking for advice and information.

If that advice and information then has to be selected on the basis of what plan they are in that they may not have even understood when they signed up for the plan, I think that that is a particular constraint.

One of the difficulties, is we use the term "choice" in lots of different ways. For some people, choice means choosing among plans. I think for most people who say they want to retain choice in health care do not mean they want to choose a plan every year, they mean they want to have the ability to switch around.

It is not always the best way to get care, but it is kind of, I think, the shorthand way in which people try to protect themselves now in a world in which there is not good information about quality.

Otherwise, if you do not like the provider that you have now and you are in traditional Medicare, you are free to go to someone else. That is a very important right that many seniors value and do not always understand when they choose plans. I am not opposed to choice.

Senator BREAUX. I appreciate that. I do not want to belabor the point. I wanted to ask something other than just one question. But, I mean, I would disagree with that. If you are under pressure and you are sick and you have to pick a doctor, or you are desperately searching for a nursing home, or which home health care you are going to use, you are under a tremendous amount of pressure when you are sick and the decisions oftentimes are not the correct ones.

We have had hearings in the Aging Committee about people making instant decisions on which nursing home to go into and making horrible mistakes because they were under the pressure that they needed to do it by tomorrow. Those are the kinds of choices that are not balanced at all.

Ms. Canja, let me chat with you for just a minute. I understand your concern about the benefits package. We had questions yesterday about that, and Senator Rockefeller raised it yesterday and has been very concerned.

Yesterday in my testimony when we talked about the benefits package and what would be included in a premium support, my

testimony said the following and I would like you just to consider it and see if you think this is adequate.

We said that, under the premium support plan, the standard benefits would be specified in law, they would consist of all services covered under the existing Medicare statute, all plans would be required to offer, at a minimum, the same benefits package beneficiaries are entitled to under current law.

What we are talking about is 90 days in the hospital, a 60-day reserve, 100 days of skilled nursing facility or home health care, the same things that are in there. I am just trying to find out, what is an adequate statement on saying that it is going to be the same as a minimum benefit package that we have under current Medicare?

Now, I would argue, it is not a good package, but it would be the same, at least at a minimum. A package that only cover 53 percent of your costs is not a good package.

Ms. CANJA. That is right.

Senator BREAUX. But I tried to spell out as clearly as I could that what we are recommending is a benefit package that offers, at a minimum, the same, identical benefits that a Medicare plan would offer. Obviously, the savings would hopefully come out by the competition of people trying to offer even better packages.

Could you comment on what we are trying to accomplish on the benefit package?

Ms. CANJA. Sure. You know that we believe that prescription drugs should be in that benefit package.

Senator BREAUX. Of course, that is not in the current system, either. I agree with that, but that is another point.

Ms. CANJA. But then there are some other things that are troubling. There could be a 10-percent variance. What is that? The Medicare board could make decisions. Would those affect the benefits?

Senator BREAUX. No, they could not change the benefits. I mean, it would be a statute.

Ms. CANJA. We just saw a lot of places where we really could not feel secure that it was a defined benefit package.

Senator BREAUX. I mean, what more could we say? I am saying, it is exactly, at least, the benefits under the current Medicare package. What else would I say?

Ms. CANJA. Well, let me say again, we feel strongly about the prescription drug benefit. It would be available, as I understand it, under your package for low income, but would not be available for others. It could be very, very, very costly for anyone that went to a plan that would provide it, because it would have to be a high-option plan. They would have to pay the entire cost of it. So, we have real problems with that and we would like to see that benefit package improved.

Senator BREAUX. Thank you.

The CHAIRMAN. Next, we have Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to talk a little bit about risk adjustment. The basic problem, I think we all agree, is that, as we move to managed care, that the managed care plans will tend to attract the wealthier and healthier and leave traditional Medicare fee-for-service where it re-

mains, with maybe the sicker and people with fewer resources. At least, I think, it is a strong temptation for companies to try to select in a profitable way.

It is my understanding that, right now in Medicare, HCFA's current adjustment and variation of predicting cost and is, at best, 1 percent, and that there are some models being looked at HCFA that maybe raise that as high as 7 percent in trying to predict costs in the future. I am told, too, that the best theoretical variation adjustment would be about 25 percent.

So the basic question, is how do we better measure so we better assure ourselves that risk adjustment is minimized so there is more uniformity in plans' costs and benefits in a very general sense, so that the sicker patients and the less-wealthy patients get the same treatment as the wealthy and the healthy?

Dr. Wilensky, why do you not start on that?

Dr. WILENSKY. The first thing, is we are going to get better at doing this if we can start the process. I mean, that has been the experience when we have introduced new payment systems.

There are problems predicting on the basis of health status. Right now, what HCFA is proposing is to phase in based on inpatient use, then go to full encounter use. To the extent that you are concerned, we may not be able to get there entirely.

The use of partial capitation, where you would pay most of the premium based on risk status, age, sex, and geography as we do now, but have a portion of the payment reflect actual use, is an idea that the vice chair of MedPAC, Chairman Newhouse, has raised and that we, in our MedPAC reports to you and to the House.

Senator BAUCUS. Is that your partial capitation idea?

Dr. WILENSKY. Partial capitation.

Senator BANCUS. You think that will help solve it?

Dr. WILENSKY. I think it will help take out the risk that, if you do not adequately capture that likely spending of sick people, you pay it. Now, you, of course, lower some of the financial response of having a capitation. I mean, as is usually the case, there is no free lunch here is making that trade-off. But it seems to me a particularly promising idea for a demonstration.

Unfortunately, and this is in response to my institutional concerns about HCFA's indecision and inaction to date, is that suggestions of this nature and getting a move on the risk adjustment process seem to be very slow in coming. This is a serious issue, unless the Congress rolls back what they have done.

Senator BAUCUS. Well, that is right.

Dr. WILENSKY. I mean, it is not just premium support.

Senator BAUCUS. Right.

Dr. WILENSKY. The CBO projects half the Medicare population, if you do nothing else, by the time the baby boomers retire, are going to be in health plans. This is not just a premium support problem.

Senator BAUCUS. I know it is not. That is why I am asking that.

Dr. Moon?

Dr. MOON. I think we should work very hard to improve this, because I think this is a real key. I think that, as I mentioned before,

we would like to continue to have private plans. I think they are going to be an essential part of Medicare.

That is one of the reasons, though, why I believe you cannot put traditional Medicare and private plans on an equal footing at this point in time, because I think that would really exacerbate the problem.

In addition, I think that using partial capitation has some real promise as well, particularly if we think about it as a way to focus on encouraging private plans to take on special needs populations and do creative things, that may be an innovative thing to try for the future.

This is not an easy thing to do. I am not totally optimistic that we will solve the problem, but I think we need to be much better before we just turn it over to the private sector.

Senator BAUCUS. Right. That is my sense right now, that we do not understand this well enough and do not predict it well enough to make the move right now in the direction that a lot would like to go. And I am trying to find some ways to help, maybe it is demonstration projects, or something, but some way to get at risk adjustment better than we do it now.

Dr. BUTLER. Yes. That said, I think, as Dr. Wilensky said, if we get going now and try and start to learn as we go forward, that is probably the best way to ultimately solve that problem.

Let me just say, on the other side of the same coin is the issue of plans carefully marketing themselves and designing themselves to appeal to particular segments of the population that may be low-risk.

I think that is where the issue of allowing federal agencies to negotiate more directly with plans and to refine both their marketing, their service areas, that sort of thing, is the other side of the same coin.

Senator BAUCUS. Yes. We talk a lot about this problem, but I am trying to advance the ball so we start getting some hard data and better models or better ways to solve it.

Dr. BUTLER. Well, I think it is not going to be solved by, if you like, a theoretical discussion.

Senator BAUCUS. This is right.

Dr. BUTLER. It is going to be solved by going ahead and trying it.

Senator BAUCUS. Well, it is going to be solved with some theoretical discussion and some practical experience.

Dr. BUTLER. I agree.

Senator BAUCUS. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bryan, please.

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

Ms. Canja, let me begin with you, if I may. Thank you for joining us today. Your group, probably more than any of the groups, has the most at stake here because you are going to be affected immediately by the changes that we might make.

My question is, I agree with your premise that the present package is inadequate. I think most, if not all of us on this panel, agree with providing a prescription benefit.

Yet, Ms. Phillips also reminds us in rather harsh and stark terms that our options ultimately are either to increase revenue,

that is the "T" word, as I understand it, or reduce benefits, the "B" word.

Now, as I have looked at your testimony, you have indicated, with respect to financing, and I would agree with this, "Medicare must have a stable source of financing that keeps pace with enrollment in the cost of the program. Ultimately, any financing source will need to be both broadly based and progressive." I agree with that.

Can you be a little bit more specific for us? What, from your perspective, should we do in terms of the financing mechanism?

Ms. CANJA. Well, I can tell you one thing that concerns us that maybe we should be very careful about doing, and that is having a cap on expenditures which is arbitrary and might shift the cost to beneficiaries and make it absolutely unaffordable for them. So, that is one thing we should not do.

I think they have to look at what the benefit packages are, how much you can ask beneficiaries to pay. Again, it has to be affordable. It may come to the point where we have to use, in a time of surplus, some of the surplus and make sure that is part of the government contribution.

I just think there are options out there. We have to look at what is available, what burden we can put on beneficiaries, realistically; what, realistically we can use in a time of surplus that the government can kick in, frankly.

Senator BRYAN. Does AARP have a plan of its own in terms of what it would like us to put in Medicare reform that would provide some specifics in terms of the kinds of revenues, where we would get those, either payroll taxes or general revenue?

Ms. CANJA. We do not have that at this time, but I will tell you what we are doing. Any Medicare reform is going to require tremendous trade-offs. We are trying to do a very sound and effective public education program with our members.

We have forums, we have town meetings, we have all kinds of meetings and trainings with them, giving them the options that are out there and saying, what is acceptable with you, because we are going to have to represent our members and we have to find consensus in what they are saying.

Senator BRYAN. As you know, this committee, in 1997, took a couple of bold steps that were approved by the Senate, but rejected in the House. That was, with respect to Part B, we embraced a concept of means testing. With respect to the eligibility, we adjusted that age to conform with the Social Security.

As an organization, what is your view of means testing? I would like to ask you specifically to respond. I have used the same example Ms. Phillips has, that Mr. Gates, who is immensely successful and we commend him on his entrepreneurial success, but he is worth between $25 and $50 billion, with all of the difficult situations that we have, the demographic challenges, it seems hard to me, as a matter of social and political policy, to fully fund Mr. Gates, with all due respect, if he became eligible for Medicare tomorrow. What is the view of AARP on means testing?

Ms. CANJA. Well, first of all, we make a distinction between means testing and income relating. Means testing, to us, is a pro-

gram like Medicaid, where, if you have an income that is above a limit, you are not eligible for the program.

For us, income relating is, you are still eligible for the benefits—and we believe that is absolutely essential with a program like Medicare. You have to be eligible for the benefits, but you may have to pay more for them depending on your income. So I think your question is probably to income relating under the way we would define income relating.

If we are going to income relate, and there have been some circumstances where, if you look at the broad balance and you want to be sure you are balanced in what burden you put on people, income relating may be appropriate.

However, there are some things you have to keep in mind. One, is that higher income persons already are paying more in payroll taxes and the cap just went up. They are also paying more in retirement in their taxes.

If it should be the policy to have older, higher-income persons, persons over the age of 65 paying more for what are now subsidized health care benefits, then that same principle should relate to the people who are under the age of 65, higher-income persons. In fairness, every generational should have the same kind of treatment.

Senator BRYAN. Ms. Phillips, what guidance would you give us with respect to means testing? I take it that you do not reject that as an approach. How would you design a means testing approach? Would you take it across the board or just with respect to some aspects of the coverage of the package? How would you recommend it?

Ms. PHILLIPS. The Concord Coalition has, from the beginning since it was founded, been in favor of means testing or income relating of all entitlement benefits, Medicare, Social Security, unemployment compensation.

I mean, if you have got a million dollars of income, or even if you have $50,000 of retirement income, it is probably not equitable to expect younger taxpayers to support the full burden of the benefits to which you have become entitled, and, therefore, you should be asked to take a smaller percentage of your benefits, and we would run it on up on a sliding scale until you get to a point where you have only a residual amount still coming in.

Your circumstances could change even after you are retired and you may be comfortably well off in your 60s and 70s and not doing so well in your 90s or as you cross the centenary mark and need to claim larger benefits. So, it should have some flexibility built in.

Means testing clearly can be very complex if you are not careful about how you set it up. Some nations have gone to testing on the basis of wealth rather than income because of the games that people can play that way.

I reject the argument that an income-related program would cause people to save less money. When you look at how much in resources you would have to divest in order to qualify for your $12,000 a year of full Social Security benefits or your $5,000 or $6,000 of Medicare, it just does not make sense for people who are aspiring to an upper middle class-style retirement package.

Maybe some people right on the edge would choose to work a little less or save a little less to get a few dollars more, but the ratio means that I do not think it would have much effect on savings once people understood how the system worked.

Senator BRYAN. Well, I thank both of you for your responses.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kerrey?

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

First of all, I have put on record before, but will say it again, I support the Breaux premium support idea. But I am not personally very optimistic that we are going to be able to fix Medicare as an intact program. I just declare that.

One of the reasons I am not optimistic is based upon our last experience in 1997. The only thing we were really able to do was reduce the money we were going to pay to the plans and to the providers, and we extended insolvency from 2001 to 2014.

In my view, the screw is tightened down so tight that we are getting a deterioration in quality of patient care out there. But, far more enthusiasm to add a prescription drug benefit than coming back in and doing something about the deterioration of quality of patient care.

I am just not optimistic that Medicare can be fixed as an intact program. I want to give you a couple of problems that I see, and I would like any of you that would like to respond to see if you are thinking the same way as I.

I have reached a conclusion that we need to step back and change the social contract between the government and an American citizen when it comes to health care. I think we need more fundamental change, and I think premium support can become the model that we would use to implement that change.

Let me give you two problems that I see. The first decision Congress has to make when it comes to our budget is, how much U.S. income are we going to spend? We have historically spent about 20 percent of U.S. income, State and local governments spend between 11 and 15 percent.

But there is a limit to how much we can spend. We have sort of come to a consensus that about 1 out of 5 dollars is about the right amount of money to collect and spend on various things.

Then we decide how we are going to spend it. Well, this year we are going to spend $100 billion on Medicaid, mandatory, $240 billion on Medicare, mandatory, $408 billion on Social Security, mandatory, $200 billion more on additional mandatory programs, $225 billion on interest on the national debt, leaving $538 billion for appropriations, $26 billion less than we spent last year.

We are not going to have enough money for Customs, we are not going to have enough money for the IRS, not enough money for special education back to the States.

I mean, we are short across the board and we are scratching our heads trying to figure out what to do, and we will probably end up busting the budget caps, spending the surplus down, and screwing everything up. That would be, my guess is, the likely outcome.

So, we have got this tremendous problem with the declining amount of money that is appropriated and used for all of the things

that American people also want to spend money on. It is shocking, seeing that trend.

The government is going to become, by 2030, an ATM machine. All we are going to be doing is collecting it and transferring it right back out. There will be no other function of government left, no other investment that we are going to be making other than that.

In addition, the other problem is, I have got 4.5 percent real growth in the first quarter this year, 6 percent real growth last year in the final quarter, and what have I got? I have got an increasing number of Americans who have a mandatory tax. We tax them.

We take that tax, we subsidize other people, and by the time they have paid all their bills, they do not have enough money for health insurance. They are uninsured. Twenty-four million workers, by my estimate, whose taxes are being collected to subsidize me, to subsidize everybody who is eligible for Medicare, Medicaid, the VA, the income tax deduction, or who work for the government, and they do not have enough money for health insurance.

It makes it impossible for this Congress to do such thing as give normal trade authority to our President on trade, because trade has become unpopular because the American people are out there saying, we are downsizing and I do not have health insurance any more.

So, I step back from looking at both of those problems and looking at what we did in 1997, and reach the conclusion that we have got to fundamental alter the social contract. I favor making eligibility based upon being an American or legal resident. Then let us have a debate.

I prefer premium support as the model, but I support changing the way we become eligible because I do not think we are going to solve either the budget problem, nor do I think we are going to solve the growing number of Americans without insurance.

By the way, there is a direct correlation between insurance and the status of your health, a direct correlation. If you have insurance, you are likely to be healthier. That is why people over this age at 65 today are healthier than they were 30 years ago.

So, I am wondering if any of you smart folks have reached a similar conclusion and are willing to state it if you have. I am particularly interested, Ms. Canja, in AARP's point of view in this regard.

Ms. CANJA. Historically, we have felt that universal health care is the answer to everything because everybody needs good health care. Right now, we are concerned with making sure that Medicare is affordable and accessible to everyone.

Senator KERREY. Well, Ms. Canja, it cannot be accessible to everyone. It is only accessible to people over the age of 65. Medicare will never be accessible to everyone.

Ms. CANJA. No, no. To the beneficiaries.

Senator KERREY. To people who are eligible as a result of meeting an age test.

Ms. CANJA. That is right.

Senator KERREY. Or a disability test. Or have a kidney that has malfunctioned. Under that standard, we cover that.

Ms. CANJA. But we worked long and hard for universal health care. We felt that our Nation does, at some point, need that.

Senator KERREY. Well, why is it not in your testimony?

Ms. CANJA. It has been in previous testimonies. Our testimony at this point is talking about Medicare reform.

Senator KERREY. Any other people willing to comment on this? As I said, in looking at what we did in 1997 and in looking at these two big problems, I just do not know how else we can get to where we need to go.

Dr. MOON. I would only say, Senator, that I think that it is a very frustrating issue because I think that serious problems of people under 65 without insurance are very important and need to be addressed.

I do not, however, believe that you get from where we are in terms of the number of people who are insured to having everyone insured by eliminating a program that serves 39 million folks who would have great difficulty in doing something.

Senator KERREY. Wait a minute. I did not say eliminate the program. I did not say eliminate the program at all. I do not presume the program has to be eliminated. You can do whatever you want to people over the age of 65.

My question is whether or not eligibility for health insurance, and not just eligibility, it is eligibility to have somebody pay your bills. I have got 24 million Americans who are paying my bills. I am service-connected disabled, make over $100,000 a year.

Now, you think that it is right that somebody who is making $20,000 a year, I have got a claim on their income and they do not have a claim on mine, simply because the federal law says that they are not eligible.

Dr. MOON. Well, I will sign up for national health insurance.

Senator KERREY. Well, it is not necessarily national health insurance. It can be socialism on one end, it can be private sector on the other. I prefer a premium support plan because I think it is much more likely that customers will be satisfied and will make the right decisions on the budget. But it does not have to be national health insurance, but it has to be changed in the way we become eligible.

Federal law makes people over the age of 65 eligible. Federal law makes you eligible if you are poor and promise to stay poor. Federal law makes you eligible to get blown up in a war. It is a federal law that does that.

The question is whether or not we should change the law and make every American or legal resident eligible, and then let us have a debate how we are going to deliver it and finance it.

Dr. WILENSKY. I think one of the questions I guess I would like to hear from you, in part, from frustration over having gone through a period in the 1993 to 1994 time where I think we could have resolved part of the problem by having a low-income support program for everyone under the poverty line, and maybe most low-income people.

My only concern is that, while it is advisable to lay out the blueprint of where you want to go and what you see as the way to get there to have very discrete steps about how you do it, I would personally like to see some of the programs that have been circulating in the last year or so of tax support, tax credits, for people who do

not have employer-sponsored insurance or a means to choose between tax credits, refundable credits, and employer-sponsored insurance.

I actually think the premium support is a good model, that something like it could be available for people who are under 65, particularly if it becomes more of the accepted structure. But I think it is equally important to think about what you do next.

How do you go from what is currently employer-sponsored, which leaves out large groups of people because their employer does not sponsor it, without any tax subsidy at all, which I think is unfair, inequitable, and inappropriate.

I just do not want to find ourselves that, if we cannot do everything, that we do not make any steps in the right direction. So, I applaud knowing where you want to go, but I would like to make sure we have some discrete steps on how to get there.

Dr. BUTLER. But, Senator, you certainly do raise fundamental debates that should be taking place. As long as we say that people who have certain eligibility requirements are going to be entitled to a certain set of services, whether it be Medicare or whatever, without regard to cost, and somebody else is going to pick up the tab, you cannot avoid exactly the problem that you mentioned.

I think as long as you have, as Gail was averring to, a situation where if you have an employment-based plan, you can get all kinds of tax relief, without limit, to the value of that plan.

But God forbid that your employer does not provide you with a plan. You are on your own, you get no tax relief, and so on. As she suggested, I think this is the time for the Senate Finance Committee and the Ways and Means Committee to look at that particular obstacle. These are all examples of exactly what you are talking about.

I think that, while I agree with Gail that until those issues are resolved and debated, it does make sense to step forward and say, how can we make, under the existing rules, the current system work better and be more cost effective?

I certainly agree with your point that it is time, long overdue, for us to stand back and say, what is the contract we have and what are the basic principles of financing and of relative responsibilities in these kinds of programs. Unless we do that, we are never, ultimately, going to solve these kinds of dilemmas.

Mr. SCHEPPACH. Senator Kerrey, I might make a point. As you know, I am kind of reluctant to put the governors in a position of how much should go to health care. But I do think you have also got to focus, to some extent, on the efficiency of the programs.

We are spending $120 billion on these dual eligibles, 35 percent of the cost of the total, in a very, very inefficient way. Nobody has got responsibility, the elderly are not particularly happy, and so on. So I think that is a component, that there are probably opportunities for significant savings and significant benefits to people.

Senator BREAUX. Mr. Chairman, could I make just one quick point?

The CHAIRMAN. Yes, Senator Breaux.

Senator BREAUX. Ms. Canja, in your testimony on page 7, you brought up an issue that I think is important. When you talked about the government's share of the contribution in a premium,

right now it is about 88 percent paid for by the government, about 12 percent paid for by the beneficiaries.

That is the same ratio that we picked in recommending our premium support plan. But you also make the point that the 88 percent and the 12 percent, that you say should not be based on an artificial budget target but should be based on the cost of the program, the benefit package.

I would just point out that that is what our recommendation, in fact, does. It says, if it is an 88 percent contribution to the package, the cost of the package goes up. Hopefully, it would not, but if it does, the government would still continue to pay 88 percent of the new, increased cost. So, it would agree with what you are recommending.

I think, also, your point that "Breaux's premium support plan would provide opportunities for stimulating debate," I find that encouraging. I think that is important. It is much better than providing riots or things of that nature. I think stimulating degate is a positive statement, and we are certainly going to have a lot of that. I thank all the panelists.

Thank you.

Ms. CANJA. Thank you.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

I want to thank all the members of the panel. The information and testimony has been most helpful. The debate will continue in the future. Thank you very much for being here.

Senator MOYNIHAN. Mr. Chairman, I wonder if we are going to be able to do the right thing by our next panel, hear their testimony and get their answers. A vote has started, three in a row. It will be 1:00 before we get back. I just suggest that, sir. I do not know whether we could hold another hearing. These are witnesses you really want to hear, and everybody should be here, or as many as can. Not to tell you how to do this.

The CHAIRMAN. My problem is when we can schedule it again. Yes. [Pause.]

Could I ask the next panel to come forward? We are on the horns of a dilemma.

[EDITOR'S NOTE.—Due to a series of floor votes, the second panel of witnesses were unable to testify—their prepared statements were included in the record.]

[The prepared statements of Karen Ignani, Charles N. Kahn, III, Mary Nell Lehnhard, Nancy Dickey, M.D., Richard J. Davison, and Lawrence Gage appear in the appendix.]

The CHAIRMAN. The committee is in recess.

[Whereupon, at 11:56 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF DAVID BLUMENTHAL, MD, MPP

Mr. Chairman, members of the Senate Finance Committee, my name is David Blumenthal. I am executive director of the Commonwealth Fund Task Force on Academic Health Centers, and director of the Institute for Health Policy at Massachusetts General Hospital and Partners HealthCare System in Boston, MA. As a primary care internist and a member of the faculty at Harvard Medical School, I am also actively engaged in caring for Medicare beneficiaries as well as teaching medical students and residents.

I greatly appreciate the opportunity to appear before you today to discuss the future of the graduate medical education and disproportionate share provisions of the Medicare program. The views I will express reflect for the most part the conclusions of the Commonwealth Task Force, which is supported by the Commonwealth Fund of New York City to study and make recommendations concerning the preservation of the social missions of academic health centers. Academic health centers consist of medical schools and their closely affiliated clinical entities, including teaching hospitals. Their social missions include teaching, research, the provision of rare and specialized services, innovation in patient care, and the care of vulnerable populations, including the indigent.

In the brief moments allotted me this morning, I would like to address a few basic issues.

The first point concerns the purpose of the graduate medical education provisions of the Medicare program. One of the most confusing things in the discussion of these provisions is the use of the term "Graduate Medical Education" or "GME" itself. The fact is that these provisions do not support and were never intended to support only or even primarily the education of physicians and other health professionals. Rather, the extra payments received by academic health centers and other teaching hospitals under Medicare were intended to pay the extra costs of caring for Medicare patients in those institutions. Therefore, the debate about the future of the GME provisions is really a debate about whether and how the Medicare program—and/or the federal government generally—should continue to pay for the greater expenses incurred when Medicare beneficiaries receive their care in academic health centers and other teaching hospitals.

The next issue I would like to address concerns this question of whether Medicare should continue to pay the extra costs of academic health centers and other teaching hospitals. The answer depends of course on what the source of those costs are and whether they are legitimate expenses for the Medicare program. There are at least two basic contributors to the additional costs of academic health centers and other teaching hospitals. The first contributor is directly related to the nature and value of the services that Medicare beneficiaries receive when they are cared for in academic health centers. There is good evidence that the Medicare patients treated in academic health centers are sicker and thus more expensive than those treated in other hospitals. Furthermore, these expenses are not fully captured by DRG payments. There is also good evidence that the quality of care provided in teaching hospitals and academic health centers is superior to that available in other institutions, and that this improved quality is associated with increased costs. To the extent that the extra expenses of teaching hospitals and academic health centers reflect the burden of illness they confront, and the quality of care they provide, those expenses are arguably legitimate and essential expenses for the Medicare program to pay.

There is also a second contributor to the extra costs of teaching hospitals and academic health centers. This is the involvement of these institutions in the production

of what economists might call "public goods." Public goods are things that have intrinsic value but are unlikely to be adequately supported in private markets, and thus deserve public financing. In the case of teaching hospitals and academic health centers, these public goods include teaching, biomedical research, continuing innovation in patient care, the provision of rare and highly specialized services that have very limited markets (such as transplantation, complex burn and trauma care), and care of the indigent. The problem with these types of services is that everyone benefits from having them available, but most of us don't benefit directly or immediately enough to pay their full value. Thus they tend to be under-supplied in private markets.

In this country, we have chosen to pay a significant portion of the costs of producing these public goods by letting teaching hospitals and academic health centers charge higher prices and use the proceeds to cross-subsidize these activities. To the extent that the extra expenses of teaching hospitals and academic health centers result from the involvement of these institutions in the production of public goods, the Task Force believes that these expenses are legitimate and deserve support from the Federal Government. Whether they deserve support from the Medicare program itself is a more complex question. The Commonwealth Task Force believes that everyone who benefits from the public goods produced by academic health centers and teaching hospitals should contribute fairly and equitably to their costs. Medicare beneficiaries are clearly among those who benefit. Indeed, given their higher burden of illness and disproportionate use of resources, they arguably benefit more than many other groups. Thus, contributing to those costs is a legitimate expenditure for the Medicare program if our country continues to support these public goods in the way we traditionally have—by leaving it to academic health centers to cross-subsidize them from patient care expenses.

Here we get to the third issue I would like to address: the question of how the Medicare program—and implicitly, the federal government as a whole—should contribute to the justifiable extra costs of teaching hospitals and academic health centers. The Commonwealth Task Force recommended the creation of an Academic Health Services Trust Fund as one approach to this task. This recommendation was based to some degree on provisions of the Balanced Budget Act of 1995, which included a proposed Graduate Medical Education and Teaching Hospital Trust Fund. Such a trust fund could be financed in a number of ways, but it should have a secure and stable source of funding that is based on contributions from all who benefit from the goods and services it supports. One way to finance it would be to require all third party payers to make a modest payment to the trust fund. Under such circumstances, Medicare should contribute its fair share. Another way would be to pay all or part of the expenses from general revenues.

The creation of a trust fund—equitably, securely and fairly financed—is in many ways an ideal long-term solution to the problem of paying the extra costs of teaching hospitals. However, the Congress faces the short-term question of what to do with the graduate medical education and disproportionate share payments under the Medicare program. The Task Force has taken the position that, whatever policies the Congress pursues, it should assure that Medicare patients who need the extra services provided by teaching hospitals and academic health centers continue to receive those services, and that the nation's ability to produce needed public goods be protected. Decisions about whether to move some of the expenses of the GME and disproportionate share provisions under Medicare into the regular appropriations process should be judged by this standard.

Before concluding, I would like to make a few additional points. First, the Task Force strongly believes that academic health centers and other teaching hospitals should be held more accountable in the future for the extra costs that they incur in serving legitimate public purposes. The Task Force is working on methods to assure such accountability. It believes that academic health centers could be more efficient in provision of routine patient services and in the production of public goods. Better measures of the quality and cost of these activities are needed in the future to help achieve these efficiencies.

Second, though the Task Force never explicitly considered the implications of a premium support approach to purchasing Medicare services, I would like to reflect on the consequences of this potential policy direction for the goods and services now partially funded by the graduate medical education and disproportionate share provisions of Medicare. It is not at all clear how premiums would cover the legitimate extra expenses of teaching hospitals and academic health centers. To simplify this matter, the Congress might decide that Medicare should pay only patient care costs, and that the expenses associated with public goods provided by academic health centers—teaching, research, indigent care—should be paid for some other way, perhaps by direct appropriation. From a technical standpoint, it is extremely difficult,

if not impossible, to separate the costs associated with the public goods produced by these institutions from the patient care costs associated with the sicker patients they treat and the higher quality of care they provide. Even if this separation were possible, however, the premium support model must confront the challenge of paying teaching hospitals and academic health centers for the legitimate extra patient care costs they incur in treating Medicare beneficiaries: the case mix and quality related expenditures. Without better measures of quality of care and better case mix adjusters, the premium support model carries the risk that Medicare patients will not have appropriate access to teaching hospitals and academic health centers in the future.

Mr. Chairman, members of the Committee, thank you for the opportunity to share these views with you today. I would be pleased to answer any questions you may have.

PREPARED STATEMENT OF HON. JOHN BREAUX

Mr. Chairman, Senator Moynihan and my fellow colleagues, I appreciate this opportunity to speak to you today about the work of the Bipartisan Medicare Commission and the legislation we are working on that reflects a FEHBP style Medicare reform proposal supported by a bipartisan supermajority of the Commission. The intent of the commission proposal was to get the basic design of the Medicare program right—not for the next year or two but for the coming decades. We realize that with advances in medical technology and the changing demographics of the Medicare population, there will be an ongoing need to revisit specifics of the Medicare program. Our proposal purposely does not attempt to prescribe every specific rule in advance. Our goal is to create a more flexible, less rigid Medicare program for future generations of Medicare beneficiaries.

We also approached reform from the basic premise that Medicare as we know it is inadequate in terms of what it provides. It does not even reflect what most Americans with employer-sponsored coverage receive. As I have said many times, prescription drugs are as important today as a hospital bed was in 1965, and Medicare's current benefit package does not cover them. In addition, Medicare covers only about half of the current health care costs of today's beneficiaries with seniors paying an average of $2000 out-of-pocket each year for health care. And even this inadequate coverage is not sustainable in its current form. Premiums for beneficiaries will double by 2007 even though benefits will not improve and the trust fund, our measure of solvency at this point, will be insolvent beginning in 2015.

Before I describe the basic elements of our proposal, I think it is also necessary to spend a little time telling you what it does not do. Since the work of the commission ended, there has been a great deal of misinformation disseminated about our proposal, namely, that it is a voucher plan or an end to Medicare as an entitlement or that it is a strict defined contribution. Let me be clear: it is NONE of these things. I am eager to engage in an honest debate about the implications of moving Medicare to a premium support system but attempts to characterize this proposal as "voucherizing" Medicare are just plain wrong. Premium support is no more a voucher plan than the health insurance program that we as federal employees receive.

The use of the word voucher implies that beneficiaries are given a set dollar amount—a defined contribution—and told to go buy insurance, leaving them exposed to whatever the difference is between the government contribution and the plan premium. That notion misrepresents how a FEHBP style system would really work. The competitive, market-based approach inherent in this system gives beneficiaries an incentive to choose a plan that best fits their health care needs—it gives them a choice. Under our proposal, beneficiaries would pay on average 12 percent of the premium for a plan. Beneficiaries choosing costlier-than-average plans would pay the full extra cost themselves and beneficiaries choosing plans with premiums less than 85 percent of the average would not pay any premium at all. Currently, all beneficiaries must pay at least the Part B premium. And if the government fee-for-service plan is the only one available in an area and the beneficiary has no choice of plans, we have guaranteed that beneficiary premiums in those areas will be limited to 12 percent of the fee-for-service premium or 12 percent of the national weighted average, whichever is lower. This provision will help protect beneficiaries, particularly those in rural areas, from paying higher fee-for-service premiums if they have no other plan from which to choose.

Premium support is also not an end to Medicare as an entitlement. In the legislation we are drafting, we make it explicitly clear that all Medicare beneficiaries will at a minimum continue to be entitled to the same benefits now described under

Title 18. No plan can be approved by the Medicare Board if it does not cover at least the same benefits that beneficiaries are entitled to today.

Another concern raised by detractors is that premiums for beneficiaries who stay in the government run fee-for-service plan will skyrocket. Before we talk about what will happen in a FEHBP style system, remember that premiums under the current system are set to double in the next ten years. In addition to the that, the trust fund is running out of money. Under our plan, government run fee-for-service will continue to be a national plan with a national premium, as it is under current law. We would recommend that cross-subsidies or payments for Medicare's non-insurance functions not be included in calculating the premium for either public or private plans in order to ensure a level playing field between the two. The government fee-for-service plan, therefore, will not be put in a position where its premiums are made uncompetitively high by the inclusion of these additional payments. There will also be a risk adjuster so that the fee-for-service plan is not penalized for serving an older and sicker population.

The Commission's analysis showed that premiums for beneficiaries choosing to remain in the government fee-for-service program would be 17 percent lower in ten years than they otherwise would be under current law—$1,500 instead of $1,820—if the plan is able to compete and slow its growth rates. I should note, however, if fee-for-service spending continues to grow as projected under current law, even as competing private plans offer the same benefits at a lower cost, then beneficiaries choosing to remain in this plan (or any other more expensive and less efficient plan) would have to pay a higher premium unless they live in an area where there is no choice of plans.

Others have attacked our plan as not saving enough or doing enough to address Medicare's solvency problem. Commission staff estimates of the Medicare Commission's plan were based on the assumption that spending in the current unrestrained fee-for service program would grow faster than the blend of fee-for-service and private plan premiums that would determine Medicare spending under premium support. Therefore the premium support plan would slow the growth of Medicare spending. The estimated savings were roughly in line with those used by CBO during the debate on health reform proposals that would have spurred competition among health plans, or about to 1.5 percentage points per year from the current long-term annual growth rate. Over time this results in substantial savings—$800 billion in 2030 alone.

But even if this growth rate is achieved, we recognize that Medicare will require additional resources as the percent of population that is eligible for Medicare increases. At the Commission's first meeting, Federal Reserve Chairman Alan Greenspan said that "the trajectory of health spending in coming years will depend importantly on the course of technology which has been a key driver of per-person health costs." Yet he went on to underscore what could be the absurdity of attempting now to determine funding levels necessary decades into the future: "Technology cuts both ways with respect to both saving medical expenditures and potentially expanding the possibilities in such a manner that even though unit costs may be falling, the absolute dollar amounts could be expanding at a very rapid pace. One of the major problems that everyone has had with technology—and I could allude to all sorts of forecasts over the recent generations—one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity." These are Allan Greenspan's words.

Still we were instructed by statute to address the issue of Medicare solvency. We concluded that the test that has been applied to Social Security is not an apt model for Medicare. Social Security Trust Funds are funded exclusively through payroll taxes; Medicare is paid for by a combination of payroll taxes, general revenue and beneficiary premiums. These ratios have changed over time such that a greater portion of program expenses is now paid by general revenues and a relatively smaller portion is paid by payroll taxes and beneficiary premiums.

Recently even this partial proof of fiscal integrity has been shattered. The notion of Part A insolvency has been used to shift more program costs to the general fund. In 1997, we shifted nearly ⅔ of home health expenditures from Part A to Part B, thus extending the fiction of the Part A Trust Fund "solvency" from 2002 through 2008 by shifting obligations to the general fund. The general fund, in great part, became the source of Part A solvency. Because of these blurry distinctions, we recommend that Part A and Part B Trust Funds be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare be developed. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays. When the funding from general revenues reaches a certain level—

we suggested 40 percent—the Trustees would be required to notify the Congress that the Medicare program is in danger of becoming programmatically insolvent and Congress would be required to act before more general revenues could be added to the program.

Now I would like to turn to a brief description of our plan. Broadly our proposal is based on the following principles:

- fair competition between the government-run-fee-for-service plan and private plans minimal disruption for current beneficiaries in either the fee-for-service or private plans
- fair competition between local, regional and national plans
- real opportunities for national and other wide-area plans to enter the Medicare market
- a competitive fee-for-service plan

For beneficiaries it offers reasonably-priced drug coverage, a reduced need for supplemental coverage, and the promise of lower premiums. For the government (and by extension, the taxpayer) it would aid the budget and reduce the need for federal micro management. For health plans, it offers greater stability and a more business-like atmosphere, with fairer, but tougher, competition. For hospitals and health providers, it would bring a less heavy-handed approach to cost control than has been used in the past.

PROPOSAL BASICS

Premiums

The Breaux/Thomas proposal would change the Medicare entitlement from the government paying all of Part A and 75 percent of Part B to the government paying 88 percent of a combined Medicare. The 88 percent figure approximates what the government share of overall program costs would be under current law when the new system was implemented. The combined Medicare spending would grow at the average rate of growth in the premiums of plans beneficiaries chose, including the traditional Medicare fee-for-service plan and private plans. That would be a significant change from current Medicare spending, which is based only on growth in fee-for-service.

Each year, beneficiaries would have incentives to choose efficient plans. On average, beneficiaries would pay 12 percent of the premium for a standard plan. But beneficiaries choosing plans more expensive than average would pay the full extra cost themselves while beneficiaries choosing plans with premiums less than 85 percent of the national average would pay no premium at all. Currently, all beneficiaries must pay at least the Part B premium.

Competition

Under current law HCFA runs the fee-for-service plan and controls the terms of competition between that plan and private plans. Under our proposal, a new Medicare Board would administer the competitive system. HCFA's role in Medicare would be focused on administering the fee-for-service plan, and the fee-for-service plan would be treated like any other plan by the Board.

As under current law, the fee-for-service plan would set a national premium and its enrollees would pay one flat amount, regardless of where they live or move. The fee-for-service plan's large enrollment (currently 85 percent of all Medicare beneficiaries) guarantees that its premium would be very close to the national weighted average for several years after the premium support system was implemented. Therefore, in both method and amount, the initial fee-for-service premium under our proposal would be similar to the Part B premium under current law.

Payments to all plans would be adjusted for the demographics, risk, and geographic location of their enrollees. The payment adjustments are needed to ensure that plans serving more or less expensive enrollees are paid fairly, and that differences in their premiums reflect efficiencies.

Benefits

The standard benefits specified in law would consist of all services covered under the existing Medicare statute. As under current law, private plans could establish their own rules on exactly how the benefits would be provided. Board approval would be required for all benefit design offerings and changes but all plans would be required to offer, at a minimum, the same benefit package beneficiaries are entitled to under current law. The hope is that premium support would enable plans to offer better benefits than beneficiaries receive today but under premium support, no beneficiary will be entitled to fewer benefits than they are entitled to under current law. This will be spelled out explicitly in statute.

Although Parts A and B would be merged into a combined program, Medicare's standard benefits would not change. The current Part A per-admission hospital deductible (currently $768) and the annual Part B deductible of $100 would be replaced by a combined annual deductible of $400. Ten percent coinsurance would be charged for home health and laboratory services. No coinsurance would be charged for inpatient hospital stays and preventive care.

Trust fund

As I noted earlier, the Breaux/Thomas plan would create a combined Medicare trust fund that would include all three sources of funds: payroll taxes, premiums, and general revenue contributions. Without further Congressional action, general revenue contributions would be allowed to grow only as fast as program spending if they otherwise would exceed 40 percent of Medicare's finances. While we must acknowledge that Medicare needs more revenue, we cannot continue to give the program an open-ended commitment of general revenues.

Prescription drugs

There has been a great deal of discussion in recent months on the need to add a prescription drug benefit to Medicare. Our proposal took an important first step by creating a viable prescription drug benefit in Medicare, fully subsidized for the poor, and available to all beneficiaries.

The proposal we are putting forward would spend an estimated $61 billion over 10 years on drug coverage and cost subsidies for the poor. In the short run, this new coverage would be provided through the Medicaid program, fully paid for by the federal government. When the premium support system was implemented, the coverage would be provided through special subsidies for high option plans in Medicare. The new drug subsidies would likely increase the participation in subsidies available under current law (for premiums and cost-sharing) and the $61 billion estimate includes this increased federal spending.

While the Commission's final proposal did not explicitly subsidize drug coverage for those above 135 percent of poverty, I strongly favor including some kind of subsidy for all beneficiaries. We need to keep in mind, however, that 65 percent of beneficiaries currently have some kind of prescription drug benefit and we have to be careful not to displace that coverage. We should also remember the valuable lesson we learned during Medicare catastrophic—it is a very difficult political proposition to ask seniors to pay more money for a benefit they already have.

As I have said many times, I support adding a subsidized drug benefit to Medicare but only in the context of fundamental reform. Adding prescription drugs is the easy part but we must also take the tough medicine inherent in comprehensive reform and I would not support any effort to do one without the other.

Medigap reform

The proposal would significantly remake the Medigap market to conform with the combined Medicare program by requiring Medigap coverage of prescription drugs and allowing varying degrees of coverage of Medicare coinsurance and deductibles.

Conclusion

Our proposal is a starting point and not an ending point. We have heard from many people concerned about raising the eligibility age from 65 to 67 and have decided against including this change in our latest proposal. We know the administration has been looking at various proposals to reform Medicare and we look forward to seeing those, as well. Nobody has the corner on the Medicare reform market.

I think I speak for Congressman Thomas as well when I say that we look forward to a vigorous debate about how to reform Medicare. The debate shouldn't be about whether to reform Medicare. We know we need to make structural changes and we need to do it now. The longer we wait, the more difficult and dramatic the changes will have to be. We can't keep waiting for someone else to go first. If someone doesn't go first, nothing will ever get done. Let's solve the problem and argue about who should get the credit rather than continue to do nothing and blame the other side for failure. I look forward to working with Democrats, Republicans and the Administration to meet this challenge.

PREPARED STATEMENT OF STUART BUTLER, PH.D.

Mr. Chairman, my name is Stuart Butler. I am Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

I am pleased to be invited to testify on the issue of Medicare reform. I believe the majority of members of the recent bipartisan commission laid out a good framework for modernizing and strengthening the program. As the commission recognized, reform involves not only addressing the financing of Medicare, but also critical governance issues. Today I would like to focus primarily on these governance issues because many of the pressing concerns facing Congress, such as how to provide a drug benefit, are in fact symptoms of flaws in the organizational design of Medicare.

SUMMARY POINTS

Let me summarize the main points I make in the body of my testimony:

(1) The Medicare Commission's premium support proposal would be the best way of guaranteeing a Medicare entitlement while introducing incentives for beneficiaries to make cost-conscious decisions.

Premium support can be:

- Indexed to adjust for changes in medical costs.
- Adjusted by income.
- Adjusted for high-cost medical conditions.
- Designed as a base amount plus a percentage of premium (a version of the FEHBP formula).

(2) Congress should create a Benefits Board to depoliticize changes in Medicare benefits and to facilitate the gradual evolution of Medicare benefits.

- Board proposals should be subject to an up-or-down vote without amendment, much like procedure used in the Base Closing Commission.
- Only broad benefits categories should be set by Congress (like the FEHBP).
- Medicare should be reconfigured as a leaner core set of benefits and a range of supplementary options.
- The Benefits Board approach should be used immediately to determine how to create a drug benefit in the fee-for-service program for a given budget.

(3) Congress should create a Medicare Board to manage the market for competing plans, taking this role a way from HCFA. The Board should be allowed to negotiate services and prices with plans.

- HCFA cannot and should not combine the role of managing a market of competing plans with the role of developing and marketing the fee-for-service plan—one of the competing plans.
- HCFA evidently cannot carry out its consumer information functions. It is significant that while HCFA spent $95 million in a futile attempt to produce a consumers' handbook for Medicare, Washington Consumers Checkbook completed the same task for the FEHBP, with complicated differences in benefits to explain, through the efforts of just one analyst working for two months and clerical assistance.
- The Medicare Board, separate from HCFA, would carry out functions similar to those of OPM within the FEHBP.
- Using the OPM/FEHBP model, the Board should negotiate benefits, service areas and prices with plans, instead of the current approach of regulation and price formulas.

(4) Congress should empower the traditional fee-for-service program to compete.

- Give HCFA greater freedom to introduce innovation into the fee-for-service program. Give the agency the power to create the equivalent of charter schools in Medicare.

REFORMING THE MEDICARE PROGRAM

Congress must move swiftly to reform Medicare before the aging Baby Boom generation makes reform increasing difficult. Several steps should be incorporated into a reform measure.

(1) The Medicare Commission's premium support proposal would be the most effective way of combining the objectives of (a) guaranteeing seniors an entitlement to an affordable core set of benefits, while (b) giving seniors the incentive to seek the most cost-effective way of obtaining Medicare services.

For some time, the Medicare debate has been portrayed as a clash between two irreconcilable approaches to providing financial support to the elderly to pay for health care. One approach—unknown as "defined benefits"—guarantees those eligible for the program a comprehensive set of specific benefits without regard to the cost to Medicare of those services. While this approach protects beneficiaries from future rises in the costs of those services, the approach has been criticized as placing a huge financial risk onto the shoulders of taxpayers. The other approach—known as "defined contribution"— would provide seniors with a specific amount of

financial help to pay for benefits. While this approach limits the risk for taxpayers and creates incentives for seniors to seek cost-effective plans, it has been criticized as shifting all the future financial risk to beneficiaries.

A sensible compromise between these two approaches is implicit in the "premium support" approach favored by the majority of members of the Medicare Commission. Under this arrangement, Medicare beneficiaries would receive financial assistance in the form of a blend of the two approaches. While several variants are possible, under a premium support system seniors could receive a contribution to the costs of a plan, but this contribution could be adjusted each year—or indexed—to cover the market price of plans providing a core set of benefits. In that way the elderly would continue to have an entitlement and know that the costs of standard coverage would be assured, but the premium support approach means they would also have a strong incentive to choose a cost effective plan.

Congress should recognize that the premium support approach does not mean that the elderly and disabled are simply given an "arbitrary" voucher and are at risk for unbudgeted changes in the cost of their health coverage. In fact, the basic idea of a premium support can be modified in several ways to address variety of policy goals and to protect enrollees. For example:

- The base amount of premium support could be adjusted by income, so the low-income senior would have a larger amount of assistance.
- The base amount could be adjusted (i.e. indexed) to account for the higher costs of certain medical conditions.
- A variant would be to combine an indexed, fixed amount of support with a percentage of the cost of a chosen plan above the standard amount up to a certain dollar limit. In this way seniors who felt it necessary to chose more expensive plans, because of their medical condition or personal preference, would only pay part of the extra cost. Such a percentage support system is used in the Federal Employees Health Benefits Program (FEHBP).

While these varied forms of the premium support approach would address the concerns of lawmakers who prefer a defined benefits system, covering only an indexed base premium, or a percentage of a higher premium, also would achieve in large part the incentives of a defined contribution. Just as federal workers in the FEHBP well know, the premium support approach would create incentives for beneficiaries to seek the best value for money in a plan, since they would gain financially by choosing a more economical plan.

(2) To enable the benefits package to be revised and improved steadily over time, the current politicized process for changing benefits should be replaced with a Benefits Board and other steps.

The current discussion about the need to add an out-patient drug benefit to Medicare simply underscores two related failings in the design of the program. The first is that ever since its inception, the Medicare benefits package has slipped further and further behind what would be acceptable in typical plans for the working population. The second is that the program will be constantly out of date as long as it takes an act of Congress to accomplish benefits changes in Medicare that in the private sector would be made in a few routine management meetings.

When Medicare was created in 1965 its benefit package was based on the prevailing Blue Cross/Blue Shield package for working Americans in large firms. As such, it was "state-of-the-art" coverage. But since then, the benefits package has gradually slipped further behind the benefits routinely available to working Americans. For example, Medicare provides no outpatient drug benefit. Yet it would be virtually unthinkable for a plan to be offered to workers in large corporations today that did not have at least some coverage for outpatient pharmaceuticals and protection against catastrophic medical costs.

The main reason that the benefits package is out-of-date despite general acceptance it needs to include such items as a drug benefit is that all major changes in benefits require an act of Congress. Consequently, discussions about changing benefits (and especially introducing new benefits by reducing coverage for less important ones) are necessarily entangled in the political process. Providers included fight hard and usually effectively to block hard attempts to scale back outdated coverage for their specialty. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties seeking to be included in Medicare benefits. Invariably, the final result depends as much if not more on shrewd lobbying than on good medical practice. The understandable reluctance of most lawmakers to subject themselves to this pressure slows down the process of modernizing benefits.

Just as problematic is the Health Care Financing Administration's (HCFA) complex administrative process of modifying benefits, determining whether certain medical treatments or procedures are to be covered under the Medicare benefits pack-

age, and under what conditions or circumstances they are to be reimbursed. This Byzantine process is marked by intense pleading by medical specialty societies, occasionally accompanied by Congressional intervention.

A long-term reform of Medicare must end the structurally inefficient and politicized system of changing or modifying benefits over time. The best way to do this involves three steps:

- Set only broad benefit categories in Congress. Rather than set specific benefits in legislation, Congress could confine itself to describing the broad categories of benefits that private plans competing in Medicare should provide (such as emergency care, drug benefits, etc.). This is the approach Congress has taken with the FEHBP program.
- Create a Medicare Benefits Board. Instead of Congress or the Administration specifying detailed benefits, Congress could create a Benefits Board to propose specific incremental changes in the core benefits for Medicare. Such an independent board would have members selected for specific terms by the Administration and Congress. The recommendations of the board package would be subject to an up or down vote by Congress. This would reduce political pressures on benefit decisions and take lawmakers out of the process of making detailed medical decisions, and yet it would give Congress the final say in any benefits changes. Essentially the practical logic for establishing a board to function in this way is the same as the logic for creating the Base Closing Commission in the 1980s.
- Establish Medicare as a combination of core and optional benefits. The broad categories for core benefits determined by Congress or a board could be confined to the "must have" basic benefits expected of Medicare rather than the comprehensive most seniors would actually obtain. In other words, the Medicare coverage for a senior (and eligible for premium support) would consist of a base set of benefits in every plan or in the traditional fee-for-service coverage plus a variety of negotiated supplemental benefits according to the needs and desires of each senior. Over time, it could be expected that the typical supplementary coverage would adapt to changing needs, desires, and medical practice. This two-tier benefits package thus would allow gradual adjustments in benefits according to the desires of individual seniors and would not require legislation by Congress to permit changes over time. This is essentially the process used in the FEHBP. In the FEHBP, broad categories of coverage are required, but the specific levels of benefits, including the kinds of medical treatments and procedures, offered by typical plans change with the times. Plans know they must keep up with medical developments yet remain cost-effective if they are to be selected by beneficiaries and thereby stay in business.

Had Medicare been able to evolve gradually, like the FEHBP, through these ways of significantly de-politicizing changes in benefits, Medicare no doubt today would have a modern and efficient system of benefits, more like the FEHBP and like Medicare at its inception.

Creating a drug benefit in the fee-for-service program. The first task for the proposed Benefits Board should be to determine the best way to introduce a drug benefit into the traditional fee-for-service segment of Medicare. With a Board in place, Congress could instruct it to develop a modified benefits package, including drug coverage, within a specified budget. To work within the budget constraints, the Board might develop a plan to make small changes in a number of features of the benefits package to achieve a well-balanced package that achieved Congress' objectives. The plan would be sent to Congress for an up-or-down vote without amendment. Should it fail to win approval, the Board would develop a modified version until agreement could be reached.

(3) Remove from HCFA the function of managing a market of competing plans and place this function under a new Medicare Board with powers to negotiate prices and services with plans.

HCFA currently is responsible for operating the traditional fee-for-service program. But is also responsible for establishing and managing the market for the increasing range of plans that are offered to seniors at a monthly premium. This combination of tasks is inherently unsound and explains many of the problems and shortcomings at HCFA.

Basic Conflict. It is a very basic principle of economic organization in a market that those responsible for setting the rules of competition, and providing consumers with information on rival products, should have neither an interest in promoting any particular product nor even a close relationship with one of the competitors. That is why the Securities and Exchange Commission maintains a wall of separation between itself and individual companies. It is why Consumers' Reports accepts no advertising from products it evaluates. And it is why umpires in baseball do not own baseball teams. It is also the reason why state and local governments (and the federal government under the A–76 program) have a different agency evaluating

competitive bids for government services from the agencies providing those services in-house. Entangling the running of a market with the management of any of the competing providers is a recipe for problems. It is interesting to note that in the federal health program that operates a market of dozens of competing plans made available to federal workers (the FEHBP), the agency responsible for running that market and providing information to beneficiaries (the Office of Personnel Management) does not run a plan itself.

This separation is not only necessary to avoid a conflict of interest, it is also necessary because the managerial cultures are very different for staff engaged in these two very different functions. Managers charged with dispassionately operating a market must display evenhandedness and pay close attention to the information that consumers need to make wise decisions. On the other hand, those managers engaged in marketing a particular plan, including a government-sponsored plan, must be highly competitive and concerned with the long-term viability of their particular product and the continued satisfaction of their customers. The cultural difference is much like that separating a judge from a trial attorney.

The simple fact is that HCFA cannot and should not carry on both of these tasks. The main reason it cannot is that the agency has, over the years, developed a culture and expertise that focuses on regulating prices and services, and identifying fraud and abuse. The training and skills of the staff reflect this general function. The agency, by contrast, has a shortage of the experience and skills needed to establish ground rules for a competitive market, develop businesslike relationships with competing private health plans, and provide consumers with the information they need to get the best value in such a market. For example, HCFA's efforts to create a handbook of information for beneficiaries that they could actually understand turned out to be a $95 million fiasco. Significantly such a handbook has been available for many years for enrollees in the FEHBP. Besides a brief booklet from OPM, a private consumers' organization, Washington Consumers Checkbook, produces a comprehensive guide, including patient rating surveys of plans, which is assembled by one analyst working for two months and backed-up by a few clerical staff.

It is not that HCFA staff is inherently incompetent, but that they have little training and expertise in these functions. It is a little like expecting experienced divorce lawyers suddenly to become good marriage counselors. The staff at OPM who operate the FEHBP, by contrast, have very different skills and backgrounds, and the agency has a different culture—which is why OPM is successful at running an nationwide program with many competing plans in each area.

But HCFA should not carry out those functions even if it had the skills to do so, because it is extremely unwise to permit an organization to be responsible for setting the rules of a competitive market when it also has a direct interest in the success of one of the competitors. As long as HCFA runs the fee-for-service program of Medicare, it can hardly be expected to benignly create a market in which other plans compete directly with the traditional fee-for-service program.

Congress must, however, accept much of the blame for the agency's problems. HCFA's current structure and statutory obligations do not allow it to maintain a proper separation between these functions, and are a impediment to the agency's ability to carry out either function very effectively. This stems from the fact that HCFA historically has acted as a bill payer and regulator, rather than a referee in a market and a consumer information agency. As the Institute of Medicine (IOM) noted in its 1996 analysis of the Medicare market, "In the past HCFA has made little effort to inform Medicare enrollees of their choices regarding health care providers, treatment options, or competing private plans."[1] And as the General Accounting Office noted in a 1995 study, HCFA amasses vast amounts of information but has a poor track record in providing information to beneficiaries that is usable.

To be sure, HCFA has been taking steps to provide better information to beneficiaries, including data on high mortality hospitals and better benefits information. However, this falls far short of what it needed to enable elderly Americans to make sensible choices when there are an increasing number of options available. Moreover, even with the recent reorganization, the conflicting functions of dispassionate market management and plan operation are still hopelessly entwined.

Comparison with OPM. It is interesting to contrast the way in which HCFA functions as a manager of a market with the manner in which OPM functions within the FEHBP. According to James Morrison, the career civil servant who ran the FEHBP during the Reagan Administration, the contrast stems not from any inherent deficiency of HCFA staff as civil servants, but from differences in the structure imposed on the agencies running the two programs. This suggests that Congress

[1] Stanley B. Jones and Marion Ein Lewin (Edit.), Improving the Medicare Market (Washington, D.C.: National Academy Press), p. 72.

must modify the program design if it is to achieve a change in the way HCFA functions. As Morrison explained to me in a note (which he has permitted me to make available to the Committee):

"There is a profound difference in the way the Health Care Finance Administration (HCFA) deals with the private sector intermediary in the Medicare program and the way in which the Office of Personnel Management (OPM) deals with the private sector plans in the Federal Employees Health Benefits Program (FEHBP). This difference derives, in large measure, from the statutory difference between the two programs.

"Medicare is a highly prescribed, statutorily defined program with benefit levels and payment rates essentially fixed in law. The FEHBP, on the other hand, has very few statutory prescriptions. Beyond the bare outlines of a core benefits package, specifics of the plan's offering and its price must be negotiated between the government and the private sector carrier. These fundamental differences shape the values, roles, responsibilities, and indeed the operating culture, of the administering agencies. Thus, HCFA employs legions of regulators bent on prescribing every detail of the Medicare program, and scores of health policy "experts" to determine the needs of beneficiaries. OPM employs a small number of contract specialists who can assess the price and value of a plan offering while leaving the determination of customer needs to individual consumers. HCFA places a premium on employees with advanced degrees in health policy; OPM values private sector health plan experience."

Create a Medicare Board. The Medicare Commission recognized this inherent problem when a majority of members voted to establish a board to take over many of the marketing functions, and the management of private plans, now undertaken by HCFA. To establish such a Board, Congress should create within the Medicare program a body that is the functional equivalent of the Office of Personal Management within the FEHBP. The function of this body, and the focus of the staff within it, should be to structure and operate a market of competing plans, including the traditional fee-for-service plan, and to provide Medicare beneficiaries with the information they need to make the wisest choice possible.

This Commission proposal is very similar to a recommendation of the Institute of Medicine's Committee on Choice and Managed Care in 1996. In making its recommendation, the IOM committee emphasized that HCFA currently tries to undertake two very different functions that demand very different approaches and skills. The IOM committee noted, among other things:

- "The administration of the multiple choice program and the management of the traditional Medicare program's involve very different mission and orientations.
- The two functions require different types of management, staff expertise, backgrounds, and knowledge. The committee is concerned that staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector be recruited and employed for this effort.
- The functions call for different organizational and corporate cultures, one operating a stable traditional public indemnity insurance program and the other a purchaser- and customer-oriented program that is required to be responsive to a diverse group of private programs in a rapidly changing and dynamic market place."[2]

The creation of a Medicare Board would permit the function of managing a market of competing plans to be separated from the operation of the traditional fee-for-service program as one of those competing plans. This would accomplish the economic and managerial objectives set out at the beginning of my testimony.

The new Board could answer directly to the Secretary of the HHS, and would have similar functions to those of OPM within the FEHBP. Among the Board's functions:

- Setting standards for all plans being offered to Medicare beneficiaries, and certifying that all plans meet those standards. The standard setting should apply to the traditional fee-for-service program as well as the new choice programs created by Congress.
- Negotiating with competing plans regarding benefits and prices. Just as OPM negotiates with individual plans before they are offered to federal employees during open season, so the board should use Medicare's purchasing power to push plans into providing the best options for seniors. One of the main reasons for doing this is to ensure that plans compete for business by offering good value rather than by introducing dubious marketing techniques (such as artificial boundaries for marketing areas, or benefits designed only to attract low risk customers). CalPERS carries out a similar function for California state employees, as do many large corporate purchasers of health care.

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[2] Jones and Lewin, Improving the Medicare Market, pp. 107–108.

• Organizing payments to chosen plans. The Board should evaluate and propose refinements of the payment system to plans, including the traditional fee-for-service plan, and recommend these to the Secretary of HHS and Congress.

• Providing data and information to consumers. The Board would take on the function of providing consumer and benefits information to seniors and guidance on how to make wise choices. This function would include examining techniques to measure quality and incorporating prudent techniques into the information made available to beneficiaries.

In order to carry out its mission effectively, the Board itself should contain certain elements. One of these should be an Advisory Council, mainly representing consumers but also organizations with a general interest in creating a market for high quality health care. However, the Board, and the Advisory Council, should receive policy and technical advise on issues affecting the market for Medicare plans from an outside advisory body with experience of other health care markets. I would suggest the Medicare Payment Advisory Commission (MedPAC), with an expanded staff, could play this role.

In addition, the Board would need a full staff to undertake its broad functions. Some of these staff could be recruited from current HCFA personnel. But for the reasons mentioned earlier, and emphasized by the IOM committee, it would be wise to recruit some staff from outside HHS in order to introduce new skills and experience. Some individuals might be recruited from OPM, and others from the private sector.

A Drug Benefit for Plans. In the FEHBP there is no statutory requirement on plans to include an out-patient drug benefit. But the plans do include such a benefit. The benefit simply emerged as plans came to realize that they could not compete without a drug benefit in a market where federal employees had a wide range of choices each open season. Like most benefits in the FEHBP, in other words, plans gradually included the benefit to reflect prevailing customer demand. In other cases, OPM actively encourages the inclusion of particular benefits by including them in its annual call letter to plans. Not all plans respond by proposing to include the OPM-suggested benefit, but typically market-leader plans that seek to market themselves as the most comprehensive available will do so. In the other cases, OPM actively negotiates with plans on ways they might include the benefit, and the result is that it may be offered in vary different ways by different plans, reflecting local conditions and market factors.

The proposed Benefit Board could encourage the inclusion of a drug benefit in the Medicare private plans in the same way. It could request plans to include out-patient drugs and it could negotiate with plans for ways to do this in the least costly way.

(4) Empower the traditional fee-for-service program to compete.

Because of the statutory basis of the fee-for-service benefits package, and the many requirements Congress places on HCFA, it is currently very difficult for agency to make improvements in the fee-for-service program to more it competitive and modern. Thus the fee-for-service is inherently at a disadvantage when competing with the more flexible private plans now being made available to seniors.

The Medicare Commission discussed giving HCFA more flexibility to enable the fee-for-service program to compete more effectively. This makes sense-though, for the reasons discuses earlier, only if the agency is relieved of the power to set the rules for competition.

If Congress were to do this, it would give HCFA the same ability to compete as states and local governments routinely give "in-house" public agencies when they are subject to competitive bids from the private sector. There is no reason why public enterprises cannot be competitive and entrepreneurial. In virtually every state of the union we see such innovation, from the delivery of municipal services to the management of public education. Congress should give HCFA the same kind of flexibility and entrepreneurial opportunities that school districts are giving teachers and principals to create charter schools.

Specifically, Congress should refrain from locking HCFA into a statutory straightjacket, where its primary function is the rigid and increasingly onerous and ineffective micro-management of the financing and delivery of health care services for senior citizens under fee-for-service. Instead, Congress should give HCFA greater flexibility to run the traditional fee-for-service program in ways that would make it an aggressive competitor to managed care plans and other emerging private sector health care options in the next century. Whenever a competitive market is introduced, the government-provided service must be given every opportunity to redesign itself to compete effectively. This should be so in Medicare. Thus HCFA should be permitted to introduce innovations into the management of traditional fee-for-service Medicare. It should be allowed, for instance, to make extensive use preferred

provider organizations of those physicians and hospitals giving the best value for money. It should also be allowed to contract out the management of the traditional program in areas where that might improve Medicare.

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PREPARED STATEMENT OF HARRY P. CAIN II

Mr. Chairman, and members of the committee, I am Harry Cain, currently executive vice president of the Blue Cross and Blue Shield Association (BCBSA). The views I express today, however, are not necessarily those of the Association. My experience with Medicare derives primarily from the ten years I was responsible for our Medicare "prime contract" (1984–1995), plus assorted minor contacts with HCFA over the last thirty years.

I am honored by this committee's invitation to speak to the substance of an article I wrote for the Health Affairs journal in 1996—the article entitled "Privatizing Medicare: a Battle of Values," a copy of which is attached to this statement—and also to speculate on the challenges you face today in trying to reform Medicare.

Other witnesses have made, or will make, the case that Medicare needs fundamental reform, so I don't intend to go further into that. Instead I'll offer some comments on why it is, and will be, so hard to do the job.

I think you have two fundamental problems in trying to modernize Medicare, one philosophical, the other structural:

(1) The philosophical problem is that among those who care about the subject there are two very different, passionately held views on the health care industry—the publichizer view and the privatizer view, both of which are described in the Health Affairs article. It will be very difficult to find workable common ground or compromise positions between those two schools of thought related to the Medicare reform issues.

(2) The structural problem is that the government holds all the financial risk for Medicare, and thus the Congress has to make all the key decisions on Medicare reform. That essentially makes you and your counterparts in the House the top policymakers for a huge health insurance company. Given the enormity and complexity of the subject, and given the multitudes of special interests and poll-takers standing at your door, your chances of doing an excellent job of this are not good.

I'll spend a little time now trying to illuminate those two points, and then we can discuss any of this you might like.

PUBLICHIZERS AND PRIVATIZERS

While talking about this subject I would refer you to the exhibit on the next to last page of the article. It offers many examples of the differences between the mindsets of publichizers and privatizers. I've represented some of those differences on this chart. [Free standing chart, #]. Admittedly, I have built two caricatures here, two somewhat exaggerated depictions of the mind-sets I've encountered in policy makers across the industry. Caricatures tend to communicate better than shades of gray, and the purpose of the article was to try to make both schools of thought more aware of where the other is coming from. My hope was that the piece might help to improve communications between the two.

I'm so familiar with both mind-sets because I've embraced them both. When I joined the federal service (at N.I.H.) out of graduate school in 1962, I was decidedly of the publichizer mind-set, and virtually everyone I met and worked with over the following 16 years—both in the Executive Branch and here on Capitol Hill—were of the same mind-set.

In 1982 I was comfortable going to work for the Blues because the Blues had a publichizing history and tradition. Since that time, however, much of the industry has changed, most of the Blues have changed, and certainly I have changed. The strengths of the privatizing mind-set have come to the fore in the health care industry, really for the first time. In the private sector this has been a time of tremendous change, innovation, and experimentation, all in an effort to understand and win customers, all in response to the dynamics of a competitive market. It has not all gone smoothly, but much progress has been made. The health care industry is beginning to resemble the other major industries in our amazingly successful economy.

Most of my friends and acquaintances from "the old days" who remain publichizers are still here in Washington, or have retreated to academia, or are somewhere in the voluntary not-for-profit sector. All would characterize themselves, appropriately, as "health policy wonks." They tend to see Medicare as one of the most successful—probably the most successful—of all the publichizer initiatives of the last four decades.

Modernizing or "privatizing" Medicare will challenge most of a publichizer's firmly held views of the world. And my publichizer friends tend to be very smart, articulate, committed, compassionate people, fun to argue with, but not easy to move off their misguided positions (that's a privatizer's opinion). The publichizing mind-set is your first problem.

GOVERNMENTAL RISK AND CONGRESSIONAL DECISION-MAKING

I believe the decision-making challenge before the Congress can best be exemplified by contrasting two federal health programs, Medicare and the FEHBP. One of those programs, I believe, created a structure that is very difficult to modernize, the other got the structure almost right. The question is, how did it happen?

Medicare was enacted in 1965 after years of congressional debate and analysis. And ever since then Medicare has been an annual focus of this committee. This consistent attention has resulted in literally thousands of changes to the Medicare law in the last three decades.

The responsible executive agency—now called HCFA—has a very large, talented staff—which often adds to its knowledge and its talent pool by using expert consultants and commissioning relevant research. The staff and the experts are nearly all of the publichizing mind-set, of course, but they are sophisticated in health policy issues and emotionally committed to the success of the program. They work very hard. This committee and its staff work very hard.

And yet, after the investment of such huge resources in making Medicare succeed, for more than thirty-five years, the program is headed toward serious trouble—as this committee obviously appreciates or you wouldn't be holding these hearings.

The design of the FEHBP, on the other hand, was rather haphazard. By accident, not forethought and design, the FEHBP became the consumer choice, price competitive model that privatizers now admire. The federal statute, passed in 1960, has been amended rather infrequently.

The responsible executive agency—now called OPM—has a relatively small staff devoted to the FEHBP, most of whom don't know much about health policy. Their expertise is in employee benefits. In fact, they don't really like several key features of the FEHBP. It's not their favorite program. On top of that, they too tend toward the publichizer mind set. Many of their rules clearly display a publichizer's preferences. So, we have a privatizer type of program administered by a conscientious but not emotionally committed staff.

And yet, compared to Medicare, the FEHBP is thriving. Its benefits are better, its cost increases have been lower, its beneficiaries are more satisfied, its future looks terrific. When participating health plans, large and small, have decided suddenly to pull out of the FEHBP, which happens, the affected beneficiaries have moved easily to other health plans, with very little upset. The contrast to the recent Medicare+Choice experience is striking.

The FEHBP is certainly far from perfect, so it seems remarkable that one large federal health program, which has received very little attention over its history, has outperformed an even larger Federal health program, which has long been the focus of the best and brightest health policy minds in the country.

How can that be?

Part of the answer I would classify as "uncontrollable," namely that the population served by Medicare is more challenging to serve than the FEHBP population, in the sense that it's much larger (4:1), more heterogeneous, less educated, and includes large pockets of very poor, very sick and disabled, very vulnerable people. Those problems are not insoluble, but they do make Medicare's challenge very difficult.

The other part of the answer is structural and is more controllable. It involves at least four inter-related elements:

1. Financial risk. Who holds the risk?
2. Decision-making. Who makes what kinds of decisions?
3. Scope of regulation. How much does the government try to regulate?
4. Complexity of policy-making. How much must the policy-maker understand in order to make sensible policy decisions?

Answers to those questions in turn affect product innovation, efficiency, customer responsiveness, and most other characteristics of any enterprise.

In Medicare, the government holds all the risk,

Which means that the government—either the Executive Branch or the Congress or both—will make all the key decisions (on a rapidly growing $200 billion enterprise),

Which means the scope of regulation will cover essentially every relevant actor in the United States—all the physicians, hospitals, nursing homes, carriers, suppliers, beneficiaries, etc.,

Which means that every health care interest group in America will camp on the government's doorstep, seeking to influence your decisions, all year, every year,

Which means that the aggregate complexity of Medicare policy-making is beyond anyone's ability to grasp.

The rest of the health care market's decision-making is not organized that way, and most of the private sector decision-makers are, of course, privatizers. So the rest of the market will always be able to move much faster and more coherently than Medicare can. Given the tremendous changes still to come in this industry, in medicine, technology, pharmacy, electronics, organization, you name it, Medicare as currently structured will always be behind the curve. (Even large private sector insurers, with well organized, efficient decision-making structures, are having difficulty keeping up.)

In the FEHBP, the health plans hold most of the risk, and make most of the key decisions. The government tries to regulate only the health plans. No decision-maker has a problem too complex to solve. The program innovates rapidly, in direct response to its customers. It keeps apace with the market.

In sum, Mr. Chairman, in my opinion, the problem you face today—how to keep Medicare both solvent and within reach of the modern world—you will face forever, unless you can fundamentally change the structure of the program.

If you want to diminish the publichizers' hold over the program, and strengthen the privatizers' interest in it, if you want the private sector to take on more of the financial risk of Medicare, and the related decisions, and be held accountable for the outcomes, then you'll have to fundamentally change the role of Congress and the role of the Executive Branch in the operation of the program. This is as true not only for any future reform but for the success of the Medicare+Choice program. I sincerely hope you don't find that prospect as discouraging as I do.

Thank you, Mr. Chairman.

Privatizing Medicare: A Battle Of Values

Can the twain meet on Medicare reform? Some new insights from one who has worked in the trenches of both public- and private-sector health care.

BY HARRY P. CAIN II

THE UNFOLDING DEBATE on Medicare reform will feature a clash of views on the proper direction of U.S. health policy. The debate is not about whether the government should subsidize health care for the elderly and disabled, nor is it about how much Medicare should spend in the next few years. Rather, it is about controlling its rate of growth, which in turn is about structure and approach and who should be able to make what kinds of decisions. On those questions there are two basic schools of thought: the privatizer school and the publicizer school.

The aim of this paper is to highlight the apparent motives and values underlying the two schools. My hope is that communications between the conflicting schools will improve if each better understands the other. Neither school, in my experience, has any edge in integrity, intelligence, character, humor, or any other important trait. The two schools simply have different perspectives that lead in different policy directions.

One might expect that I contrast the liberal, Democratic, northeastern, academic view of the world with the conservative, Republican, southwestern, pragmatic view. But those are not very useful categories or adjectives. Too many exceptions come to mind. "Privatizer" and "publicizer" convey the different perspectives more concisely.

By "privatizer" I mean the private business insurer, the competitive health maintenance organization (HMO), the health plan entrepreneur, the aggressive Medicare reformer. By "publicizer" I mean essentially a public policy-oriented, governmental, health planning person—a traditional Medicare supporter. The publicizer tries to detect the "public interest," and sometimes succeeds. The privatizer tries to detect publicizers, and gets out of their way.

181

Please note that "publicizer" is simply a word that I manufactured because no other seemed to fit the bill. The last two syllables of "publicizer" are pronounced like "kaiser," the German word for "caesar," which refers to ancient Roman emperors, not modern salads with anchovies.

A SHIFTING PERSPECTIVE

I personally have subscribed to both of these world views. For sixteen years, I worked for the federal government in various health programs, not only as a government health official and policy wonk, but also as a health planner in the 1960s and 1970s.

In the 1980s and now in the 1990s, I was and am a private health insurer, fighting in a price-competitive market to win more than my share of customers. My organization is not only trying to win more than our share, we are

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trying to do it in such a way as to earn a significant profit.

Most readers will now be thinking to themselves, "How far can one fall from truth and justice?" A few will secretly be thinking, "How high he has climbed—from government bureaucracy to the real world." (I am assuming that most of you are publicizers, because privatizers do not usually read health policy journals.)

I joined the Blue Cross/Blue Shield system in 1982, when much of the Blues' world view—and nearly all of its history—was more publicizer than privatizer. That is why I was comfortable going there. Over the past thirteen years, however, the Blue Cross/Blue Shield mind-set has moved much more to the privatizer side of the ledger. That has happened not as a result of philosophical exploration, but rather as a response to changes in the marketplace.

182

That movement among the Blues, by the way, has made many publicizers within the government come to view Blue Cross/Blue Shield as an old friend gone wrong: The Blues have succumbed to temptation. As a prime example, the Health Care Financing Administration (HCFA) does not trust Blue Cross/Blue Shield as it once did. The 1994 decision by our board to allow Blues plans to become for-profit entities was probably the last straw.

THE BIG PICTURE

Most of us would agree that there is a full-scale revolution under way. The health care industry is becoming a truly price-competitive sector of the economy for the first time. (One could argue that the industry was price-competitive before the development of health insurance, but that was also before scientific developments made the industry big, expensive, and anything to get excited about.) In my view, as a result of price competition, total costs are in fact coming under control. Quality is rising. Some companies, some hospitals, and some individual practitioners are going under; they are exiting the industry. Most individual consumers and group buyers are and will be better off, but some will get hurt. Consolidated and integrated delivery systems are becoming the order of the day. A cottage industry is collapsing. Traditional indemnity insurance is dying. In short, the health care sector is beginning to operate like the housing sector operates, or like the food, clothing, or transportation sectors operate.

> *"There is a full-scale revolution under way.... The privatizers are making it happen."*

The privatizers are making it happen. The publicizers are really not part of the action, but they are very concerned about what is going on and are not sure what to do about it. And when the publicizers develop proposals to take to Congress to improve the situation—which is what publicizers do when confronted with a problem—progress will be difficult. By most counts, the Republican Congress is sympathetic to the privatizer viewpoint, with this caveat: Most politicians of either party can and will become publicizers when necessary, if it will keep them in office.

BACK TO BASIC VALUES

From the publicizer viewpoint, the basic problems with today's health care system are that there are too many people left out, too many uninsured, and costs are too high, which is largely a function of private profiteering, fraud, and abuse. In short, the public interests are ill-served by today's marketplace. For the privatizer the basic problem is that the market has been distorted by tax policy, by excessive regulation, and in some markets by risk selection.

Why do the two groups see the same environment so differently? In large part it is because they begin with very different sets of values. The publicizers value equity, security, predictability, and control (to protect the public interest). The privatizers value effi-

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ciency/effectiveness, flexibility, change, and freedom. These different values are played out in efforts to address all other questions. Let us look at three questions in more detail: What is a successful health plan? How should scarce resources be allocated across health plans? Do we need a national standard benefit package?

■ WHAT IS A SUCCESSFUL HEALTH PLAN? The publicizer's model health plan (meaning an entity that actually provides care) is a voluntary, nonprofit organization that consistently provides high-quality service at a reasonable cost because it is the right and ethical thing to do. The organization does a high volume of service, even though it does not resort to advertising. It is staffed by outstanding professionals who have no ownership interest in anything in the industry that might create the appearance of a conflict of interest. Their salaries are slightly higher than those in the civil service. These professionals are so honorable that they will voluntarily open their accounting books to anyone, including the press, whenever asked. They have absolutely nothing to hide. Not only that, these organizations will accept as reasonable whatever the government or Blue Cross decides to pay them for serving their beneficiaries. Publicizer organizations do not complain.

The privatizer is in another world. The privatizer says to herself or himself, "This is an expensive business; my organization cannot succeed without adequate capital; and I can only attract capital if I consistently make a good profit. If I ever forget that, I am dead. My other, equally important, goal is to attract and retain customers. And I can only do that if I provide consistently high quality services at a competitive price. Unfortunately, the price competition is becoming so fierce that I cannot maintain as high a profit margin as I would like, I cannot afford much overhead, and I have to keep getting more efficient. But that is the game I am in, and I intend to win."

When publicizers see privatizers behave like that, they immediately suspect that there is something unethical afoot, probably fraud or at least profiteering. Indeed, look at the title of chapter 3 in a U.S. General Accounting Office (GAO) study of Medicare's vulnerability to fraud and abuse, published in February 1995: "Health Care Delivery Expansion Widens Opportunity for Profiteering." The title provides a good example of the publicizer's view of privatizer organizations. In the GAO lexicon, "health care delivery expansion" refers to all changes, consolidations, and integrations. The industry keeps changing, and that is dangerous. It gives the crooks of the world even more opportunity to cash in.

■ HOW SHOULD RESOURCES BE ALLOCATED? The publicizer's view is that price competition neither can nor should be the best mechanism for allocating important health care resources. For many years (the early 1960s to mid-1980s) health planning was the most popular publicizer approach to the task. Health planning—a local (or state), representative, public (or private, nonprofit) body, backed by a technically competent planning agency, reviewing and approving the investment of new resources in health care services and facilities—assumes that price competition in this industry just will not work, at least not constructively.

Why? Publicizers cited many reasons: Price competition creates the wrong incentives (toward profits, rather than compassionate care). Providers are too strong and medical care is too magical for consumers armed only with money. Demand for health care is unlimited. Health insurance distorts the market signals. And so on.

Until the early 1980s I personally had accepted all of these arguments as valid. Most of the experts said the same thing. The balance of power between consumers and providers was just too uneven, and the consequences too important, to ever produce an acceptable marketplace. Health planning offered a reasonable alternative.

I changed my mind only after getting thoroughly involved in the Federal Employees Health Benefits Program (FEHBP) at a time when that program was becoming very competitive. To compete more effectively in that market, we had to make our product (Blue Cross/Blue Shield's "FEP" product) more at-

tractive to the eligible population—in price, benefits, and service. That is to say, we had to get our prices down, we had to assure high quality, and we had to keep our subscribers happy—or we were going to take a terrible financial bath.

We succeeded in doing what we had to do. Then our competitors tried to do the same thing. But that just made us work even harder and more creatively. That competitive dynamic, not surprisingly, has led to an aggregate performance of the FEHBP that is quite impressive. It surpasses Medicare on every important performance indicator over at least the past eight years. Although there is more to that story, the bottom line is clear: Price competition is not supposed to fly in health care, but it can and it does.

The opposite was true of health planning. Most of the experts said that it should and would work, but it didn't. Publicizers said that it didn't work because the planning agency didn't have enough money to attract and retain top-flight staff or enough regulatory power to enforce its decisions. Privatizers said that health planning failed because the health care industry is far too complex for any one set of actors to understand and manage. Only a price-competitive market, with its invisible hands, can do that.

■ DO WE NEED A NATIONAL STANDARD BENEFIT PACKAGE? Publicizers strongly support the idea of a national standard benefit package. The idea appeals to their preferences for equity, security, control, and predictability. A standard package would ensure that there are no schlock programs out there. It would protect any citizen who gets coverage. It would ensure that most people around the country get essentially the same set of benefits. And, it would make plan comparisons easier if we have to go down the price-competition road. Publicizers may not like that road, but if we are going to do it, having a standard package would facilitate price competition and ensure that it takes place within a more controlled environment.

From the privatizer's standpoint, standardization of benefits is a terrible idea. The privatizer believes that our science is not strong enough yet to determine what should be in the package, but our politics are more than strong enough to influence the process and outcome. Any centralized body trying to standardize a package—and it would require a centralized body—would be besieged by every interest group in the industry. That means it would be slow to come to a decision and even slower to change. (On the other hand, privatizers would support better "truth in packaging" rules and more standardization of terminology, to reduce consumers' confusion and health plans' inefficiencies.)

Moreover, one does not need to standardize the benefit package to guard against low-quality products. Examples such as the FEHBP act suggest that it is possible to set some general ground rules and then let the competitive market respond. Competing privatizers will keep modifying their benefit packages, either to satisfy their customers or to keep up with the competition, or both.

Most privatizers would agree to a standard benefit package within specific accounts or purchasing groups, so that, for example, all of the employees of GTE, in trying to choose from among various HMOs and other options, could hone in on comparative prices and on which providers are in which plans. Most privatizers would not, however, support a standard package for Medicare health plans. Medicare's power is too massive nationwide. No aspiring health plan will be able to stay out of the Medicare market, so a standard package there would reach a publicizer's goal of a national standard benefit package, but with the consequence of a less innovative, slower-moving marketplace. (See Exhibit 1 for a summary of these views.)

Looking Forward To Reform

If and when some market-oriented Medicare reform is enacted, implementation will be difficult, but not because the Republicans control Congress and the Democrats control the White House. The basic dilemma is that most government agencies have a lack of senior staff who are widely experienced in the pri-

EXHIBIT 1
A Comparison Of Publicizer And Privatizer Views

Issue	Publicizer view	Privatizer view
Problem with current system	Public interests ill-served: Too many uninsured Cost too high Too much private profiteering	Market distorted by: Tax policy Risk selection in small-group, individual markets Excessive regulation
Highest values	Equity, predictability, security, control	Efficiency/effectiveness, flexibility, speed, change
Nature of beneficiary	Vulnerable, needs to be protected	Customer, needs to be satisfied
Price competition in health care	Cannot work	Is the only way
Favorite federal health program	Medicare	FEHBP
Successful health plan	Meets one goal: High-quality service at reasonable cost	Meets two goals: Attracts capital Attracts customers
Management focus	Cost and consistency Constituencies Motives and effort	Price and value Buyers and competitors Results
Managed care abuses	Make them illegal	Market will weed out
Providers and insurers	Suppliers or thieves (maybe both)	Partners or competitors (maybe both)
Who assures integrity of health plans?	Inspector general and audit army	Buyers/consumers with choices
Profit	Tolerable only at low level	Essential fuel; earn or die
Accounting statement	Every line	Bottom line
Conflict of interest	Should be a disqualifying condition	Get it on the table; take it into account
Insurance rating	Community rating; spread the risks	Large group experience; reward smart buyers
Insurance benefits	National standard benefit package, in splendid detail	Let markets decide; standardize only within accounts
Best allocator of resources	Public body backed by technically competent planning agency	The "invisible hand"
Approach to health care reform	Comprehensive; balance conflicting interests	Incremental; improve market dynamics

SOURCE: Author's observations.
NOTE: FEHBP is Federal Employees Health Benefits Program.

185

vate sector, especially in entrepreneurial enterprises (as opposed to academic, lobbyist, or philanthropic enterprises). Both publicizers and privatizers tend to work where they are most comfortable, where they are best able to satisfy their own values. In addition, the structural constraints on senior-level government jobs (relatively low pay and restrictions on postgovernment work) make for an intractable problem.

The concept of competing, accountable health plans is a great one if the administering agency believes in it and trusts the market and health plans to impose and accept accountability. If, however, the publicizer mind-set prevails in administration, we can anticipate extensive government involvement in health plans' marketing, enrollment, customer service, appeals, accounting, executive compensation, and so on. The prevailing bias will be for equity, which usually means "one size should fit all." The publicizer will not resonate to the fact that dynamic markets move very fast or to the notion that a first-to-market motivation is good, not bad. If the market works, some beneficiaries will get a better deal than others will get, which will lead to more innovations, not all of them successful. So the publicizer reaction will be to require that all new ideas, or variations on old ideas, have to be approved by a publicizing government. If that happens, the end-of-century Medicare reforms will largely freeze today's market in place until perhaps 2025. Not a good idea.

186

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PREPARED STATEMENT OF ESTHER "TESS" CANJA AARP PRESIDENT-ELECT

Mr. Chairman and members of the Committee, I am Tess Canja, President-elect of AARP. I appreciate the opportunity to share with you AARP's perspective on the future of the Medicare program.

For over thirty years Medicare has provided dependable, affordable, quality health insurance for millions of older and disabled Americans. My home state of Florida has one of the largest beneficiary populations in the nation and I see firsthand what a difference Medicare makes in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program.

Medicare must be capable of serving the enormous influx of beneficiaries who will enter the program when the baby-boom generation begins to enroll in 2011. Just as important, longer life spans are already causing rapid growth in the very old population. Medicare must be prepared to handle the unique health care needs of this population. As rapid advances in medicine are made, Medicare's benefits and its means of delivering care must continually keep pace. And, of course, the program's long-term financial solvency must be secure. AARP supported the Balanced Budget Act of 1997 as a first step towards securing Medicare's long-term solvency. The recent report of the Medicare Trustees projected seven additional years of solvency—to the year 2015. While this is good news, it does not mean that we can postpone the debate over Medicare's future.

In fact, the deliberation over Medicare's future must be ongoing. It will take a sustained effort to continually update and improve Medicare. Changing a program that 39 million Americans depend on for their health care is no small task. There must be a careful and thorough examination of the full range of issues, including how the issues interact, as well as an understanding of the trade-offs that will be necessary.

Senator Breaux's premium support plan, and other emerging legislative proposals, provide opportunities for examining different reform options and for stimulating debate. Genuine debate over the issues and options surrounding Medicare are critical to building public understanding and support for reform. AARP has reserved judgment on the Breaux proposal. We believe that it would be a serious mistake for anyone to hinder debate on such proposals or, by the same token, for Congress to rush to judgment on the Breaux plan or other reform options.

LESSONS FROM THE BALANCED BUDGET ACT OF 1997

In addition to the need to build understanding and support, a further reason to move cautiously with Medicare reform is that many of the sweeping changes made to Medicare by the Balanced Budget Act—most notably the creation of the new Medicare+Choice options—are still being implemented. The overall effect of these changes—on beneficiaries, providers and the program—is not yet clear and there is still much to be learned. The challenges and successes of Medicare+Choice will have important implications for the next phase of Medicare reform.

For instance, last fall's unexpected disruption in Medicare HMO availability served as a wake-up call to those who seek to bring private sector solutions to bear on Medicare's problems. While some private managed care options have been able to help remedy some glaring gaps in original Medicare—namely, the lack of prescription drug coverage and high out-of-pocket costs—these options are not without their own problems.

When private businesses are given the authority to manage a beneficiary's care in exchange for the opportunity to earn a profit, several things can happen. On the plus side, the innovations in administrative efficiency, and improved health care delivery may benefit the patient through lower costs, additional benefits and better coordinated care. On the minus side, patients may have fewer choices of providers, be subject to service reductions, and have no control over whether their health plan continues to be available from year to year. It is a challenge to separate the positive from the negative because the same factors create both results.

A private business may be more innovative and efficient, yet in the absence of an opportunity to earn a profit, will leave (or not enter) the market. The beneficiary who gained extra benefits in the short run may lose them in the long run.

One of the lessons learned from the initial implementation of Medicare+Choice was that, with every change to Medicare, there are unintended consequences. Therefore, it is absolutely essential that policymakers and the public understand proposed changes to Medicare and their effect on beneficiaries, providers and the Medicare program in general. As we all learned from the legislative debates over the Catastrophic Coverage Act in the late 1980s and from the health care reform debate of the early 1990s, unless the American public understands why changes are necessary and what trade-offs they are being asked to make, their initial support can quickly erode.

KEY PRINCIPLES OF MEDICARE THAT SHOULD GUIDE REFORM

Since its inception, there have been some fundamental tenets that have helped to make Medicare such a successful program. AARP believes strongly that any viable reform option must be based on the principles which are enumerated on the following pages.

Defined benefits including prescription drugs

All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute is important for a number of reasons. First, it assures that Medicare remains a dependable source of health coverage over time. Second, a defined benefit package serves as an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. Without this kind of benchmark, the government's contribution could diminish over time, thereby eroding Medicare's protection. Third, a benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare. And finally, a defined benefit package provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

When Medicare began, the benefit package was consistent with the standards for quality medical care. In any reform, it will be important that the benefits be clearly defined and reflect modern medical practices. To this end, prescription drugs must become part of the benefit package for all beneficiaries in whatever plan they choose.

Pharmaceutical therapies have become increasingly important in the treatment of virtually every major illness. In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, thus improving the quality and length of life for the patient. While nearly all private health insurance plans include some type of outpatient prescription drug coverage, Medicare does not. Put simply, prescription drugs in Medicare are smart medicine.

Because of Medicare's lack of coverage, beneficiaries must either pay for prescription drugs out of their own pockets—and they pay top dollar because they do not receive discounts negotiated by 3rd party payers—obtain private or public supplemental coverage that assists with costs, or join a Medicare HMO that offers a prescription drug benefit.

While it has been reported that 65 percent of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading. Medicare beneficiaries' current prescription drug coverage may not protect them from high out-of-pocket expenses. For example, some beneficiaries buy Medigap policies that provide a drug benefit. But the premiums on these policies often exceed $1,000 a year and the coverage is quite limited. Two of the three Medigap policies that cover prescription drugs have an annual cap of $1,250 on drug coverage; the third policy has a $3,000 cap. All three Medigap policies that have a prescription drug benefit require the beneficiary to pay a 50 percent coinsurance.

Because almost all Medigap policies with drug coverage medically underwrite, many Medicare beneficiaries cannot obtain such coverage. Beneficiaries seeking drug coverage through Medicare HMOs find that these plans are not available in many locations and, in some cases, the drug benefits may be becoming more expensive and/or more restrictive. And, many beneficiaries with drug benefits from former employers are seeing their companies cut back on coverage or drop it altogether.

Including drug coverage in all Medicare plans would lessen the problem of adverse selection. Medigap plans that offer generous drug benefits tend to attract high-risk, high-cost enrollees. Healthy individuals with a low risk of chronic illness may prefer inexpensive plans with limited drug benefits. As a result, insurance plans that include adequate drug benefits become extremely expensive and can price themselves out of the market, as illustrated by the current Medigap market situa-

tion. Therefore, if a Medicare drug benefit were not part of all Medicare plans, those plans offering drug coverage would attract the sicker, higher cost prescription drug users and would become extremely expensive because the insurance risk would not be broadly shared. Similarly, a voluntary drug benefit could pose serious risk selection problems unless it were designed like Part B to attract nearly universal participation.

Beneficiaries comprise 12 percent of the U.S. population but account for one-third of prescription drug spending. Higher utilization, higher costs and less coverage pose a serious problem for Medicare beneficiaries. Thus AARP believes it is essential to include affordable drug coverage as part of the benefit package for all beneficiaries.

Adequate Government contribution toward the cost of the benefit package

It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. CBO estimates (April, 1999) that once the changes in the Balanced Budget Act are fully implemented, beneficiaries will pay 12–13 percent of total program costs in a given year. (This estimate includes Part B premiums, Part A premiums for those who pay it, and the annual income from the HI payroll tax; it does not include cost-sharing paid by beneficiaries.) If the government's contribution were tied to an artificial budget target and not connected to the benefit package, there would be a serious risk for both the benefits and government payment to diminish over time. In addition, a change that results in a flat government payment—regardless of the cost of a plan premium—could yield sharp out-of-pocket premium differences both year-to-year and among plans, with resulting turnover in enrollment.

Out-of-Pocket Protection

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. The average Medicare beneficiary spends nearly 20 percent of his or her income out-of-pocket for health care expenses, excluding the costs of long-term care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a $100 annual Part B deductible, a $768 Part A hospital deductible, 20 percent coinsurance for most Part B services, a substantially higher coinsurance for hospital outpatient services and mental health care, and significant coinsurance for hospital and skilled nursing facility care. Currently, there is no coinsurance for Medicare home health care.

AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare. However, if cost-sharing were too high or varied across plans, Medicare's protection would not be affordable, and many beneficiaries would be left with coverage options they might consider inadequate or unsatisfactory.

Protecting the availability and affordability of Medicare coverage

Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare. Denying Medicare coverage to individuals based on income threatens this principle. Similarly, raising the age of Medicare eligibility would have the likely affect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, AARP views it as unacceptable to raise the eligibility age for Medicare.

Administration of Medicare

Effective administration of the program remains essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. It must have the tools and the flexibility it needs to improve the program—such as the ability to try new options like competitive bidding or expanding centers of excellence. It must ensure that a level playing field exists across all options; modernize original Medicare fee-for-service so that it remains a viable option for beneficiaries; ensure that all health plans meet rigorous standards; and continue to rigorously attack waste, fraud and abuse in the program.

Financing

Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, any financing source will need to be both broadly based and progressive. Additionally, AARP supports using an appropriate portion of the on-budget surplus to insure Medicare's financial health beyond 2015.

KEY ISSUES RAISED BY THE BREAUX PREMIUM SUPPORT PROPOSAL

One of the Medicare reform proposals currently under discussion is Senator Breaux's premium support model. AARP has reserved judgment on the Breaux plan because many of the critical details have not yet been spelled out and because we want to encourage constructive debate over the key issues of Medicare reform.

In reviewing what we know of Senator Breaux's plan thus far, based on the March 16 version, we have used our principles for Medicare reform, some of which are described above, to begin to identify the critical questions that will need to be answered about the Breaux option. The answers to these questions should assist public understanding of how the Breaux premium support option would work and what its impact would be on beneficiaries.

While the answers to some of the questions we raise are beginning to be addressed as Senator Breaux's proposal evolves, until there is actual legislative language, the questions remain relevant.

The remainder of my testimony today will focus on six elements of the Breaux plan: the benefit package, prescription drug coverage, the government payment or contribution for the benefits, beneficiary out-of-pocket costs, the role of the proposed Medicare Board, and Medicare's financing and solvency.

Benefits

The most recent description of Senator Breaux's proposal would establish a standard benefit package, specified in law, that all plans participating in Medicare would be required to offer. The benefit package would consist of the services currently covered by Medicare. The proposal would allow some variation (10 percent is specified) with the approval of the Medicare Board. Plans could offer additional benefits beyond the core package but only the cost of the standard benefit package would be used in the calculation of the national weighted average premium. Because the national weighted average premium would be the basis of the government contribution, beneficiaries would be responsible for the full cost of any portion of a plan's premiums that exceeded the national weighted average and for the full cost of any additional benefits above the standard package (referred to in the Breaux proposal as the "high option"). Plans could also vary the amount of the beneficiary coinsurance and deductible with the approval of the Medicare Board. AARP has a number of questions about the benefit package in the Breaux proposal, including:

- Given the flexibility that would be allowed in the benefit package, what assurances are there that there would continue to be a dependable, defined benefit package over time?
- Would the 10 percent variation be fixed in law? What does the 10 percent variation apply to benefits? to cost-sharing? What types of changes would be permissible or precluded under this standard?
- What is the base against which the 10 percent variation would be measured? What criteria would the Board use to determine whether a 10 percent variation is allowable? What might be the cumulative affect of the 10 percent variation?
- How would the actuarial value of the benefit package be determined?
- By how much could the Medicare coinsurance and/or deductible vary?
- Would private plans and the fee-for-service plan be allowed to vary the benefits and cost-sharing?
- If the standard benefit package consists of all services covered under existing Medicare, does this include all of the current regulations and manual instructions?
- How, as a practical matter, would premiums that could vary by county and plan be collected? Deducted from the Social Security check? To what extent would this be possible administratively?

Prescription drug coverage

The Breaux proposal does not provide outpatient prescription drug coverage as part of the standard benefit package. Private Medicare plans and the government fee-for-service plan would be required to offer a "high option" that would include at least the standard benefits plus outpatient prescription drugs and a cap or "stop loss" on out-of-pocket expenses. There would be no government subsidy for any portion of the drug coverage except for lower-income beneficiaries. Some beneficiaries (with incomes up to 135 percent of the poverty level) would be eligible for government payment of the high option plan that would include prescription drug coverage. All current Medigap plans would be required to offer basic coverage for prescription drugs and one plan would provide only prescription drug coverage.

On prescription drug coverage, AARP believes that a number of questions must be answered, including:

- What kind of prescription drug coverage would be available through high option plans?
- What would beneficiaries be required to pay for the prescription drug premium, deductible and co-insurance in the high option plans? What would be the levels of the spending cap and stop-loss? Would it be affordable?
- Is the low-income benefit a Medicare or Medicaid benefit? How would this benefit design avoid limiting beneficiaries' choice of plans?
- Would low income beneficiaries have to pay cost-sharing for the prescription drug benefit beyond the premium? Would an asset test be applied?
- Would prescription drug coverage for beneficiaries be guaranteed issue?
- Because prescription drugs would not be part of the basic benefit package for all Medicare beneficiaries, how will adverse selection be avoided in the high option plans and in Medigap?

Government contribution toward the cost of the benefit package

The Breaux proposal would base the government's payment on a national weighted average cost of all of the plans participating in Medicare. Only the cost of the standard benefit package would be used in the calculation, and plan premiums would be weighted by the number of beneficiaries in each plan. For plans with premiums at or below 85 percent of the national weighted average, the government would pay 100 percent of the premium. For plans between 85 percent and 100 percent of the national weighted average, the government's contribution would be based on a sliding scale. For plans with premiums at the national weighted average, the government would pay 88 percent of the premium. The higher the plan premium, the lower the percentage of the plan premium paid by the government's contribution.

The area of the country in which beneficiaries live would also affect their premium. Currently, the Medicare Part B premium is the same regardless of where the beneficiary lives and despite geographic differences in the cost of their care. Under the premium support proposal, the Medicare fee-for-service premium would still be based on a national premium but would now be competing against Medicare private plans that are locally priced. As a result, the beneficiary premium for a fee-for-service plan in a low cost area would likely be higher than Medicare private plan premiums in the same area. AARP has identified several questions about the government's contribution, including:

- To what extent will the government contribution assure adequate choice for beneficiaries over time, without regard to where they live?
- What options for affordable coverage would be available to modest income beneficiaries who want to remain in fee-for-service but have one other plan in their community with a premium significantly below the national weighted average, thereby assuring a substantially higher premium for fee-for-service Medicare?
- What percent of beneficiaries live in areas where the government contribution is likely to be less than the cost of most plans? less than the cost of the fee-for-service plan?
- Will there be an adequate risk adjuster? If not, how will the proposal accommodate the likely outcome that enrollees in fee-for-service Medicare are older, sicker, and therefore more expensive than the average beneficiary?
- How will the fee-for-service plan be assured an adequate government contribution?
- How will beneficiaries who remain in fee-for-service be assured of an affordable premium?
- Will there be an annual index or cap on the growth in the weighted national average or the growth in individual plan premiums?

Beneficiary out-of-pocket costs

The proposal would merge Parts A and B of Medicare and establish a combined health care deductible (the proposal suggests $400 indexed to the cost of Medicare). Health care plans would be allowed to vary beneficiary cost-sharing with the approval of the Medicare Board. A new 10 percent coinsurance would be applied to any service, excluding hospital stays and preventive care, which is not currently subject to coinsurance such as home health care. AARP has a number of questions about how cost-sharing would be treated in the Breaux proposal, including:

- How likely is it that Medicare beneficiaries would pay an increasing share of the cost of their care? For example, while a single Medicare deductible may appear to be efficient from an administrative standpoint, wouldn't the majority of beneficiaries (those who do not have a hospitalization) have substantially higher out-of-pocket costs?
- Would the beneficiary's deductible and coinsurance be set in statute?

- Could deductibles and coinsurance vary across plans?
- To what extent will traditional Medicare remain an affordable option for all beneficiaries?
- Would there be a cap on total beneficiary out-of-pocket costs?

Medicare Administration

Under Senator Breaux's proposal, two separate entities would assume responsibility for parts of Medicare. A new Medicare Board would be created to oversee the selection of private insurers to offer health insurance plans to Medicare beneficiaries. The Medicare Board would negotiate contracts with plans, negotiate premiums, determine Medicare's payment, designate geographic areas in which plans would operate, oversee open enrollment periods, and provide comparative information about plans to beneficiaries. There are no specific details available on who would serve on the board, how members would be chosen, or to whom the Board would be accountable. The Health Care Financing Administration (HCFA), which currently administers the entire Medicare program, would continue to operate but would oversee only the government-run fee-for-service plan (the current non-managed care part of Medicare). Given the vast responsibilities of the new Board, we have several questions, including:

- Would the Board be a government agency or a government-sponsored enterprise such as Fannie Mae?
- To whom would the Board be accountable? If the Board is a quasi-governmental entity, to what extent would it be accountable to Congress?
- What is the mechanism and process by which the Board would determine benefits and any allowable variation in benefits? Would the Board simply review plans for benefit equivalency or would it have the authority to modify benefits?
- What latitude would the Board have to negotiate premiums with plans and to determine beneficiary cost-sharing?
- How much discretion would the Board have in making changes in program policy to respond to changing market conditions? Could it reject premiums submitted by plans?
- How would the Board risk adjust rates? How would the Board deal with the issue of adverse selection?
- How would the Board measure and assess plan performance?

Financing

Senator Breaux's proposal does not specify any new financing sources beyond extending provisions of the BBA. It does establish a new method for gauging the solvency of Medicare. Medicare's Part A and B Trust Funds would be combined. The "new" Medicare Trust Fund would continue to be funded through a combination of payroll taxes, beneficiary premiums and general tax revenues. Each year, the Medicare Trustees would be required to examine Medicare spending. If the Trustees determine that general tax revenues are funding more than 40% of Medicare program costs, Congress would consider whether changes, such as increasing beneficiary premiums or raising the payroll tax, would be necessary. AARP has questions about the new solvency standard:

- What sources of financing are being considered for Medicare reform?
- What is the rationale for establishing a new "solvency standard?"
- Why use a standard of 40 percent of general revenues rather than a standard that more accurately reflects trends in the entire health care sector?
- What is the process for responding to the 40% trigger?
- Would Congress be required to reduce Medicare spending if the trigger were exceeded? How much would spending be reduced and how would this amount be determined?
- Would there be an across-the-board spending reduction? Would beneficiaries be required to pay more for Medicare?

CONCLUSION

AARP believes that an extensive debate about the issues surrounding Medicare reform is essential. The success of any changes to Medicare and the long-term strength and stability of the program depend on a good understanding—on the part of the public and policymakers alike—of the changes that are being contemplated. This will require not only extensive dialogue, but also a thorough analysis of how the proposed changes would affect current and future beneficiaries.

If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging "public judgement" about the changes, this would be a very serious mis-

take. In such a circumstance, we would be compelled to alert our members of the dangers in such legislation and why we could not support it.

AARP fully expects to continue to work with members of this Committee and the Congress to advance the debate over Medicare reform and to carefully explore the best options for securing Medicare's future.

PREPARED STATEMENT OF HON. ARGEO PAUL CELLUCCI

Chairman Roth, Senator Moynihan, distinguished Committee Members, thank you for inviting me to testify on the topic of Medicare financing. I am pleased to represent the nation's Governors on an issue of such importance.

One of the most important responsibilities we have an policymakers is to protect and improve the health and welfare of our nation's citizens. To this end, the Medicare and Medicaid programs have been tremendously successful. Together these federal and state programs provide health insurance for one in four Americans and are responsible for more than one third of the nation's health care expenditures.

Medicare has given seniors and adults with disabilities access to mainstream medicine, and it has prevented many individuals from falling into poverty through illness or disability. Moreover, Medicare has given American families the assurance that they will not have to bear by themselves the burden of illness of their elderly or disabled parents or other family members.

Despite Medicare's success, the program faces enormous challenges on two fronts. First, the gaps that have always existed in Medicare coverage—for preventive care, outpatient prescription drugs, and long-term care—are widening. In fact, Medicare now covers only about half of seniors' health care costs. Second, as you are well aware, Medicare expenditures have risen faster than the rate of overall economic growth since the program's inception. Government officials project that Medicare spending will surge over the next quarter century from 12% of federal expenditures to more than 25%.

I am here today because the challenges facing Medicare are as important to Governors as they are to you.

For low-income Medicare beneficiaries, Medicaid fills the gaps in Medicare coverage by providing assistance for Medicare premiums and cost sharing expenses, and through coverage of outpatient prescription drugs and long-term care. Medicaid serves not only low-income Medicare beneficiaries, but also higher income individuals as well, who turn to Medicaid after exhausting their own resources to pay for their care.

States are affected by the same factors that are driving up Medicare spending. The rising cost of medical care leads to higher beneficiary premiums and cost-sharing expenses, which in turn drive up Medicaid spending for low-income beneficiaries. Additionally, the aging baby boom population and medical advances are leading to an increasing number of chronically ill beneficiaries who need long-term care and support with basic activities of daily living, such as eating, bathing, and dressing. These factors will place an enormous strain or state Medicaid budgets in the years to come.

Moreover, because Medicaid's role in providing coverage for these individuals is supplementary to Medicare, states are in the unreasonable position of sharing responsibility for providing coverage, without any way to affect the policies that govern Medicare or to manage the up-front primary and acute care treatment decisions that drive beneficiaries' us of long-term care services and Medicaid spending.

These factors alone are cause for substantial concern. Yet they are compounded by the fact that states—through Medicaid and other state-funded programs for elderly and disabled individuals—are susceptible to tremendous cost shifting from Medicare.

For example, the Balanced Budget Act of 1997, which included immediate cuts in Medicare provider payments, has led directly to increases in state spending for Medicare beneficiaries. As states, we view these cuts as the tip of the iceberg, and are alarmed at the prospect that more extensive Medicare reform may have many times the impact on state spending that the BBA has already had.

You must know that any time you change Medicare, it affects Medicaid and other state-funded programs, typically through a combination of unfunded mandates and other forms of cost shifting. As you embark on the difficult task of reforming Medicare, I urge you not do so at the expense of states!

DUALLY ELIGIBLE BENEFICIARIES

Although states pay a key role in funding services provided to many low-income seniors, the most evident connection between Medicare and state is for individuals

eligible for both Medicare and Medicaid coverage. According to the Health Care Financing Administration, fifteen percent of Medicare beneficiaries are also eligible for Medicaid. These dually eligible beneficiaries, however, account for thirty percent of all Medicare spending.

Dually eligible beneficiaries are also an expensive population for Medicaid programs. Although they account for only sixteen percent of Medicaid recipients, dual eligibles account for thirty-five percent of Medicaid expenditures.

Medicare and Medicaid spend about the same amount for dually eligible beneficiaries. In 1997, Medicare spending for dually eligible beneficiaries total $62 billion. That same year, Medicaid spending for this population totaled $58 billion. Combined Medicare and Medicaid spending for dually eligible beneficiaries averages more than $20,000 per person.

The majority of the six million dually eligible beneficiaries, about 5.4 million, receive full Medicaid coverage. Medicaid provides coverage for their Medicare premium and cost sharing expenses and for services not covered by Medicare, including long-term care and outpatient prescription drugs.

The remaining 600,000 beneficiaries are not eligible for full Medicaid coverage, but do receive Medicaid assistance with Medicare premiums and/or cost sharing. They include individuals with incomes up to 120% of the poverty level ("Qualified Medicare Beneficiaries" and "Specified Low-income Medicare Beneficiaries") and, at least through 2002, individuals with incomes between 120% and 175% of the poverty level ("Qualified Individuals").

Not included in these population figures are low-income Medicare beneficiaries who are eligible for Medicaid coverage, but who decide to forgo such assistance or who are not aware that assistance is available. HCFA and the states are working together to identify effective outreach methods, but in many cases the cost of outreach exceeds the value of the benefit to an individual. One option that deserves serious consideration would have the QI–I and QI–2 programs, which are fully federally funded, administered by the Social Security Administration or another federal agency. Assistance could be provided to beneficiaries in the form of cash payments.

Dually eligible beneficiaries are a particularly vulnerable and high-cost group of individuals. Compared to other Medicare beneficiaries, dual eligibles are more likely to suffer from chronic illness and to require significant long-term care and social support services. They are also more likely to live along or in a nursing facility and less likely to have a spouse still living. Of course, dually eligible beneficiaries are much poorer, on average, than other beneficiaries: 80 percent have annual incomes of less than $10,000.

These differences are a function of Medicaid eligibility criteria, which restrict coverage to individuals with low incomes and those who are medically needy—that is, individuals whose medical care costs are so great that they are spend down to qualify for Medicaid. Generally, such individuals have chronic and complex care needs, and most require long-term care in a nursing facility.

Dually eligible beneficiaries are also different from other Medicare beneficiaries in another, very important way: they do not have the same financial incentive to choose among fee-for-service and managed care options based on differences in price and benefits, because Medicaid programs cover their out-of-pocket costs and provide comprehensive coverage. In fact, national data show that dual eligibles are 75% less likely than other Medicare beneficiaries to enroll in a managed care plan.

COST SHIFTING

Because of pressure to contain costs, both Medicare and Medicaid have incentives to shift costs to one another. States are especially susceptible to cost shifts from Medicare.

For example, recent cuts in provider payments under the Balanced Budget Act of 1997 have shifted significant costs to Medicaid and other state programs and are increasing pressure on states to increase Medicaid provider rates. In Massachusetts, the number of home health visits covered by Medicare dropped by 26 percent in the year following the introduction of the Interim Payment System for home health. Medicare payments decreased by $130 million, and fifteen agencies went out of business. This has had a direct impact on the demand for Medicaid and state-funded home care services, which saw a 250 percent increase in the number of clients served.

More important is the impact on the 10,000 individuals who lost their coverage for Medicare home health as a result of these changes—a drop of 15 percent. It will cost the state more than $1 million a month to provide the extra services that will allow 4,000 seniors to remain in their homes. Other beneficiaries will have to pay

out-of-pocket for their care, and many are expected to go without care. Inevitably, some of these individuals will end up in nursing homes and on Medicaid.

Efforts to redirect federal payments to low-costs areas, as well as reductions in Medicare funding for graduate medical education (GME) are also putting pressure on state budgets, as providers turn to states to make up for lower Medicare payments. States particularly affected by cuts in Medicare GME funding are those with a concentration of large teaching hospitals, such as California, Connecticut, Florida, Illinois, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, Virginia, and Wisconsin. Teaching hospitals in Massachusetts and elsewhere have been the vanguard of important medical advances and continue to provide an array of specialized services of Medicare beneficiaries. Any reduction of federal support for medical education would compromise this important social mission at the very time when teaching hospitals must respond to the pressures of an increasingly competitive marketplace.

INSTITUTIONAL BIAS

Cost shifting is not the only concern of states. Another major concern is the degree of institutional bias under the current system. Senior consumers generally prefer to live in their own homes and remain as independent as possible, yet current federal eligibility, coverage and payment policies are biased toward institutional care. Also, existing distinctions between Medicare and Medicaid policies related to coverage of and eligibility for nursing facilities and home- and community-based care are particularly complicated and often favor institutionalization.

Although institutional care must be available and affordable to those who need it, federal policies must be redesigned to eliminate the institutional bias of the Medicare and Medicaid programs. Such policies must encourage the availability of a continuum of services, including home- and community-based long-term care when cost-effective. The independence of the individual must be maintained and enhanced to the maximum extent possible; family efforts to assist the individual must also be supported.

LACK OF CARE COORDINATION

An equally severe problem for dually eligible beneficiaries is the lack of coordination among primary, acute and long-term care providers. In general, seniors needing long-term care also need a great deal of acute care. Yet our health care system focuses on addressing specific service needs and does a poor job of addressing the interaction of acute and chronic needs. Primary and acute care providers are often unaware of the full range of private and publicly-funded long-term care and social support options available to their patients, or may lack knowledge about the social and environmental circumstances of their patients that can be critical to the onset or progression of disease or disabling conditions.

As a result of the lack of clinical care coordination, primary care physicians or specialists are frequently unaware when their patients are admitted to nursing facilities, and home care case managers are often not informed when their clients are hospitalized. This fragmentation of care and a lack of accountability for health outcomes contribute to higher rates of preventable hospitalizations and to nursing facility admissions. Ultimately, poor clinical outcomes and service decisions that are reimbursement-driven lead to higher expenditures for both Medicare and Medicaid:

SEPARATE MANAGEMENT OF MEDICARE AND MEDICAID

Additionally, for dual-eligible seniors, the lack of coordination between the Medicare and Medicaid programs contributes to fragmentation of acute and long-term care. It is currently impossible for Medicaid to participate in the acute care decisions made when Medicare is the primary payer. Medicare's current managed care program is incapable of addressing these issues, because participating Managed Care Organizations are neither responsible for providing long-term care services, nor accountable for the cost of such services.

These problems cannot be solved unless greater attention is paid to the interactions between Medicare and Medicaid. The simple fact is that separate management of the two programs does not work for frail beneficiaries. One reason is that the two programs operate under different financial incentives. Medicare costs are higher when frail seniors receive care in the community than when these individuals receive their care in a nursing facility. By contrast, Medicaid costs are higher for frail seniors who reside in a nursing facility. A second reason that separate management doesn't work is that it prevents either program for holding health plans and providers accountable for health outcomes.

INTEGRATING ACUTE AND LONG-TERM CARE

There are many personal tragedies that illustrate the human cost of the current system to beneficiaries and their families. Along with my testimony, I am submitting a copy of an article titled "Saving Medicare: Why Medicaid Must Be Part of the Solution." This article, which highlights many of the problems with the current system, includes the story of an elderly woman who was, in her daughter's words, "bounced around (in the current system) like a ping pong ball," until she finally lost her independence and was confined to a nursing facility.

For the sake of all Americans, we can and must do better.

More effective coordination of acute and long-term care services must occur if we are to serve our beneficiaries better and to prevent decline in disability. Case management is one approach to coordinating care more effectively. A more comprehensive approach to improving the coordination of care for consumers is through contracting with integrated care plans to cover the full range of acute and long-term care benefits covered by Medicare and Medicaid.

Integrated Medicare/Medicaid programs are the best way to both improve health outcomes for consumers and control spending. The benefits to integrated programs include: a comprehensive service package that recognizes the interaction of acute and chronic needs; greater flexibility for providers and consumers to design a care that meets the individual's needs and that is unencumbered by fee-for-service reimbursement restrictions; and an emphasis on prevention and coordination of care across providers and settings, including the coordination of medical services with social support services. Integrated programs also offer HCFA and states an opportunity to hold a single entity accountable for quality of care and health outcomes.

The Program of All-Inclusive Care for the Elderly (PACE) is one model of an integrated care program. The BBA expanded PACE, and it is now a permanent part of the Medicare and Medicaid programs. In my state, we found that a local PACE program was able to cut in half the number of hospital admissions due to preventable conditions. Despite the tremendous success of PACE, it is only available to low-income, frail seniors who meet strict clinical eligible standards. We need an approach that addresses the needs of middle- and low-income seniors before they become frail and dependent on Medicaid.

Among the Medicare options available to beneficiaries—which currently include traditional fee-for-service, Medicare+Choice plans, and Medical Savings Accounts—should be the option to enroll in an integrated program. In particular, federal policies should allow seniors to use their Medicare benefit to enroll in an integrated program administered by a federal/state partnership. States should have the flexibility to determine whether Medicare's contribution would be paid directly to the integrated plan or collected by the state which would then pay a single combined Medicare/Medicaid payment to the integrated plan.

States are in a strong position to take the lead in administering and managing integrated programs through federal/state partnerships, especially if Congress decides to adopt a "defined contribution" plan patterned after the Federal Employee Health Benefit Plan. One reason for states' readiness is that many publicly-funded health programs are operated as the state-level, as detailed above. A second reason is that states have already developed expertise in the area of managing health plans to improve quality and health outcomes while controlling costs. In addition, states have shown that they can target long-term care services appropriately while maintaining informal support in the home or community.

BARRIERS TO INTEGRATION

Unfortunately, a number of significant obstacles, both statutory and administrative, have arisen to conducting effective coordinated care demonstrations. Among the major administrative obstacles is a lengthy and complicated federal review process for demonstration waivers. Other barriers include arbitrary Medicare and Medicaid budget neutrality requirements, difficulty coordinating program oversight, including HCFA's reluctance to deviate from Medicare+Choice policies without the clear support of Congress, and low Medicare payments to managed care plans for frail, community-dwelling beneficiaries, relative to Medicare fee-for-service expenditures for its population.

As a result, only one state—Minnesota—is currently operating an integrated care program that is available to the full range of unimpaired, moderately impaired, and severely impaired dual-eligible seniors. Many more states, however, have expressed an interest in developing integrated programs. They include California, Colorado, Connecticut, Delaware, Florida, Maine, Maryland, Massachusetts, New Hampshire, New York, Oregon, Rhode Island, Texas, Vermont, Virginia, and Washington.

If these states are to make case management and integrated programs broadly available to low-income seniors. Congress and the administration will have to address federal barriers to the timely development of such programs. The authority to test new approaches could be clarified either through explicit legislative authorization or through the creation of Medicare waiver authority similar to the waiver options that exist in Medicaid. In addition, strongly partnerships between HCFA and states are needed to strengthen the coordination of Medicare and Medicaid. I understand that several states have drafted language that would address some of these problems, and that this language is being reviewed by the National Association of State Medicaid Directors.

CONCLUSION

The nation's Governors support Medicare reform to ensure the long-term solvency of the program, as well as to improve the quality of the program of all beneficiaries. As reform measures are considered, however, they must be assessed for their impact on dual eligibles and on Medicaid and other state-funded programs. Medicare reform must not create unfunded state mandates or otherwise shift costs to states. Such reform must also account for the fact that dual eligibles, who account for 30 percent of program expenditures, have no incentive to select a health plan based on price because their out-of-pocket costs and paid for by Medicaid. In addition, Medicare reform should support state flexibility to develop mechanisms to contain growth in Medicaid spending. Finally, Medicare reform should support federal-state partnerships to coordinate and integrate Medicare and Medicaid to ensure greater accountability for health outcomes.

As the baby-boom generation begins to retire in 2010, the need for sensible solutions to the senior health care crisis will grow dramatically. Federal and state action is needed now to plan for this certainty. Some time remains to develop and assess policies that could lead to cost-efficient, quality medical and support services. However, if this time is not used wisely, the cost in terms of quality of life for individuals and their families, and in state and federal spending, could be quite substantial. The nation's Governors support Medicare reform and we are eager to work with Congress toward this goal.

I thank you again for the opportunity to be a part of this hearing. I look forward to answering any questions you may have.

SAVING MEDICARE:

Why Medicaid Must Be Part of the Solution

By Bruce Bullen, Christopher Perrone, and Pamela Parker

At age 77, Vivian was diagnosed with Alzheimer's disease. For the next four years, she was cared for at home by her husband and children. At age 81, however, Vivian fell and was taken by ambulance to the hospital. This seemingly minor fall led Vivian into a health care system that, in her daughters words, "bounced her around like a ping pong ball."*

* Fictitious name

After four days in the hospital, Vivian was transferred to an intermediate rehabilitation facility for ten days. From there, she was transferred to another floor, and spent nearly two weeks in a transitional care center. Vivian was then discharged to a skilled nursing facility, where she remained for five days before being transferred to a board-and-care home. Less than a week later, she fell again and was transferred to the hospital for emergency outpatient treatment. Agitated and violent, she was transferred to a local psychiatric hospital where she spent two weeks.

Vivian continued to be bounced from doctor to doctor and facility to facility for seven months. During this time, she was evaluated by more than 20 doctors, countless direct care nurses, and 14 discharge planners, and was treated and cared for in 14 different facilities. She fell two more times, broke her hip, and lost her independence.

With the constant movement, her daughter noticed that Vivian's dementia advanced quickly. She no longer recognized her daughter, and her husband could no longer bear the emotional strain of being with her and began to suffer from severe depression. Vivian now lives in a nursing facility.

Though she does not blame the doctors, discharge planners, social workers, or other medical professionals who cared for her mother, Vivian's daughter does question a system that "can have such a great disregard for what is truly important."

"Alzheimer's disease had taken some of my mother's mind and independence, the disjointed system that moved her around like a piece of cargo has taken the rest."

—Excerpted from Vivian's daughter's testimony before the U.S. Senate Special Committee on Aging

In an effort to extend the financial solvency of Medicare, Congress and the Clinton Administration passed the Balanced Budget Act of 1997 (BBA), instituting what many are calling the most significant changes to Medicare since its inception. The 200-plus Medicare-related provisions of the act alter the way health care providers and institutions are paid and attempt to infuse consumer-driven competition into the 33-year-old program. In addition, the BBA encourages increased enrollment of beneficiaries into managed care by opening the program to several types of health plans other than health maintenance organizations (HMOs), and requires the Health Care Financing Administration (HCFA) to provide quality-related and other comparative information to help beneficiaries make informed health plan choices.

These reforms are aimed at reducing Medicare spending levels, which have been growing at an annual rate of 11 percent during the 1990s (HCFA, 1997). Fueling these increases has been a dramatic growth in the use of home health and skilled nursing facility (SNF) services in the last decade, due in part to the liberalization of Medicare coverage guidelines for these services. Between 1989 and 1996, Medicare spending for home health increased by an average of 33 percent per year—from $2.4 billion to $17.7 billion—while the use of SNF services increased by an average of 22 percent per year—from $2.8 billion to $11.3 billion (Scanlon, 1997a).

Responsible for a disproportionate share of this growth are the six million persons eligible for both Medicare and Medicaid.[1] Nationally, these dual-eligibles use 46 percent more home health services and 59 percent more SNF services than other Medicare beneficiaries (HCFA, 1996). Data for dually eligible seniors in Massachusetts—available as a result of collaboration between HCFA and the state to create a linked Medicare/Medicaid data set for this population—show that between 1992 and 1995 Medicare expenditures for this population rose 33 percent faster than for other Medicare beneficiaries (12 percent and 9 percent, respectively). These data also show that during the same period, Medicare

[1] *Dually eligible beneficiaries include Medicare beneficiaries who are eligible for full Medicaid coverage (i.e., traditional categorical or medically needy individuals) as well as Medicare beneficiaries who receive partial Medicaid coverage (i.e., Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualified Disabled Working Individuals).*

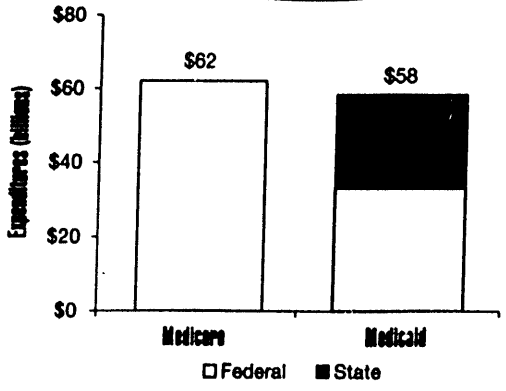
expenditures for frail dual-eligibles participating in the state's home- and community-based waiver program grew at a rate nearly double that of other Medicare beneficiaries—16 percent and 9 percent, respectively (Massachusetts Division of Medical Assistance, 1997).

To have a real impact on controlling Medicare costs and ensuring the long-term viability of the program, policymakers must address the problems dually eligible beneficiaries experience with the current system. These problems stem from a bifurcated system with overlapping benefits and a lack of coordination and accountability. Medicare covers primarily acute hospital and physician services, while Medicaid covers mainly long-term care, prescription drugs, and Medicare copayments and deductibles. Both programs cover some home health and nursing facility services. Efforts by the two programs to shift costs lead to higher overall costs, and too often take precedence over what is in the best interest of the patient.

For many states, providers, advocates, and beneficiaries, the way to begin addressing these problems is clear: adopt federal policies which recognize the uniqueness of the dual-eligible population and which encourage federal and state partnerships to develop integrated Medicare/Medicaid programs. Effective integrated programs emphasize the coordination of acute and long-term care services, as well as such geriatric concepts as initial screenings and ongoing assessments, early intervention, multidisciplinary teams, and consumer involvement in care planning. Because they allow Medicare and Medicaid to measure and manage quality across the full spectrum of acute and long-term care services, integrated programs represent the best approach for improving the health outcomes of dually eligible beneficiaries. They are also the key to realizing any budgetary savings policymakers hope to achieve for this population through managed care, since dually eligible beneficiaries lack any financial incentive to enroll in non-integrated

Figure 1

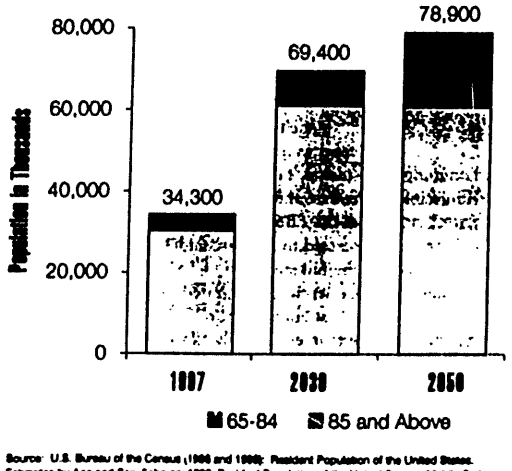
Medicare and Medicaid Expenditures for Dually Eligible Beneficiaries, 1997



Source: Massachusetts Division of Medical Assistance. Extrapolated using federal spending data from the Congressional Budget Office, as reported in *The Economic and Budget Outlook*, August, 1996, and data on the proportion of Medicare and Medicaid spending for dual eligibles, as reported by William J. Scanlon in testimony before the U.S. Senate Special Committee on Aging: Medicare and Medicaid: Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues, April 29, 1997.

Figure 2

Cohort Growth in Number of Dually Eligible Beneficiaries, 1997–2050



Source: U.S. Bureau of the Census (1996 and 1996): Resident Population of the United States: Estimates by Age and Sex, February 1996; Resident Population of the United States: Middle Series Projections, 2015 to 2030, by Age and Sex, March 1996; Resident Population of the United States: Middle Series Projections, 2035 to 2050, by Age and Sex, March 1996.

Medicare-only managed care plans because of their Medicaid coverage.

Why Are Dually Eligible Beneficiaries An Important Population?

Dually eligible beneficiaries—who are elderly or disabled or both—are a particularly vulnerable and high-cost group of beneficiaries. Dual-eligibles are more likely than the general Medicare population to suffer from chronic illnesses and to require significant long-term care and social support services (Massachusetts Division of Medical Assistance, 1997). They are also more likely to live alone or in a nursing facility, and less likely to have a spouse living. Of course, dually eligible beneficiaries are much poorer, on average, than other Medicare beneficiaries: 80 percent have annual incomes of less than $10,000.

Medicare and Medicaid spending for dual-eligibles reflects their relatively poor health status. Dual-eligibles constitute only 16 percent of the Medicare population but account for 30 percent of Medicare expenditures. Similarly, they account for an average of 17 percent of the Medicaid population and 35 percent of Medicaid expenditures (Scanlon, 1997b).[2] In 1997, federal spending for dually eligible beneficiaries totaled at least $95 billion.[3] This amount includes $62 billion in Medicare spending and $33 billion in federal Medicaid spending (see Figure 1). The states' share of Medicaid spending for dual-eligibles totaled another $25 billion.

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[2] *These data may substantially underestimate the size of the dual-eligible population and Medicare spending for this population. Because estimates based on Medicare eligibility and claims data identify dual-eligibles using the state buy-in indicator for Medicare Part B coverage, they fail to identify dual-eligibles in nursing facilities who pay their own Part B premiums as part of their patient-paid amount. Massachusetts' analysis of linked Medicare/Medicaid data found that 40 percent of dual-eligibles in nursing facilities did not have a state buy-in indicator in the Medicare files.*

[3] *Extrapolated using federal spending data from the Congressional Budget Office, as reported in The Economic and Budget Outlook, and data on the proportion of Medicare and Medicaid spending for dual-eligibles from Scanlon, 1997b. These figures are consistent with those reported by HCFA for earlier years. These figures may underestimate Medicare and Medicaid spending for dually eligible beneficiaries.*

Dual-eligibles are becoming an increasingly important population. As noted previously, Medicare expenditures for dual-eligibles have been growing at a much faster rate than for other Medicare beneficiaries. In addition, the size of the dually eligible population is growing rapidly because of the aging of the U.S. population. Census projections indicate that the number of individuals age 65 and over will double between now and 2030, from 30 million to 61 million (U.S. Bureau of the Census, 1998). Even more striking, the number of individuals age 85 and over—who have nearly twice the rate of disability as those age 65 to 74—is also expected to double during this period, from 4 million to 8 million, then double again by 2050 (see Figure 2). This growth will place a significant strain on our health care system, and on our ability to pay for long-term care through public programs.

A Broken System

From a dually eligible beneficiary's perspective, the problems with the current system arise from the need to navigate between two programs with overlapping benefits to gain access to an appropriate level of health services and long-term care supports. This can be a confusing and frustrating experience for dually eligible beneficiaries and their caregivers. As Vivian's story illustrates, these problems are compounded by the lack of coordination among providers and across care settings that all beneficiaries with chronic illnesses experience.

The lack of appropriate clinical care coordination means that primary care physicians or specialists are frequently unaware of their patients' admittance to nursing facilities, or that home care case managers are not informed of their clients' hospitalization (Applebaum & Austin, 1990). This fragmentation of care and lack of accountability contribute to poor outcomes, including higher rates of preventable hospitalizations and nursing facility admissions, and to higher expenditures for both Medicare and Medicaid.

Federal and state efforts to control spending for dually eligible beneficiaries through managed care have had only limited success. For dual-eligibles and others with chronic care needs, the managed care approach is undermined by many of the same factors that have hobbled the Medicare and Medicaid fee-for-service systems. Since Medicare managed care providers do not cover long-term care, they have difficulty controlling payment policies or nursing facility practices that encourage hospitalization and lead to higher acute-care costs. Likewise, states and their managed care partners have been frustrated by an inability to influence medical practice patterns which lead to increased use of Medicaid services for dual-eligibles.

How Can States Help HCFA Improve Medicare?

State Medicaid programs can help HCFA achieve several key objectives, including controlling Medicare spending, measuring and improving the quality of care and health out-

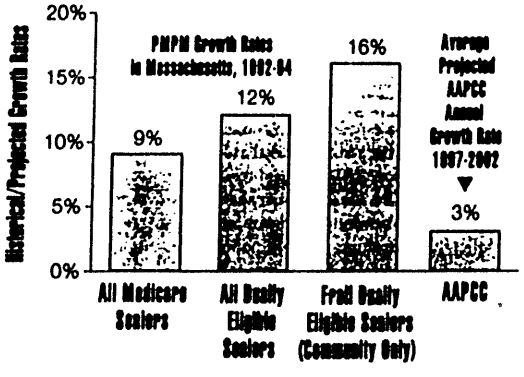
comes, expanding the number of plan options available to dually eligible beneficiaries, and increasing managed care enrollment. To achieve these goals, HCFA and states must work in partnership to implement programs which integrate both the payment and service delivery components of Medicare and Medicaid for dually eligible beneficiaries.

Control Medicare Spending

A primary goal of the BBA is to control Medicare spending. To achieve this goal, BBA provisions substantially alter the way both fee-for-service providers and managed care plans are paid. Changes to the fee-for-service system mandate the use of prospective payment systems for providers who are currently reimbursed based on their costs, while changes targeting managed care plans reduce the growth rate of capitation payments, and mandate the use of a risk adjustment methodology that considers enrollee health status.

Figure 3

Medicare [illegible]



Source: MA Division of Medical Assistance. Based on analysis of Massachusetts' linked Medicare/Medicaid data for CY92-96 and projected Medicare rates in Massachusetts published by the Rural Policy Research Institute.

Though clearly not intended to do so, these changes may exacerbate the problems the current system creates for dual-eligibles. For example, the interim payment methodology adopted for home health providers (to be used until a prospective payment system is completed) is causing many home health agencies to close and others to discontinue providing service to their highest-cost patients. This is likely to result in a shift in cost to states for dual-eligibles needing home health services, and may force more beneficiaries to leave their communities and enter nursing facilities.

A second problem was created when the BBA severed the link between the annual increase in the average cost of fee-for-service Medicare expenditures and the annual update of the Average Adjusted Per Capita Cost (AAPCC), which is the basis for calculating Medicare capitation payments. For the next several years, AAPCC rates for most managed care enrollees will increase annually by only about 2 percent. As a result, several health plans are abandoning the Medicare managed care program in markets that are no longer profitable. Moreover, because Medicare spending for dual-eligibles has been growing faster than the Medicare average, dual-eligibles are becoming an increasingly unattractive population for managed care plans to enroll (see Figure 3).

A third problem is that the diagnosis-based risk adjustment methodology HCFA has proposed would substantially underpay Medicare managed care plans for enrollees residing in the community who are frail. A recent analysis of this methodology—called the Principal In-Patient Diagnostic Cost Group Model or PIP-DCG—found that it would underpay plans 46 percent for beneficiaries in the community needing help with one or more activities of daily living, such as bathing, dressing, or feeding (Gruenberg, Silva & Corazzini, 1998).[1] As a result, there would be no incentive for a plan to develop a specialized program that would attract more of these beneficiaries to enroll.

A much more effective approach for controlling Medicare spending, however, would be for HCFA to partner with states to develop inte-

[1] *Results were similar for dually eligible beneficiaries and all Medicare beneficiaries. The analysis was completed prior to September 8, 1998, when HCFA announced in the Federal Register that the model would incorporate Medicaid and prior disability status. These changes are unlikely to alter the finding that the PIP-DCG model would substantially underpay plans for beneficiaries with severe impairments who reside in the community because the majority of seniors are not disabled prior to turning age 65.*

grated programs and payment methodologies appropriate for the full range of dually eligible beneficiaries. A Medicare payment methodology that pays managed care plans appropriately for frail dual-eligibles living in the community would encourage plans to expand community-based long-term care options, thereby attracting more beneficiaries to enroll. In addition, capitation of a combined package of Medicare and Medicaid services redirects the fiscal and clinical incentives to give health plans an incentive and the flexibility to operate more efficiently and to provide services in the most cost-effective manner. Moreover, integration under a fully capitated model would eliminate incentives to shift costs between the two programs.

Measure and Improve Quality and Health Outcomes

The BBA also strives to ensure that high-quality care is provided to Medicare managed care enrollees. The BBA requires HCFA to measure the performance of Medicare managed care plans and to provide beneficiaries with information on quality of care and consumer satisfaction so they can make informed choices. The BBA also requires Medicare managed care plans to develop practice parameters for monitoring care, including developing improvement plans in areas where deficiencies are found.

Partnering with states to develop and manage integrated programs for dual-eligibles could help HCFA in two ways. First, HCFA could more effectively manage its health care plans to improve quality and health outcomes by collaborating with states that have already developed expertise in this area. For example, since 1992, Massachusetts has applied the principles of continuous quality improvement to its managed care programs with measurable success (Friedman, Bailit & Michel, 1995). From 1993 to 1996, the state's quality improvement efforts for beneficiaries with asthma resulted in a drop in the number of asthma-related acute hospital admissions from 24 per 1,000 to 15 per 1,000. Moreover, the number of asthma-related emergency department visits dropped from 73 per 1,000 to 68 per 1,000 during this same period. With federal permission, the experience of Massachusetts and other states could be used to better serve the dually eligible population as well.

Second, integrated programs enable HCFA and states to hold a single entity accountable for quality of care and health outcomes across the full spectrum of care. Without this type of partnership, HCFA can do little to monitor or manage the quality of care of non-Medicare services provided to dually eligible beneficiaries. Likewise, states find it difficult to hold Medicaid managed care plans accountable for outcomes when most medical care decisions are made by physicians who are not under the plan's control because they are being reimbursed by Medicare on a fee-for-service basis or are affiliated with another health plan.

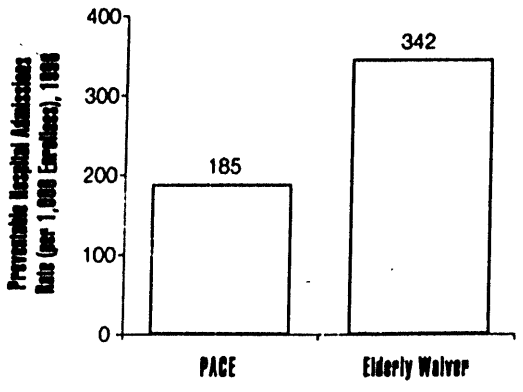
The clinical benefits of integration are measurable. As Figure 4 illustrates, a recent analysis of nursing home eligible seniors in Massachusetts found that frail, dually eligible seniors who enrolled in an integrated program have a much lower rate of preventable hospitalizations than those who have access to home- and community-based waiver services through the unmanaged, uncoordinated fee-for-service system.

Expand the Number of Health Plan Options and Increase Managed Care Enrollment

Another principle goal of the BBA is to increase enrollment of Medicare beneficiaries in managed

Figure 4

Preventable Hospitalizations for Frail Seniors
Comparison of PACE and Elderly Waiver Programs



Source: Massachusetts Division of Health Care Financing and Policy, 1998.

care. To achieve this goal, the BBA expands the health plan choices available to Medicare beneficiaries to foster greater competition for both price and quality. In addition to HMOs, Medicare beneficiaries can now enroll in provider-sponsored organizations or preferred-provider organizations, where these options exist.[1]

Health plans that manage only Medicare services—as is characteristic of all the aforementioned health plan options—however, are not likely to attract dually eligible beneficiaries because they provide little value to this population. The reasons for this include:

- Medicare managed care plans do not address the lack of coordination between the Medicare and Medicaid systems, nor do they provide the level of coordination among acute, long-term care, and social support services that is critical to improving consumer satisfaction and health outcomes for dually eligible beneficiaries.
- Unlike other Medicare beneficiaries, dually eligible beneficiaries have no financial incentive to enroll in traditional Medicare managed care plans because Medicaid programs already cover beneficiary copayments and deductibles and the extra benefits that managed care plans may offer as an incentive to enroll.
- Dually eligible seniors are less likely to "rollover" from commercial managed care plans into Medicare managed care plans, since few have employer-sponsored health coverage prior to becoming Medicare eligible.

As a result, less than 5 percent of dually eligible beneficiaries are enrolled in Medicare managed care plans—one third the enrollment rate of other Medicare beneficiaries (Medicare Payment Advisory Commission, 1998).

By contrast, programs that integrate Medicare and Medicaid have several features that would be attractive to dually eligible beneficiaries. Some of the more important features to beneficiaries include:

- a comprehensive service package that recognizes the interaction of acute and chronic needs, as well as the dynamic nature of these relationships (Stone & Katz, 1996);
- the flexibility to provide the most appropriate services for the beneficiary, including the option to expand the availability of community-based long-term care services or to provide services not otherwise covered by Medicare or Medicaid that prove to be cost-effective, such as access ramps in the home;
- initial and ongoing risk screenings, accompanied by early intervention and greater prevention;
- emphasis on providing more coordination across providers and settings, including the coordination of medical services with social support services, such as meals and non-medical transportation;
- a reduction in the amount of paperwork associated with Medicare claims; and
- "one-stop shopping" for persons using an array of services, possibly including a single number to call for assistance.

These features will attract dual-eligibles into integrated programs who may not have otherwise

[1] *The BBA also added Medical Savings Accounts and private fee-for-service as new Medicare options. Also, in a few areas, beneficiaries can choose to enroll in a Social HMO or Program of All Inclusive Care for the Elderly (PACE).*

selected a Medicare managed care plan. Moreover, integrated plans expand the choices available to dually eligible beneficiaries and may facilitate greater competition among all plans.

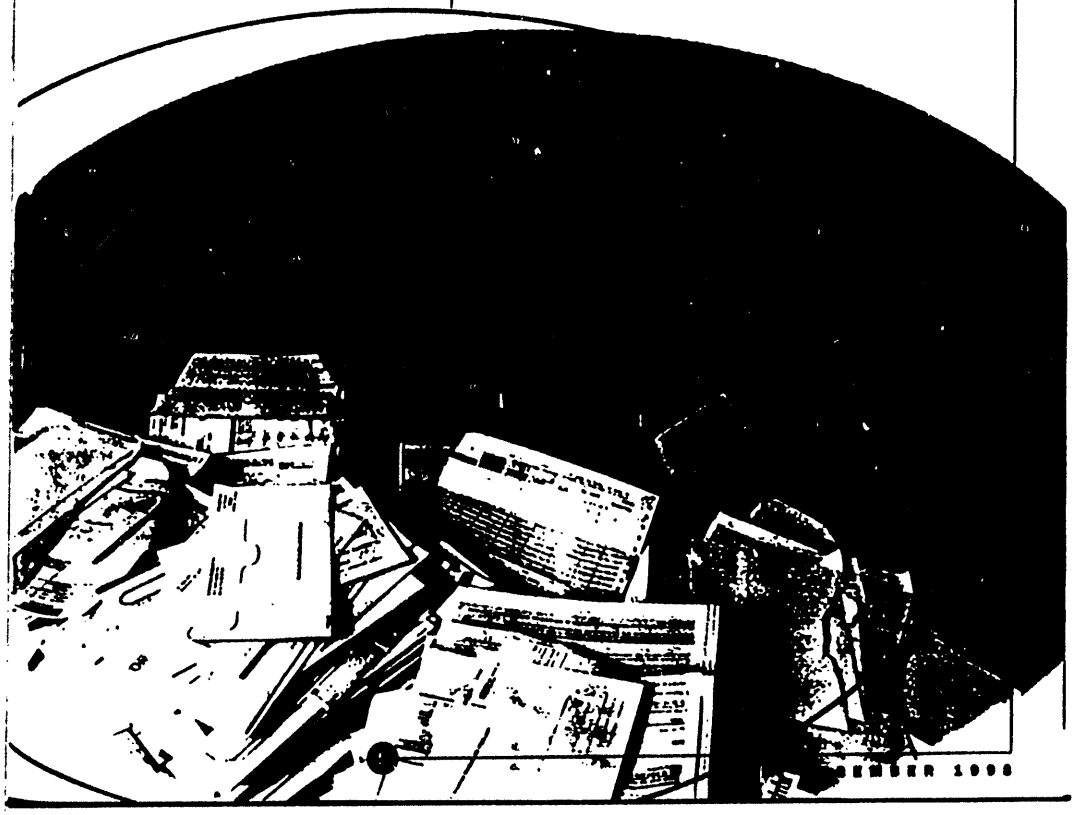
State initiatives

The concept of integrating Medicare and Medicaid is not new. The Program for All Inclusive Care For the Elderly (PACE) was initiated in 1990, and its predecessor, the On-Lok program in San Francisco, has been operating an integrated program since 1983. But these programs target a small number of beneficiaries, and their restrictive eligibility standards (enrollees must meet nursing facility clinical criteria to qualify) limit the impact they can have on the system.

More recently, states have begun expanding the concept of integration to broader populations. In 1992, the Robert Wood Johnson Foundation awarded a grant to Minnesota to develop an integrated program and three years later Minnesota became the first state to receive federal waivers from HCFA to integrate Medicare and Medicaid funding and service delivery for dually eligible seniors. The Minnesota Senior Health Options (MSHO) demonstration was implemented in March 1997 in the seven-county Minneapolis-St. Paul metropolitan area. The voluntary MSHO program serves the full range of dually eligible seniors, including those in nursing facilities. As of September 1998, approximately 2,600 dually eligible seniors were enrolled in MSHO.

Since then, the Robert Wood Johnson Foundation has funded initiatives to develop integrated programs in several other states, and HCFA has also provided grant funding to states. At last count, projects were underway in Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Hampshire, New York, Oregon, Rhode Island, Texas, Vermont, Washington, and Wisconsin.

Unfortunately, some states—including Minnesota, which has the only integrated



program up and running, Massachusetts, whose waiver request HCFA has been reviewing for over a year, and Colorado, whose three-year negotiation with HCFA ended after the state concluded that an agreement could not be reached—have been discouraged by numerous federal barriers to the development integrated programs. The barriers include:

- Medicare payment methodologies for managed care plans discourage plans from enrolling and appropriately serving all dual-eligibles. For example, both the current demographic risk adjuster for Medicare capitation payments and HCFA's proposed diagnosis-based risk adjuster substantially underpay plans for dual-eligibles who would most benefit from increased coordination—frail beneficiaries residing in the community. The proposed risk adjuster also encourages unnecessary hospitalization because payments are based solely on diagnoses collected from inpatient hospital stays. A more appropriate risk adjuster would incorporate measures of functional dependency and take into account managed care enrollees' diagnoses from a broad range of community and institutional settings.
- Medicaid and Medicare budget neutrality requirements which the Office of Management and Budget (OMB) placed on states put states at increased financial risk. For example, OMB's budget neutrality requirements for Medicaid §1115 waivers do not account for important differences between the mandatory Medicaid managed care programs for which these requirements were developed and voluntary programs in which only a fraction of those eligible may actually enroll. As a result, states would have to assume financial risk for Medicaid expenditures for all dual-eligibles, including those who remain in the fee-for-service system. This policy is unfair to states which have little control over Medicaid spending for this group because Medicaid expenditures for dual-eligibles in the fee-for-service system are affected by Medicare policies.
- HCFA is reluctant to deviate from policies of the Medicare+Choice program to address administrative differences between Medicare and Medicaid. These differences, in areas such as enrollment and disenrollment, beneficiary outreach and education, appeals and grievance procedures, quality management, payment schedules, and plan marketing, must be addressed if HCFA and states are to coordinate the two programs effectively.

Compounding these barriers is HCFA's apparent lack of resources to develop integrated programs in partnership with states. This is due in part to recent increases in HCFA's responsibilities, related to implementation of the BBA and the Health Insurance Portability and Accountability Act, without a corresponding increase in the agency's funding for administration. In addition, despite the agency's recent reorganization, responsibility for policies pertaining to dual-eligibles is dispersed over many different units within HCFA. These factors have contributed to a lengthy federal waiver approval process which can last for several years.

Beneficiaries who are dually eligible for Medicare and Medicaid are an important and unique population at the nexus of the problems facing the Medicare program. Any effort to relieve Medicare's financial woes must address the problems of the current system for this population, including a lack of coordination across services and settings and a lack of accountability for outcomes and cost. Integrated programs represent an important opportunity to address these problems and to improve the health of dually eligible beneficiaries, while also controlling Medicare and Medicaid spending.

Many states are anxious to work with HCFA to develop integrated programs. Federal policies present a number of barriers to states, however, and only one state is currently operating an integrated program. If such programs are to flourish, federal policies must provide HCFA and states greater flexibility to develop appropriate payment and administrative systems, and federal resources must be committed to developing and implementing these programs in a timely manner. ●

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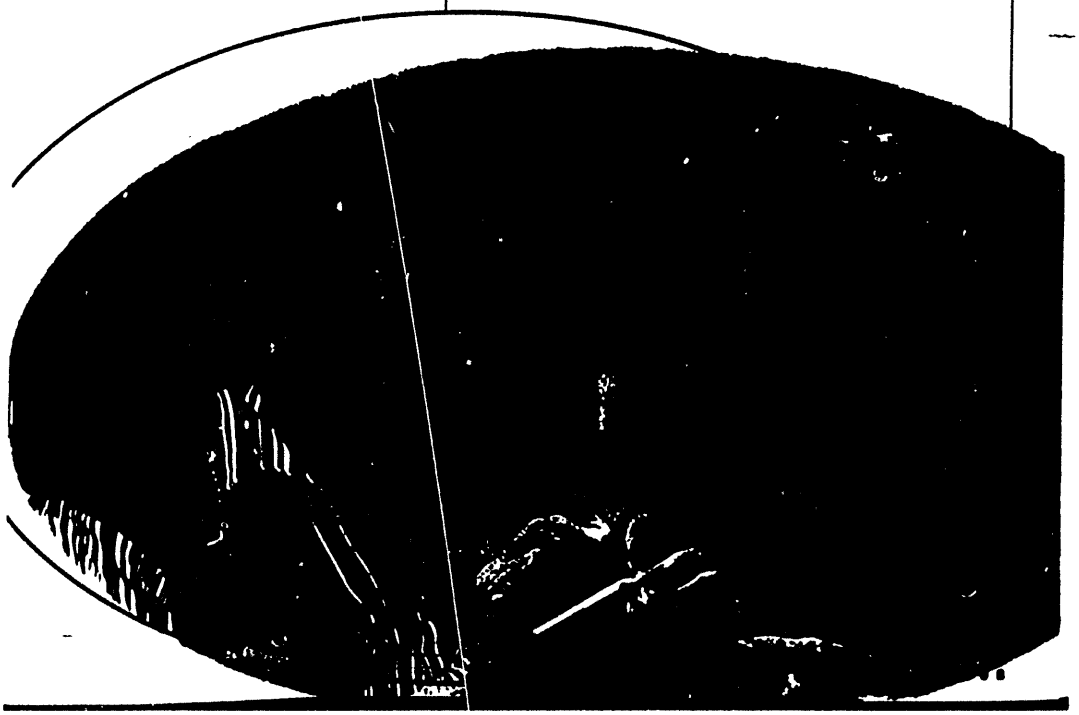


PREPARED STATEMENT OF DAN L. CRIPPEN

[MAY 5, 1999]

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the implications of Medicare financing for the federal budget and the U.S. economy. Growth in Medicare spending has slowed remarkably in 1998 and 1999. Spending during the first half of the current fiscal year is actually $2.6 billion less than during the comparable six-month period in 1998. That slowdown is unprecedented and contributes to the favorable near-term outlook for the federal budget, which will accumulate a large and growing surplus.

But the budget is expected to face mounting pressures in the long term from demographic changes and rising health care costs. Left unchecked, those pressures would greatly increase the cost of providing health services under Medicare. The higher costs would ultimately be borne by taxpayers and Medicare beneficiaries.

MEDICARE SPENDING AND THE BUDGET

The Medicare program pays for the health care of 39 million elderly or disabled people in the United States. This year, spending for benefits is expected to top $200 billion. That amount makes Medicare the second largest entitlement program; only Social Security is larger. For many years, Medicare spending has grown substantially faster than both the economy and the spending of other major federal programs. Despite recent slowdowns in that growth, the Congressional Budget Office (CBO) projects that Medicare spending will continue to increase faster than the resources that finance it.

Table 1.—Medicare Benefits, Federal Outlays, and GDP, 1979–2009

(By fiscal year)

	Billions of dollars				Average annual growth rate (percent)		
	1979	1989	1999	2009	1979–1989	1989–1999	1999–2009
Medicare benefits	28	94	212	443	12.9	8.4	7.6
Total federal outlays	504	1,144	1,704	2,344	8.5	4.1	3.2
Gross domestic product	2,497	5,356	8,846	13,688	7.9	5.1	4.5
Memorandum:							
Medicare benefits as a percentage of federal outlays	5.6	8.2	12.4	18.9	n.a	n.a	n.a
Medicare benefits as a percentage of GDP	1.1	1.8	2.4	3.2	n.a	n.a	n.a

ASource: Congressional Budget Office.
ANote: n.a. = not applicable.

Spending on Medicare benefits grew at double-digit rates during the 1980s (see Table 1). The share of both the federal budget and gross domestic product (GDP) accounted for by Medicare increased by about half between 1979 and 1989. That spending slowed somewhat during the early 1990s, rising at an average rate of almost 10 percent a year between 1993 and 1997.

In 1998, however, the growth of Medicare spending slowed sharply. After increasing by more than 8 percent in 1997, outlays for benefits rose by just 1.5 percent in 1998. Medicare spending has actually declined during the first six months of fiscal year 1999, dropping by over 2 percent from the comparable period the year before. Between its January and March baselines, CBO has lowered its projection of program spending for the year by about $6 billion.

The slowdown in Medicare spending that began in 1998 is related to three factors:

- The Balanced Budget Act of 1997 reduced payment rates for many Medicare services and restrained the update factors for payments through 2002,
- Widely publicized efforts to clamp down on fraud and abuse have improved providers' compliance with Medicare's payment rules, and
- The average time for processing Medicare claims rose dramatically in 1998.

Those factors notwithstanding, outlays for benefits are expected to grow by 8.4 percent a year over the next decade. At that rate, Medicare spending will account for almost 20 percent of the federal budget by 2009, up from 12.4 percent in 1999. It will also rise from 2.4 percent of GDP to 3.2 percent.

In spite of rapidly growing outlays for Medicare, CBO projects that the federal budget will accumulate growing surpluses over the next 10 years, assuming that current policies do not change and the economy stays on its projected course. Those

large and rising surpluses will reduce the federal debt and the interest costs of servicing it; thus, they will provide a substantial cushion against future expenses.

THE LONG-TERM OUTLOOK FOR THE BUDGET

In future decades, the federal budget will face mounting pressures as the baby-boom generation begins to draw benefits from both Social Security and Medicare. A larger elderly population will also have growing needs for long-term care, resulting in higher Medicaid spending. The substantial financial cushion that resulted from surpluses in the near term will eventually disappear, and hard choices will have to be made about how to allocate the budget between competing programs.

A major factor in the rapid expansion of Medicare and Social Security in coming decades is growth in enrollment. Under the intermediate assumptions of the Social Security trustees, the elderly population will increase by slightly more than 1 percent a year between 2000 and 2010 (when the first baby boomers become eligible for Medicare and Social Security benefits). Between 2010 and 2030, by contrast, the elderly population will grow by almost 3 percent a year, rising from 39 million to 69 million people. Because of increased longevity, the proportion of that population over age 75 will rise as well.

Medicare costs are likely to grow much faster than program enrollment, however. The cost per beneficiary of providing health care services has risen dramatically since the program began in 1965, and it is expected to keep growing rapidly in the future. That growth reflects advances in medical technology that will raise health care costs, as well as continuing increases in beneficiaries' use of services. Medicare has not changed appreciably since its creation and remains largely a fee-for-service program—whereas health care for most of the working population has been converted to some type of managed care (with generally more generous benefits than Medicare's).

If Medicare is not reformed, changing demographics and rising health care costs will place greater demands on both the budget and the economy. Currently, Medicare, Medicaid, and Social Security together account for about one-third of federal spending and 8 percent of GDP (see Table 2). By 2030, when the last of the baby boomers will have reached age 65, those programs will account for two-thirds of federal spending and 15 percent of GDP, according to CBO's long-term projections, which are based in part on the assumptions of the Medicare trustees. The largest share of that growth is attributable to Medicare, which is projected to increase from 2.5 percent of GDP in calendar year 1998 to 5.6 percent in 2030.

After 2030, rising entitlement costs and interest on the public debt are expected to produce growing budget deficits (under current laws and policies). CBO projects that the deficit will rise from 1 percent of GDP in 2030 to 14 percent in 2060. Debt held by the public, which is projected to fall below zero by 2012, will rise to positive levels after 2030 and reach 100 percent of GDP before 2060.

The projection of Medicare spending, based on the forecasts of the Medicare trustees, assumes that growth in spending per beneficiary will gradually decline to be more in line with growth in hourly earnings, even without a significant policy change. Consequently, after 2020, Medicare spending is expected to grow as a share of GDP only to the extent that Medicare beneficiaries grow as a share of the population. That assumption is probably unrealistic; if spending per beneficiary does not slow, Medicare's share of GDP will be significantly higher than CBO has estimated.

Table 2.—Federal Receipts and Expenditures as a Percentage of GDP Under CBO'S Base Scenario, 1998–2060

(By calendar year)

	1998	2010	2020	2030	2040	2050	2060
NIPA Receipts	22	21	21	21	21	21	21
NIPA Expenditures:							
Federal consumption expenditures	5	4	4	4	4	4	4
Federal transfers, grants, and subsidies							
Social Security	4	5	6	6	6	6	7
Medicare	2	3	5	6	6	6	6
Medicare	1	2	2	3	3	3	3
Other	5	4	4	4	4	4	4
Net interest	3	a	−1	a	1	4	11
Total	21	18	20	22	24	27	35

Table 2.—Federal Receipts and Expenditures as a Percentage of GDP Under CBO'S Base Scenario, 1998–2060—Continued

[By calendar year]

	1998	2010	2020	2030	2040	2050	2060
NIPA Deficit (−) or Surplus	1	3	1	−1	−3	−6	−14
Debt Held by the Public	44	5	−12	−7	16	53	129
Memorandum:							
Gross Domestic Product (trillions of dollars)	8.5	14.3	21.1	30.3	43.2	60.6	82.1

AAASource: Congressional Budget Office.
AAANotes: The base scenario assumes that rising deficits affect interest rates and economic growth.
AAAThese numbers are based on the 10-year budget projections that CBO published in January 1999 (in The Economic and Budget Outlook: Fiscal Years 2000–2009, Table 2–5, p. 43) and on the 1998 assumptions of the Medicare trustees. CBO's projections largely anticipated the trustee's 1999 revisions.
AAANIPA=national income and product accounts.
AAAa. Less than 0.5 percent.

CONCLUSION

A great deal of uncertainty surrounds budget projections beyond the next few years. For one thing, CBO's baseline projections depend on the 10-year budget outlook. Although that outlook has improved dramatically with the passage of the Balanced Budget Act of 1997 and the robust performance of the economy in recent years, unanticipated increases in federal spending or a weaker-than-expected economy could place greater pressure on the budget than anticipated. In addition, the long-term projections are sensitive to assumptions about the future path of population growth, productivity, interest rates, and health care costs assumptions whose accuracy will not be clear for many years.

What is clear, however, is that Medicare must prepare for the unprecedented demands that the baby-boom generation will soon impose on it. The nation should expect to devote more of its income to health care in the coming decades. The ability to pay for goods and services, including health care services, grows as the economy grows. Policies that enhance economic growth, even outside the Medicare program, will make it easier to meet the needs of the retired population. Moreover, since the elderly will become an increasingly dominant part of the population, public acceptance of larger federal health spending may also increase. But the trade-offs between health care and other goods and services would be less marked if Medicare was more efficient, so that enrollees' needs were met in the least costly way and demands for health care reflected the true costs and benefits of that care. Moving toward that goal requires adopting proposals to fundamentally restructure the Medicare program.

Some people have stated the policy options for Medicare succinctly—but, I believe, incompletely—by stating that only two choices exist: raising taxes or cutting benefits. However, at least part of the solution might be found in using medical resources more efficiently. For example, hospitals now use only half of their available beds; shedding some of that excess capacity would help reduce costs. Similarly, estimates suggest that too many physicians, particularly specialists, are currently in practice. The wide variation in practice patterns across the country suggests room for improvement in either health outcomes or costs. The millions of hospitalizations for "ambulatory sensitive conditions" such as diabetes and asthma, which could be prevented with proper care, are clearly a situation in which health could be improved and costs reduced simultaneously.

There are other opportunities to increase the efficiency of the health care system. Rather than belabor the point today, I simply want to state that there may be a "third way" that has the possibility of improving health while reducing costs.

RESPONSES OF DR. CRIPPEN TO QUESTIONS FROM SENATOR GRASSLEY

Question: Some, including the Administration, have suggested diverting general revenues to the Medicare HI Trust Fund in order to shore it up. If that is done, how will the relative shares of federal spending devoted to mandatory and discretionary spending change over the next ten years? Will this Fundamentally address the imbalance between income and payments? What costs and benefits of this approach should we consider?

Answer: Payments from the general fund to Medicare are intrabudgetary transactions that would not affect total federal spending or the shares devoted to mandatory and discretionary programs. Such transfers, however, would not address the underlying problem: rapid growth in spending for Medicare, Social Security, and

other federal programs will cause total outlays to outstrip total anticipated revenues.

PREPARED STATEMENT OF DAN L. CRIPPEN

[MAY 26, 1999]

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss reforming Medicare for the long term. Growth in Medicare spending has slowed remarkably in 1998 and 1999, partly because of provisions of the Balanced Budget Act of 1997 (BBA). Nonetheless, without reform the program is expected to face mounting pressures in coming years arising from rapid growth in the number of eligible people and increases in the cost of care per patient.

PROJECTIONS OF MEDICARE COSTS UNDER CURRENT LAW

Spending for Medicare is expected to exceed $200 billion this year, providing benefits to 39 million elderly or disabled people. Despite the recent slowdown in the growth of spending, outlays for benefits are expected to grow by more than 8 percent a year in the next decade.

At that rate, Medicare spending will account for almost 20 percent of the federal budget by 2009, up from about 12 percent in 1999. Medicare's share of the budget will continue to increase rapidly thereafter under current law, partly because of the influx of the baby-boom population. According to the intermediate assumptions of the Social Security trustees, the elderly population will increase by about 1 percent a year between 2000 and 2010 but will increase by almost 3 percent a year between 2010 and 2030—rising from 39 million to 69 million people. And, as in the past, Medicare's costs will probably grow faster than its enrollment, reflecting continuing advances in medical technology and increases in the use of services by enrollees.

Although such projections involve much uncertainty, Medicare has to prepare for the unprecedented demands that the baby-boom population will soon impose on it. The nation should expect to devote more of its income to health care in the coming decades, and since the elderly will become an increasingly dominant part of the population, public acceptance of larger federal health spending may grow. Furthermore, the ability to pay for goods and services, including health care services, grows as the economy grows. Thus, policies that enhance economic growth will make it easier to meet the needs of the elderly population. But the trade-off between health care and other goods and services would be less marked if Medicare was more efficient, meeting enrollees' needs in the least costly way. Improving the program's efficiency may involve a more fundamental restructuring of the program than has been done so far.

CONSIDERATIONS FOR RESTRUCTURING MEDICARE

Medicare enrollees now make up about 14 percent of the population and will reach 22 percent by 2030. Medicare pays for about 30 percent of all spending for hospital and physician services and for about half of all home health care. Thus, changes in Medicare have consequences far beyond the federal budget, substantially affecting the private health care market as well, for better or worse.

The key to improving Medicare's efficiency lies in the payment system and the incentives it produces for participating health plans, providers, and enrollees. Those incentives should be consistent with the multiple goals that policymakers have for the program. Medicare's main goal is to ensure that enrollees can obtain medically necessary care of reasonable quality in the most appropriate clinical setting. An important secondary goal is to obtain such care at the lowest feasible cost. Additional goals—which might ultimately help to achieve the main objectives—could include expanding the type and number of plans from which enrollees may choose, ensuring that options in addition to fee for service are available in rural areas, and establishing the basis for a more competitive Medicare system in the future. The Congress began to address those additional goals through the BBA.

For a competitive system to be viable, Medicare's payment methods must adequately compensate participating health plans and providers while giving them incentives to control costs. That means that plans or providers must bear some financial risk—earning greater returns by providing services efficiently and smaller returns when inefficient. Large health plans may be able to assume full financial risk for their enrollees, but smaller plans may require limits on the risk they assume—an important consideration in designing such a system.

In addition, Medicare's traditional fee-for-service sector will be a major part of the program for the foreseeable future. Consequently, efforts to control costs cannot ignore that sector. A major focus of the BBA was to change the financial incentives

facing fee-for-service providers, largely by expanding prospective payment systems. Further efforts to control costs in the fee-for-service sector may need to focus on changing the financial incentives facing enrollees.

ENHANCING COMPETITION IN MEDICARE

In establishing the Medicare+Choice (M+C) system under the BBA, the Congress wanted to make Medicare's risk-based sector more competitive by seeking to expand the range of available plans—both the kinds of plans offered and the areas in which they were offered. The Congress also mandated a coordinated open-enrollment process intended to better inform beneficiaries about their options.

But the BBA left in place the administered pricing system, which sets Medicare's payments to plans. Consequently, the program has no meaningful price competition among plans for the basic benefit package. Instead, plans have incentives to increase optional benefits rather than to reduce costs, just as they did before the BBA. Therefore, even though enrollees benefit from the greater efficiency of risk-based plans than of the fee-for-service sector, Medicare does not. Changing to a premium-support or bidding system could expand competition to include price as well as benefits and quality of service, so that Medicare could capture some of the savings from plans' more efficient health care management. Many issues would have to be resolved, however, before Medicare could implement such an approach nationwide. The competitive bidding demonstrations mandated by the BBA, if successfully implemented, could provide some answers.

In its first year, Medicare did not succeed in attracting more types of plans to the M+C system, largely because of the lead time plans need to develop new markets and because of uncertainties about key elements of the regulations governing the plans. In fact, the number of plans dropped appreciably in some areas—a response to lower payment updates than in past years in many local markets, the complexity of new program rules, and earlier deadlines for submitting premium proposals to the Health Care Financing Administration (HCFA). Some plans withdrew from markets where the plans had low enrollment and their financial viability was doubtful even before the changes implemented by the BBA. One facet of the changes made under the BBA—the payment rate floor and the move toward national rates—will probably tend to reduce the rate of enrollment growth in urban markets, and it may not attract plans to less populated areas.

Plans with low enrollment are especially vulnerable to losses from the unexpected use of services by a few seriously ill people because such plans may have too few enrollees with below-average health needs to offset those with high needs. Eliminating all such risk would be undesirable since financial risk promotes more efficient practices. Nonetheless, undue vulnerability to financial risk could be reduced in the following ways:

- Payment adjusters. Currently, HCFA uses demographic factors for age, sex, Medicaid receipt, and institutionalization to adjust payments to plans for the expected costs of their enrollees. Beginning in 2000, HCFA will add an adjuster based on prior inpatient admissions to better account for health status. However, a payment adjustment based on prior inpatient admissions creates an obvious way for plans to increase their Medicare payments by hospitalizing enrollees unnecessarily—a problem that HCFA is well aware of. Consequently, HCFA plans to develop a more comprehensive health status adjuster as soon as possible.
- Partial capitation. Because even the best payment adjuster can account for only a modest amount of variation in health spending at the plan level, the Medicare Payment Advisory Commission (MedPAC) and others have suggested that some kind of partial capitation may be necessary to ensure that plans do not skimp on the services provided to their enrollees. Partial capitation could be introduced by blending a capitated rate and a fee-for-service rate, supplementing payments for cases that are outliers, providing stop-loss protection on total costs at the plan level, or carving out selected high-cost services. All but the first of those approaches would reduce the capitation rate across the board, imposing a kind of premium on plans in return for insurance against excessive risk.

REFORMING FEE-FOR-SERVICE MEDICARE

About 85 percent of Medicare enrollees remain in the program's traditional fee-for-service sector. Under current Congressional Budget Office (CBO) projections, the share of enrollees in the fee-for-service sector will fall to 70 percent by 2009. Thus, Medicare's fee-for-service sector should remain dominant, especially in less populated areas, at least through the next decade. Consequently, efforts at cost control

must include the fee-for-service sector. Previous efforts have focused almost entirely on providers. Although some additional policy changes affecting providers could be made, changes affecting enrollees could also be considered.

Policies Affecting Providers

Paying separately for each service a patient receives encourages providing unnecessary services. One alternative to separate payments is a single payment, determined prospectively, for all services deemed appropriate to treat a given condition. Prospective payment encourages providers to treat the patient with the fewest services possible to adequately address the condition. Medicare has had a prospective payment system for hospital inpatient services since 1983. The BBA mandates new prospective payment systems for hospital outpatient, skilled nursing, and home health services.

Prospective payment could be expanded. One example of doing so is bundling together acute and postacute hospital services. Another example is combining payments for physician and facility services during a hospital stay. However, developing viable prospective payment systems is difficult. More comprehensive bundles of services reduce the opportunity to shift services to sites or times not included in the prospective payment, increasing incentives to reduce costs; but such bundling also imposes greater financial risk on providers. One way to reduce excessive risk and the resulting incentive to avoid difficult cases is by including severity adjustments in the payment system, similar to the risk adjusters applied to capitation rates paid to M+C plans.

Policies affecting enrollees

Enrollees in Medicare's fee-for-service sector have to pay part of the costs of their covered services and all of the costs of prescription drugs, which are not typically covered by Medicare. In principle, cost sharing gives patients an incentive to use services more prudently. For several reasons, however, Medicare's cost-sharing requirements are not as effective in that regard as they might be. First, the requirements are too varied and complex to be well understood by patients. Second, some cases in which cost-sharing requirements could help reduce the inappropriate use of services (such as home health) have no such requirements; other cases, which have high cost-sharing requirements, have little possibility of adjusting the use of services (such as long hospital inpatient stays for severely ill patients). Third, because Medicare does not limit enrollees' cost-sharing liabilities, most enrollees seek some kind of supplementary coverage to limit their financial risk. Such supplementary coverage often eliminates the incentives for prudently using services that cost sharing is intended to create.

In its latest budgetary savings volume, CBO discussed one policy option that could better protect enrollees from catastrophic expenses and improve the effectiveness of Medicare's cost-sharing requirements. That option would change Medicare's cost-sharing requirements to more accurately reflect the costs of the services used and make them easier for enrollees to understand. It would also cap each enrollee's annual liability for cost-sharing expenses. Medicare could implement the option for no net cost by raising cost-sharing requirements somewhat for the majority of enrollees who use relatively few services during the year and using those savings to finance the cost-sharing cap for the minority of patients with more serious health problems that year.

A complementary option, which would further increase the effect of Medicare's cost-sharing requirements, is to restrict the kind of coverage that medigap plans may provide. For example, medigap plans might be prohibited from covering Medicare's deductible amounts, or they might be permitted to offer only coverage for a lower cost-sharing cap than the one provided under Medicare—one set at $1,000 a year, for example, when Medicare's cap was set at $2,000. Restricting medigap coverage could generate considerable savings for Medicare, which pays most of the costs of the additional services used by medigap policyholders. Those savings could be used either to reduce the deficit or to improve Medicare's benefits. For example, they might be used to finance the costs of a prescription drug benefit.

CONCLUSION

The BBA introduced changes to both Medicare's risk-based and fee-for-service sectors that have slowed the growth in costs. But further action is needed to maintain Medicare's financial viability in the decades ahead.

The Congress could consider raising Medicare revenues by increasing the payroll tax, allocating more revenues to the program from the general fund, or increasing the costs imposed on enrollees. Options to raise revenues for the program, however, are likely to succeed only temporarily as health care costs continue to escalate. The

Congress could also consider reducing Medicare benefits, but that would impose greater financial burdens on the elderly and disabled that could eventually prove unacceptable.

A third approach would address the inefficient use of medical resources in Medicare. Treatment patterns vary greatly nationwide, with consequences for both health outcomes and program costs. For example, patients are more likely to be hospitalized in areas with high bed-to-population ratios than in other areas, even though they have identical medical conditions. Patients in fee-for-service settings rely more on specialist care than patients in managed care. In addition, managed care settings emphasize disease prevention and primary care more than fee-for-service settings do.

Medicare could be restructured to allow health plans to compete on price as well as on benefits and quality. Enrollees could be given better information on their health plan choices, including a report card that could help them assess the quality of care. Payment systems and cost-sharing requirements could be revamped to provide both plans and enrollees with clear financial incentives for efficiency. But the actions necessary to bring competition to Medicare are complex and require the effort and goodwill of everyone: plans, providers, enrollees, and policymakers. The discussion today could be an initial step in the direction of real reform.

PREPARED STATEMENT OF DICK DAVIDSON

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association (AHA). The AHA represents nearly 5,000 hospitals and health systems, networks and other providers of care. We appreciate this opportunity to present our views on an issue that is critical to our members and their communities: Medicare reform.

Over the past 30 years, the Medicare program has contributed not only to seniors' health improvement, but to something much more important for all Americans: the opportunity to age with dignity.

Growing older brings many pressures: moving from work to retirement; substantially reduced income; and changes in family structures, to name a few. And of course, growing older involves a natural decline in health status.

KEEPING THE PROMISE

We believe that a goal of our society must be to enable all Americans to age with dignity. That means maintaining good health, and the ability to live independently or with some assistance, as long as possible. It means offering opportunities for health security as well as opportunities for financial security in our retirement years. And it means the ability to retain one's personal autonomy and responsibility whenever possible.

For three decades, the promise of Medicare has been central to our vision of individuals reaching their highest potential for health.

Medicare's promise is health security. The guaranteed benefits provided by the program have served the nation and its seniors very well. Medicare has substantially improved seniors' access to services. And the health status of seniors in the U.S. has improved markedly since the creation of Medicare.

Medicare's promise is financial security. Without the Medicare program, many seniors could not afford the health care they need. Medicare, since its inception, has lifted millions of seniors out of poverty, and prevented millions of others from falling into poverty. By defraying health care costs that are often substantial, Medicare is much more than a health care program—it is an integral component of the nation's retirement policy and plays as important a role in ensuring seniors' financial security as Social Security or employer pension plans. For seniors, Medicare and Social Security are intertwined—Medicare IS Social Security. They are both "contracts" with the nation's elderly to provide health care and a measure of financial security. The Medicare benefits Americans receive are irreplaceable. They would not be available through any other source. For most seniors, the value of their Medicare package is as important as Social Security. A recent AHA national Medicare survey of voters drives home that point. The survey shows voters link Social Security and Medicare. They want to see the programs reformed together and they view Medicare budget cuts as cuts to Social Security.

Medicare's promise can—and should—make it easier for seniors to manage and maintain control of their own health-related affairs. The program today has fallen short of the mark. The piecemeal evolution of the way in which the program pays for services has resulted in a patchwork program of care. Medicare is difficult for most seniors to navigate. They often have to rely on others to help them understand

a maze of covered benefits and bills. Medicare reform should be an opportunity to create a more cohesive approach to the delivery of care—an approach that better coordinates care for seniors, focuses on wellness and prevention, and encourages participation by seniors in the improvement of their own health.

As we consider reforming the Medicare program, we must keep these fundamental promises for today's seniors and for future generations. The principles outlined later in this testimony can help make sure that happens. But while keeping those promises, we must also acknowledge that impending change demands immediate action.

- The number of Medicare beneficiaries is expected to increase from 37 million today to 55 million by 2027 as the "baby boom" generation ages.
- The number of Medicare beneficiaries expected to reach and exceed the age of 80 will continue to increase.
- The number of workers whose contributions to the program support benefits for retirees is expected to decline, from three workers per retiree today to two workers per retiree in 2020.
- National investment in biomedical research continues to yield new services, technologies, and pharmaceuticals that extend and improve the quality of life.

All of these trends promise to increase Medicare's costs and decrease its revenues. It has been suggested that spending on the program could grow from about 12 percent of total federal funding in 2000 to more than 30 percent of federal spending by 2030. Time will tell whether this prediction becomes reality. One thing is clear: the current rate of growth in Medicare spending is unsustainable. No amount of provider payment reductions or improved efficiency will change these major forces driving the future of Medicare. But, some sort of change must be made if Medicare's future is to be secure. A good starting point for reform would be to simply take steps to make the program better for seniors. A few suggestions:

First, the program's incentives should encourage continuity of patient care so care is delivered in the right place at the right time. The result would be more efficient and effective patient care.

Second, the benefit package should be aligned to the changing needs of the patient population. The health needs of patients have changed since the program was created and will continue to change into the future. We see more need for treatment of chronic conditions, for instance, and the benefit package should reflect that need.

Third, we need to do a better job of focusing on health promotion and prevention. A report from the third national release of the Dartmouth Atlas of Health Care shows that, despite the known benefits of such preventive services as screening for breast cancer and eye exams for diabetics, too many seniors are not receiving this type of care. Physicians and other providers need to work together with their patients to make sure all receive what are often life-saving preventive services.

GUIDING CHANGE

Many suggestions for reforming Medicare have been put forward over the years, and many more will come. We must evaluate suggested options against some set of guiding principles that keep us focused on Medicare's purpose and promises.

The following is a set of principles that we believe can guide the choices we must make as we work to ensure that Medicare can keep its promise to America's seniors.

- Continuity. Protect the long-run viability of the Medicare program, which is important not only for today's seniors, but also for future generations and the communities in which we live.
- Coverage. Ensure that no current Medicare beneficiary loses coverage as a result of changes made in reforming the program.
- Benefits. Ensure that, at a minimum, the existing package of benefits remains available to seniors, especially for the poor and disabled who have the greatest need. And ensure that funding is sufficient to cover that package of benefits.
- Health Promotion. Through Medicare, encourage a focus on seniors' health and wellness, and promote their ability to continue living in community and family settings.
- Coordinated Care. Encourage the development of delivery models that coordinate care for seniors.
- Provider Payments. Provide predictable, stable and appropriate payment to the providers who care for America's seniors—payments that reflect the health risks of the populations served, geographic differences in the price of items and services that are used to deliver that care, and more standardized levels of utilization across the country.
- Participating Health Plans. Health plans that provide care under Medicare should meet high qualification standards that ensure continuity of care and coverage for seniors.

• Social Mission. Continue Medicare's support for the high costs of clinical education and serving disadvantaged populations.

• Financing. Financial solvency for the program can only be achieved through a combination of financing and program changes.

We urge policy makers to apply these principles to the evaluation of each potential reform proposal.

We commend this committee for holding hearings on Medicare reform, and for your willingness to follow up on the work done by the National Bipartisan Commission on the Future of Medicare. One area of the commission's work that has drawn considerable interest is the premium support idea proposed by Senator John Breaux and Representative Bill Thomas, the commission's former co-chairmen. Under premium support, the government would make a contribution on behalf of seniors toward purchasing coverage through a health plan, including the traditional Medicare fee-for-service plan. Health plans, in turn, would compete with traditional Medicare for enrollees.

The AHA applauds Senator Breaux's and Representative Thomas' courage in offering a creative alternative to restructure Medicare through fundamental reform. The complexity of the program begs for such thoughtful analysis. We urge the committee to proceed carefully as it considers this approach, because a number of questions and concerns have been raised.

For example, could Medicare beneficiaries lose their current level of benefits as a result of the Breaux-Thomas plan? Would health plans be required to meet high qualification standards and be accountable to their communities? Are the low-income protections included in the proposal sufficient to cover all those in financial need?

We look forward to more detail and answers to these and other questions, so that the AHA can completely evaluate this premium support proposal. We believe the concept of premium support requires further exploration, and we look forward to continuing our dialogue with Congress on this important issue.

THE BALANCED BUDGET ACT OF 1997: IMPACT ON HOSPITALS

The Balanced Budget Act of 1997 was the biggest reform of the Medicare program made during the past 30 years. It was a major piece of legislation encompassing 350 changes that have serious implications and consequences for the program, for caregivers, and for the people we serve. Hospitals and health systems are greatly affected by those significant changes. I urge the committee to evaluate the consequences of the Balanced Budget Act—intended or unintended before proposing even bigger structural reforms to Medicare.

Mr. Chairman, balancing America's budget shouldn't deprive Americans of the health care they need and deserve. But that's exactly what's happening across the nation, even though two-thirds of the cuts have yet to take effect. Today's hospitals and health systems encompass all elements of health care delivery affected by the Balanced Budget Act: home health, skilled nursing, outpatient, inpatient, and health plans. This makes the act's changes particularly burdensome, and the worst is yet to come, as a new analysis from The Lewin Group, a highly respected health care consulting firm, makes clear.

The Lewin Group was asked by the AHA to forecast the Balanced Budget Act's impact through the year 2002 on payments for hospital services including inpatient, outpatient, hospital-based home health, rehabilitation, long-term care, psychiatric and cancer services.

Findings from the analysis show:

• For all hospitals, total Medicare margins are projected to be between negative 4.4 percent and negative 7.8 percent in 2002.

• Already in the red when treating Medicare patients, rural hospitals' total Medicare margins may plummet to between negative 10.4 percent and negative 7 percent in 2002 as a result of BBA payment cuts. Urban hospitals' total Medicare margins in three years are predicted to range from negative 7.3 percent to negative 3.9 percent.

• Outpatient service margins also are expected to drop. Medicare outpatient margins—already negative in 1999—are estimated to drop to a negative 28.8 percent if costs increase at a more historical rate of growth; and negative 20.3 percent if hospital costs increase more slowly.

• In just one year, margins for hospital-based home health services are predicted to drop dramatically from negative 4 percent in year 2000, to negative 11.6 percent margin in 2001. Fifty percent of hospitals now provide home health care.

The new report contributes to the growing evidence that hospitals and their communities are facing hardship. A report released last month by Moody's Investors Services stated that U.S. not-for-profit hospitals' credit deteriorated at a faster clip in the first quarter of 1999 than the previous year. Moody's cited the fiscal pressures of the Balanced Budget Act as one of the reasons for the downward slide. And other recent analyses by Ernst & Young and HCIA Inc. and the Association of American Medical Colleges echo that hospital margins and, therefore, their stability, will be greatly eroded.

Mr. Chairman, caregivers won't compromise quality. But they simply can't afford to continue providing services if their costs aren't even covered. How are they to survive? Communities already are losing access to vital health care services even as Washington debates how to spend a federal budget surplus of billions of dollars. Hospitals are being forced to cut back or shut down services, which affects not just the elderly who rely on Medicare, but all patients. When the government acted to reduce Medicare spending to help balance the budget, no one was certain what effect such enormous reductions would have. That's why the AHA strongly opposes any plan that includes additional years of the Balanced Budget Act's Medicare cuts.

We are gravely concerned that Medicare reform will come on the backs of providers. We need structural changes to sustain the program, but Medicare reform must include a combination of solutions, not business-as-usual reductions in provider payments.

BUILDING BLOCKS FOR REFORM

America's hospitals, and the patients and communities they serve, must have relief from the unintended consequences of the Balanced Budget Act. That relief is critical to reforming Medicare. We need both administrative and legislative solutions. Medicare should be treated like Social Security: a portion of the federal budget surplus should be used to address the Balanced Budget Act's unintended consequences * * * because Medicare is Social Security.

Relief from the Balanced Budget Act should include:

- Repeal of the Balanced Budget Act's unreasonable transfer provision (H.R. 405/S. 37);
- Reform of the proposed Medicare outpatient prospective payment system. Set a floor for outpatient reductions; repeal the proposed volume cap; and modify the Health Care Financing Administration's (HCFA) formula for setting payment rates;
- Increase Medicare inpatient hospital service updates to reflect the cost of providing health care services;
- Relief from reductions for teaching hospitals and academic medical centers;
- Repair the extreme damage to America's small and rural hospitals. Ensure that a portion of the federal budget surplus is devoted to providing relief to small and rural hospitals and health systems, and the entire field;
- Restore adequate reimbursement for skilled nursing facilities (SNF). Establish a pool of funds making additional payments available to costly medically complex SNF patients;
- Redress for inequities in home health care services. Address short-term inequity in the interim payment system; and reduce the 15 percent cut in payments;
- Protect access to psychiatric, rehabilitation and long-term care services; and
- Remove barriers to expanded Medicare options through Medicare+Choice.

Mr. Chairman, allow me to elaborate on this last point. We had hoped that the new Medicare+Choice options made available to seniors would truly provide them with many of the same options available to the current working population, and therefore offer some of the same efficiencies that we have been able to achieve in private sector health care delivery. Unfortunately, this has not been the case to date. A significant impediment to building consensus around specific reformation of Medicare is the myriad of problems with Medicare+Choice. While offering the promise of new, more efficient ways of providing care for seniors, the program has been plagued with unintended, but detracting, policy consequences.

- The regulatory burden associated with becoming a Medicare+Choice plan was greater than many plans anticipated, resulting in fewer-than-expected participating plans. Seniors as a result don't have access to the Medicare+Choice options they might otherwise have had.
- Information designed to educate seniors about their new plan choices and to encourage participation in Medicare+Choice was not as helpful as it should have been.

- While rate changes designed to make payments more equitable across the country for Medicare+Choice plans were enacted into law in 1997, a lack of funding prevented these changes from being implemented. One result: Plans that otherwise might have opted to offer a Medicare+Choice option chose not to participate.
- Worse, plans that were previously offering a Medicare risk contracting product have actually dropped out in many areas, making it impossible for seniors to maintain connections with their current health care providers in a managed care arrangement.

We believe that the goals of the Medicare+Choice program, as well as lessons learned from other demonstrations, can be a successful blueprint for the future. However, if we hope to move ahead and reach a consensus about broader Medicare reform, it is critical that problems in the Medicare+Choice effort be corrected. Improved consumer confidence in, and adequate financing for, the current Medicare program—especially initiatives like Medicare+Choice that should be building blocks for future reform—are critical if we are to enact broader change.

We believe the following short-term changes are necessary to shore up confidence in Medicare:

- The government must solve the practical problems that will ultimately determine the success of Medicare+Choice. These include:
- Ensure implementation of congressional intent to begin to equalize Medicare+Choice payment rates across the United States. The BBA required that Medicare+Choice plans be paid the greater of a blended national/county rate, a minimum floor rate, or 2 percent. But because the law also requires that the program spend no more money after these changes are implemented than before, funding has been and may again in the future be insufficient to actually pay blended national/county rates. Congress should make additional dollars available to fully fund the blended rates, and thereby encourage increased plan and beneficiary participation in Medicare+Choice.
- At the same time, ensure that special Medicare payments intended for hospitals serving disproportionate numbers of low income individuals are "carved-out" from Medicare+Choice payments to plans and paid directly to the hospitals incurring the costs.
- Revisit the timing of certain Medicare+Choice plan requirements. Plans are currently required to submit, in May of each year, a list of the benefits they intend to offer and the premium price at which they will offer those benefits. But they aren't told what the Medicare+Choice program will actually pay them until later that year. This leaves plans little time, once payment rates are determined, to bring the provision of services in line with actual payments. The effect is to make the program financially unpredictable and difficult to manage for many plans and, for some, simply unworkable.

With these changes, we can immediately point to the strengths of the Medicare program and the innovations that Medicare+Choice can bring for America's seniors. Building on these short-term successes, we can consider the broader, longer-term reform of Medicare's future.

The environment for hospitals today is filled with uncertainty—financial pressures in the private market, mergers and consolidations, the ebb and flow of managed care, implementation of the Balanced Budget Act, unstable Medicare revenue streams that result, and the specter of even more change on the horizon. For many hospitals, Medicare has been an anchor in choppy waters. It has been a major and relatively stable source of revenue for hospitals over time. Reform of the program should be carefully undertaken in a manner that ensures this stability for the future.

In other words, Mr. Chairman, let's finish what we started in reforming Medicare for the new century. At the same time, let's get the details of premium support, so that there can be an informed, national public debate.

PREPARED STATEMENT OF NANCY W. DICKEY, MD

The American Medical Association (AMA) appreciates the opportunity to present to this Committee its views on and plan for Medicare reform, and applauds the efforts of the members of this Committee in focusing on this important issue.

For years the AMA has been a strong advocate of basic, essential reforms of the Medicare program. It is clear that the system, as currently structured, cannot continue to support the provision of quality medical services to the elderly and disabled in this country, particularly as the baby boom generation becomes Medicare-eligible

while at the same time the numbers of employees in the workforce who financially support the system dwindle.

Congress has already acknowledged that Medicare must be reformed to keep the promise of health care for this and future generations of elderly Americans, as represented by the establishment under The Balanced Budget Act of 1997 (BBA) of the National Bipartisan Commission on the Future of Medicare. We urge, however, that this Committee and Congress not delay in passing badly needed reform. Now is the time, before the new millennium, to fix the Medicare program.

Medicare's current tax-based "pay-as-you-go" financing structure makes it highly unlikely that the promise of health care to our elderly can be sustained in the coming years. Moving Medicare from an open-ended entitlement system to one in which the government makes a contribution that allows individuals to have meaningful choice and quality care is the key to gaining budgetary control over outlays.

FOR THE LONG TERM: DEAL WITH THE TRUST FUND MYTH

Because the term "trust fund" is officially used to describe the financing of Medicare, many people think that the payroll taxes they pay are saved and accumulate interest to pay for their personal medical needs in retirement. In fact, the Part A program is financed on a "pay-as-you-go" basis, with taxes paid into the program being used to pay for the benefits received by current retirees, and the excess used to purchase federal debt. Part B is financed mostly out of general revenues, with the premiums that retirees pay calculated to cover only about 25 percent of the outlays. Part B is modeled after private sector health plans, with a significant difference: beneficiaries fund only 25 percent of the cost of their services through premiums, leaving taxpayers to fund a significant portion of the remaining cost of providing Part B services.

Most retirees have received much more in benefits than their contributions to the program could purchase. The pay-as-you-go financing is often likened to a "Ponzi" or "pyramid" scheme. The similarity lies in the promise of future benefits to those who fund services for current beneficiaries, and the need for a growing number of new contributors to fund the growing number of beneficiaries. Pyramid schemes, almost by definition, must eventually collapse from an insufficient influx of new participants. The number of workers contributing payroll taxes to finance the current hospital trust fund is declining. In 1965 when Medicare was enacted, there were 5.5 working-age Americans for every individual over age 65. Today, there are only 3.9 workers supporting each Medicare-age individual. In the coming decades, as the "baby boom" generation continues to age, this number will fall more rapidly. By the year 2030, it is estimated that there will be only 2.2 working-age Americans for each individual over age 65. By that time, Medicare will enroll 20 percent of the population, compared with the 12.8 percent of the population now enrolled.

Medicare's actuaries base their calculations for funding the Medicare fee-for-service program on the assumption that the rate of health care cost inflation will be controlled over the next 25 years. This assumption allows them to project a significantly lower tax increase needed to fund the program than would be needed if the historical rate of cost inflation continued. Continuing the "pay-as-you-go" system of financing Medicare will impose an ever-increasing burden on working U.S. taxpayers. While this country's obligations to those who are and will be dependent on Medicare in the future must clearly be honored, we need to implement reforms so that the program is available for future generations.

How would we design Medicare if we had it to do over again? How would we protect the younger generations that will face ever-increasing taxes and prospects of eroding benefits and less choice if the current program were to be continued?

To restore the viability of the program's promise to future generations, certain immediate priorities must be met, including shifting from the "pay-as-you-go" system to one in which the government makes a contribution that allows individuals to have meaningful choice and quality care, and improving the fee-for-service Medicare program.

This will assure that all working Americans have access to health care in retirement and will maintain choice and quality of care for the elderly.

IMMEDIATE PRIORITIES

Improving Fee-for-Service Medicare

Despite the establishment of and focus on Medicare+Choice, 85 percent of Medicare beneficiaries receive health care through the Medicare fee-for-service program. It is imperative to improve the efficiency of the fee-for-service program, thereby constraining Medicare's cost growth at a sustainable level over the next several decades and limiting out-of-pocket costs incurred by beneficiaries. The AMA proposes the fol-

lowing structural modifications to the program that would save both beneficiaries and the government money by providing needed incentives for efficiency.

THE PATH TO SCOREABLE SAVINGS: ELIMINATE THE "GAP" PROBLEM

The large cost imposed on the Medicare program and beneficiaries by the "Medigap problem" has long been recognized as a potential source of significant government budget savings. When Medicare's intended cost sharing is covered by private supplemental insurance (Medigap), it has been demonstrated that beneficiaries use more services than they would otherwise. Since more than 75 percent of beneficiaries own such supplemental coverage, Medicare's outlays are considerably higher than they would be if the cost sharing were not subverted by Medigap insurance.

Effectively solving this problem presents the best source of scoreable budget savings because the savings produced are the result of efficiency improvements, rather than from imposing additional costs on taxpayers, beneficiaries or providers of medical care.

The potential cost sharing exposure for beneficiaries under the current system can reach more than $34,000 per year since, unlike most private insurance policies, Medicare does not place a ceiling on the out-of-pocket cost that beneficiaries can be required to pay. The current system is designed so that the beneficiary's rational response is to purchase supplemental coverage, which over three-quarters of beneficiaries do as a hedge against economic catastrophe. This occurs, despite the fact that 20 percent of beneficiaries incur no actual cost sharing liability each year, while 70 percent incur a cost sharing liability under $500 and 80 percent incur under $1000 of expense. The risk of paying tens of thousands of dollars out-of-pocket is not one that most beneficiaries want to take.

It is safe to assume that if beneficiaries were not exposed to such potentially high out-of-pocket costs, they (and/or their former employers who provide insurance to supplement Medicare as a retirement benefit) would not feel compelled to insure against it. In fact, the government does not need to expose beneficiaries to such high risk, precipitating the increased burden on beneficiaries and its own budget. The government can give beneficiaries and their former employers an economic break by eliminating their need for supplemental coverage. In so doing, the government can also lessen the pressure that Medigap puts on the federal budget.

The AMA proposes that Medicare restructure its cost sharing to reduce potential beneficiary liability in a manner that eliminates the need for private Medigap insurance. In exchange, beneficiaries would pay a somewhat higher premium than they do now, but they would also have more money available to help cover out-of-pocket costs, such as prescription drugs that are not covered by Medicare. The premium charged by Medicare for the expanded coverage would be much less than that charged by private insurance companies because the government's premium would not be padded by marketing expense and profit. The reinstitution of effective cost sharing would reduce government outlays for medical services. The balance to be struck would be one in which beneficiaries would be provided an effective incentive to reasonably moderate their demand for covered services, while eliminating their need to insure against an enormous potential out-of-pocket liability.

Specifically, the AMA proposes that Medicare convert its current cost sharing into a modest deductible with no coinsurance requirement above the deductible, and charge a fair premium for the extra coverage implied by lowering the cost sharing. In this way, beneficiaries would readily know in advance the maximum liability to which they would be exposed. In turn, few would be motivated to buy supplemental insurance (which would no longer be valuable because its premium cost would meet or exceed the liability it would be purchased to insure against). Beneficiaries would be trading the unknown for the known.

As an illustration of this reallocation approach, we estimate that the average cost of the Medigap "Plan C" that covers all of Medicare's potential cost sharing liability as about $1,330 in 1999. This amount could be divided into two parts, consisting of a modest, single deductible for both Parts A and B of Medicare, and a premium for the extra Medicare coverage represented by eliminating all existing cost sharing liability except for the single deductible. Dividing the current cost of Medigap Plan C into two parts—a deductible and a premium for extra coverage—would guarantee that beneficiaries would incur no greater out-of-pocket expense than they do now, and many of them would actually save money.

For example, consider dividing the current Medigap cost into a $500 deductible and a premium of $830. According to the most recent actuarial analysis by PriceWaterhouse, the average beneficiary would spend only $400 of the $500 deductible, saving $100 per year from the cost of $1,330 for Medigap. By neutralizing the first-dollar-coverage incentive of Medigap, the Medicare program would save an av-

erage of $334 per beneficiary, which could be returned to beneficiaries in the form of reduced Part B premiums or additional coverage. If the government savings were used to reduce the deficit, a total of $40 billion of savings would accrue over the 5–year budget period 1999–2003.

Medicare's current cost sharing requirements are self-defeating because they frighten beneficiaries into insuring against them with expensive private coverage. By incorporating most of Medigap's coverage into Medicare benefits, the government could save beneficiaries money by reducing the premium required for the coverage. In turn, the government can achieve the intended benefit of effective cost sharing to reduce program expenditures.

Neutralizing Medigap is a "win" for patients and beneficiaries, the government and taxpayers. For example, we understand that Congress and the Administration are exploring various methods to help beneficiaries pay the exorbitant cost of pharmaceutical drugs. As discussed above, it is expected that beneficiaries' out-of-pocket costs will almost double over the next couple of decades. A significant portion of those costs will be for pharmaceutical drugs that are covered by the Medicare fee-for-service program, which CBO projects will increase between 13 percent and 21 percent each year during the next decade. The savings received by beneficiaries as a result of eliminating the Medigap problem will help offset the cost of the drugs.

INCREASED COMPETITION WILL IMPROVE MEDICARE

Prices in Part A of Medicare are controlled through the prospective payment system for hospital payment and in Part B through the payment schedule system for physician payment. These price controls prevent prices from varying, provide no incentive for either innovation by physicians or price-comparison by beneficiaries, and results in payments levels that are not based on the real cost of services.

For example, under the BBA, Congress implemented a payment update system for physicians' services that is based on a cumulative target rate of expenditure growth, *i.e.*, the sustainable growth rate (SGR). Although the SGR is tied to real gross domestic product (GDP) per capita, utilization of, and thus expenditures on, health care services are not related to GDP. Indeed, GDP does not take into account such factors as changes in technology or shifts in usage of sites-of-service. Payment updates under the SGR will match inflation only if utilization growth meets the target of real per capita GDP growth. Yet, utilization growth has historically been much greater than GDP growth. If history is any guide, future Medicare physician payment levels will decline significantly under the current SGR formula. The AMA believes that the SGR system needs to be improved so that the 85 percent of Medicare beneficiaries in the fee-for-service program continue to receive the benefits to which they are entitled. In the long term, as discussed, price controls should be replaced with price competition.

Continued cuts threaten to drive physicians from Medicare when the baseline cost of treating Medicare patients is greater than the Medicare allowance. The reduction in beneficiary access to care seems inevitable in such a scenario. Physicians have had to adjust in a number of ways to the failure of Medicare payment rates to keep up with their cost of providing services. They are reducing staff, curtailing salary increases, and replacing full-time with part-time staff to reduce fringe benefit expense. Some have eliminated research such as outcome studies of procedures they perform frequently. There is pressure to reduce the time spent with Medicare patients on each visit, although the complexity of these cases has not changed, and multiple visits for multiple problems are sometimes required. Some physicians selectively refer the more difficult, costly cases to other physicians. Services formerly offered for patients' convenience are being dropped, such as arranging for community-based services, in-office phlebotomy and x-ray services, and incidentals such as post-procedure care kits. Screening and counseling are being curtailed. Satellite offices are being closed. Telephone consultations are being reduced, with office staff rather than physicians returning more telephone calls from patients. Offices are no longer offering commercially produced patient education pamphlets and brochures. Medicare patient loads are being reduced, limited or eliminated. Some physicians accept Medicare patients only by referral. Money-losing services, especially surgical procedures, are not being offered to Medicare patients; simple procedures formerly performed in the office are done in outpatient facilities. Many physicians are not renewing or updating equipment used in their office, and instead are shifting to hospitals to perform Medicare procedures. Purchases of equipment for promising new procedures and techniques are being postponed or canceled.

Under this cost-cutting environment, physicians must continually ask themselves whether they can continue seeing Medicare patients when Medicare's fixed prices are too low to even cover costs. The AMA believes that the replacement of price con-

trols with price competition in Medicare's fee-for-service sector would help alleviate this problem. Price competition would be achieved by allowing physicians competitively to establish conversion factors that convert relative values into dollar charges under Part B, and likewise, DRG payments for Part A services would also be competitively determined.

ADDITIONAL MODIFICATIONS TO FEE-FOR-SERVICE MEDICARE

There are several other considerations that we believe are necessary for reforming fee-for-service Medicare. First, Medicare reform legislation must address funding for graduate medical education. We believe that a national all-payer fund should be established to provide a stable source of funding for the direct costs of GME, including resident stipends and benefits, faculty supervision and program administration and allowable institutional costs. Without predictable and reliable funding, this important training program is seriously undermined, with a resulting adverse impact on patient care.

Additionally, other issues should be addressed, including increasing the age of Medicare eligibility to match the eligibility requirements for purposes of Social Security and establishing income-related premium payments for Medicare benefits.

Improving Medicare+Choice

Seniors may choose to receive health care benefits through the new Medicare+Choice program. While this program will eventually provide many choices of health insurance coverage to Medicare, there are a number of related matters for Congress to consider to improve upon the program. We must protect the erosion of patient and physician protections that currently are at risk under this program.

Medicare+Choice plans must be held to adequate standards of accountability. Currently, we believe plans in this program are being held to a lower standard than is applicable to the Medicare fee-for-service program, especially with respect to payment policy and timeframes. For example, while carriers that process Medicare fee-for-service claims are required to pay 95 percent of claims within 30 days, there are no deadlines for payments to physicians who contract with Medicare+Choice plans that use fee-for-service reimbursement. There is no reasonable justification for this duality of accountability standards between the Medicare+Choice and Medicare fee-for-service programs. Medicare+Choice plans using fee-for-service reimbursement or that make capitation payments should be held to the same payment deadlines and policies as apply under the fee-for-service program.

Further, as plans pull out of the Medicare+Choice market, resulting in a significantly more concentrated payer market, there must be checks and balances in place to protect against arbitrary health plan anti-patient actions and to increase quality of care for patients by permitting effective advocacy by their physicians. Physicians increasingly face enormous health plan bureaucracies at the negotiating table, and are thus not in a position to advocate effectively on behalf of their patients. Thus, we strongly urge Congress to pass legislation that would allow self-employed physicians and other health care professionals to engage in joint negotiations with Medicare+Choice plans without violating the antitrust laws.

In addition, we agree with concerns raised by Members of the National Bipartisan Commission on the Future of Medicare about providing HCFA with increased authority to contract for health care services with lowest cost bidders, and believe HCFA's contracting authority should be strictly limited. Such authority often permits HCFA to contract selectively for individual services. Competition should be based on choice of a comprehensive health plan, not with respect to individual services. Proposals that carve out certain services dangerously fail to recognize a crucial dynamic within the health care market. That is, certain services are a mainstay for many providers' economic base. If that base is jeopardized because HCFA has the ability to contract elsewhere for this singular service, the cost of other services offered by that provider will significantly increase, or, worse, the provider may cease to exist due to insolvency. Either alternative is extremely damaging to patients with respect to cost, quality and continuity of care and convenience.

Indeed, AMA policy firmly opposes competitive bidding initiatives for professional medical services with respect to the Medicare program and health care payers generally. First, as discussed above, this type of system threatens a dramatic decrease in quality of and access to medical care. In any bid process, there are always low cost bidders that wish to corner a large share of the market. The low cost bidder may drive competitors out of the market, in which case the bidder will obtain a monopoly and will be free to set prices in an environment that is unconstrained by competition. Since the current health care payer market has become more significantly concentrated, as discussed above, this result would be a significant threat. Additionally, providers, including those that provide the highest quality of care

using new state-of-the-art technology, will have a strong incentive to provide less costly and lower quality alternatives to maintain competitiveness within a competitive bidding environment. Further, there have been cases when the competitive bidding process has resulted in the procurement of services from organizations that have gone bankrupt, thereby disrupting continuity of and access to care, as well as causing harm to physicians and other providers who rely on a failed contractor for payment. This would be even more damaging if competitors have already been driven from the market.

Finally, the AMA is aware that there is interest among a number of states in allowing them to make managed care enrollment mandatory for dually-eligible Medicare and Medicaid beneficiaries. State medical societies have told us of numerous serious problems in states with mandated Medicaid managed care programs for their non-Medicare populations, including Tennessee, Kentucky, Massachusetts, Florida, Nebraska, Washington, and others. Given the current instability within both Medicare and Medicaid managed care plans, we urge Congress not to extend the states' authority to mandate managed care enrollment to their dually-eligible populations.

CONCLUSION

The tax-based method of financing Medicare originally envisioned is no longer sustainable. Putting Medicare on sound financial footing requires a multi-faceted transformation of the program's funding, actuarial design, and incentive structure, as outlined above. We urge this Committee and Congress to consider these proposals and to act now to fulfill the promise of health care for the elderly in this country.

We appreciate the efforts of the members of this Committee to explore approaches to Medicare reform, and also appreciate the opportunity to present our reform proposal. We are prepared to engage fully in detailed discussions with this Committee and Congress as we work to find a common solution.

PREPARED STATEMEN OF CHRISTINE FERGUSON

Good morning, Mr. Chairman, and members of the Committee. Thank you for inviting me to testify on the significance to the Medicaid program of developing solutions for the long-term survival of the Medicare program.

In my current position, as Director of the Rhode Island Department of Human Services, I am responsible for the State's largest Department accounting for 30% of the State budget. This includes about 66% of all Medicaid expenditures, and the designation as the single state agency for Medicaid.

I have been in this role since 1995, prior to this I had the privilege to work for Senator Chafee, and with many of you, working through many versions of long-term care reform, catastrophic health insurance, health care reform, as well as in helping shape the Medicaid and Medicare programs through TEFRA, DEFRA, COBRA and countless other omnibus budget reconciliation Acts.

Although the discussions during all of these initiatives acknowledged the patchwork nature of our health care system and the confusion of consumers, I did not truly understand the impact of that fragmentation until working at the State level.

At the Federal policy level, we tend to compartmentalize programs; in fact, some of you may have one staff member who is responsible for Medicare, another responsible for Medicaid and yet another responsible for Social Security and another for the budget.

In the Senate and House there are at least eight Committees with jurisdiction over these programs: Senate Finance; Health, Education, Labor and Pensions; Budget; House Commerce, and Ways and Means to name a few.

The same is true at the Federal agency level. At the Department of Health and Human Services, within the HCFA alone, there are separate Centers which work on Medicare, Medicaid and State Operations, and areas that handle Medicaid waivers, legislation and regulation and strategic planning. The Office of Management and Budget is also compartmentalized in accordance with distinctive program areas.

At the State level we have our own ways of dividing program areas. For instance, many different agencies within the State of Rhode Island house a portion of the State match for Medicaid. In addition there are separate agencies, Business and Insurance Regulation and the Department of Health, that regulate the private plans that offer Medicare HMOs. And of course we have our own Budget office and Legislature.

As a result, when one finally gets down to trying to help an individual consumer or family, one is faced with what appears to be an extraordinary complex, some-

times down right stupid, maze of bureaucracy that lacks compassion and concern for the individual. All traits that give government a black eye.

Current way of doing business: The stream of unintended consequences

Medicare and Medicaid have separate administration and financing, yet often share in the delivery of health and social services to high-cost chronically ill elderly and disabled individuals. Together they have an enormous impact on our health care delivery system as well as on the private sector insurance market. The incremental development of these two programs has created many distortions and inefficiencies in providing care to individuals who qualify for both programs, as well as in the delivery system as a whole.

In order to access the full range of care that is necessary, a beneficiary must deal with two very different public systems, as well as private insurance, all with a myriad of complex and often incompatible policies and rules, which have presented numerous clinical, operational, and financial problems. These program characteristics lead to cost shifting between the states and the federal government, gaming on the part of some providers and insurers, and fragmentation of care and services for the beneficiary.

Here are a few case studies my staff was able to document on short notice:

- Mr. N is a 71–year-old male veteran who lives with his 71–year-old wife. Both are enrolled in Medicaid and Medicare. They live in a second floor apartment in the city of Cranston. Mr. N's doctor is located in Providence. Due to his medical condition his doctor sees him at least once a month. Mr. N can not walk up the stairs in his apartment and his wife is unable to assist him. Without the transportation services provided under Medicaid, Mr. N would not be able to visit his doctor. His condition would worsen and he would require frequent hospitalization for which Medicare would pay. There is no coordination of the benefits between the programs and Medicaid receives no credit for saving Medicare costs.
- Mrs. S is an aged patient who occasionally receives home health care under Medicare for an acute infection requiring intravenous antibiotics. Medicare does not reimburse for the medication being infused. Prior to her spending down and becoming Medicaid eligible, Mrs. S. would receive her therapy either in a hospital setting or a skilled nursing facility. Now that she is on Medicaid, her infusion medication is reimbursed and can be administered in her home. By providing her therapy in her home, the costs to Medicare are lowered and providing her therapy in her home enhances Mrs. S clinical outcomes enhanced since there is a decrease in the risk of further infection from institutional pathogens. No recognition is given of the increased Medicaid costs, which have lowered Medicare expenditures.
- Sheila, now age 41, was an administrative assistant at a legal firm when she developed a sudden onset of Multiple Sclerosis that caused full blindness and quadriplegia. Under a Medicaid waiver, Sheila, receives personal care assistance and obtains needed durable medical equipment. Sheila panicked when she was notified that she would be going on Medicare, because she feared that she would have difficulty obtaining durable medical equipment from vendors due to the problems that vendors have with billing for dual eligible services under our system today. Medicaid policy requires that Medicare process its payments before Medicaid reimburses for service. Specialized wheelchair services are a concern to Sheila. Many providers will no longer provide these items and those who do have to wait weeks before Medicare pays. Rhode Island has thought about seeking a waiver from the Medicaid cost avoidance requirements and to develop a pay and chase process, but Rhode Island's request for a provider number to bill for DME services was denied by the fiscal intermediary.
- Lou is a 39–year-old man who had been a truck driver. He sustained a spinal cord injury at age 25 that resulted in quadriplegia. Through a Medicaid waiver, he is able to get the personal care services and equipment that enable him to work part time and live at home. Although his Medicare is used for acute medical care, without the support services provided by Medicaid, he would be unable to lead a productive life and would require substantial Federal assistance. Yet, his acute and long-term care needs are not coordinated and the two programs frequently cost shift between each other.
- Primrose is an 86 year old woman who lives alone in a first floor tenement. She has severe rheumatoid arthritis and found herself unable to use the steep stairs to get in and out of the house. For two years she was fully homebound except for emergency trips to the hospital via ambulance and paid for by Medicare. She now has a modular ramp that she can use independently as the result of Medicaid funding and is able to get in and out of her house. Primrose is now able to access health care less expensively and more appropriately. Medicare reaps the benefit savings, and Medicaid eats the cost.

• Sandra is a 50-year-old woman confined to a wheelchair with progressive multiple sclerosis. On a number of occasions, Sandra receives home care through Medicare. Recently, these home care services came under review by Medicare because she would participate in weekly religious services and other activities and her status of being homebound came under question. Sandra requires assistance to get in and out of bed, to use the toilet and to get in and out of her wheelchair. Fearing that she would lose Medicare funding for these home care services, Sandra applied and was found eligible for Medicaid. Now, when Medicare questions payment for her services, she will be able to continue with her services under the Medicaid program, even though they are more appropriate as Medicare services.

• Mr. H had a heart transplant over three years ago. For the first three years, Mr. H. Medicare paid for his immunosuppressive drugs. But after October 1998 Medicare no longer paid for his medication, since coverage for immunosuppressive drugs is limited to 36 months. Mr. H. continues to need this medication to prevent rejection of his transplanted heart. Mr. H does not have the resources to pay for these drugs himself. He is eligible for Medicaid, only for part of the year, which has been paying for these drugs since October. Medicare will pay for all of the complications resulting from non-use of the drug, but not for the less expensive preventative use of the rejection drug which Medicaid ends up covering.

The fact is that at the very least Medicare Part A, Medicare Part B, Medicaid and private health insurers are inextricably intertwined. There are numerous other Federal and State programs that also affect the above, but for today I will only focus on those I have outlined.

On a less individual basis, the best example of the interaction between Medicare and Medicaid is the change in the Medicare home health benefit that was put into effect with the passage of the Balanced Budget Act of 1997. The full impact of which is only now being felt.

In Rhode Island, as a result of the change, Medicare beneficiaries are receiving fewer services and Medicaid is frequently picking up the slack. But there has also been a widespread decrease in access to home care services for all Medicaid recipients and private pay patients due to limited capacity and forced closures of home health agencies.

We believe, but can't yet prove, that the result has been an increase in the number of hospitalizations, as well as an increasing number of individuals with disabilities and the elderly at risk of long-term institutionalization.

Another broad-based example of the interconnectedness of these two programs is those eligible for both Medicare and Medicaid called the "dually eligible."

I know that Governor Cellucci testified before this Committee last week about the cost of those who are "dually eligible." However, I do believe that it is important to reemphasize that a disproportionate share of the Medicare spending growth is due to the six million people who are eligible for both programs. As Governor Cellucci stated in his testimony, "Medicare and Medicaid spend about the same amount for the dually eligible beneficiaries. In 1997, Medicare spending for dually eligible beneficiaries totaled $62 billion. That same year, Medicaid spending for this population totaled $58 billion." On the Medicare side, this accounts for thirty percent of all spending for only fifteen percent of the beneficiaries. For Medicaid, sixteen percent of the Medicaid recipients account for thirty-five percent of expenditures.

As restructuring of the Medicare moves forward the impact on the dually eligible will be profound. States will be put in the position of having to decide whether to continue to make up the difference or to cut back on coverage.

Medicare cannot control the cost of this population unless Medicaid funded services are used to lower Medicare's acute care costs. Medicaid cannot manage and coordinate care for the elderly and disabled unless the states are given responsibility, in all or in part, for the full continuum of care. Finding a means to effectively manage the dually eligible is essential if we are going to reduce costs in both programs. Few incentives exist to keep costs down or provide for a balanced deliyery of services as individuals move between the two programs.

For example, because the two payers offering distinct yet overlapping benefit packages to the same consumer much confusion exists for all parties. It is often impossible for states to know what service decisions, which ultimately tap Medicaid funding, are being made while the beneficiary is in the Medicare system. Another inefficiency in the system is the dual administration of claim payments. The major reason for this problem is because Medicare and Medicaid claims processing systems are not compatible and their respective payment policies differ.

Coordinated Systems of Care, Informed Consumer Choice, and Partnerships Between the Public and Private Health Care Programs: The Land of OZ or A Reality?

The compartmentalized nature of the administration of these programs is typical of the middle 20th century hierarchical management structure. If we were to approach this issue as a restructuring exercise using modern management techniques, the first step would be to bring line staff and leadership together and develop a clear statement of purpose on vision and mission. My guess is if you were to do this today, you would receive conflicting statements from OMB, HCFA Medicare, HCFA Medicaid and States about their respective missions and goals regarding these programs.

When a clearly stated and understood mission was agreed upon, identifying top priority results would be the next step that would move the State and Federal bureaucracies closer to achieving the goals they articulate for the populations served. Benchmarks that could be used to determine when those results had been achieved would then be designed.

Without some effort to clearly articulate our shared purpose and desired results of these programs, the future we all face is continued frustration, increased costs and lower health outcomes. There is no question that it can be done . . . and when it is done, wonderful results will begin to materialize. In Attachment #1 to this testimony, you can find a summary of the Long-Term Care Shared Vision process spearheaded in Rhode Island which begins to get all of our stakeholders to reach a consensus on purpose and goals for an improved long-term care delivery system.

In order to achieve this we must also recognize the importance of analyzing new data resources. We should not continue to make decisions based on projections and "guess-timates" rather than reality. I would like to highlight for you a few initiatives that we in Rhode Island are involved with that, for the first time, scrutinize data from various sources to determine what is happening to the populations the Medicare and Medicaid programs serve.

New England States Consortium

In 1995, the commissioners of Health and Human Services from the six New England States (CT, ME, MA, NH, RI, and VT) met to discuss the federal legislation that ultimately became the BBA of 1997. We quickly decided to focus on dually eligible beneficiaries and to share our research, policy analysis, and program development resources. Care for this group was thought to be significantly fragmented and filled with perverse incentives to use institutional services, making the group a logical target for improved services. Furthermore, dually eligible beneficiaries represented the single most expensive subpopulation in the Medicaid program.

The relationship was formalized with a memorandum of understanding creating the New England States Consortium in January 1997. By January 1998, the Consortium as a whole and as individual States was awarded a Robert Wood Johnson grant from the Medicare/Medicaid Integration Project.

As planning began on our initiatives, it became evident that each State would be seriously limited in our analysis if only Medicaid eligibility and claims data was to be considered. In order to analyze the relationship between the programs of acute and long-term care, at the care-delivery level, we needed Medicare data at the beneficiary level. An effort to create person-level linked Medicare-Medicaid files was established. To date four States, (CT, ME, MA, and NH) have at least two years' worth of linked data. Due to factors such as Y2–K, HCFA's reorganization and conflicting divisional management objectives, Rhode Island is still awaiting accurate Medicare data to link with our Medicaid data.

Working collaboratively to compile and analyze linked data, the New England States have already learned much about the pattern and cost of Medicaid and Medicare services used by the dually eligible beneficiaries in the region. By finally looking at the combined information on individuals, we can: (1) support the development of programs that provide dually eligible individuals with the appropriate care at the appropriate time; (2) prevent the progression of disability or chronic disease; (3) manage overall public (Medicare and Medicaid) costs and most importantly (4) make the lines between the programs invisible to beneficiaries.

By developing multi-year files over time and supplementing the linked data with assessments and other State information in the future, applications of the data will be expanded to include identification of beneficiaries at risk, examination of care patterns for signs of true integration, development of quality—oversight systems that address the combined impact of Medicare and Medicaid, and development of more sophisticated payment systems. These applications require longitudinal files, demanding sustained effort, interest and attention on the part of State, HCFA, foundations, researchers and other interested parties. (See Attachment #2 for Data Charts)

Rhode Island Governor's Advisory Council on Health (GACH)

Rhode Island taxpayers were spending over $1 billion on health care and related services provided directly by the State, and consumers, and another $3–$4 billion on services in the medical marketplace. We did not have a solid and mutually agreed upon approach for monitoring the impact of the rapid changes occurring in our health care marketplace. Without a common knowledge base to guide State policy makers, we found ourselves in highly emotional, highly political disputes over which policies will advance "the greater good."

Before committing to dramatic interventions, Governor Almond wanted to enhance our mutual understanding of how market pressures are affecting the health care industry, how the industry is responding, and which strategies are likely to meet with success while at the same time contribute positively to the State's economy as a whole. This challenging environment made it ever more imperative that the State-government actively solicit the knowledge and insights of the private sector and academic communities.

To create a vehicle for doing so, Governor Almond established and chairs an Advisory Council on Health Care. (GACH). The Council's charge is to: (1) provide the Governor and the Legislature with systematic information about the changes occurring in the health care marketplace and the public policy issues they raise; (2) examine the implications of the changing market for the health and economic prosperity of the State; and (3) provide an expert forum for the consideration and discussion of a wide-range of health care issues, including the projected impact of state actions or decisions on the health care marketplace. I have included with my testimony the first summary GACH report that has been released. The full report can be found on the Governor's Web-site.

RWJF: Medicare and Medicaid Integration Project (MMIP)

The purpose of MMIP is to end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. States are being provided with both grant funding from the RWJF and technical assistance from the University of Maryland, Center on Aging as they begin to restructure the way in which they finance and deliver acute and long-term care benefits in order to provide better services to the population dually eligible for both programs.

The current grantee states include Colorado, Florida, Minnesota, the New England States Consortium, Texas, Virginia and Washington. Each of the grantees believes that this approach is a thoughtful way to address the highest cost cases in both programs. By replacing the fragmented, costly and inefficient system of today with an integrated managed care approach we will not only lower the costs for both public programs but also provide the appropriate care at the appropriate time for all beneficiaries.

This project has evolved into the beginnings of a true partnership between the States' and the Department of Health and Human Services, HCFA Central and Regional offices and increasingly a partnership between the public and private sectors. The expectation of the States involved is that joint responsibility for the projects will include the planning and evaluation of the project, which includes the establishment of all contracting requirements including, but not limited to, quality standards. Individuals qualifying for both programs would have the option to join in this state/federal partnership to receive case-managed care which would provide them a full continuum of acute, long-term, and preventative services designed to meet their individual needs.

(See Attachment #3 for MMIP Grantee recommendations)

Recommendations and conclusion

I. Re-examine the implementation of the Home Health Care changes in the BBA

At a minimum repeal the fall back provision which would cut reimbursement by another 15% in the event that HCFA fails to implement the prospective system on time. It would be even better to develop a formula that does not continue to penalize providers who have been cost-efficient in providing high quality care. We want to ensure that people remain in the community and in their home as long as possible. The current reimbursement structure for home health care will relegate high cost chronic care patients to permanent residence in hospitals or nursing homes, or to fend for themselves an outcome I know none of you intended.

II. Enact the technical revisions, submitted today, to the Social Security Act to streamline programs for the dually eligible Beneficiaries

You would expect that by spending an average of $20,000 a year per beneficiary, we would be providing each beneficiary a top-notch health and social service system.

Unfortunately, since HCFA and the states separately administer the Medicare and Medicaid, program rules are often inconsistent and create perverse incentives to use expensive institutional care, and to shift costs from one program to the other. Statutory authority for programs that try to coordinate or integrate services and benefits offered by both programs is unclear at best and, at worst, creates significant barriers to innovation.

In Attachment #4, to this written testimony are proposed revisions to the Social Security Act that I believe provide clear, flexible and complimentary authority in both the Medicare and Medicaid titles of the Act, providing a flexible approach that can accommodate the numerous program models currently under discussion across States. Staff from the various MMIP grantee states, UMCA, and Muskie School of Public Policy worked collaboratively to develop the document.

III. Provide clear HCFA authority to allow States to participate in the recently enacted Medicare Coordinated Care Demonstration

It is imperative that HCFA allows participation by States, who are working towards coordination of the Medicare and Medicaid programs, in the BBA's authorized Medicare Coordinated Care Demonstration.

As the federal government continues to expand its role as purchaser of managed care plans, for the elderly and the disabled, it must not forget to address the following concerns. First, how can we provide coordinated care for beneficiaries who decide to stay in the current fee-for-service Medicare program? Secondly, how can we provide coordinated care to Medicare beneficiaries who are also eligible for Medicaid, commonly called "dually eligible"?

Using the 1115 Waiver process, many states have now become the purchaser of managed care plans for their Medicaid population. Through the contracting process, many states have been setting standards and providing incentives for plans to provide quality health care to Medicaid enrollees.

Many chronically ill Medicare beneficiaries remain concerned about selecting a managed care health plan and choose to remain in traditional fee-for-service Medicare. Medicare can incorporate cost-effective case management into the traditional program and achieve better health outcomes. Involved thoughtful case management with State assistance would allow a tremendous opportunity for better care and outcomes.

If intent of the Care Coordination Demonstration is to emulate, in the Medicare program, the cost savings found by private fee-for-service health plans by incorporating case management into fee-for-service Medicare. Many private sector fee-for-service health plans and States like Rhode Island have begun to provide case management on a voluntary basis to individuals with chronic or catastrophic illnesses. These programs offer greater flexibility in the array of services needed, on a case by case basis, and have been proven to be very cost effective.

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates services to meet an individuals needs through communication and available resources to promote quality, cost effective health outcomes. I, along with my colleagues in the New England Consortium, am working with the HCFA contractor to include States working to coordinate the Medicare and Medicaid programs to be part of these demonstrations. Together we should be able to determine the best-cost effective case management system for the current fee-for-service Medicare program.

Conclusion

As the only Committee in Congress that has jurisdiction for both the Medicare and Medicaid programs you are uniquely positioned to address the coordination of the programs in order to better serve seniors and individuals with disabilities in this country.

This is a historic opportunity for the members of the Senate Finance Committee to take the Medicaid and Medicare programs and reshape them to coordinate beneficiary services not only with each other, but also with the private insurance market.

This is the time to stop the cost shifting between programs which ultimately results in increasing costs to the federal and state governments and the taxpayers and, more importantly poor health outcomes for the elderly and individuals with disabilities.

Thank you again for inviting me to testify today. I will be happy to answer any questions that you may have.

ATTACHMENT 1

Shared Vision

Working Together 1999

THE VISION

Rhode Islanders will have a dynamic LTC system that supports high quality, independence, choice, and coordination of services with the necessary public and private funding.

HIGH LEVERAGE RESULTS
("Must Have" to accomplish Visions)

1. There is an understandable, easily accessible, coordinated delivery system* that is driven by individual assessments and sound case management and within which the supply of services is based on consumer choice and needs.

   * Delivery system in this context means direct care - home health providers, physicians, nursing homes, hospitals, assisted living, etc.

2. There is a financial system that provides the reimbursement necessary to support the development and maintenance of a necessary supply of quality services based on acuity, quality incentives, outcomes and consumer satisfaction with innovative use of all funding.

3. Long term care is a political hot button issue through 2003 and beyond.

4. There is a LTC Management information system that collects, compiles and disseminates accurate information from multiple data sources and encompasses quality measures, service delivery, demographic and financial data, and consumer satisfaction and provider performance measures in order to support ongoing improvement in the LTC system. This information respects confidentiality and is periodically published, available for the general public, and will be user friendly.

5. There is a continuously evaluated uniform set of quality principles, measurements, and improvement goals that tracks consumer outcomes and progress along the long term care continuum.

6. There is an integrated I & R network that is culturally sensitive and accessible with multi-language capability including: An interagency /consumer/provider consortium that develops, monitors, evaluates, and oversees the network; accurate, standardized information and terms; universal procedures (including a series of exploratory questions); a data bank; well trained workers; linkage with community service providers; client centered (humanistic orientation); provide a process to identify needs with the consumer, including office and home visits as necessary; standardized follow up procedures; easily accessed by computer; available access after traditional business hours.

1. Delivery System

There is an understandable, easily accessible, coordinated delivery system* that is driven by individual assessments and sound case-management and within which the supply of services is based on consumer choice and needs.
**** Delivery System in this context means direct care: home health providers, physicians, nursing homes, assisted living etc.....***

Action Step	Responsibility	Date Due
1.Inventory Delivery System(s)	Delivery System group using data gathered by AGING 2000 and solicitation of data from other sources such as Home & Community Advisory Group, Senate Committee on Transportation, etc. Work group to pursue funding source for additional data gathering i.e. Surveys, focus groups	11/30/98 - Aging 2000 to submit compilation to Steering Comm.
1.1. ID components of delivery systems		
1.2. Assess quantity/volume of supply (consider geographic, socioeconomic, other access dimensions).		
1.3. Assess quantity/volume of demand (use market, epidemiologic, severity bases).		
1.4. Inventory physical/capital assets, personnel/volunteers, etc.		
2. Research measures for determining supply requirements	Aging 2000 for Delivery System Group	11/30/98
3. Analyze adequacy of current supply of long term care services	Delivery System Work Group	3/31/99
3.1. Conduct current benefits analysis	DHS Staff	12/15/98
3.2. Identify barriers to accessing care	Delivery System Workgroup	3/31/99

Action Step	Responsibility	Date Due
4. Conduct resource gap analysis (to include funding and infrastructure - human and capital)	Joint Delivery System/Finance Work Groups	3/1/99
5. ID "administrative" or "process" impediments to consumer access	Delivery System Work Group	3/31/99
6. Research and select or invent yardsticks (benchmarks) for selected administrative functions, i.e discharge planning process, client processing times	Delivery System Work Group	12/31/99
7. Propose organizational structure which will sustain a consumer-driven, community-based, LTC system	Delivery System Work Group	12/31/99
8. Adopt & implement a standardized assessment process which ensures capacity for outcomes measurement, uniform costing methodology, and consumer-centered case management	Ongoing interagency group - DEA, DHS, DOH, MHRH & LTCCC	12/31/99
9. Develop a case-management network which is accessible to all LTC users and their families, without regard to income, age, or other categorical criteria. This CM network will include and/or connect program eligibility determinations, functional health and mental health assessments, care planning and coordination, and health plan coordination.	Delivery System Work Group	6/30/2000
9.1 Assessment/inventory of existing case management capacity	Delivery System Work Group Subcommittee	6/30/99

2. Financial System

There is a financial system that provides the reimbursement necessary to support the development and maintenance of a necessary supply of quality services based on acuity, quality incentives, outcomes and consumer satisfaction with innovative use of all funding.

Action Step	Responsibility	Date Due
1. Obtain Information	GACH and Administration Department Reports (else where if necessary)	1/99
Legislative & Administrative Options	Finance Committee	1/99
Existing Base line LTC budget: $$$	GACH & LTCCC	1/99
Population profile & Projections	GACH	1/99
Other Information	Finance Committee	1/99
Current reimbursement methodologies by payor	Finance Committee / Staff	6/99
Current eligibility for current programs	Finance Committee / Staff DHS	6/99
Dual eligibility - claims utilization information	Finance Committee / Staff DHS	6/99
Utilization of Services by Client	Finance Committee/Staff DHS	6/99
2. Research and ID Financing Options for LTC System (Public & Private)	Finance Committee / Staff	2/99
Potential sources of revenue and disbursement; i.e. benefits	Finance Committee / Staff	2/99
3. Redesign Payment System to Support Delivery System & Finance High Leverage Results	Finance Committee	10/99
ID actual budget for new plan	Finance Committee	1/2000
Select Reimbursement Methods	Finance Committee	10/99
4. Test New Reimbursement Methods	Finance Committee	7/2000
5. Full Implementation New Reimbursement Methods	Finance Committee / Staff	7/2001

3.

Long Term Care is a political hot button issue through 2003 and beyond.

Action Step	Responsibility	Date Due
Create time line reflective of other HLR action plans		
Establish a common agenda and a political action plan by 1998-99 legislative year.		
Develop context in which to build agenda		
Who are stakeholders? Possible contract?		
Establish statewide LTC campaign — create conflicts and tensions		
Schedule forums		
Establish political action group		
Identify common language for materials		
Target political education to high-level policy makers		
State, federal/local		
Identify resources for LTC campaign — human (volunteer) and financial.		

4. LTC Management Information System

There is a LTC Management Information System that collects, compiles and disseminates accurate information from multiple data sources and encompasses quality measures, service delivery, demographic and financial data, and consumer satisfaction and provider performance measures in order to support ongoing improvement in the LTC system. This information respects confidentiality and is periodically published, available for the general public, and will be user friendly.

Action Step	Responsibility	Date Due
Identify and survey data sets, data systems and the capacities existing in the communities	System Workgroup	4/99
Define funding sources	System Workgroup	2/99
Define barriers to attaining goals	System Workgroup	4/99
Hire Consultant	?	6/99
Define data elements	System Workgroup	9/99
Define what measurable outcomes are to be collected	Quality Workgroup	?
Define system design	Consultant	12/99
Establish skills, equipment, and language needed	Consultant	12/99
Identify additional resources	Consultant	12/99
Define procurement process	System Workgroup	2/00
Purchase hardware/software	?	5/00
Develop training program: staff, public, stakeholders	I & R Consortium	3/01
Develop web site	?	3/01
Market to the public	I & R consortium	3/01
Implement System	?	3/01

5. Quality

There is a continuously evaluated a uniform set of quality principles, measurements, and improvement goals that tracks consumer outcomes and progress along the long term care continuum.

Action Step	Responsibility	Date Due
Gathering Information		
Identify consumer input	Aging 2000	12/98
Identify global LTC needs of consumers	Work Group	8/99
Assemble glossary of terms	Quality Group	4/99
Identify glossary of terms	Quality Group	4/99
Identify all currently used data elements	Quality Group	8/99
Identify all sources of data	Quality Group	8/99
Identify existing consumer satisfaction measures	Aging 2000	12/98
Identify existing deficiency correction mechanisms	Quality Group	8/99
Identify existing outcome measures	Quality Group	4/99
Identify existing principles of quality systems	Aging 2000	1/99
Identify existing provider qualifications	Quality Group	3/99
Identify existing standards of care	Quality Group	3/99
Identify existing systems of appeal	Quality Group	3/99
Identify guidelines of practice	Quality Group	3/99
Identify other needed input (i.e. transportation & housing)	Delivery Group	8/99
Survey best practices	Quality Group	6/99

Designing System		
Define & develop consumer information & education effort	Aging 2000	8/99
Define applications for quality data	Quality Group	8/99
Define how data is communicated	Quality Group	8/99
Define necessary legislative actions	Quality Group	8/99
Define quality improvement expectations	Quality Group	8/99
Define quality monitoring approaches	Quality Group	8/99
Design consumer tracking system	Quality Group	8/99
Develop consumer satisfaction survey	Quality Group	8/99
Develop measurement of whether assessment is effective	Quality Group	8/99
Develop provider report card	Quality Group	8/99
Develop system for continuous evaluation	Quality Group	8/99
Establish certifications at all levels	Quality Group	8/99
Establish consistent policy of required provider qualifications	Quality Group	8/99
Establish consistent system of appeal	Quality Group	8/99
Establish principles for new quality system	Quality Group	8/99
Establish standards for consumer choice	Quality Group	8/99
Establish standards of care	Quality Group	8/99
Establish system of correcting deficiencies	Quality Group	8/99
Establish uniform system of outcome measures	Quality Group	8/99
Establish implementation time line	Quality Group	8/99

Continuous Evaluation		
Establish measurement of whether system meets holistic consumer needs	Quality Group	10/99
Investigate relationship between assessment & admission to services	Quality Group	10/99
Investigate relationship between quality outcomes & incentives	Quality Group	10/99

The group identified these indicators in no particular order. Some conversation ensued on how findings of specific indicators would have to be integrated with other findings to provide a comprehensive provider rating (i.e. one provider may show great effectiveness with a much lower staffing ration than another).

In addition, it would be impossible to have one rating system for all provides along the continuum of care. Rather, the group seemed in agreement that there would be different standards of measuring quality for different types of settings (i.e. Home Health Agency vs. Nursing Home).

Action Step	Responsibility	Date Due
Education		
Information (to consumer & care provider)		
Referral		
Access to care and information (24 hour)		
Consumer Choice and Direction		
No Unnecessary Decline in Health		
Appropriate Standards of Care		
Appropriate Staffing levels		
Appeals Process - Timely, Easily Accessed		
Timely Assessment/Intake		
Appropriate Assessment		
Appropriate Assistive Technology/Adaptations Available		
Qualifications/Certification Standards for Case Managers or other Currently Unregulated Providers		
Consumer Tracking System		
Response Time to Request/Need for Services		
Care Plan/Goal Setting - Appropriateness and Consumer or Designee Participation		
Goal Achievement Consistent with Averages/Expectations		
Risk Adjustment to Account for Non-Compliance, "Difficult Client"		
Immunizations/Preventive Services Availability and Utilization		

6. Information & Referral

There is an integrated I & R network that is culturally sensitive and accessible with multi-language capability including: as interagency/consumer/provider consortium that develops, monitors, evaluates, and oversees the network; accurate, standardized information and terms; universal procedures (including a series of exploratory questions); a data bank; well-trained workers; linkage with community service providers; client centered w/humanistic orientation; provide a process to identify needs with the consumer, including office and home visits as necessary; standardized follow-up procedures; easily accessed by computer; available access after traditional business hours.

Action Step	Responsibility	Date Due
Organize an initial consortium meeting	DEA	11/1/98
List of invites, date, time, place to be built utilizing the 12 member network established by DEA pursuant to law.		
Membership: 1 representative from each of the following: DEA, DHS, MHRH, DOH, Long Term Care Coordinating Council, Subsidized Housing, Senior Center Executive Director, Adult Day Care, Nursing Home, Home & Community Base Care, Alliance for Better Long Term Care, Cross disabilities Council, Alliance for the Mentally Ill, Minority Elder Task Force , Forum of Aging, Alzheimer's Association, Developmental Disabilities Council, CMHC, Disabilities Coalition.		
Two representatives from each of the following: Elderly Consumer, Disabled Consumer & Family Consumer		
*This consortium will be convened by the RI Department of Elderly Affairs & co-chaired by the DEA representative and consumer representative. This group shall consist of **no more than 25 members**, reflecting the state's cultural diversity.		
Format universal procedures and standardized, accurate information	DEA/Consortium	3/99
Consortium Agreement (MOU)	DEA/Consortium	3/99
Training of I & R Workforce	DEA/Consortium	3/99 — ongoing

Action Step	Responsibility	Date Due
Recruit and include agencies providing or interested in providing I & R services		1/99 - ongoing
Protocols, etc., develop initial curriculum and mechanism for periodic updating & retraining		3/99 - ongoing
Train workforce with capability to respond to I & R request with a person-to-person interview, either home or office, which would identify issues and needs with the consumer		6/99 - ongoing
Linkage to Community Services	DEA	ongoing
Identify community location	DEA / Consortium	2/99 - ongoing
Insure required updating / computer linkage		2/99 - ongoing
Schedule of visits by I & R workers to community services providers.		6/99 - ongoing

Shared Vision / Working Together

Long Term Care (LTC) Reform

Rhode Island

Actions---prior to 1997

RI Long Term Care Coordinating Council (LTCCC) develops 1995-2000 RI Long Term Care Plan

Minnesota Study reports RI Home and Community-Based Services receive state low of 7% Medicaid funding

New England AARP State Legislative Committees gather in New Hampshire for a conference on consumer monitoring of DHS (NE Consortium) directors contemplating a joint dual eligible waiver-----December, 1996

RI AARP creates a seven member LTC Taskforce to monitor RI dual eligible activities

Efforts of RI LTCCC result in state law mandating RI Directors of Health, Human Services, Elderly Affairs, and Mental Health, Retardation and Hospitals to jointly develop a RI LTC Plan and five year budget

1997

AARP Taskforce begin regular meetings with DHS director and key staff

AARP forms 15 member Senior Long Term Care Action Coalition (Senior Coalition), all appointed by the RI Advisory Commission on Aging, the RI Forum on Aging, and the RI AARP

The State Administration forms an Administration LTC Coalition (Administration Coalition) comprised of the four department directors plus representatives of The Office of the Lt. Governor and the Governor's Policy Office

The Administration and Senior Coalitions join in five Educational Meetings, led by the DHS Director and the President of RI AARP

LTC Consumer Values Statement prepared by the Senior Coalition

First Retreat with Senior and Administration Coalitions
(All Retreats posed three questions)

1.——How do we view our RI LTC Syatem?
2.——How would we like it to be?
3.——How do we get there?

1998

Second and Third day long Retreats with Senior and Administration Coalitions

Retreats held between Administration and Home and Community Based Coalitions

Retreats with Nursing Home and Administration Coalitions held

General Assembly unanimously passes Consumer LTC Values Law

Combined Retreat with all Four Coalitions (August 5th and 6th)

(CONSENSUS reached on SHARED VISION PLAN Outline)

(Work implementation Teams Formed—— 1.—Quality, 2.—Delivery, 3.—Finance, 4.—Information and Referal, 5.—Advocacy, and 6.—Information Management)

Shared Vision Steering Committee formed, representative of Four Coalitions

Combined Four Coalition Retreat (October 27th and 28th)

(Reports of Work Implementation Teams)

(Four Coalitions reach consensus on Shared Vision Plan)

(Consensus reached on Budget Priorities for fiscal year 2000)

Work Implementation Teams continue meetings

New England States Consortium

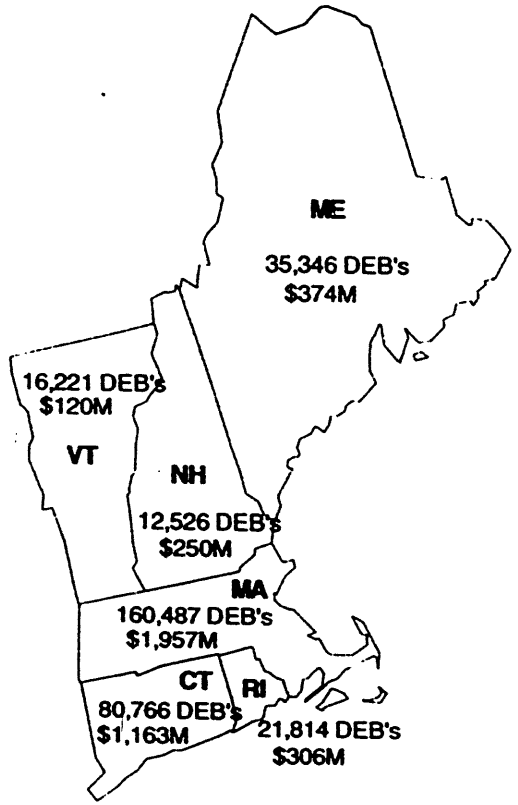
Dually Eligible Beneficiaries in New England

For more information, visit the Consortium's website at www.necconsortium.org, or call the New England States Consortium Coordination Center at (207) 780-4430

Dually Eligible Beneficiaries: Medicaid Data 1994

Figure 1

In 1994, the six New England States had over $4 billion in Medicaid expenses for about 325,000 dually eligible beneficiaries (DEB's).

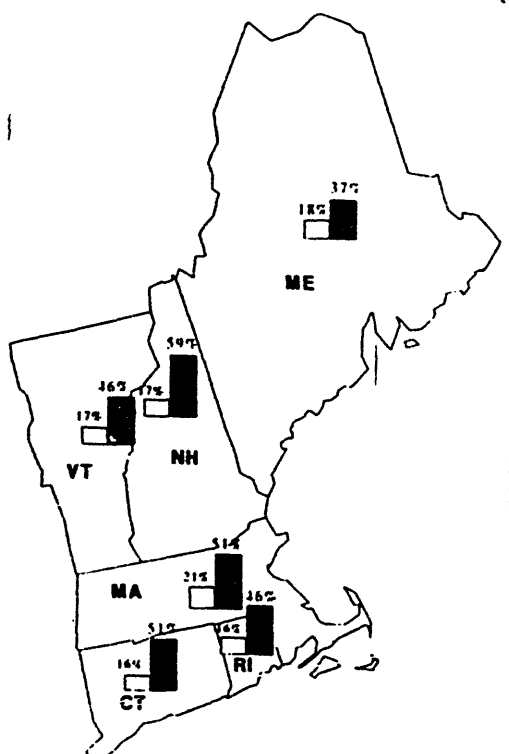


Source: State Medicaid Offices

Dually Eligible Beneficiaries: Medicaid Data 1994

Figure 2

The percent of total State Medicaid costs associated with dually eligible beneficiaries far exceeds the percentage of the total number of Medicaid beneficiaries they represent.

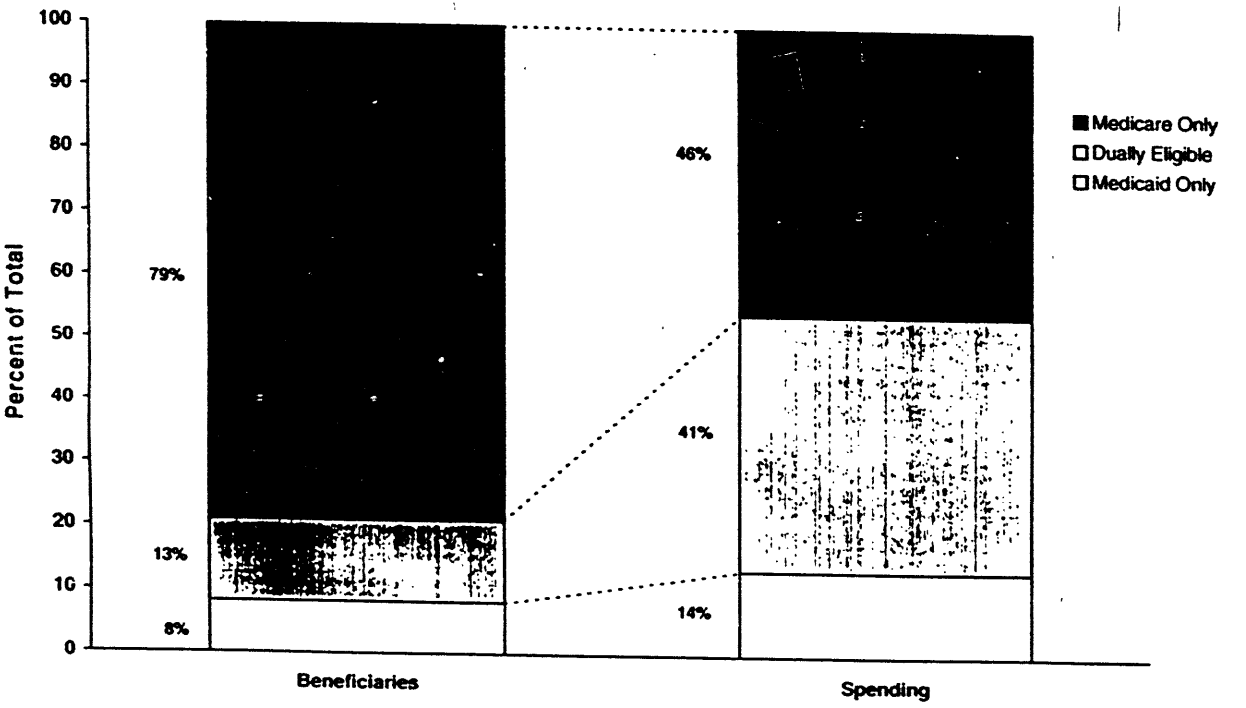


Source: State Medicaid Offices

Dually Eligible Beneficiaries: Linked Data from CT, ME, MA, and NH, 1995

Figure 3

Dually eligible beneficiaries comprise 13% of all elderly and disabled beneficiaries in four New England states, but account for 41% of combined Medicare and Medicaid spending.

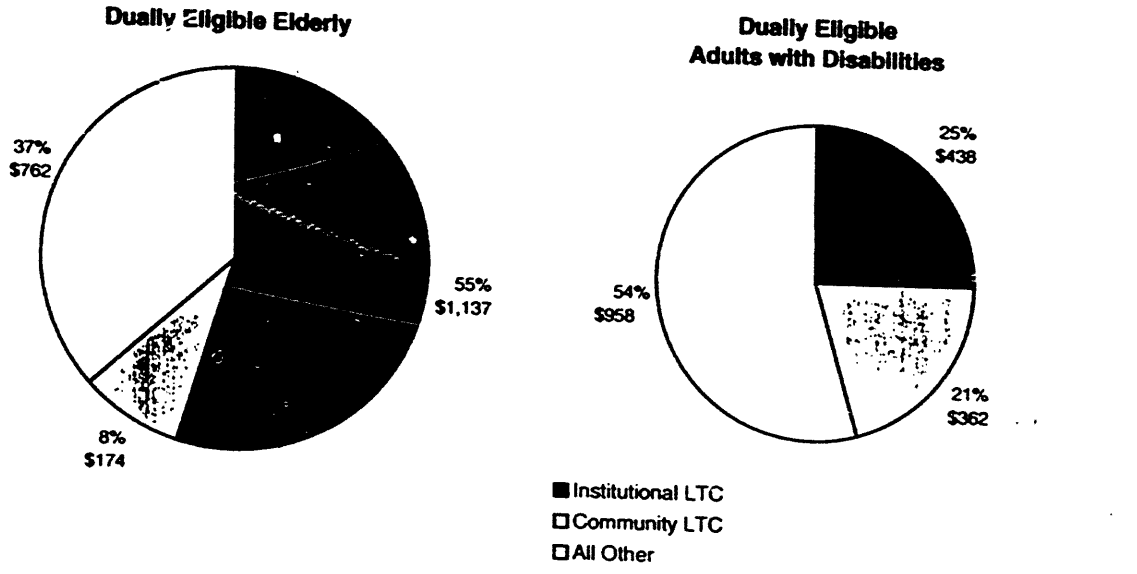


Source Linked Medicare-Medicaid data files in CT, ME, MA & NH

Dually Eligible Beneficiaries: Linked Data from CT, ME, MA, and NH, 1995

Figure 4

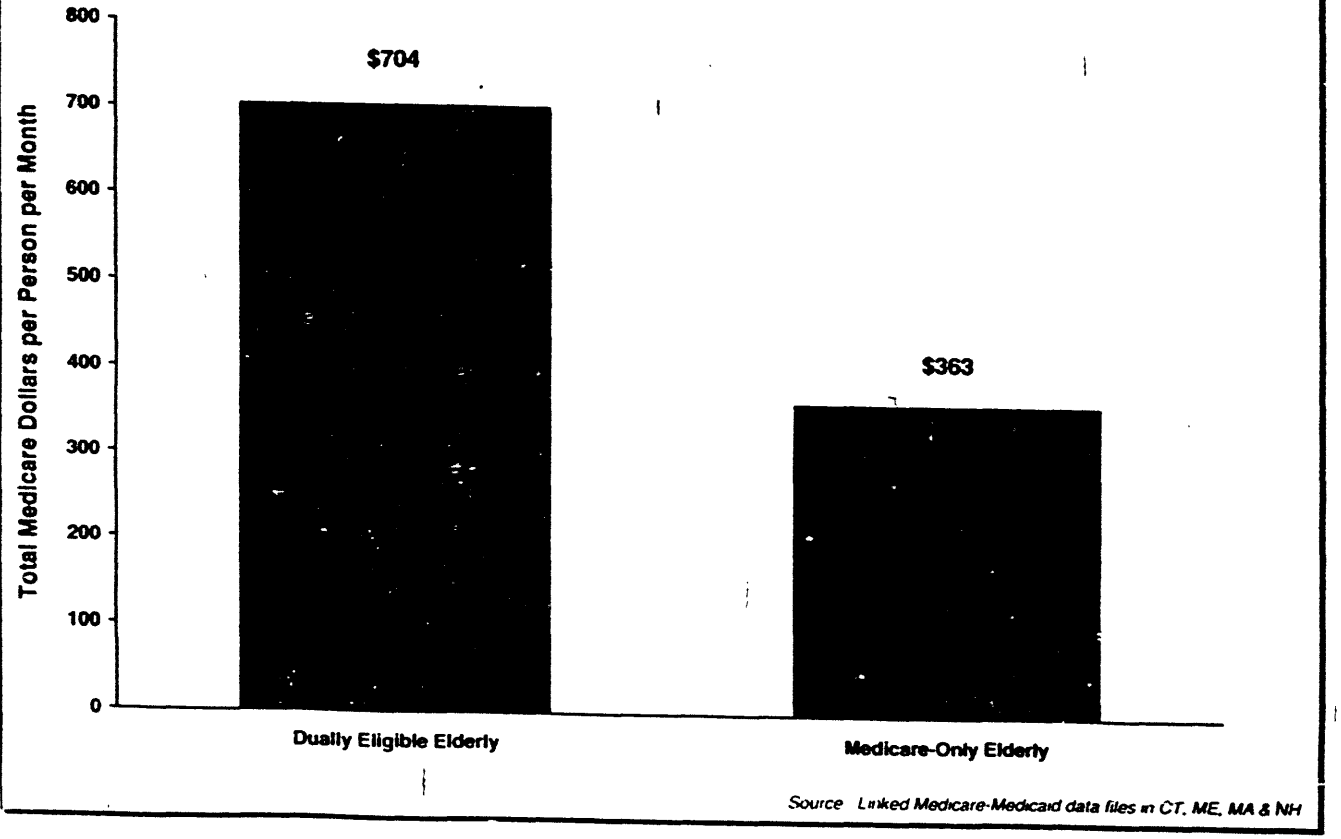
Institutional long-term care accounts for half of the combined Medicare and Medicaid per person per month costs for dually eligible elderly beneficiaries and one-quarter of the combined per person per month costs for dually eligible adults with disabilities.



Source: Linked Medicare-Medicaid data files in CT, ME, MA & NH

Figure 5

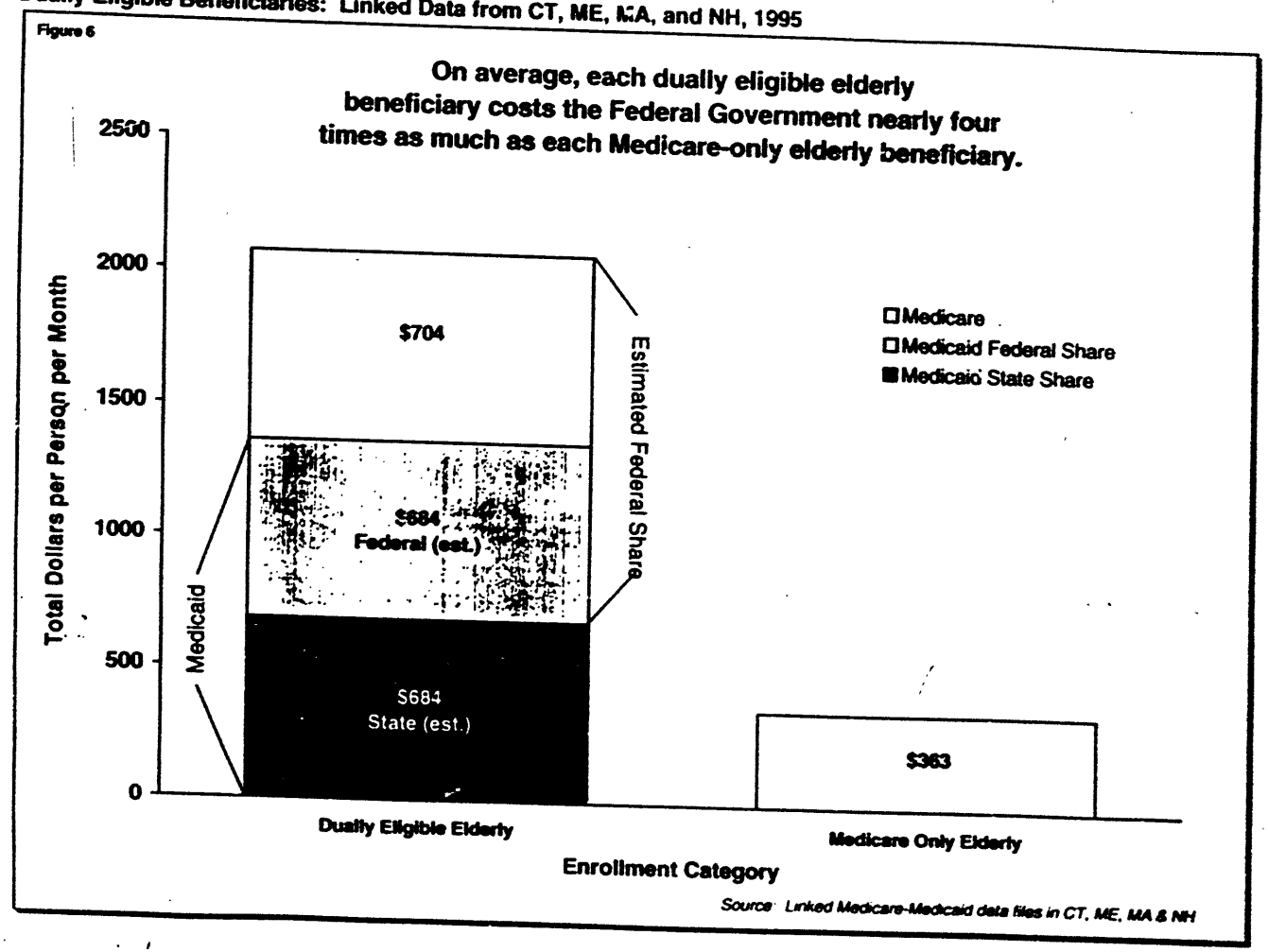
Medicare spends nearly twice as much per dually eligible elderly beneficiary as it spends per Medicare-only elderly beneficiary.



Source Linked Medicare-Medicaid data files in CT, ME, MA & NH

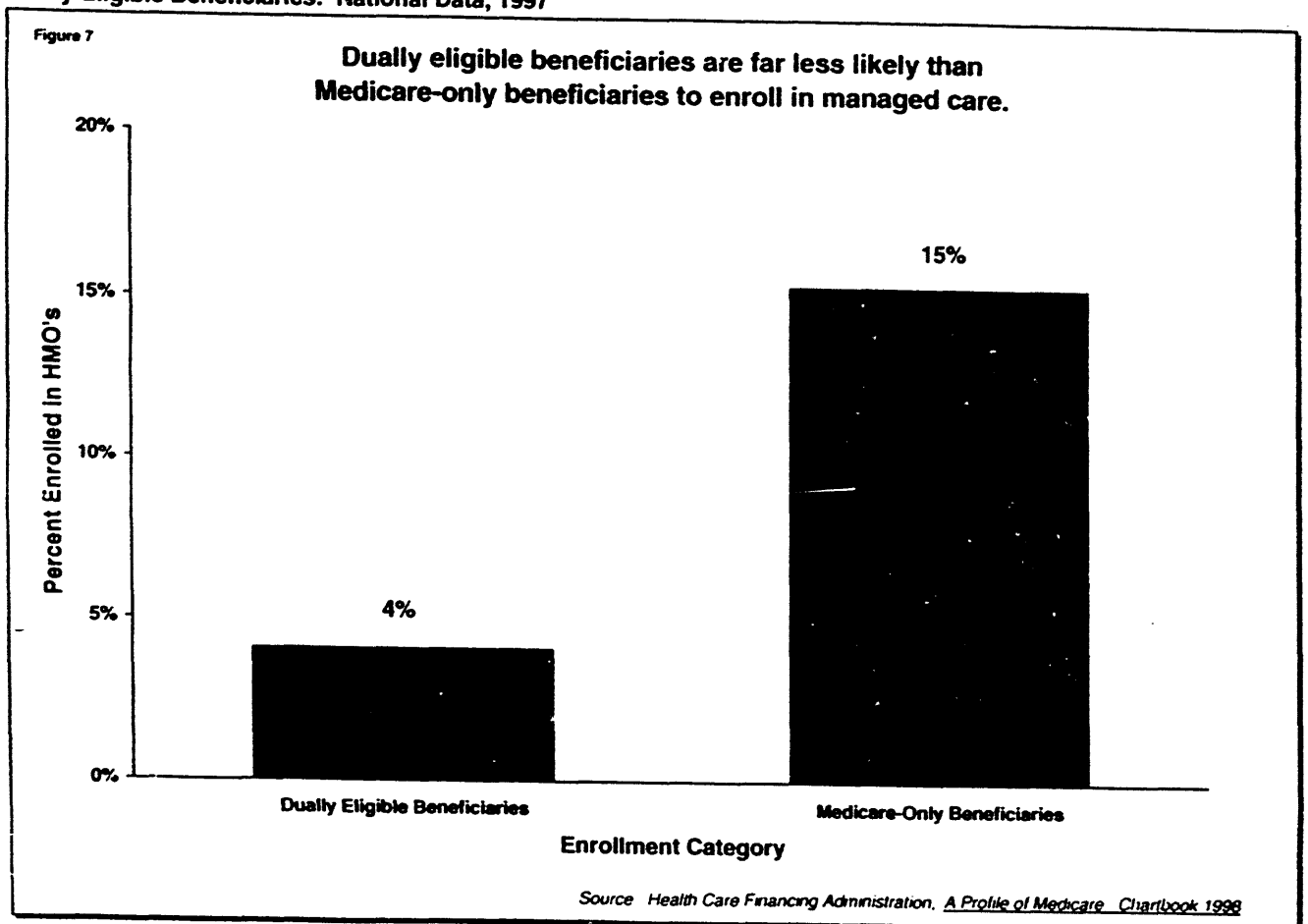
Dually Eligible Beneficiaries: Linked Data from CT, ME, MA, and NH, 1995

Figure 6



Dually Eligible Beneficiaries: National Data, 1997

Figure 7



ATTACHMENT 3

CENTER ON AGING
Medicare/Medicaid Integration Program
UMCA
Director: Mark R. Meiners, Ph.D.
National Program Office
University of Maryland Center on Aging
1240 HHP Building, College Park, MD 20742
Phone (301) 405-1077 Fax (301) 314-2025

March 4, 1999

Dear Colleague:

On behalf of the Robert Wood Johnson Foundation (RWJF) Medicare/Medicaid Integration Program (MMIP) National Program Office, we are pleased to share with you our list of Medicare and Medicaid issues. This list has been compiled by staff from the MMIP grantee states for the purpose of educating and problem solving concerning the key issues that affect the design and implementation of programs for the dual eligible population.

The current grantee states include Colorado, Florida, Minnesota, the New England Consortium (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont), Texas, Virginia and Washington.

The purpose of MMIP is to end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. States are being provided with both grant funding from RWJF and technical assistance from UMCA as they begin to restructure the way in which they finance and deliver acute and long-term care benefits in order to provide better services to the population dually eligible for both Medicare and Medicaid.

For further information, please contact Margaret Schulte at (301) 405-0252.

Sincerely,

Mark R. Meiners

Mark R. Meiners, Ph.D.

The Medicare/Medicaid Integration Program is a national initiative supported in part by The Robert Wood Johnson Foundation

Executive Summary of Medicare/Medicaid Issues
Developed by the Medicare/Medicaid Integration Program (MMIP) States
March 1999

I. Financing and Payment

- **Budget Neutrality:** Federal standards for Medicare and Medicaid budget neutrality are forcing states and participating health plans to assume a disproportionate share of the financial risk for waiver programs. The Medicare budget neutrality standard should be based on fee-for-service costs, rather than Medicare capitation rates, and the Medicaid budget neutrality standard should be the Medicaid Upper Payment Limit. In addition, federal budget neutrality should be based on combined Medicare and Medicaid expenditures.

- **Medicare Payment:** Medicare payment methodologies developed for health plans that enroll a large number of beneficiaries are not appropriate for specialized programs targeting specific subgroups of dually eligible beneficiaries. In general, greater flexibility is needed so that Medicare payment methods are sensitive to differences across states and in program design. States must be involved in the development and testing of Medicare risk adjusters that incorporate measures of beneficiary functional status. Furthermore, until such a risk adjuster is developed, states must be allowed to adopt alternative Medicare risk adjustment methodologies on an interim basis.

II. Data and Reporting Requirements

Two major issues have emerged in this area. First, states need ongoing access to Medicare data in order to effectively monitor and improve care for dually eligible beneficiaries. Access to Medicare data has been inconsistent and intermittent. Secondly, demonstration projects should not be subject to Medicare reporting requirements when the standard reports are not designed for the target population and/or are unduly cumbersome for small, innovative programs.

III. Program Design and Implementation

Designing programs for dual eligibles requires coordination across programs that often have competing incentives and objectives. Furthermore, providing services that most effectively meet the needs of this high-risk population requires unique and innovative approaches. There is a need for flexibility and a recognition that universal protocols may not work for the programs serving this population. The specific issues that states are concerned with in the area of program design and implementation are: primary care fragmentation, lack of incentives for voluntary enrollment, need for joint efforts on appropriate quality measures, marketing and Medicare flexibility.

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The Robert Wood Johnson Foundation

IV. Waiver Policy

States have many questions with respect to current waiver policy. Changes in the Balanced Budget Amendment raise issues regarding the appropriate use of and the necessity for various types of Medicaid and Medicare waivers. States seek clarification and guidance from HCFA on various waiver approaches. Additionally, the waiver approval process has become bogged down and has put many projects in jeopardy. The waiver process need to be streamlined and reasonable time frames developed.

V. Develop a Federal-State Partnership Focused on Serving Dual Eligibles

Developing an ongoing relationship between a core set of HCFA staff and states that are designing projects for dual eligibles would help states in the design, development and implementation of these projects. A central focus within HCFA would provide a known point of contact, allowing states to develop relationships early on in the process before important decisions are made. It is important that adequate HCFA resources are devoted to this effort, particularly staff who have the authority to work across Medicare and Medicaid, and that states are given the opportunity to provide input on issues that affect their projects.

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The Robert Wood Johnson Foundation

MEDICARE/MEDICAID ISSUES LIST
Developed by the Medicare/Medicaid Integration Program (MMIP) States
March 1999

Section I. Payment and Financing

A. Budget Neutrality Policies

Federal budget neutrality policies for Medicare and Medicaid are forcing states and participating health plans to assume a disproportionate share of the financial risk for waiver programs. Consequently, they discourage states from developing innovative programs for dually eligible beneficiaries, and discourage health plans and providers from participating in such programs.

- **Medicare Budget Neutrality:** HCFA's own data show that unlike other Medicare beneficiaries, the overwhelming majority of dually eligible beneficiaries will remain in the fee-for-service system in the absence of special initiatives. Therefore, the Medicare budget neutrality standard for initiatives targeting dually eligible beneficiaries should be based on fee-for-service costs, rather than Medicare capitation rates. Using Medicare capitation rates as the baseline restricts state flexibility to propose payment options that would attract quality health plans and providers while also ensuring that Medicare spends less than it would otherwise.

  In addition, the standard for federal budget neutrality should be based on combined Medicare and Medicaid expenditures. Evaluating federal spending for Medicare separately ignores the interaction between Medicare and Medicaid costs, and limits states' flexibility to design cost-effective programs.

- **Medicaid Budget Neutrality:** The cap that HCFA and OMB place on per-beneficiary Medicaid spending under 1115 waivers is inappropriate for demonstrations targeting dually eligible beneficiaries with voluntary enrollment. Because states cannot know in advance which beneficiaries will voluntarily enroll, and because they do not have full control over Medicaid costs for those who remain in the fee-for-service system, a more appropriate standard is the Medicaid Upper Payment Limit. This continues to be an issue, even with the new 1915(a) option, since states may still need to pursue 1115 waivers for other reasons (e.g., if they want to expand eligibility).

B. Medicare Payment Policies

In the push to develop a single, standardized Medicare payment methodology for all capitated providers, more costs and more financial risk may be shifted to states. Payment methodologies developed for health plans that enroll a large number of beneficiaries are not always appropriate for specialized programs targeting specific subgroups of beneficiaries.

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- **Medicare Risk Adjustment:** HCFA's demographic-based and diagnosis-based risk adjusters significantly underpay health plans for frail beneficiaries residing in the community, and result in cost shifting to Medicaid. (This is true even after HCFA added in variables to account for Medicaid eligibility and prior disability status to the risk adjuster they will begin phasing in next year). Elimination of the Medicare institutional adjustor also penalizes projects with large numbers of nursing home residents and reduces incentives to enroll them in managed care. States must be involved in the development and testing of Medicare risk adjusters that incorporate measures of beneficiary functional status. Furthermore, until such a risk adjuster is developed, states must be allowed to adopt alternative Medicare risk adjustment methodologies on an interim basis.

- **Flexible Payment Methods:** A one-size-fits-all approach to Medicare payment is not appropriate for dually eligible beneficiaries, given differences among the 50 state Medicaid programs, differences in program design and target populations (e.g., community v. NF), and differences in other market characteristics. For example, largely rural states and states with low AAPCC rates have difficulty attracting health plans to participate in programs targeting dually eligible beneficiaries, while states with high AAPCC rates worry that blending local and national rates will either drive managed care plans out of the market, or exert pressure on providers to reduce care. Greater flexibility is needed for specialized initiatives so that Medicare payment methods are sensitive to these differences.

Section II. Data and Reporting Requirements

Two major issues have emerged in this area. First, states need ongoing access to Medicare data in order to effectively monitor and improve care for dually eligible beneficiaries. Access to Medicare data has been inconsistent and intermittent. Secondly, demonstration projects should not be subject to Medicare reporting requirements when the standard reports are not designed for the target population and/or are unduly cumbersome for small, innovative programs. Specific data and reporting issues follow.

A. Need For Ongoing State Access to Medicare Claims and Eligibility Data

Over the past several years, HCFA has provided Medicare claims and eligibility files to a growing number of states. The states are using the Medicare data to create linked Medicare-Medicaid claims files for dually eligible beneficiaries. The linked files allow states to study the relationship of Medicare and Medicaid at the beneficiary level for the first time, providing a far superior policy and program planning tool. The files have also been very important in identifying the historical Medicare FFS costs of the target group.

Additional states will want access to Medicare data in the future, and several states that have enjoyed access in the past wish to create longitudinal files for policy research. However, HCFA recently became subject to a legislative mandate to charge all users for

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its data, creating a significant obstacle to continuing collaboration in this area. To provide short-term relief, HCFA is currently fulfilling pending requests at no charge, but the issue of payment must be resolved in the longer term. The Office of Strategic Planning had proposed a barter system, in which demonstration states could receive Medicare data in return for the analytic files that would be created with them. Several states have supported that approach, but it has yet to be formally adopted as HCFA policy. HCFA and the states should quickly fashion a permanent solution to this problem, including a legislative remedy, if necessary.

B. Need For Access to Live Medicare Claims Data

Though invaluable for planning and research purposes, Medicare claims files are inadequate for program management because of the time lag involved. (Claims from one year generally become available eight to nine months into the following year.) In order to experiment with managed FFS models, states will need access to live Medicare claims, perhaps via intermediaries. This would allow, for example, a state to implement a PCCM model for dually eligible beneficiaries and monitor both Medicaid and Medicare claims as they occur.

C. Access To Information From HCFA's Multi-State Linked Data Project

HCFA has begun a linked data project of its own, linking state MSIS data to Medicare files. (Mathematica is the project contractor.) HCFA has offered participating states access to the linked files. States are anxious to learn when the files might become available and what kind of information they will provide. Several states have proceeded with their own linking for two reasons: 1) states are concerned about significant time lags involved in the linking process; and 2) states are concerned that important state-specific program detail is lost in the MSIS formatting process.

D. Access To Medicare+CHOICE Enrollment Data

State access to person-level M+C enrollment data is inconsistent across regions. Some states get enrollment tapes on a regular basis but others still do not have access and cannot get clarification from their regions about access. States need this data for third-party liability (TPL) activities, and to track when dually eligible beneficiaries are in more than one managed care plan.

E. Cumbersome and Inappropriate Reporting Requirements

In general, dual eligibility demo projects are expected by HCFA to meet all M+C reporting requirements, even when they may not be appropriate. This creates unnecessary administrative cost to the programs, creating a significant disincentive for small programs with population-specific expertise to participate. A recent example is the Health of Seniors Survey. This self-reported survey is inappropriate for most nursing home residents and for people with significant cognitive disabilities, and the scaling of

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the responses is not likely to pick up variation among sub-groups of people with significant impairments.

Section III. Program Design and Implementation

A. Primary Care Fragmentation

Current requirements that primary care is handled separately from Medicaid managed care for dual enrollees when Medicaid managed care enrollment is mandatory results in fragmented care and poor clinical incentives. Without a direct relationship with primary care, it is difficult to hold states or plans accountable for quality of care provided. Plans and states are also financially at risk for services ordered by physicians outside the plan so managed care initiatives for dual eligibles are seen as too risky.

B. Lack of Incentives for Voluntary Enrollment

While primary care fragmentation is not a problem in voluntary enrollment projects, the lack of incentives for voluntary enrollment in integrated managed care projects makes it difficult to reach enrollment numbers needed for viability. Small voluntary projects do not address state issues with dual eligibles on a broad enough scale to influence provider behaviors or produce different outcomes.

C. Need for Joint Efforts on Appropriate Quality Measures

There is a lack of commonly accepted and standardized measures capturing both acute and chronic care needs. HCFA application of Medicare+CHOICE QA approaches to dual projects may result in measures and data collection procedures which are inappropriate for a largely frail and institutional population. HCFA investment in silo based FFS measurement tools (OASIS and MDS) ignores measurement approaches capable of looking at outcomes across provider types and programs.

HCFA policies increasingly imply state responsibility, oversight and control of complete scope of care including primary care for duals (i.e. HCBS waiver case management, Medicaid Director's letter re: psycho pharmaceuticals, QISMIC etc). Yet states do not have the tools to control or influence primary care outside of special demonstrations. Quality initiatives affecting duals need to recognize this problem and must be jointly worked out with states.

D. Marketing

HCFA's Medicare+CHOICE annual information campaign approach adds more confusion for dual eligibles. It does not recognize the interface between Medicare managed care choices and state Medicaid managed care requirements that may be in place and leaves out information on the availability of special demonstrations like those being established for dual eligibles. How can marketing efforts for state managed care

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projects be coordinated with this campaign? HCFA's Region I office is examining some of these issues in a special project aimed at developing marketing materials for dual eligibles. This effort has not been very successful yet, as it has for the most part focused on QMB/SLMB/QI and QII enrollment issues.

E. Creation of Medicare Flexibility

In areas where managed care does not exist or is not feasible, models for coordinating care of dual eligibles are still needed. One concept being explored is "Managed FFS". States have many questions that they need to discuss with HCFA on this issue. What does the concept really mean? What forms might it take and how would it be applied to dually eligible beneficiaries? Who would manage it? Who would select participating providers? How would the perverse incentives of FFS be addressed? Would HCFA entertain risk sharing with states in such an approach?.

Section IV. Waiver Policy

A. Medicaid Waivers

States need more information about the parameters of various Medicaid waiver options. If states are deterred from using 1115 waivers for voluntary demonstrations due to onerous budget neutrality cap requirements stemming from OMB policy, states need to be able to explore other Medicaid waiver combinations in order to better serve dual eligibles. However, there is much confusion over what can and cannot be accomplished through these other waiver combinations.

- **Combining 1915(a) and 1915(c) waivers:** HCFA is considering granting this waiver combination to several states, however, there is a lack of clarity about this new approach. Can other states now propose this approach? Can this approach accommodate medically needy spenddown issues or is an 1115 still required?

- **Combining 1915(b) and 1915(c) waivers:** HCFA is developing guidelines for this waiver combination. Early drafts would dramatically change the parameters of 1915(b) when combined with 1915(c) eliminating many of the tools required to manage care. HCFA needs to increase, not reduce flexibility for states and to work in partnership with them rather than dictating new criteria which micro-manages state purchasing strategies.

B. Combining Medicaid and Medicare Waivers

There is a need for policy information regarding the use of various combinations of Medicaid and Medicare waivers. It would be helpful for states to engage in discussions with HCFA regarding the various options in order to gain an understanding of the underlying policy differences and an understanding of which approach(es) best fits their circumstances.

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C. Administrative Coordination Between Medicaid and Medicare

What is the potential for resolving some of the administrative conflicts between Medicare and Medicaid (e.g., between Medicare+CHOICE products and Medicaid managed care) without Medicare payment waivers? Can HCFA provide flexibility to states through variances without a state applying for a Medicare payment waiver?

D. Waiver Approval and Amendment Processes

There is a need for a streamlined waiver approval and amendment process with specific time frames. The current length of these processes and lack of clarity puts projects in jeopardy as market and provider commitments change in the face of uncertainty.

Section V. Develop Federal-State Partnership Focused on Serving Dual Eligibles

A central focus of responsibility for dual eligibles projects within HCFA would help states in their design, development and implementation of various kinds of dual eligibles projects. This group would be responsible for coordination across the various Centers and offices that are now contact points or have program responsibility for dual eligibles projects. This focused responsibility would aid in providing consistent and timely answers to policy issues.

Consistent Vehicle/Contact For Reviewing Dual Eligibles Projects.

A HCFA Dual Eligibles coordinating group would provide a point of contact that could respond to a state inquiry and provide technical assistance before the state selects a particular waiver vehicle (Section 1115, 222, 1915a, 1915b, 1915c). The coordination across offices will help provide states consistent and timely technical assistance and approvals.

A. Early Development of Relationships

Facilitate developing relationships between states and HCFA contacts while projects are still in the planning stage. Early technical assistance will inform states of their program options before some choices are foreclosed.

B. Adequate HCFA Resources and Staff Devoted to Dual Eligibles Projects

It is necessary that these staff have the authority to work agreements across Medicaid and Medicare programs. Early Medicare staff involvement in program design decisions will facilitate development efforts.

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C. Consider Dual Eligibles in Medicare Policy Discussions

Incorporate an analysis of the implications for chronically ill and functionally impaired Medicare beneficiaries into Medicare policy discussions. Involve states in the analysis of policy implications. States expect recognition of the joint responsibility and interaction of policy changes on dual eligible clients.

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ATTACHMENT 4

Technical Revisions to the Social Security Act to Streamline Programs for Dually Eligible Beneficiaries

Background

Several states are developing better ways to serve dually eligible beneficiaries, those eligible for both Medicaid and Medicare. Because Medicare and Medicaid are separate programs administered by HCFA and the states, respectively, program rules are often inconsistent and create perverse incentives to use expensive institutional care, and to shift costs from one program to the other. Statutory authority for programs that coordinate or integrate Medicare and Medicaid is unclear at best, and provides significant barriers to innovation at worst. In attempting to negotiate waivers, states and HCFA have been frustrated by the lack of clear authority in this area. These proposed revisions to the Social Security Act provide clear, flexible and complementary authority in both the Medicare and Medicaid titles of the Act, providing a flexible approach that can accommodate the numerous program models currently under discussion across the states.

Summary of Revisions

1. Sections 1 and 2 amend the Medicare+Choice statute and general provisions of the Medicare statute, respectively, to create explicit new Medicare waiver authority for voluntary programs that coordinate or integrate Medicare and Medicaid services. The language goes beyond existing authority (§222) by explicitly including many programmatic elements in the waiver authority.

2. Sections 1 and 2 provide two options for consideration regarding budget neutrality. Option 1 requires that Medicare costs, considered alone, must be no greater than they would be for similar people served in traditional fee-for-service settings. Option 2 departs from the current practice of treating Medicare and Medicaid separately. Instead, total Medicare and Medicaid costs would be taken into consideration, and projects would be cost neutral as long as Medicare and Medicaid payments combined did not exceed combined costs in traditional fee-for-service.

3. Section 3 amends §1915(a) of the Medicaid statute to streamline the contracting process for programs serving either dually eligible beneficiaries or Medicaid-only benficiaries by incorporating certain features of 1915(c) waiver programs under 1915(a). Specifically:

- Paragraph (A) incorporates the eligibility provisions currently used in home- and community-based waiver programs, allowing states to use those eligibility provisions without the significant complication of combining a (c) waiver; and
- Paragraph (B) incorporates spousal impoverishment provisions currently used in home- and community-based waiver programs.

4. Section 3, Paragraph C gives states explicit authority to seek Medicare waivers in conjunction with 1915(a) programs. Whether to pursue Medicare waivers is a state option. States are not precluded from operating Medicaid-only programs under this section.

5. At Section 3, Paragraph D, two options are offered for consideration regarding budget neutrality. Option 1 requires that Medicaid costs, considered alone, must be no greater than they would be for similar people served in traditional fee-for-service settings. Option 2 adds a second cost neutrality definition for programs that combine Medicare and Medicaid. For those programs, total Medicare and Medicaid costs would be taken into consideration, and projects would be cost neutral as long as Medicare and Medicaid payment combined did not exceed combined costs in traditional fee-for-service. Draft Legislation Follows:

An Act Making Technical Revisions to the Social Security Act to Streamline Programs for Dually Eligible Beneficiaries

Section 1. Amend Title XVIII, §1859(d) as follows:

Sec. 1859(d). COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.--Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan. The Secretary may waive requirements of this title to permit states to enhance the coordination and integration of services and administration provided under this part with services provided under title XIX. The Secretary shall issue an approval, denial or request for additional information within 90 days of receiving a waiver request under this section. Coordination and integration of services and administration may include, but is not limited to: a unified enrollment process; a unified quality improvement program; a streamlined grievance and appeals process; streamlined reporting requirements; and

alternative Medicare payment methodologies, including modified risk adjusters and risk sharing approaches; provided that--

(1) waiver services developed under this section are offered as a voluntary option to beneficiaries; and

[SUBSECTION 2, OPTION 1]:
(2) waiver services are cost effective to Medicare. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare program than providing Medicare services on a fee-for-service basis to an actuarially equivalent population group.

[SUBSECTION 2, OPTION 2]:
(2) waiver services are cost effective. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare and Medicaid programs combined than the combined costs of providing Medicare and Medicaid services on a fee-for-service basis to an actuarially equivalent population group.

Section 2. Create a new §1897 as follows:

Sec. 1897. DEMONSTRATIONS TO COORDINATE AND INTEGRATE SERVICES AND ADMINISTRATION.-- The Secretary may waive requirements of this title to permit states to enhance the coordination and integration of services and administration provided under this title with services provided under title XIX. The Secretary shall issue an approval, denial or request for additional information within 90 days of receiving a waiver request under this section. Coordination and integration of services and administration may include, but is not limited to: a unified enrollment process; a unified quality improvement program; a streamlined grievance and appeals process; streamlined reporting requirements; and alternative Medicare payment methodologies, including modified risk adjusters and risk sharing approaches; provided that--

(i) waiver services developed under this section are offered as a voluntary option to beneficiaries; and

[SUBSECTION 2, OPTION 1]:
(2) waiver services are cost effective to Medicare. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare program than providing Medicare services on a fee-for-service basis to an actuarially equivalent population group.

[SUBSECTION 2, OPTION 2]:

(2) waiver services are cost effective. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare and Medicaid programs combined than the combined costs of providing Medicare and Medicaid services on a fee-for-service basis to an actuarially equivalent population group.

Section 3. Amend §1915(a) to add sub-§3 as follows:

SEC. 1915. [42 U.S.C. 1396n] (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)--

(1) [no change to current law]; or

(2) [no change to current law] ; or

(3) has entered into a contract with an organization to provide care and services, which may include care and services beyond those offered in the State plan, to individuals eligible for medical assistance who have elected to obtain care and services from the organization and are at least 65 years of age or have a disability or chronic illness, including individuals who are also eligible for medicare benefits under title XVIII.

(A) For purposes of payments to States for medical assistance under this title, individuals who are eligible to receive care and services under this subsection and who meet the income and resource eligibility requirements of individuals who are eligible for medical assistance under section 1902(a)(10)(A)(ii)(VI) shall be treated as individuals described in such section 1902(a)(10)(A)(ii)(VI) during the period of their enrollment in a program established under this subsection.

(B) Section 1924 applies to individuals receiving care or services under this subsection. For purposes of applying section 1924, "institutionalized spouse" means--

(i) an individual who is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(ii) is married to a spouse who is not in a medical institution or nursing facility.

(C) States may seek waivers under Title XVIII, sections 1859(d) and 1897 to integrate services provided under this subsection with services provided under Title XVIII.

PARAGRAPH D, OPTION 1

(D) Under a risk contract executed under this subsection, aggregate medical assistance payments to the organization, for a defined scope of services to be furnished to beneficiaries, may not exceed the medical assistance costs of providing those same services on a fee-for-service basis, to an actuarially equivalent population.

PARAGRAPH D, OPTION 2

(D) Services provided under this subsection must be cost effective, as defined in subparagraph (i) or (ii), as applicable.

(i) For purposes of programs implemented under this subsection with no corresponding waivers under Title XVIII, aggregate medical assistance payments to the organization, for a defined scope of services to be furnished to beneficiaries, may not exceed the medical assistance costs of providing those same services on a fee-for-service basis, to an actuarially equivalent population.

(ii) For programs implemented under this subsection in combination with waivers under Title XVIII, section 1859(d) or 1897, services offered will cost no more to the Medicare and medical assistance programs combined than the combined costs of providing Medicare and medical assistance services on a fee-for-service basis to an actuarially equivalent population group.

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PART ONE
FINAL DISCUSSION DRAFT 1998 - 1999

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Editor

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Table of Contents

Part I

Governor's Advisory Council on Health

PREFACE

Introduction and Background:

Rhode Island's health care system is a major factor in the State's quality of life and a leading contributor to its economic well being. However, it is also an industry in the midst of turmoil. Growing competitive pressures and demands for cost control are forcing providers to make changes in the way they organize and deliver services. Trends toward managed care, consolidation, integration, and corporate ownership are changing the face of the medical marketplace. All of this activity is creating an environment of tremendous uncertainty.

Whether these changes signal positive or negative developments for Rhode Island is, at present, a matter of conjecture and opinion rather than hard-nosed analysis. Some perceive an opportunity to right-size the expensive oversupply of certain high-cost services in the State.... Others are concerned about reductions in access for certain groups of people that may result from these changes....Some fear that developments in provider-driven integration and consolidation may have negative implications for the labor market and the relative incomes and job opportunities of people in this State....Others see an opportunity for employers to reduce their health benefit costs and invest in product and workforce development. In fact, we do not have a solid and mutually-agreed upon approach for monitoring the impact of changes in this industry. We lack the means for evaluating any of these assumptions. As a result, we find ourselves in pitched, highly emotional, highly political disputes over which policies will advance "the greater good," without a common knowledge base to guide us.

Rhode Island taxpayers currently spend over $1 billion on health care and related services provided directly by the state, and consumers, another $4-$5 billion on services in the medical marketplace. Before we commit to dramatic interventions, the State must enhance its understanding of how market pressures are affecting the health care industry, how the industry is responding, and which strategies are likely to meet with success while contributing positively to the State's economy as a whole.

Rhode Island has been a leader in innovation, with strong and experienced leadership at the Cabinet level. However, monitoring and responding appropriately to the increasing pace of change in this highly complex system is a monumental undertaking. The challenging environment makes it ever more imperative that the State-government actively solicit the knowledge and insight of the private sector and academic communities.

To do so, Governor Lincoln Almond created by Executive Order an Advisory Council on Health. The Council's purpose is to: (1) provide the Governor, the Legislature, and the public with systematic information about the changes occurring in the health care marketplace and the issues they raise; (2) to examine the implications of the changing market for the health and economic prosperity of the State; and 3) to provide an expert forum for the consideration and discussion of a wide-range of health care issues, including the projected impact of state actions or decisions on the health care marketplace.

This *First Annual Report* of the GACH commences an organized effort to collect, review, and publish solid information about the health care industry in Rhode Island. The Council emphasizes that the mighty forces driving changes in this system are less determined by a narrowly defined local health care system and its needs, than by changes in science, technology, economics, demography, epidemiology, social values, education and other global factors to which the system must accommodate

The Council's principle objective for its First Annual Report has been the creation of a "baseline" document report that...

- Describes, in quantitative terms, the major components of the health care industry in Rhode Island;
- Approaches this description not as a service gap analysis, but as a *structural and economic* analysis of entities that the make up the system;
- Represents the first data "dots" on a multi-year trend line;
- Has been thoroughly vetted;
- Is the foundation of an ongoing reference work — so that policy is grounded in fact and empiricism rather than opinion and conjecture.

Organization of this Report

This report is presented in two parts.

Part I provides an Introduction and Overview for this project. It discusses population characteristics, economic factors, and health care resources that affect the consumption of health care goods and services in Rhode Island. It establishes the health care sector within the overall state economy, providing basic statistics about the health care labor force and industry payroll. When possible, Rhode Island's experience is compared against regional or national benchmarks. Next, the Introduction presents the sources and distribution of the national health care dollar as estimated by the Health Care Financing Administration's National Health Statistics Group, and suggests some of the ways that Rhode Island's particulars might be used to derive a state-specific health care "funds flow" profile. Finally, Part I contains summary versions of the Health Sector Studies in Part II.

Part II describes in detail each of the major sectors in Rhode Island's health care industry by chapter. Each chapter presents descriptive information about sources of funds, trends in utilization, and workforce characteristics for major health industry groups. While fairly extensive information is available about the entities that contract with the State or federal governments to provide services, in many instances, private sector transactions and dynamics remain a virtual "black box". Thus, blank tables scattered throughout Part II reflect the current state of our knowledge base and hold places for future data gathering.

INTRODUCTION AND OVERVIEW: THE HEALTH CARE INDUSTRY IN RHODE ISLAND

DEMOGRAPHIC TRENDS[1]

Rhode Island has a population of just over one million in a land area of 1,055 square miles, making it the smallest in size, the seventh smallest in population, and the third most densely populated state. Eighty-six percent of the population live in urban areas, which constitute only one third of the geographic area, while the remaining two thirds of the land area is more rural in character. The State consists of five counties (Providence, Kent, Washington, Bristol and Newport) comprised of 39 cities and towns.

Between 1990 and 1995, Rhode Island's total population changed from 1,003,464 to 996,325. The total population is expected to recover by the year 2000, to a projected 1,011,960, and to increase about 1 percent over each succeeding five-year interval. As the result of a general migration from the city to the suburbs, Providence will continue to lose population over the next decade. Newport and Washington counties are expected to have small population gains (Table 1).

Table 1. Rhode Island Population by County: 1990-2010

MUNICIPALITY	1990	1995	2000	1995-2000	2005	2000-2005	2010
Bristol County	48,859	48,511	48,986	0.98%	49,157	0.35%	49,230
Kent County	161,135	159,989	162,965	1.86%	164,986	1.24%	166,727
Newport County	87,194	86,572	89,262	3.11%	91,476	2.48%	93,577
Providence County	596,270	592,028	594,677	0.45%	593,924	-0.13%	592,326
Washington County	110,006	109,225	116,070	6.27%	122,637	5.66%	129,385
TOTALS	1,003,464	996,325	1,011960	1.57%	1,022,180	1.01%	1,031,245

Selected population charachteristics are presented in Table 2 below:

Table 2. Selected Population Characteristics, US and RI

	Rhode Island	*United States*
Total Population (1996)	996,325	265,283,783
Population Density (persons/square mile)	947.6	75
Median Age (1996)	35.8	34.6
Percentage of Population:		
Age 65 and Over (1996)	15.8	12.8
Age 85 and Over (1996)	1.9	1.4
Male/Female (1996)	48.1/51.9	48.9/51.1
Below Poverty Level (1996)	11.0	13.7
School Age Children Below Poverty Level (1996)	12.4	18.9
Live births to Mothers ages 10-17 (1995)	3.9	5.3

[1]. The demographic data and projections are supplied by the Statewide Planning Program.

Table 2. Selected Population Characteristics, US and RI (continued)

	Rhode Island	United States
Racial/Ethnic Distribution of Population		
White	92.7	83.2
Black	4.7	12.5
Asian/Pacific Islander	2.1	3.5
American Indian/Alaskan Native	0.4	0.8
Hispanic	5.8	10.0
Educational Attainment (ages 25 and over) (1996)		
Less than HS Degree	21.4	18.3
HS Grad	78.6	81.7
Bachelor's Degree or more	24.5	23.6

Aging of the population

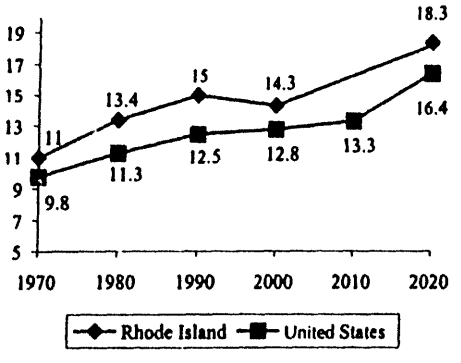
As with most of the United States, Rhode Island's over-65 population is growing both in real terms and as a percentage of the total. Rhode Island's under-65 population, on the other hand, has been shrinking. Rhode Island has a higher proportion of elderly than the nation as a whole. In 1995, 15.7 percent of Rhode Islanders were over the age of 65, compared with 12.8 percent nationally; 1.8 percent were over the age of 85, compared with 1.4 percent nationally. In the year 2000, 14.4 percent of Rhode Island's total population will be over age 65, still well above the national average of 12 percent, while 26.7 percent of the population will be under age 19, below the national average of 28%. (Table 3)

Table 3. Rhode Island Population by Age Groups by County (Projected: 2000)

COUNTY	Ages 0-19	Ages 20-44	Ages 45-64	Ages 65-74	Ages 75+
Bristol	12,377	16,872	11,922	4,158	3,657
Kent	39,857	57,455	41,128	12,935	11,590
Newport	23,254	33,896	20,335	6,213	5,564
Providence	163,807	216,540	127,713	42,945	43,672
Washington	31,747	42,755	27,639	7,427	6,502
TOTAL	**271,042**	**367,518**	**228,737**	**73,678**	**70,985**
	(26.7%)	**(36.3%)**	**(22.6%)**	**(7.3%)**	**(7.1%)**

It is likely that the proportion of elderly in Rhode Island will remain higher than the national average in coming years (Fig. 1).

Figure 1 – Population Projections, Age 65 an I Older, Rhode Island and US

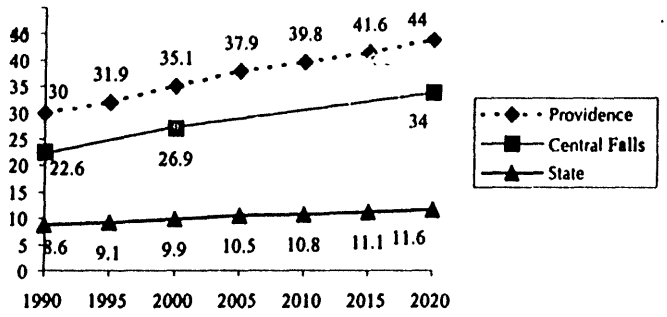


The aging of the population has a significant impact upon the size of the population of disabled persons and the consumption of health care services. Persons age 85 and older constitute a substantial share of all people who are dependent in physical functioning. Results of Rhode Island's 1996 Health Interview Survey indicate that more than a third of persons in Rhode Island over age 65 have some kind of limitation, and about one out of every four persons in this age group has a severe disability.

Growth in Minority Population

Disparities between minority health and health of the general population are evident in a number of the health indicators presented in this Report (see Chapter 13). Continued growth in the size of Rhode Island's minority population, while low for the state as a whole, will be dramatic in those cities where a substantial proportion of Rhode Island's minorities reside, such as Providence and Central Falls (Fig. 2). If disparities in health persist, the health care burden in the state's urban areas will grow disproportionately.

Figure 2 – Rhode Island Minority Population Projections, 1990-2020, State, Providence, and Central Falls



Source: Rhode Island Population Projections by Age, Sex, and Race, Rhode Island Office of Statewide Planning, 1996

In recent years, there has been an influx of immigrants to Rhode Island, with Latinos representing the fastest growing segment of the population. Those of minority race or ethnicity are especially likely to be uninsured. In 1996, results of the Behavioral Risk Factor Survey reported that 17 percent of African Americans and 29 percent of Hispanics versus 9 percent of whites are without health insurance. While only 4.7 percent of Rhode Islanders are unemployed, unemployment for minorities has been consistently higher: 12.6 percent for African Americans, 10.7 percent for Asians, and 11.9 percent for Hispanics.

EMPLOYMENT IN THE HEALTH CARE SECTOR

Rhode Island's economy provides employment for half a million Rhode Island residents in both goods and service producing industries. Overall, the movement of the state economy is from the goods producing (e.g., manufacturing and construction) sector to the service producing sector. Employment in the latter has

increased over 13% in the past decade. Health services is the fastest growing industry group, generating over 15,000 new jobs in the past 10 years[2].

With a stronger economy, Rhode Island faces a tighter labor market in 1998. Although Rhode Island unemployment rate was higher than the New England average through the year – it declined from 5.3% to 4.9 percent in calendar year 1997, and has held steady in the first quarter of 1998. More Rhode Islanders are holding jobs than at any time since 1990.[3]

In this market, health facilities and health service providers are challenged to find and successfully recruit and retain personnel. Rhode Island's nursing homes, home health agencies, and other providers are reporting difficulty in adequately staffing to meet current service demands. The problem is particularly acute with regard to nurses aides. Nursing facilities also are reporting a shortage of available physical and occupational therapists.

The health care industry is the largest employment sector in Rhode Island. Health services account for over 11.5 percent of total employment, or almost 51,000 jobs. This percentage is much higher than the national share of 7.8 percent. Moreover, this figure represents a lower bound, as neither U.S. nor RI labor market statistics permit a full accounting of persons employed in health-related research and education.

Table 4 – Health Services Employment: Rhode Island and U.S.

RHODE ISLAND (1997)			UNITED STATES (1998)		
Total Employed	441,370		Total Employed (non Farm)	126,676,000	
Health Services (private and Government)	53,635	11.5%	Health Services Employment	9,929,3000	7.8%
Health Services (Private Only)	50,785	11.35%			

Source: Rhode Island Department of Labor and Training National Bureau of Labor Statistics

Comparative statistics for other states in the New England region are not available from the federal Bureau of Labor Statistics[4]. However, the Boston Federal Reserve Bank estimates that 10.5 percent of total regional employment is in the health care services and related industries. Although the point estimate for Rhode Island is much lower than that maintained by the State, the Bank's figures for each of the six New England states are useful for purposes of comparison:

Table 5 – Health Sector Employment, New England

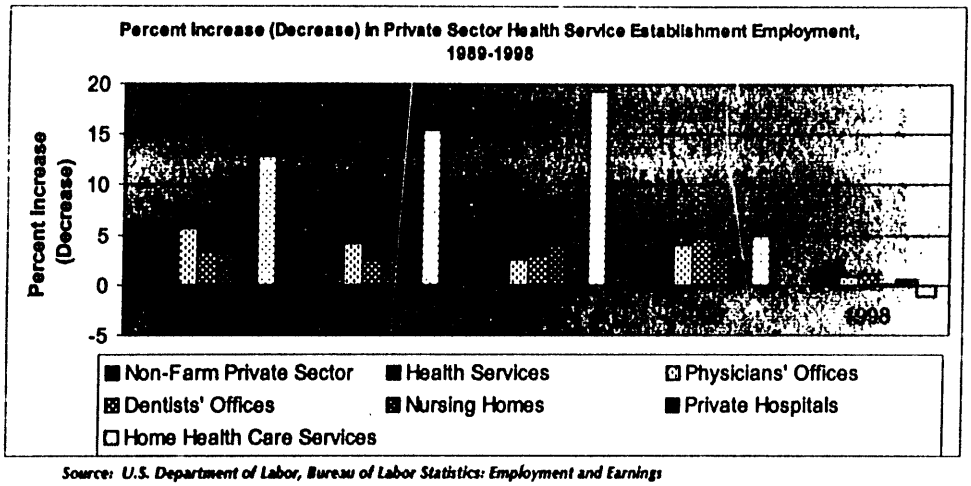
State	Health Sector Employment percent
Connecticut	8.90
Maine	9.20
Massachusetts	10.05
New Hampshire	9.32
Rhode Island	**10.20**
Vermont	8.91

[2] Vincent K. Harrington, Rhode Island Economic Development Corporation, Research Division "Rhode Island's Economy".
[3] Rhode Island Department of Labor and Training: Labor Market Information for Rhode Island Planners, 1998,
[4] The Federal Bureau of Labor Statistics uses a mathematical sampling method that results in sample sizes for New England states' sector-specific employment too small to be statistically valid.

Both nationally and in Rhode Island, employment in the health care industry has grown faster than private sector employment as a whole. Nationally, employment growth in private sector health services has outpaced employment growth in the business sector in 8 out of the last 10 years, primarily because employment in the health services industry has been able to withstand economic pressures that dampened growth rates in other sectors. For example, during the recession of the early 1990s, when private sector employment dipped 1.4% overall, the health services industry added jobs at the rate of 4.7% (Figure 3).

Within the health care sector, employment growth in home health agencies was especially strong through 1996. Recent changes in Medicare reimbursement have reversed that trend. Also this decade, growth in nursing homes, dental offices, and physicians' offices has been especially strong compared to the overall economy.

Figure 3. Employment in Private Sector Health Service Establishments, United States: 1991-1998



Source: U.S. Department of Labor, Bureau of Labor Statistics: Employment and Earnings

Rhode Island's health services sector added over 3,600 jobs between 1994 and 1997. Most of these jobs were concentrated among home health care providers and HMOs.[5]

Most recently, the Department of Labor and Training reports that Rhode Island's top 25 expanding industries in 1997 included Residential Care, Home Health Care Services, and Physicians' Offices (Exhibit 1).[6] An expanding industry is defined as experiencing consistent job growth of at least 10 percent over five years.

[5] Rhode Island Department of Labor and Training: Labor Market Information for Rhode Island Planners, 1998.
[6] Ibid.

Exhibit I

Rhode Island's Expanding Industries

Top 25

Personnel Supply Services	Mortgage Bankers and Brokers
Eating and Drinking Places	Miscellaneous Special Trade Contractors
Residential Care	Partitions, Shelving, Locker and Office
Home Health Care Services	Automotive Repair Shops
Miscellaneous Health and Allied Services	Engineering, Architectural and Surveying
Retail Bakeries	Motor Vehicle Dealers (New and Used)
Child Day Care Services	Offices and Clinics of Dentists
Offices and Clinics of Doctors of Medicine	Masonry, Stonework, Tile Setting ,Plastering
General Building Contractors (Residential)	Landscape and Horticultural Services
Elementary and Secondary Schools	Electrical Work
School Buses	Real Estate Agents and Managers
Electrical Goods	Miscellaneous Business Services
Services to Dwellings	

In general, wages in the health care industry are higher than average. While the health care industry in Rhode Island accounts for 11.5 percent of total employment, it accounts for more than 15 percent of total payroll.

Nationally, average hourly earnings within the health care service sector increased 3.1 percent per year between 1992 and 1997, and 2.8 percent in 1998. Hospital personnel and home health service providers saw slightly slower earnings growth in 1998 than in the 1992-1997 period, while nursing and other health care practitioners saw more rapid gains. (Table 6).

Table 6: Annual Percentage Rage of Increase in Average Hourly Earnings: Health Services Industries U.S.

	Percentage growth	
SERVICES	1992-1997	1998
Health Services	3.1	2.8
Offices of Medical Doctors	3.8	3.8
Offices of Other Health Practitioners	4.6	5.6
Nursing and Personal Care	3.5	4.4
Hospitals	2.9	2.8
Home Health Services	2.6	1.8

Source: U.S. Department of Labor, Bureau of Labor Statistics.
Note: data are for non-supervisory workers.

The health services sector of the economy is an important source of employment for women and minority populations. Nationally, women comprise 46 percent of the total labor force, but 77.8 percent of total health services employment. Similarly, African Americans comprise 10.4 percent of all employment, but 14.8 percent of total health services employment. In Rhode Island, women make up an even larger share of the health services workforce. (Exhibit 2)

Detailed Health Related Occupations by Sex, and Minority in the United States

United States	Total Labor Force	Occupation as a % of Labor Force	Males	As a % of Occupation	Females	As a % of Occupation	Total Minority	As a % of Occupation
Health Diagnosing								
Physicians	586,715	.48%	465,468	79.33%	121,247	20.67%	14,364	19.49%
Dentists	155,529	.13%	135,588	87.18%	19,941	12.82%	17,610	11.32%
Veterinarians	48,744	.04%	35,755	73.35%	12,989	26.65%	3,383	6.94%
Optometrists	27,515	.02%	23,463	85.27%	4,052	14.73%	2,205	8.01%
Podiatrists	8,908	.01%	7,904	88.73%	1,004	11.27%	746	8.37%
Health diagnosing practitioners	47,114	.04%	32,241	68.43%	14,873	31.57%	4,274	9.07%
Health Assessment & Training								
Registered nurses	1,885,129	1.53%	107,244	5.69%	1,777,885	94.31%	311,467	16.52%
Pharmacists	181,798	.15%	114,949	63.23%	66,849	36.77%	25,976	14.29%
Dietitians	90,223	.07%	9,629	10.67%	80,594	89.33%	25,949	28.76%
Respiratory therapists	65,589	.05%	26,155	39.88%	39,434	60.12%	12,847	19.59%
Occupational therapists	37,995	.03%	3,957	10.44%	33,938	89.36%	4,637	12.24%
Physical therapists	92,022	.07%	22,540	24.49%	69,482	75.51%	11,597	12.60%
Speech therapists	64.713	.05%	5,736	8.86%	58,977	91.14%	5,234	8.09%
Therapists, n.e.c.	71,402	.06%	19,755	27.67%	51,647	72.33%	11,575	16.21%
Physician's assistants	25.569	.02%	12,962	50.69%	12,607	49.31%	4,927	19.27%
Health Technologists & Technicians								
Clinical laboratory technologists	329,892	.275	82,202	24.92%	247,690	75.08%	85,185	25.82%
Dental hygienists	72,394	.06%	1,174	1.62%	71,220	98.38%	4,818	6.66%
Health record technologists & tech.	55,764	.05%	4,663	8.36%	51,101	91.64%	15,484	27.77%
Radiologic technicians	130,383	.11%	36,176	27.75%	94,207	72.25%	21,004	16.11%
Licensed practical nurses	429,473	.35%	27,569	6.42%	401,904	93.58%	112,217	26.13%
Health technologists & technicians	411,191	.33%	119,103	28.97%	292,088	71.03%	90,519	22.01%

Source: 1990 Census of Population Housing, CD90 - EEO-2, January 1993

Detailed Health Related Occupations by Sex, and Minority in the United States

United States	Total Labor Force	Occupation as a % of Labor Force	Males	% of Labor Force	% of Occupation	Females	% of Labor Force	% of Occupation	Minority	% of Labor Force	% of Occupation
Health Diagnosing	874,525	.71%	700,419	.57%	80.09%	174,106	.14%	19.91%	142,582	.12%	16.30%
Health Assessment & Treating	2,514,340	2.04%	322,927	.26%	12.84%	2,191,413	1.77%	87.16%	414,209	.34%	16.47%
Health Technologists & Technicians	1,429,097	1.16%	270,887	.22%	18.96%	1,158,210	.94%	81.04%	329,327	.27%	23.04%

Health related occupations are dominated by females, but there are four times as many males than females in the Health Diagnosing Field.

Detailed Health Related Occupations by Sex and Minority for Rhode Island

Rhode Island	Total Labor Force	Occupation as a % of Labor Force	Males	% of Labor Force	% of Occupation	Females	% of Labor Force	% of Occupation	Minority	% of Labor Force	% of Occupaton
Health Diagnosing	3,886	.74%	3,030	.58%	77.97%	856	.16%	22.03%	316	.06%	8.13%
Health Assessment & Treating	12,217	2.34%	1,328	.25%	10.87%	10,889	2.08%	89.13%	583	.11%	4.77%
Health Technologists & Technicians	6,445	1.23%	974	.19%	15.11%	5,471	1.05%	84.89%	402	.08%	6.24%

The percentage of health related occupations of the total labor force is slightly higher for Rhode Island than the national percentage..
The percentage of health related occupations of the total labor force for females is higher for Rhode Island than the national figures.
The percentage of females in the health related field is higher for Rhode Island than the national figures.
As in the national figures, females dominate the health related occupations, but there are over three times more males in the Health Diagnosing Field.
The percentage of minorities in the health related occupations in Rhode Island are lower than the national percentages.

Source: 1990 Census of Population Housing, CD90 - EEO-2, January 1993

FEDERAL GRANTS AND TRANSFER PAYMENTS

Rhode Island's changing demography will change the contributions of various payment sources to the health care dollar in the State. As our population ages, a greater share of health spending will derive from Medicare, Medicaid , and other federal sources that pay for programs and services targeted primarily to the elderly. At the same time, there will be fewer working age people (ages 15-59) (Table 7); and more minorities immigrants who are most likely to lack health insurance coverage. These changes could further shrink the proportion of the health care dollar that derives from private sources and increase reliance on government transfer payments.

Table 7: Comparison of Rhode Island Age Cohorts in 1990 and 2020

1990	85,852	87,772	78,576	69,041	47,210	38,406	64,931
2020	69,105	67,909	64,468	59,322	65,325	52,083	75,949
% Change	(19.5%)	(22.6%)	(17.9%)	(14.1%)	38.4%	35.6%	17%

Already, fewer people are paying taxes than in Rhode Island than in 1989, and there is a corresponding greater reliance on federal outlays as a portion of the state's total income. Transfer payments ((outlays from government to individuals, including Social Security, Medicare, welfare, food stamps, unemployment, and workers compensation insurance) now account for about 21 percent of total income in Rhode Island .

The state maintains a positive balance of payment with the federal government, meaning that it receives more in federal spending that it pays in federal taxes. As such, Rhode Island experiences a net gain in economic activity. According to the Tax Foundation[7], in 1996, Rhode Island received $1.08 in federal spending for every $1.00 it sent to the federal government that year

However, there is some risk associated with this position: federal budget cuts, changes in federal-state cost-sharing formulas, or shifts in federal program priorities, can have a more noticeable effect on Rhode Island's general fiscal condition, and a significant impact on publicly-supported health care programs. Federal aid and grants are the largest single source of State government revenue, comprising 28.6% ($1,804.8 million) of the State's government's FY 1998 budget, and 50.2% of all state spending on human service programs[8] (the largest of these being Medicaid).

According the U.S. Census Bureau, combined, federal spending in Rhode Island in 1997 amounted to $5,956 per capita and placed the state 9th in the nation in receipt of federal funds per capita (Table 8).

[7] Tax Foundation, Special Report, July 1997, No.7 Bureau of the Census, as reported in Rhode Island Public Expenditure Council Special Bulletin "Federal Taxes and Spending in Rhode Island", September 30, 1997.
[8] RIPEC, Special Bulletin, September 30, 1997

Table 8– Federal Government Expenditures in Rhode Island: FY 1995-1997 (Billions)

	Total	Per Capita Rank	Grants to State and Local Governments		Direct Payments to Individuals		Salaries, Wages, Procurement, and Other
1995	$5.763		$1.276		$3.227		$1.260
1996	$5.658	8	$1.176		$3.266		$1.216
1997	$5.879	9	$1.144	4	$3.443	4	$1.293

Source: U.S Bureau of the Census: Federal Expenditures by State for Fiscal Year 1997

Census Bureau calculations show that Rhode Island's state and local government health programs drew in roughly $520 million in federal support in 1997 (Table 9).

Table 9 – Federal Grants to State and Local Governments by Agency and for Selected Programs Fiscal Year 1997.

	Health Care Financing Administration (Medicaid)	Health Resources and Services Administration	Centers for Disease Control	Substance Abuse and Mental Health Administration
1997	$503,067,000	$8,084,000	$2,556,000	$5,309,000

Source: U.S. Bureau of the Census: Federal Expenditures by State for Fiscal Year 1997

Over $3.44 billion in federal payments to Rhode Island in 1997 came in the form of direct payments to, or on behalf of, individuals, including Medicare, Social Security, and other federal retirement and disability benefits (Table 10). Medicare Part A (hospital) payment amounted to $626.09 per capita, the 6th highest per capita amount in the nation. Medicare Part B (medical and other) payments amounted to $290.75 per capita, or 8th in the nation..

Table 10 – Federal Grants Direct Payments to Individuals by Selected Program, Fiscal Year 1997.

	Social Security	Medicare Part A Hospital Payment	Medicare Part B Supplementary Insurance Payment	Federal Retirement and Disability Payment
1997	$1,591,503,000	$617,949,000	$286,969,000	$267,600,000

The Health Care Dollar:

National health policy leaders have for the past 30 years recognized the importance of monitoring sources and uses of health care expenditures. Since the 1960s, a team of economists, actuaries, and statisticians housed in the federal Health Care Financing Administration has been publishing the National Health Expenditures series. From time to time these national estimates are prorated to the states to produce synthetic health care expenditure estimates at the state level.

The last time that the State of Rhode Island undertook a comprehensive analysis of the flow of health care dollars to and through the Rhode Island economy was in 1980. The Council believes that such an analysis is foundational to any understanding the health services industry and its impact on the State's economy. It is crucial to be able to understand and predict the effects of changes in various subsectors of the industry, as well as the impact of outside forces on the industry as a whole. While synthetic estimates, based on national data, have the advantage of being producible in a short time and of giving a reasonable estimate of per capita expenditures, the Council is interested in a deeper insight into how Rhode Island's health care system compares to that of the nation and to other states. To achieve this, the Council early in 1999 will commission a focused "funds flow analysis" that draws on published and unpublished data sources specific to Rhode Island.

In the interim, a review of the major components of health care spending follows. Whether or not national rates of growth in health care spending, as well as sources and uses of health care funds, translate to Rhode Island depends on whether the dynamics driving the system operate in the same way and same direction in the local market, and whether there are other reinforcing or countercurrent forces at work. Some of the likely sources of deviation from the national statistics are suggested below, but await fuller discussion in the Council's next report.

Health Spending Growth (U.S.):

Table 11

Year	National Health Expenditures (in billions)	Growth Rate
1991	$ 766.8	9.6%
1992	$ 836.6	9.1%
1993	$ 895.1	7.0%
1994	$ 947.7	5.7%
1995	$ 993.7	4.9%
1996	$1,042.5	4.9%
1997	$1,092.4	4.8%

In 1997, spending on health care averaged $3,925 per person (Table 11). That year's 4.8 percent growth rate was the lowest since 1960, and the total $1.092.4 trillion accounted for 13.5 percent of the nation's economy.[9] Low inflation, more people in managed care, and new government spending curbs all contributed to slower expansion of the nation's health care bills.

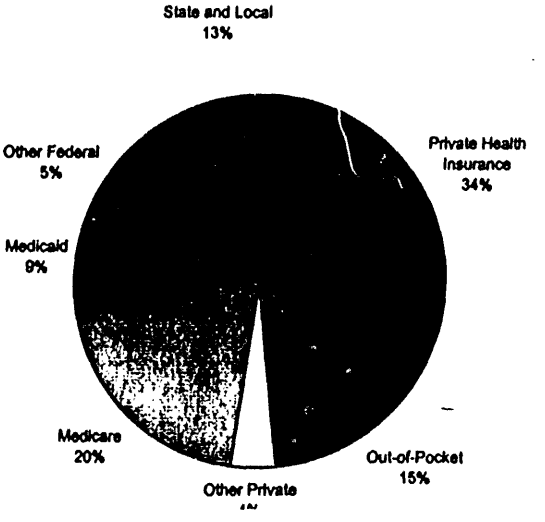
Sources of Funds (U.S.)

The portion of health care paid for by government rose from 40 percent in 1990 to 47 percent in 1998. The growth comes from increased Medicare enrollment, expanded Medicaid coverage, and comparatively slower growth in private sector health insurance premiums. Medicare and Medicaid together financed

[9] Katherine Levit at al, "National Health Expenditures in 1997: More Slow Growth", *Health Affairs* November/December 1998.

more than one-third of the total health care bill, suggesting the influence government brings to bear on the configuration of the overall system. Private funding paid for 53.6 percent of health care, down from 59.9 percent at the start of this decade. About 60 percent of amount private payers expended for health care services

Figure 4. The Health Care Dollar - Where it Comes From (U.S., 1998)



was spent by employers and employees to purchase health insurance. Consumer out-of-pocket spending, which includes expenditures for insurance copayments and deductibles, as well as direct payments for services not covered by a third party, accounted for just over 15 percent of the total.

The percentage of total funding represented by any payment source is a function of the number of people covered by that source, the volume of services those people consume, and the relative cost (price) of those services across payment sources. It is likely that in Rhode Island, patient "out-of-pocket" spending equals a smaller share of total funds source than the national figures suggest. Out-of-pocket payments are calculated as a "residual" amount after the other categories have been exhausted. In Rhode Island, an older population and generous Medicaid eligibility criteria will generate a greater-than-average share of total health care funding from Medicare and Medicaid. In addition, Rhode Island enjoys relatively high rates of insuredness and relatively rich benefit packages among the privately insured, so that this source, too, is likely to be somewhat more significant in Rhode Island than it is nationally.

Comparable data on payment rates and utilization of health care services by payer source for Rhode Island versus the national (and the region) currently are available only for Medicare covered services and only through calendar year 1996 (Tables 12-15).[10] While these figures are drawn from a scientific sample of Medicare claims, they should be used only for gross comparisons. They represent Medicare payments on behalf of Rhode Island *resident beneficiaries, and* payment recipients may include out-of-state providers.

[10] All tables are from the Health Care Financing Administration's *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1998*

Table 12: Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short Stay Hospitals, by Area of Residence: Calendar Year 1996

Area of Residence	Discharges	Hospital Days of Care		Program Payments	
	Per 1,000 Enrollees	Per 1,000 enrollees	Per Discharge	Per Discharge	Per Part A Enrollee
US	359	2,347	6.5	$6,998	$2,405
New England	329	2151	6.5	$7,793	$2,480
Connecticut	295	2,023	6.9	$8,656	$2,500
Massachusetts	365	2,328	6.4	$8,085	$2,806
Rhode Island	336	2,357	7.0	$7,610	$2,451
Vermont	289	1,890	6.5	$6,632	$1,886

Table 13: Covered Admissions, Covered Days of Care, and Program Payments for Skilled Nursing Facility Services Used by Medicare, by Area of Residence: Calendar Year 1996

Area of Residence	Covered Admissions	Covered Days of Care		Program Payments	
	Per 1,000 Enrollees	Per 1,000 enrollees	Per Admission	Per Admission	Per Day
US	55	1,409	25.5	$5,373	$208
New England	64	2,030	31.6	$5,831	$184
Connecticut	61	2,266	37.3	$6,246	$167
Massachusetts	79	2,402	30.4	$6,273	$205
Rhode Island	55	1,694	30.7	$4,669	$152
Vermont	42	1,181	28.1	$3,266	$116

Table 14: Persons Served, Visits, and Program Payments for Medicare Home Health Agency Services, by Area of Residence: Calendar Year 1996

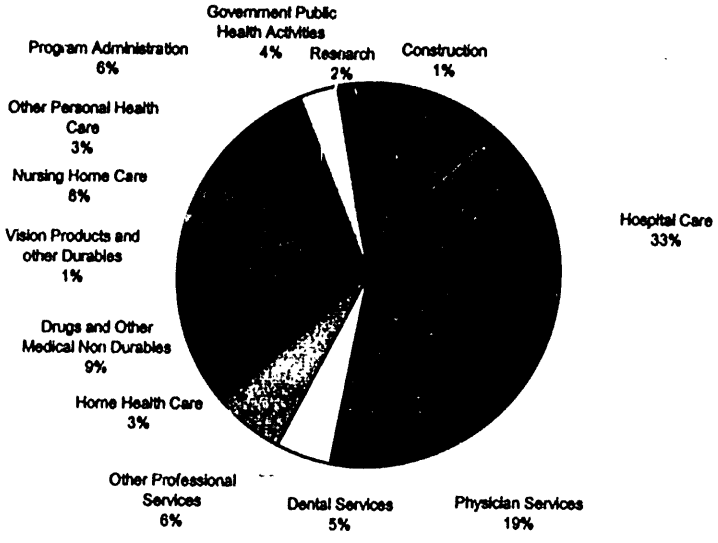
Area of Residence	Persons Served	Covered Visits		Program Payments	
	Per 1,000 Enrollees	Per 1,000 enrollees	Per Person Served	Per Person Served	Per Visit
US	108	7,995	74	$4,691	$63
New England	136	11,704	86	$4,677	$54
Connecticut	125	10,376	83	$4,834	$58
Massachusetts	150	14,925	71	$5,186	$52
Rhode Island	132	8,980	68	$4,423	$65
Vermont	144	10,047	70	$3,056	$44

Table 15 Persons Served, Services per Person, and Program Payments for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 1996

Area of Residence	Persons Served	Covered Services	Program Payments	
	Per 1,000 Enrollees	Per Person Served	Per Person Served	Per Enrollee
US	967	36.8	$1,447	$1,339
New England	975	35.4	$1,424	$1,334
Connecticut	983	36.5	$1,487	$1,413
Massachusetts	972	37.3	$1,536	$1,437
Rhode Island	976	41.1	$1,499	$1,420
Vermont	958	24.0	$970	$877

Expenditures

Figure 5. The Health Care Dollar: Where it Went (U.S. 1998)[11]



In 1998, almost 88 percent of the health care dollar bought personal health care services and supplies. However, the distribution of that spending is changing, mirroring the impact of managed care and, to a lesser extent, changes in Medicare payment policies. Physicians and hospitals are reaping a smaller share of the dollar (52 percent in 1998 compared to 57.8 percent in 1990). A greater share is going to nursing homes, home health aides, and alternative caregivers such as optometrists, paralleling increased in Medicare spending for home health and skilled nursing facility services.

Spending for inpatient and outpatient hospital services continues to dominate distribution of the health care dollar, though a larger share of that spending now comes from Medicare than was the case a decade ago. A large portion of private health insurance spending on hospital services has followed patients out the door to outpatient/ambulatory and post-discharge settings.[12] New Medicare payment policies enacted as part of the Balanced Budge Act of 1997 will reduce the growth in Medicare spending for hospital services in several ways. Despite these changes, hospitals so far have maintained their profit margins by reducing expenses, expanding their capacity to provide outpatient services, and diversifying into post-discharge care.[13]

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[11] Health Care Financing Administration, Office of the Actuary

[12] Sheila Smith et al, "The Next Ten Years of Health Spending: What does the Future Hold?" Health Affairs, September/October 1998

[13] Stuart Guterman, "The Balanced Budget Act of 1997: Will Hospitals Take a Hit on Their PPS Margins?" Health Affairs, January/February 1998.

Spending on physician services represents almost 20 percent of the health care dollar. Growth in this sector also has slowed as Medicare's physician fee schedule has taken hold, and as managed-care organizations have succeeded in pushing medical costs down for both publicly and privately insured populations.[14]

Spending on medical research and development has increased steadily in recent years. Federal support for basic and applied research at the National Institutes for Health increased by $2 billion in fiscal 1999. Over half of health-related R&D is supported by the pharmaceutical industry.

Prescription drugs are the fastest growing component of national health expenditures, amounting to over $80 billion in 1998, a 14.1 percent increase over the previous year. Explanations for the increase include broader insurance coverage of prescription drugs, growth in the number of drugs dispensed, more approval of expensive new drugs by the Food and Drug Administration, and direct-to-consumer advertising of pharmaceuticals.

Health Spending in Rhode Island

For its next report, the Council will develop information that describes Rhode Island's health care spending position relative to the United States overall, and relative to other New England states. State level health care expenditure data will indicate the amount spent per capita and how that amount compares in size and distribution to neighboring states. Several factors that can influence the level of health care expenditure at the state level will be investigated:

Border Crossing: An important methodological weakness in state-level health expenditure data is that they do not account for care provided in each state to out-of-state residents. Expenditure totals included care provided to those who travel to the state to receive care or who become ill while visiting. To the extent that a state is a net exporter of care (i.e., providing more care to non-residents than other states provide to its residents), or vice versa, state-level expenditure data will be distorted. Available hospital data indicate that RI is a next exporter of care for births and deaths, but utilization of other hospital services by resident status is not yet available. Approximately 11 percent of Rhode Islanders commute to work in Massachusetts and Connecticut[15]. The extent to which these commuters seek care from providers who are close to their places of employment rather than close to their homes is not known. A related question is the influence of regional hospital networks and regional insurance carriers on patterns of cross-border migration for health care.

Care of the Uninsured: In comparing states' total health expenditures, it is useful to examine the portion of the state's population that lacks health insurance. A high number of uninsured is presumed to deflate total health expenditures as the uninsured tend to use fewer health services over a given period. The uninsured use only a fraction of the services used by insured individuals, even accounting for the documented fact that the uninsured tend to delay accessing health care services until medical conditions worsen sufficiently to force the issue, resulting often in the need for higher cost, more intensive interventions. However, while population-wide spending may be suppressed by uninsurance, prices and premiums may be inflated if providers shift the cost of uncompensated care to those with private insurance coverage. Rhode Island's rate of uninsurance – though climbing – is relatively low. In 1996, approximately 11.1% of Rhode Island's non-elderly population was uninsured,[16] compared to 17.7% of the non-elderly population nationally.[17]

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[14] Smith, op. Cit.
[15] Rhode Island Department of Labor & Training: Labor Market Information for Rhode Island Planners, 1998
[16] Rhode Island Department of Health, Health Interview Survey
[17] Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured", Dec. 1997

Health Care Delivery Infrastructure: Health care spending generally increases with the size of a state's health care delivery infrastructure. In general, the richer the available resources in health care delivery facilities and personnel, the higher the observed expenditures. The available data support the view that on a per capita basis, Rhode Island has a relatively robust health care delivery infrastructure compared to the region and the nation as whole. Health care employment represents over 11% of total employment in Rhode Island – the highest proportion in the region. The number of physicians per capita in Rhode Island is surpassed among the New England states only by Massachusetts and Connecticut, and is well above the national average. In addition to its wealth of health care delivery personnel, Rhode Island is also generously supplied with health care facilities. For example, the number of nursing home beds per capita is higher in Rhode Island than in other New England states and than the national average.

Utilization Patterns: The style of care and utilization patterns in a geographic area may be among the most important contributors to health care expenditures.[18] The Council will provide information that shows how Rhode Island compares to the region and the nation in terms of health care resource use (i.e., population-based utilization of providers/services). Current observed high utilization rates for some services (e.g., ambulatory surgery centers[19]) are somewhat perplexing, given the state's relatively large managed care penetration. Nationally, Rhode Island ranks very high[20] in terms of the portion of its population with HMO coverage. Such observations may reflect the presence of managed care organizations in RI whose style is more akin to traditional indemnity insurers than to tightly managed HMOs.

Benefit Package Design: As indicated above, more generous health care coverage is presumed to be associated with higher health care spending as individuals are able to obtain a wider array and greater number of health care services at lower marginal cost. State level data comparing health care benefit packages does not exist for the overall insurance market. In addition, benefit information is entirely unavailable for employees whose benefits are provided by self-insured companies. An estimated 60% of medium and large companies in New England self-insure. The federal Employee Retirement Income Security Act (ERISA) exempts these companies from state benefit requirements. While Rhode Island's rate of self-insurance is much lower, the phenomenon renders state-wide comparisons of health plan design extraordinarily difficult. Comparisons may be possible within subsets of health plan products, and within public programs (e.g., Medicaid managed care plans).

[18] The Dartmouth Atlas of Health Care in the United States, 1998 http:/www.dartmouth.edu/atlas/toc98.html
[19] See Chapter 3: "Hospitals and Ambulatory Surgery Centers".
[20] See Chapter 2 "Health Plans", for a more complete elaboration of managed care penetration in Rhode Island.

HEALTH PLANS

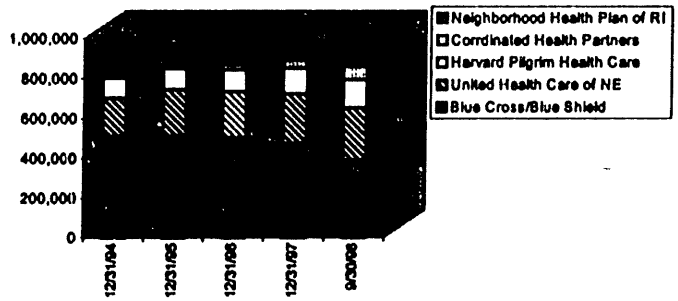
- - Overview - -

While many health insurers do business in Rhode Island, there are five major plans which serve over 90 percent of the employer-based market, 100 percent of state insurance programs, and the nearly 34 percent of the Medicare beneficiaries who have selected Medicare risk-contracts in Rhode Island. Combined, these plans employ a workforce of over 2,200 employees, command $468 million in assets[1] and direct $1.47 billion in premiums and expenditures.[2]

Current Market Penetration

Figures 1 and 2 summarize historical enrollment in the health plans that cover the vast majority of Rhode Island people with health coverage. These figures represent plans' *total membership* (some of the plans enroll members in contiguous geographic markets).[3]

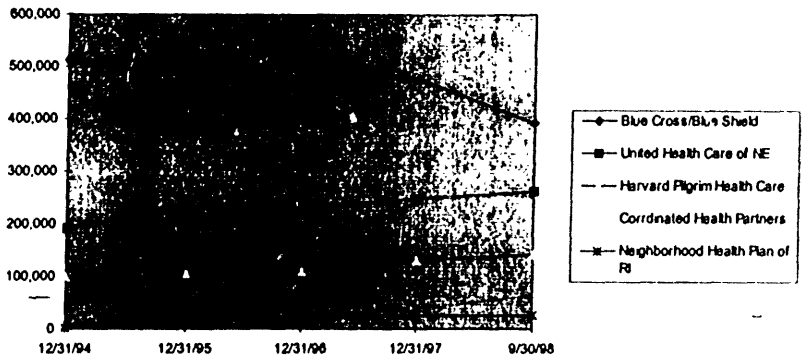
Figure 1 - Rhode Island Health Plan Cumulative Enrollment 1994-1998



Department of Business Regulation, Health Plan Annual and Quarterly Reports

[1] As of 12-3-97; from 1997 Health Plan Filings at the Department of Business Regulation. Premium income excludes investment income.
[2] Ibid; Total health care expenses for the year were $1,343,874,168.
[3] Figures do not include Pilgrim Health Care, a very large regional HMO whose membership is gradually being moved into Harvard Pilgrim Health Care of New England.

Figure 2 - Rhode Island Health Plan Enrollment Trends 1994-1998

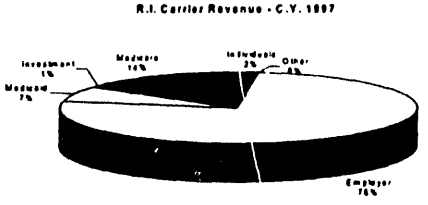


Source: Department of Business Regulation, Health Plan Annual and Quarterly Reports

These five plans for the year ended December 31, 1997, covered collectively 863,344 Rhode Island members (adding in Pilgrim Health Care) as of the end of that year. In the case of commercial membership, this means people who receive coverage through a Rhode Island place of employment or other affiliation and does not necessarily equate to residency.

Funds Flow: Revenue

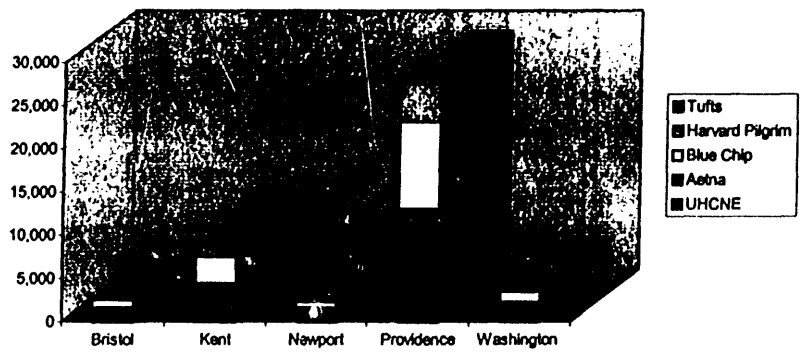
In the aggregate, Rhode Island health plans derive more than three-quarters of their revenue (76 percent) from the employer-based health insurance market. A small (14 percent) but growing share of total revenue flows from Medicare risk business. Medicaid accounts for just 7 percent of health plan revenue, and premiums from individual sales comprise just 2 percent. As noted above, the relative distribution of individual carriers' sources of income varies considerably from the average reflected in the illustration below. For example, Medicaid accounts for almost one-quarter of Blue CHIP's total revenues, but nearly 100% of Neighborhood Health Plan premium income.



Source: Plan 1997 Annual Filings, Department of Business Regulation

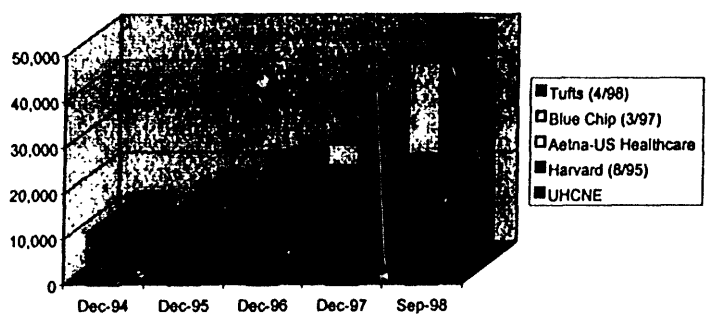
Five licensed HMOs currently offer Medicare managed-care products (so-called risk plans) in Rhode Island. Figure 3 shows the distribution of members among these competitors by Rhode Island County as of June 30, 1998.

Figure 3 - Enrollment in Medicare Risk Plans by County



In just four years, Medicare managed care has grown from covering 8 percent to over 30 percent of the total Medicare eligible population in Rhode Island (Figure 4). In fact, as a percentage of beneficiaries covered by managed-care plans, Rhode Island was fourth highest as of March, 1998, tied with Florida, and behind only Arizona, California, Colorado, and Pennsylvania.

Figure 4 - Medicare Risk Contracts – 1994-1998



Medicaid (RIteCare Managed Care

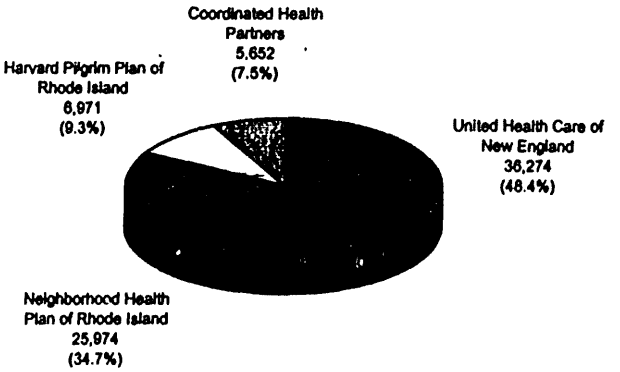
With the implementation of RIteCare in August of 1994, Rhode Island began mandatory Medicaid enrollment of (AFDC)[4] recipients and Medicaid-only families into HMOs. Included among those eligible for the program are uninsured pregnant women and children up to age 18[5] living in families with incomes

[4]Now Temporary Assistance to Needy Families (TANF)
[5]The uninsured child population originally eligible for RIteCare was up to age 6. On March 1, 1996, this was expanded to up to age 8. On May 1, 1997, it was expanded again up to age 18.

up to 250 percent of the Federal poverty level (FPL). By January, 1999, RIteCare eligibility will be expanded to include parents of eligible children with family incomes below 185 percent of the FPL.

Figure 5 reflects membership in RIteCare, by Plan, as of September 30, 1998.

Figure 5 – RIteCare Enrollment by Health Plan



HMO Premium Rates

Premium rates in the commercial market vary greatly due to a number of factors in the approved rating formulas. However, in general, Rhode Island purchasers and consumers enjoy a relatively favorable position in the cost of health insurance:

	Average Family Premium	Average Individual Premium
Rhode Island	$384.39	$140.98
Massachusetts	517.20	185.25
Connecticut	545.41	183.65
Maine	559.03	177.39
New Hampshire	519.12	172.04
OVERALL AVERAGE:	**$434.08**	**$150.22**

Provider Reimbursement

In spite of the relatively high concentration of managed care in Rhode Island, the Rhode Island marketplace is still somewhat immature from a provider reimbursement method perspective. Compared to other marketplaces, where providers take over or share financial risk with the managed-care plans, Rhode Island is very much in its infancy.

Neighborhood Health plan of Rhode Island makes use of capitated arrangements for primary care, and both Coordinated Health Partners and United HealthCare make use of capitated health partners under the RiteCare program. Also numerous health plans and commercial insurers make use of "carve out" risk

delegating arrangements for selected services such as behavioral health, prescription drugs, vision services, chiropractic services, radiology laboratory services, etc.

However, Rhode Island has not seen the widespread growth of arrangements under which organized provider groups assume global responsibility for managing health care and its associated costs for a defined member population. Nor has there been serious development of capitated arrangements covering physician specialty services, e.g. cardiology, orthopedics, obstetrics, etc. that are commonplace in other markets.

FACTORS INFLUENCING THE FUTURE HEALTH PLAN MARKETPLACE IN RHODE ISLAND:

Regulation of Health Plans in Rhode Island

HMOs in Rhode Island are currently licensed in three separate ways: (1) as HMOs; (2) as utilization review agents; and (3) under Zainyeh. Each constitutes a separate licensure process and a separate licensure fee. The Department of Business Regulation (DBR) has the overall responsibility for regulating the business of insurance including the licensure of HMOs and other risk bearing entities and monitoring of financial solvency.

The Department of Health (DOH) regulates the health care delivery and access aspects of managed-care, as well as utilization review activities in Rhode Island.

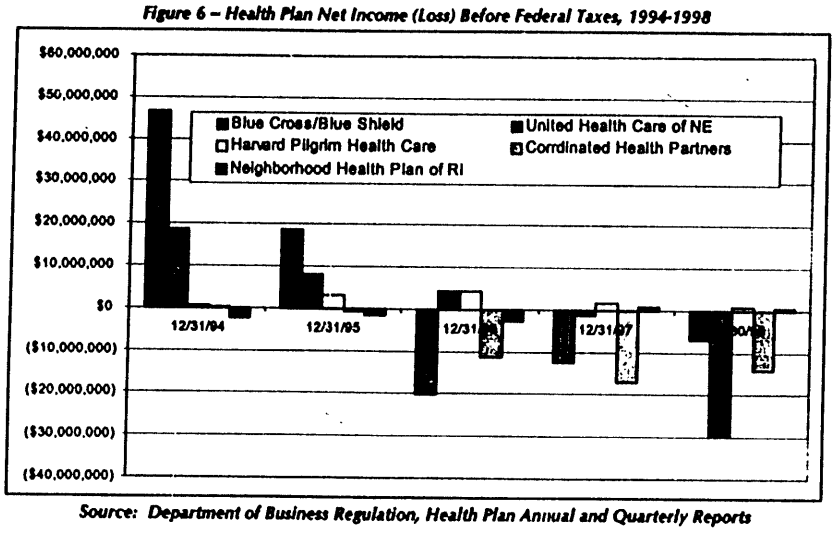
Health Plan Financial Performance

Rhode Island's health plans, in total, are experiencing a rapid and accelerating decline in financial performance. Figure 6 illustrates that a swing of nearly $53 million in net profitability occurred between 1995 and 1996. The level of losses experienced in 1996 was approximately equaled in 1997, and has been exceeded by 75 percent in just the first nine months of 1998.

It is axiomatic that all Health Plans seek to maintain or improve their market position and they employ a variety of strategies to do so. Health Plans compete, just as do other businesses, on the basis of the four P's: products, price, place, and promotion. As noted earlier, new products continue to evolve in the market place; and the Health Plans promote them heavily through advertising and marketing. While all health plans in the State operate statewide (and increasingly regionally), significant differences in network characteristics may have a profound effect on the overall product. Thus, price and product can become principal factors differentiating the various health plans. To overcome product differences, plans may make an aggressive bid to achieve market share through deep discounted offerings. To take one example: during the State's 1997 procurement of employee health benefits, Blue Cross/Blue Shield (BC/BS), UHCNE and Harvard Pilgrim offered their products at very aggressive rates in order to maintain their existing market shares of the more than 20,000 eligible State employees selecting coverage. However, such a strategy may have limited success in both the short- and long-terms. As insurers bid down prices in an effort to buy market share, they cannibalize their own margins as well as those of their competitors and are less well positioned to absorb subsequent increases in health care costs or negative claims experience. Such practices may help explain why BC/BS and United have been posting significant losses. Some companies appear to be employing the identical strategy for the Medicare population by offering very expansive products at very closely shaved rates. Such practices are of special concern to advocates for the elderly, who fear that as plans establish Medicare market share, they will cut benefits and raise prices.[6]

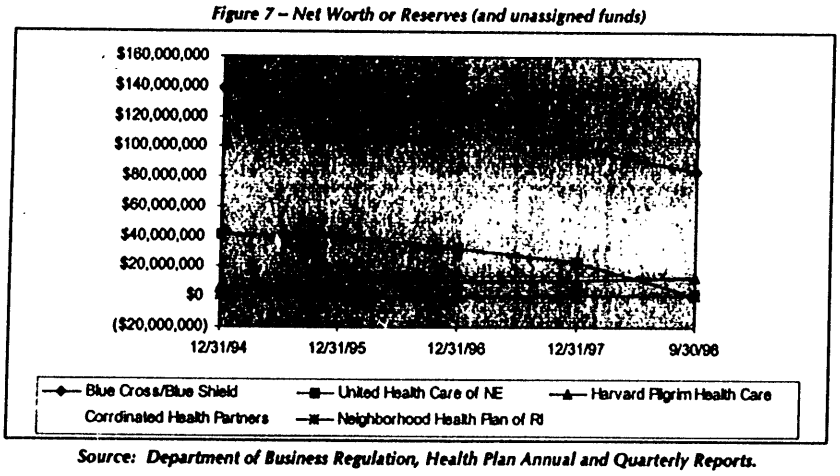
[6] "Medicare HMOs Trim Benefits," *The Providence Journal Bulletin*

Figure 6 – Health Plan Net Income (Loss) Before Federal Taxes, 1994-1998



Source: Department of Business Regulation, Health Plan Annual and Quarterly Reports

Figure 7 – Net Worth or Reserves (and unassigned funds)



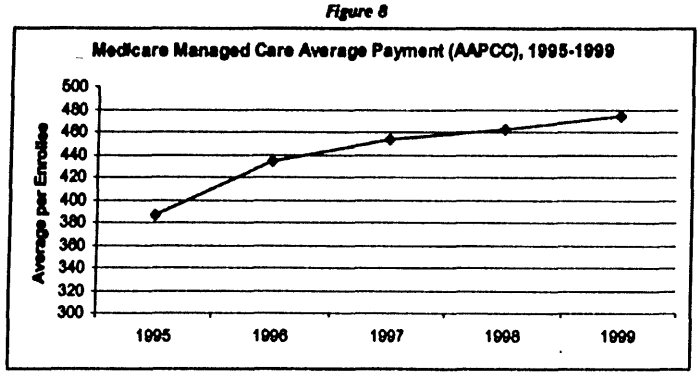
Source: Department of Business Regulation, Health Plan Annual and Quarterly Reports.

The Impact of Medicare Managed Care

The intensified competition in the Medicare managed care market, along with efforts to contain the costs of the Medicare program at the federal level, are combining to put significant new cost pressures on both hospitals and health plans.

Figure 8 reflects a five-year trend in Medicare's average payment rates to health plans. Sharp declines in the rate of increase began occurring in 1997 and are expected to continue under a new 2 percent cap enacted as part of the Balanced Budget Act.

Figure 8



Managed Care Reform

The rapid growth in managed-care enrollment has created concerns around consumer rights. Governments at both the Federal and State levels have sought to address these issues. The most visible current effort at the federal level is the debate around the "Consumer Bill of Rights," which stemmed from a series of recommendations contained in the final report of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. President Clinton established this commission in March of 1997.

In May, the Rhode Island Department of Health issued a Health Policy Brief, which compared current Rhode Island law to the recommendations contained in the Consumer Bill of Rights. It concluded, "Rhode Island law meets most of the recommendations of the Consumer Bill of Rights. Efforts to improve the quality of care in Rhode Island should focus on assuring access to emergency services and participation in treatment decisions, and on full implementation of our existing laws."

Health Care Reform

Although not as visible, there is another reform process of a less regulatory nature underway in many parts of the country. As managed-care organizations have increasingly penetrated markets across the country, they have demonstrated their ability to reduce medical costs by minimizing the inappropriate use of expensive services and stimulating the growth and development of less costly alternatives. But such efficiencies will only go so far. There is consensus growing that continued savings for managed-care plans in mature markets will more likely come from improving the health of the population they serve than from screening out one more unnecessary procedure.[1] (See also **Public Health**)

At the same time, there is increasing interest on the part of public health officials in the ability of MCOs to measure and report on the delivery of preventive services to the populations they serve and their developing skills regarding disease management processes. For example, The New England Regional

[1] *State Initiatives in Health Care Reform*, The Robert Wood Johnson Foundation and the Alpha Center, May/June, 1996.

Public Health and Managed-care Collaboration has been instituted to harness the strengths of public health and managed care in applying prevention and population-based health care to improve the health status of New Englanders and their communities.

Several types of data on Health Plan performance are now available. HEDIS (Health Plan and Employers Data and Information Set) 3.0, issued in early 1997 by the National Committee for Quality Assurance, includes measures of health plan performance and specifications for the provision of description information in eight domains, including effectiveness of care (quality), access, member satisfaction, plan stability, and outreach.

Unfortunately, despite the availability of such tools, the majority of employers have been slow to hop on the "quality" bus. Only a handful of the largest purchasers routinely use quality information to make health plan decisions for their employees. Very few small employers are even aware that such ratings exist. Council staff queried a convenience sample of Rhode Island enrollment brokers, health plan representatives, purchasing cooperative administrators, and affinity group sponsors – together representing 50,000 lives – during the 1998 health plan marketing/enrollment season, about their criteria for health plan selection. Rarely was there any basis for selection other than price and, for the aggregated groups, administrative service. The majority of purchaser representatives felt they had neither the capacity nor the incentive to gather or use published performance reports. The prospect of negotiating specific performance requirements on behalf of their own insureds was absolutely out of the question.

Health Care Spending Projections

Since 1990, HMO premium *increases* have been trending downward, as indicated by the following data[8]:

	Premium Increases	
Year	Family	Individual
1990	18.4%	17.0%
1991	13.2%	13.2%
1992	10.6%	10.1%
1993	8.1%	8.0%
1994	6.6%	6.3%
1995	0.0%	(0.7%)
1996	(0.4%)	(0.5%)

All indications are that this trend bottomed out and began to reverse itself in 1997. According to the federal government's top health actuaries,[9] following five years of near-stability, health spending is expected to rise as a share of gross domestic product (GDP) beginning in 1998, climbing from 13.6 percent to 16.6 percent by 2007.

There are a number of assumptions that drive these projections, including the macroeconomic factors such as the aging of the population and increases in the underlying costs of health care services; e.g., wages and salaries, technology, etc.

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[8] American Association of Health Plans.

[9] Shiela Smith, et al, "The Next Ten Years of Health Spending: What Does the Future Hold", *Health Affairs*, September/October, 1998.

Projections are for moderate but nevertheless upward growth in plans' underlying costs for the next few years, suggesting that either premiums will increase a pace or plans' financial position will further deteriorate. In 1997, premium increases for the major national managed care firms averaged in the 5 percent range and approached 9 percent in 1998. Indications are that premium increases for 1999 are in the 8-9 percent range overall, with some smaller groups facing substantially higher rate-hikes.

HOSPITALS AND AMBULATORY SURGICAL CENTERS

-- *Overview* --

The hospital industry that exists today in Rhode Island is undergoing a period of dramatic change. Following decades of rising healthcare cost, payers and consumers are becoming more cost-conscious, trying to hold constant or even decrease the dollars being contributed to the healthcare system. Technological advances are allowing and encouraging the shifting of medical practice from inpatient to ambulatory settings. Employers, consumers, third-party payers, state governments and the American public now are demanding changes in the way healthcare is financed and delivered. These parties are also demanding, and receiving, a seat at the table as decisions get made that will drive even more fundamental realignment of the healthcare marketplace.

Financial Impact of Rhode Island Hospitals

According to a study by the Howell Group—a Boston based consulting company commissioned by the RI Hospital Association–

- The direct expenditures of Rhode Island hospitals accounted for over 6% of Gross State Product (GSP) in 1995, a 35% increase from the 4.5% share in 1985;
- Rhode Island hospitals spend about $1.4 billion annually in the local economy;
- Rhode Island hospitals had 23,400 employees (16,000 Full Time Equivalent Personnel (FTEs)– an estimated 10.2% of total statewide employment – the fourth highest employment sector in the state. Direct payroll expenditures amounted to $823.6 million. The hospital sector payroll represented 3.6% of total personal income, and accounted for an even larger 5% of statewide personal income growth.
- The hospitals provided $36.2 million in revenues to state and local governments through state income tax payments (representing 5% of total state income tax revenues) and temporary disability payments;
- Hospital expenditures on facility improvements and capital equipment totaled $86.4 million in 1995. It was estimated that the hospitals represent 9% of total construction spending in the state;
- $33 million in research funding was received by hospitals with teaching affiliations with the Brown University Medical School – an important platform for expansion of research, technology, and continued growth.

Other than the government-operated hospital and one joint venture between a non-profit entity and a for-profit entity (Rehabilitation Hospital of Rhode Island), all hospitals are not-for-profit facilities. Seven of the hospitals are members of one of the two networks operating in the state, and an eighth is allied with a network. Bradley, Miriam, Rhode Island, and Newport, with 1,226 beds, are affiliated through the Lifespan network, with South County being allied with Lifespan without a formal affiliation. Butler, Kent County, and Women and Infants Hospitals, with 601 beds, form the Care New England network.

Of the fifteen non-governmental hospitals in the state, six are affiliated with the Brown University Medical School. Those are Bradley, Butler, Memorial, Miriam, Rhode Island, and Women and Infants Hospitals. The federally operated Veterans Administration Medical Center in Providence is also affiliated with Brown.[1]

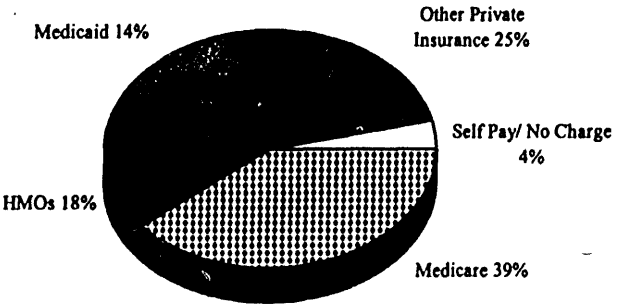
[1] Brown University School of Medicine, Department of Public Relations, 1998.

Sources of Funds

Based on the FY1996 discharge data reported by the eleven community general hospitals, governmental programs (Medicare, RIteCare, and fee-for-service Medicaid) are the expected source of payment (as determined at admission) for 52.8 percent of patients, accounting for 64.1 percent of days of care and 61.5 percent of hospital charges. Among the private insurers, the largest proportion of discharges (18.6 percent) were paid by Blue Cross plans, but nearly as many discharges (18.1 percent) were paid by the state's licensed HMOs. Self-pay patients, presumably those who are "uninsured," comprised 3.8 percent of hospital inpatients, compared to 10 percent of the population as a whole in 1996.[2] This category of inpatients can not be assumed to represent the patient population receiving "charity care" because there is no indication whether these patients paid some or all of their hospital charges out-of-pocket.

Nationally, the distribution of hospital payments by third-party payer is somewhat different from the pattern seen in hospital charges for Rhode Island In 1995, Medicare patients accounted for 39.1 percent of payments to community general hospitals, Medicaid patients for 14.7 percent, patients in other government programs for 1.6 percent, and patients paid by private third-parties for 35.8 percent. The comparison of national data to the statewide data may be inexact for two reasons – (1) actual reimbursements are used in the national data, whereas, hospital charges are used in the Rhode Island data, and (2) all hospital services are included in the national, whereas inpatient services only are included in the Rhode Island data.[3]

Figure 1 - Pay Source for Hospital Discharges, Rhode Island, FY 1996



Source: Rhode Island Department of Health, Uniform Hospital Discharge Data Set

[2] Rhode Island Department of Health, Uniform Hospital Discharge Data Set.
[3] Ibid.

Total Expenditures, Expense Categories, and Employment

Expenses for care in the 13 private hospitals and the inpatient rehabilitation facility approached 1.5 billion dollars in FY1997, or approximately $1,472 dollars per resident. Table 1 presents these data.[4]

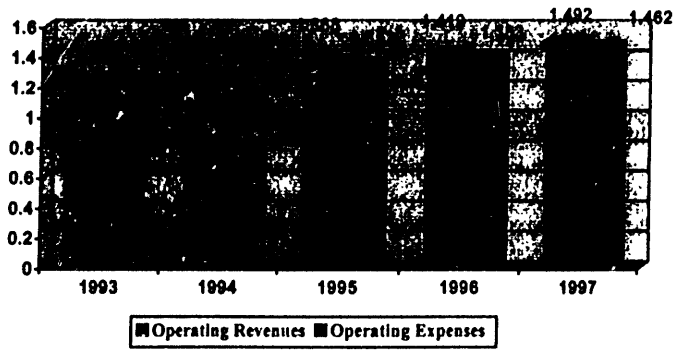
Table 1 – Selected Financial and Other Data, Rhode Island Hospitals
Fiscal Year 1996 & 1997

Revenue/Expenses	Amount ($ Million)	
	1996	1997
Total Operating Revenue	1,419	1,492
Net Non-Operating Gains	22	38
Net Income	57	57
Operating Income	36	20
Total Operating Expenses	1,383	1,472
Wages and Salaries	647	673
Charity Care (@ Costs)[5]	15	16
Bad Debt	59	77
Other	**Value of Measure**	
	FY 96	**FY 97**
Licensed Hospital Beds	3,279	3,240
Patient Days[6]	712,145	716,423
Discharges[7]	123,344	122,803
Total FTEs	15,933	16,175
Medicare Case Mix[8]	1.397	1.405

Source: Rhode Island Department of Health, "The Financial Health of Rhode Island's Community Hospitals," December 1997.

[4] Rhode Island Department of Health, "The Financial Health of Rhode Island's Community Hospitals," December 1997
[5] Charity Care (charges-foregone) adjusted by each hospital's ratio of costs to charges.
[6] Includes intensive neonatal volume at W&I.
[7] Includes intensive neonatal volume at W&I.
[8] Weighted average based on discharges (not applicable to Bradley, Butler, Rehab of RI, and W&I, therefore, they are assigned values of "1", i.e., unweighted).

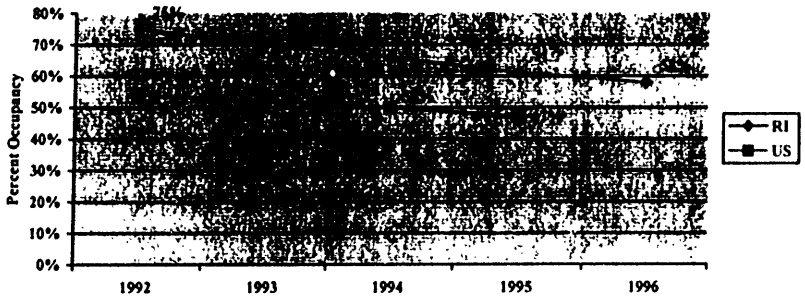
Figure 2 - Operating Revenue and Expenses
(billions of dollars)



Hospital Occupancy Rates

Driven by evolving technology, changing practice patterns and, beneath all this, the policies of major payers, hospital occupancy has been on a downward trajectory for the past decade. [9] Figure 3[10] shows the general downward trend in occupancy, though Rhode Island hospitals remained more highly utilized on an inpatient basis than their national counterparts[11].

Figure 3 - Hospital Occupancy



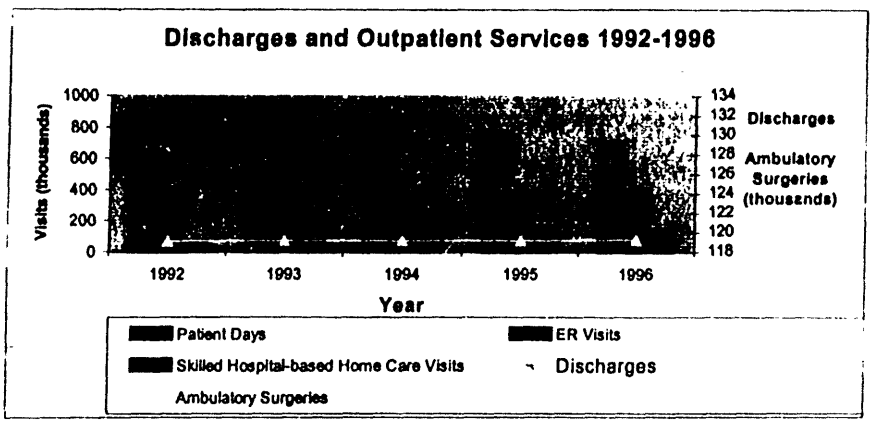
[9] Occupancy rates for Rhode Island hospitals have been computed on the basis of number of beds licensed to the hospitals by the Department of Health. Low occupancy rates do not necessarily imply that there is inefficiency in the system due to the costs of maintaining unused capacity, as hospitals typically maintain a smaller number of "staffed" beds within their licensed capacity that reflects their historic utilization experience. Additional measures of utilization that complement occupancy rates are the population-based rates of inpatient discharges and inpatient days. These measures will be available when information on Rhode Island residents hospitalized in neighboring states is obtained

[10] Ibid, RI Dept. of Health.

[11] RI is the state total and US is the US median (i.e., mid-point) based on a constant sample size. The RI total and not the median is used as a more accurate representation of the state, because of the small population and large size differences among hospitals.

Figure 4 shows that, as inpatient days declined, other modalities of hospital-based outpatient care increased[12] (i.e., ambulatory surgeries, emergency room visits, skilled home care visits).

Figure 4



Source: Rhode Island 1997 Hospital Financial Data Set

Interstate Migration

As shown in Table 2 below, the large majority of inpatients in Rhode Island community general hospitals are residents of the state. Smaller percentages are residents of Massachusetts and Connecticut, primarily from communities that border Rhode Island and are geographically closer to Rhode Island facilities than those in their own states. A small number of residents of more distant states are treated in Rhode Island hospitals; these are presumed to be summer residents, tourists, or other travelers, primarily.[13]

Table 2 - Discharges by State of Residence, Rhode Island Community General Hospitals Fiscal Year 1996

State of Residence	Number	Percent
Rhode Island	117,058	91.9
Massachusetts	7,560	5.9
Connecticut	1,934	1.5
Other States	817	.06
Unknown	65	.01
Total	**127,434**	**100.0**

Source: Rhode Island Department of Health, Uniform Hospital Discharge Data Set

[12] 1992-1996 changes: patient day (-25%), ER visits (+5%), skilled home care visits (+135 %), ambulatory surgeries (+17 %).
[13] Ibid

Comparable data on Rhode Island residents who receive hospital care in other states are not yet available for this period. More complete discharge data from neighboring states has been requested to describe conclusively the patterns of interstate migration for hospital care.

Uncompensated Care

All hospitals in Rhode Island provide some unreimbursed healthcare services. Depending on patient financial status and hospital billing practices, these services generally are classified as either charity care or bad debt. Charity care is healthcare provided to the medically indigent (i.e., the uninsured poor) without expectation of payment[14]. Each hospital has its own policies and criteria for who qualifies for charity care. Table 3[15] shows cost-adjusted charity care for the past four years (for which data are available), both in dollar amounts and as a percent of net patient revenue.[16]

Table 3 – Hospital Charity Care (Dollar Amounts in $000s)

Net	←1994→ Charity Care[17]	←1994→ % of Pat. Rev.	←1995→ Charity Care	←1995→ % of Net Pat. Rev.	←1996→ Charity Care	←1996→ % of Net Pat Rev.	←1997→ Charity Care	←1997→ % of Net Pat. Rev.
Bradley	$230	1.3%	$213	1.2%	$337	1.7%	$1,144	5.5%
Butler	$660	3.1%	$842	3.4%	$790	2.8%	$775	2.5%
Kent County	$582	0.5%	$629	0.5%	$768	0.6 %	$655	0.5%
Landmark[18]	$3,635	5.9%	$427	0.6%	$605	0.6%	$347	0.5%
Memorial[19]	$1,366	1.7%	$1,191	1.4%	$1,292	1.6 %	$1,351	1.3%
Miriam	$1,513	1.5%	$1,058	0.9%	$1,056	0.9%	$994	0.8%
Newport	$1,066	2.2%	$765	1.5%	$871	1.7 %	$967	1.8%
Rehab of RI[20]	$20	0.1%	$24	0.1%	$15	0.1%	$26	0.1%
RIH	$3,591	1.2%	$3,968	1.1%	$5,310	1.4%	$5.529	1.5%
RWMC	$529	0.7%	$639	0.7%	$313	0.3%	$432	0.5%
South County	$360	1.0%	$368	1.0%	$525	1.2%	$478	1.1%
St. Joseph	$504	0.5%	$663	0.4%	$454	0.6%	$666	0.6%
Westerly	$685	1.9%	$636	1.7%	$380	0.9%	$362	0.8%
W&I	$1,586	1.5%	$1,797	1.5%	$2,153	1.8%	$1,898	1.5%
Totals	$16,308	1.5%	$12,980	1.0%	$14,649	1.1%	$15,626	1.2%

[14] The 1996 AICPA Audit and Accounting Guide for Health Care Organizations (aka the Hospital Audit Guide) distinguishes charity care as healthcare services never expected to result in cash flows and bad debt as healthcare services expected to be reimbursed but written off as an expense as uncollectible.

[15] RI Dept. of Health, "Hospital Uncompensated Care in Rhode Island (1993-1997), June 1998.

[16] For purposes of comparison and standardization, the charity care data here have been cost-adjusted to controls for variations in hospitals' prices and presents an approximation of the actual expenses incurred to provide the service.

[17] Standardized by multiplying charity care (charges foregone) by a cost adjustment factor (Medicare Cost Reports, Worksheet C, Part 1, Column 5, Line 103/Column 6, line 103, i.e., total costs/total charges); except Bradley Hospital (Medicare Cost Report Short-Form, Worksheet G-3, line 4/Line I, i.e., operating expenses/total (gross patient revenue), Medicare Cost Reports are on file with the RI Dept. of Health.

[18] Charity care charges-foregone is self-reported (not audited) in 1994.

[19] Charity care charges-foregone is self-reported (not audited) in 1994 & 1995.

[20] Opened in 1994, charity care charges-foregone is self-reported (not audited) in 1994 & 1995.

Bad debt in contrast, is the write-off of payment for healthcare services that is expected, but never received. Table 4[21] presents bad debt for the past four years (for which data are available) both in dollar amounts and as a percent of net patient revenue.

Table 4 – Hospital Bad Debt (Dollar Amounts in $000s)

	←1994→		←1995→		←1996→		←1997→	
Rev.	Bad Debt	% of Net Pat.	Bad Debt	% of Net Pat. Rev.	Bad Debt Rev	% of Net Pat.	Bad Debt Rev.	% of Net Pat.
Bradley	$0	0.0%	$662	3.8%	$427	2.2%	$4,946	23.8%
Butler	$725	3.4%	$903	3.7%	$1,356	4.9%	$1,890	6.2%
Kent County	$4,990	4.5%	$5,183	4.4%	$5,278	4.1%	$6,350	4.7%
Landmark	$3,370	5.5%	$4,410	6.6%	$4,537	6.7%	$4,078	5.8%
Memorial	$3,299	4.1%	$3,902	4.5%	$4,518	4.9%	$4,427	4.4%
Miriam	$3,600	3.6%	$3,670	3.2%	$4,130	3.6%	$5,188	4.2%
Newport	$1,783	3.7%	$2,171	4.2%	$2,542	4.9%	$3,103	5.7%
Rehab of RI	$150	0.9%	$117	0.6%	$46	0.3%	$108	0.6%
RIH	$22,164	7.4%	$22,874	6.3%	$23,401	6.3%	$32,290	8.5%
RWMC	$3,978	5.1%	$4,274	4.7%	$4,175	4.5%	$4,168	4.6%
South County	$814	2.4%	$967	2.5%	$1,343	3.2%	$1,234	2.9%
St. Joseph	$3,420	3.4%	$3,700	3.3%	$3,919	3.6%	$4,585	3.9%
Westerly	$1,698	4.8%	$3,106	8.3%	$1,525	3.5%	$1,804	4.0%
W&I	$2,792	2.7%	$2,826	2.4%	$1,638	1.4%	$2,359	1.8%
Totals	$52,783	4.8%	$58,765	4.7%	$58,835	4.5%	$76,530	5.6%

Uncompensated care is the total of charity care (in this case, cost-adjusted) and bad debt (uncollected accounts). Uncompensated care simply means that payment was not received. Over the period 1994-1997, the provision of uncompensated care varied from less than 1 percent of net patient revenue to over 8.5 percent at individual hospitals[22].

[21] RI Department of Health, "Hospital Uncompensated Care in Rhode Island (1993-1997), June 1998..
[22] RI Department of Health ibid.

AMBULATORY SURGICAL CENTERS

Ambulatory surgery refers to surgery performed on an outpatient or ambulatory basis in a hospital, freestanding surgical center, endoscopy units, and cardiac catheterization laboratories. The utilization of ambulatory surgery has been increasing in the United States since the early 1980's, when Medicare began paying facility charges for such procedures.[23]

As of December 31, 1997, there were eleven hospital-based ambulatory surgical facilities and five free-standing ambulatory surgical facilities operating in Rhode Island. [24] All of the state's community general hospitals were performing surgery in their operating rooms on patients who were not admitted as inpatients. These hospitals included a total of 137 staffed operating rooms, or an average of approximately 12 OR's per facility. These statistics include OR's used for inpatient as well as outpatient surgery. The five free-standing facilities included a total of 14 OR's, or just under three OR's per facility on average. These OR's are used only for outpatient surgery.[25]

Comparisons with National and Regional Data

Utilization rates for surgical procedures in hospitals and free-standing surgicenters are higher in Rhode Island than elsewhere in New England or in the United States as a whole. These data are detailed in Table 5. The Rhode Island rate for performance of surgical procedures per 1,000 population is 14 percent higher than the national rate and 17 percent higher than the New England rate. Free-standing surgical centers perform 11 percent of surgery in Rhode Island, a lower figure than is found nationally (16 percent) but higher than the New England average (8 percent).[26] The reason for such utilization differences is not clear, but may be due to differences in health status and underlying demographics (e.g., age distribution), differences in access to health care, such as might result from differences in the numbers and geographical distribution of providers and differences in health insurance coverage, and/or differences in physician practice patterns and inclinations to prescribe surgical interventions in lieu of other treatment options.

Table 5 - Surgical Operations (Inpatient and Outpatient) per 1,000 Population, by Type of Provider, Rhode Island, New England and United States, 1995

Type of Surgical Facility	RI	NE	U.S.
Hospital-based	105.1	93.2	88.2
Freestanding Ambulatory	13.5	8.3	16.3
Total	**118.7**	**101.5**	**104.5**

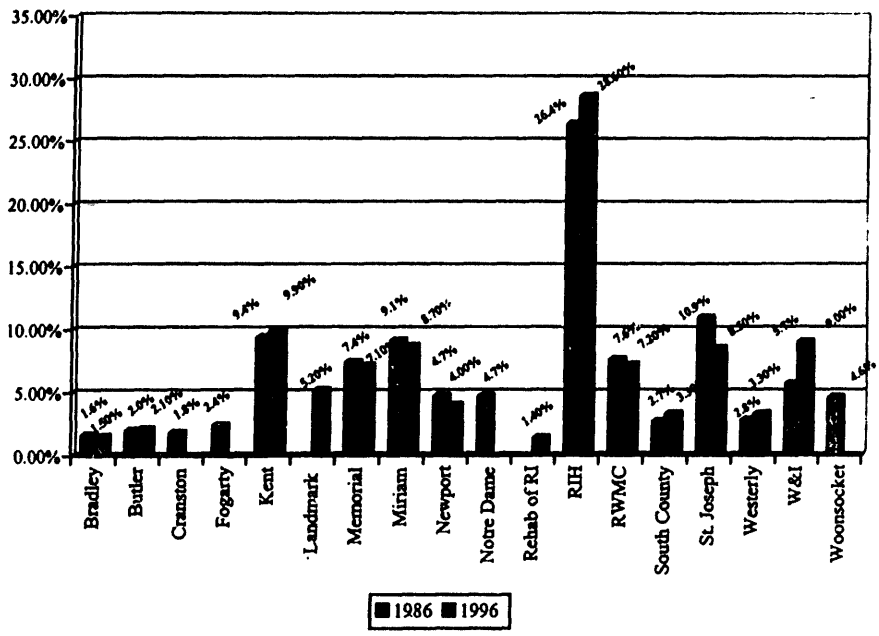
Source: H. Zimmerman, "Need for Ambulatory Surgery Facilities in Rhode Island: 1997 Update," (January 1998)

[23] Hall MJ, Lawrence L. Ambulatory Surgery in the United States, 1995. Advance Data No. 296. Hyattsville, MD: National Center for Health Statistics. December 1997.
[24] Zimmerman H. Need for Ambulatory Surgical Facilities in Rhode Island: 1997 Update. Providence, RI: Rhode Island Department of Health. January 1998.
[25] Zimmerman H. Need for Ambulatory Surgical Facilities in Rhode Island: 1997 Update. Providence, RI: Rhode Island Department of Health. January 1998.
[26] Ibid.

Hospital Market Share

While some hospital markets have seen the closure of 30 percent of their facilities and the redistribution of large pieces of business, Rhode Island's hospital market has remained remarkably stable. In 1986, there were sixteen hospital generating $575 million in patient revenue. Ten years later, there were fourteen hospitals generating $1.3 billion in patient revenue. Figure 4[27] graphs the changes in individual hospital market shares[28] as a percentage of patient revenue.

Figure 4, 1986 and 1996 Hospital Market Shares



Source: Rhode Island Department of Health, "Concentration of Hospital Market Share in Rhode Island", July 1997.

(In the intervening years between 1986 and 1996, Cranston General closed and Notre Dame Hospital was acquired by Memorial. Fogarty and Woonsocket merged into Landmark; Bradley, Miriam and RIH formed Lifespan; and Butler, Kent and W&I formed Care New England.)

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[27] RI Dept. of Health, "Concentration of Hospital Market Share in Rhode Island", July 1997.

[28] With the shift in hospital services to outpatient care, market share based on patient revenue becomes most relevant. It includes both inpatient and outpatient activity whereas discharges and patient days do not. This market share is defined as the percentage of statewide community hospital net patient revenue.

Forces Driving Change:

- **Increased Managed Care Enrollment:** The growth in the percentage of all patients holding health care insurance coverage through managed care organizations such as health maintenance organizations, preferred provider organizations, point of service programs, and other similar types of systems.[29]
- **Cost-containment: Medicare's Prospective Payment System:** In 1983, the federal Medicare program fundamentally altered the way hospitals are paid by being the first major payer to abandon cost-based reimbursement. Until 1986, Medicare payments on average still exceeded the costs of providing care. However, 1987 began a six-year period during which Medicare payments were less than costs. At the same time using similar reimbursement strategies, Medicaid programs were even more restrictive, with payment-to-cost ratios falling as low as 0.76. More recently, Medicare margins have been trending upward again, and hospitals as a group have experienced strong financial performance overall. In 1996, hospitals posted their largest cumulative profits in fourteen years.[30] In turn the BBA, enacted in 1997, targeted these profit margins for nearly $32 billion in Medicare savings over five years nationally.[31]
- **Federal Policy Changes to Encourage Medicare Managed Care Growth:** The Balanced Budget Act of 1997 established multiple incentives for managed care organizations to expand Medicare managed care penetration, and for enrollees to join. At the same time, it capped the amount that Medicare will pay health plans for each enrollee. Health Plans will, in all likelihood, pass this squeeze on to the hospitals.
- **Emergence of Provider Sponsored Organizations:** Multiple states have developed regulatory authority for provider sponsored organizations (PSOs) to accept risk under direct contract with employers or payers such as Medicaid and Medicare. This usually includes a simplified application and certification process that allows providers (especially hospitals and health systems) to become an HMO "look-alike". The Balanced Budget Act of 1997 authorized PSOs to contract and accept Medicare risk enrollment directly from the federal government without having to use HMOs or other payers as intermediaries.
- **Private Investment capital** is aggressively seeking a role in for-profit healthcare delivery programs that stress economies of scale and control over costs.
- **Physicians are increasingly willing (and able) to consolidate** among themselves, and with hospitals in myriad structures.

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[29] Etheredge L, Jones SB, Lewin L. What is driving health system change? Health Affairs 15(4):93-104 (Winter 1996).
[30] Stuart Guterman, "The Balanced Budget Act of 1997: Will Hospitals Take a Hit on Their Profit Margins?" – Health Affairs, Jan./Feb. 1998.
[31] Ibid.

LONG-TERM CARE INDUSTRY

-- Overview --

The long-term care industry is among the fastest growing of health care sectors, both in terms of number of persons served and expenditures. Because of the dominant influence of government programs (i.e., Medicare and Medicaid), the growth in state and federal LTC expenditures has been particularly rapid. LTC consumes an ever-larger share of the state budget. Although nearly half of Medicaid spending is derived from state dollars, its payment policies, as well as those for Medicare, are determined largely by the federal government. Payment policies of the two programs differ markedly. Medicare has been relatively generous in its payment for home health care, and Medicaid is the dominant payer for nursing facility services. It follows then that State LTC spending has been concentrated on institutional services. The combined policies of both programs largely determine both the array of available LTC services and the actual delivery of care.

Classically, LTC care is thought of as nursing facility care, however the range of services has expanded dramatically and now includes an overlapping continuum from simple chore and homemaker services, to adult day care, to assisted living facilities, to institutional living with both acute and 24-hour chronic care. The evolution of the LTC market has been driven by a number of forces:

- The increasing size of the elderly population;
- Increased pressure on state and federal budgets caused by the growing costs of long-term care;
- Increasing use of prospective payment for long-term care services;
- More delegation of risk from managed care organizations to providers;
- Increased use of nursing facilities and home health to care for individuals recently discharged from hospitals with medically-complex conditions;
- Increased consumer demand for alternatives to institutional care;
- Higher expectations for provider accountability for cost effective, quality care, and specific patient outcomes;

The supply of community-based providers has increased rapidly due to Medicare payment policies, but there has not been a concomitant growth in community-based services for Medicaid enrollees. Medicaid waiver programs offer states some flexibility in terms of services covered and sites of care, but Rhode Island has been slow to take advantage of these features. Until recently, Medicaid payment rates for home health care have been low, and home and community-based waiver programs have limited the number of participants.

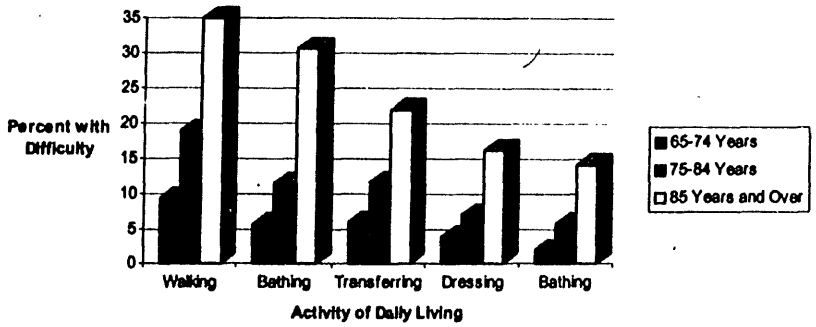
Need for LTC - One in six Rhode Islanders has a chronic condition that inhibits their lives to some degree. The populations needing long-term care include people with developmental disabilities, those with physical disabilities, individuals with mental illness, and the frail elderly population. Services for people with developmental disabilities represent a significant state expenditure, comparable in amount to that spent on nursing home care for the elderly. However, services for the developmentally disabled are viewed as a separate and distinct system from the long-term care system and are not examined in this chapter.

The need for LTC is commonly assessed in terms of dependencies in particular *Activities of Daily Living* (bathing, dressing, eating, transferring, and toileting) or according to the total number of ADL dependencies. The ability to predict the need for long-term care services on the basis of ADL

dependencies may be improved by considering the presence of other factors, such as co-existing cognitive impairments or certain medical diagnoses. Furthermore, the impact of ADL dependency may be moderated by the presence of strong social supports.

The percentage of the elderly needing assistance increases sharply with age (Fig. 1). Twenty percent of people age 65 and older needs assistance with activities of daily living (ADL), and even more need assistance with instrumental activities (IADLs). People age 85 and older are the heaviest users of long-term care. In Rhode Island, slightly more than a third of the elderly using Medicaid-paid services are at least 85 years old.

Figure 1 - Functional Limitations of Persons 65 Years and Over



Source: US Bureau of the Census

Funds Flow - The data do not exist with which to compile a complete and accurate picture of total spending, private and public, on long-term care services in Rhode Island. The most detailed and accurate data on the expenditures for long-term care services in Rhode Island is compiled and published annually by the Long-Term Care Coordinating Council (LTCCC) in its "RI Long-Term Care Spending"[1], and much of the information that follows is extracted from that work. However, "RI Long-Term Care Spending" is concerned with expenditures of State and state-administered revenue sources only. Comparable data on other revenue sources, including private out-of-pocket contributions, private insurance payments, and Medicare payments, does not exist in comparable form. This Chapter attempts to fill in some of that information.

Medicare Revenue

Although the Medicare program is not designed to cover long-term and/or chronic care services, the program is an important revenue source for many long-term care providers, including skilled nursing facilities and Medicare certified hospice and home health agencies. In calendar years 1996 and 1997 (the most recent years for which complete data are available) the Medicare program made payments in excess of $146 million to long-term care providers in Rhode Island (Table 2).

[1] Long-Term Care Coordinating Council, "Rhode Island Long-Term Care Spending: Where do the $$$ go?"

This amount represents an overall 15.3 percent increase over calendar year 1996 payments.

Table 2: Medicare Payments to Selected Long-Term Care Provider Categories, Rhode Island, CY 1996,1997

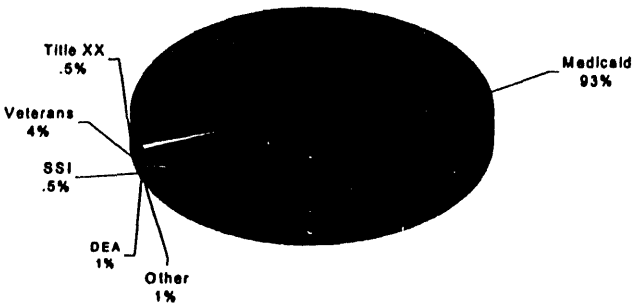
LTC PROVIDER CATEGORY	1996	1997
Skilled Nursing Facility	$38,357,344	$48,854,952
Home Health Agency	$88,383,316	$97,297,610
Hospice	$87,127	$87,264
TOTAL	$126,827,787	$146,239,826

Source: Health Care Financing Administration, 1998

State-Administered Funds

In fiscal year 1998, the State of Rhode Island spent $350,256,872 for long-term care services, a 5.6[2] percent increase from FY 1997. Forty-eight percent were state dollars, and 52 percent federal. Medicaid funds accounted for 93 percent of State-directed spending on long-term care services (Figure 2).

Figure 2- Rhode Island Spending for Long-Term Care by Revenue Source
Fiscal Year 1998



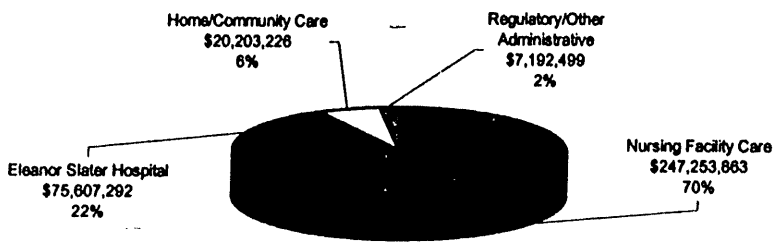
Source: Department of Human Services and Long-Term Care Coordinating Council

Ninety-two percent ($322,861,155) of state and state-administered dollars for long-term care in Rhode Island was spent on institutional services (Fig. 3). Over 70 percent or $247,253,863 was paid to nursing facilities under the Medicaid program, and 22 percent to Eleanor Slater Hospital. Home and community based services providers accounted for 6 percent, and state regulatory activities, 2 percent.[3]

[2] This amount does not include adjustments for accounts receivable and recoupments from nursing facilities, which totaled $2.13 million in FY 97 and (-$10.1 million) in FY 98. Thus, service-generated costs actually increased by $5.6 percent while budgeted spending only increased 2 percent.

[3] See above. Within the private nursing home sector (excluding Tavares Pediatric Center), service generated costs increased 5.2 percent, but Medicaid budgeted costs decreased 0.6 percent.

Figure 3 – Rhode Island Long-Term Care Expenditures, FY 1998
Total -$350,256,872

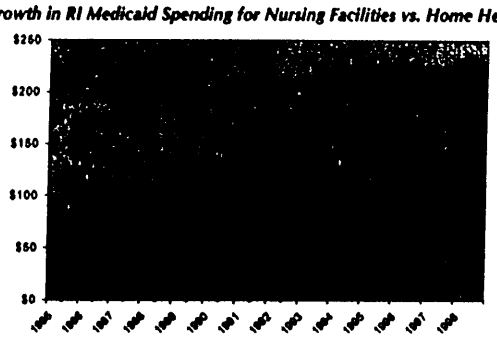


Source: RI Long-Term Care Coordinating Council and Medicaid Fiscal Office

In addition to these amounts, Medicaid spent an additional $4,558,643 for skilled home nursing/therapy visits in FY 1998.[4]

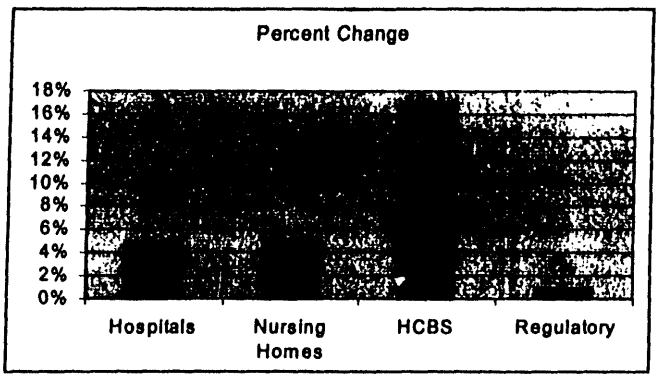
Overall, FY '98 State spending in long-term care (Fig. 4) is consistent with historical patterns. However, home and community services have seen significant percentage point increases. These services, which include home health, homemaker, personal and respite care, among others, increased 17 percent overall between FY '97 and FY '98 (Fig. 5). Administrative spending, which includes case management and screening and assessment services, as well as survey and inspection functions, increased one percent over FY 98 (Fig 6). This spending category includes functions such.

Figure 4 - Growth in RI Medicaid Spending for Nursing Facilities vs. Home Health Services



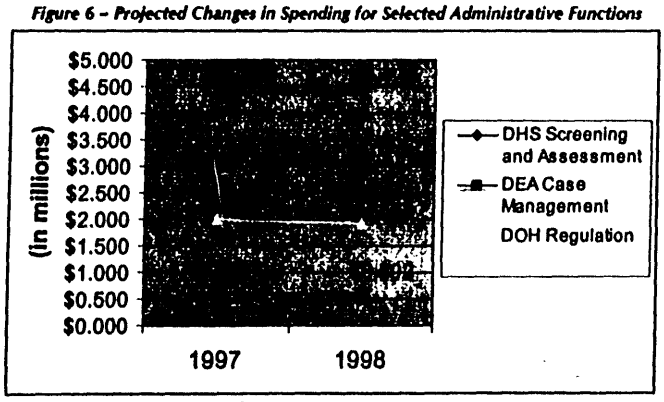
[4] Again, while these services generally are regarded as post-acute rather than long-term care, they are part of a service continuum and revenue source that help shape the behavior and financial condition of long-term home care providers

Figure 5 – Percentage Change in State LTC Spending by Component 1997-FY 1998



A major component of the increase in total state payments to home and community based providers were rate increases for both Adult Day Care providers and Home Heath Providers in FY 1998.

Figure 6 – Projected Changes in Spending for Selected Administrative Functions



Source: RI Long-Term Care Coordinating Council

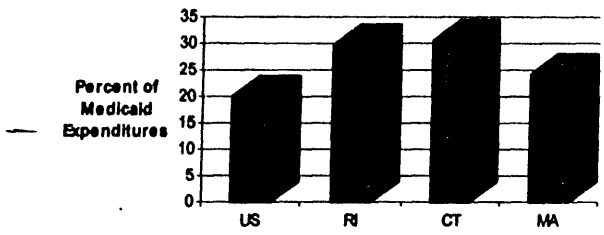
PAYERS, PROVIDERS, AND PATIENTS

Nursing Facilities - In 1998, Medicare was primary payer for 8.9 percent of Rhode Island nursing facility residents, Medicaid was primary payer for 73.2 percent, and private pay and insurance covered 17.9 percent. This reflects a 2.1 percent increase in Medicare, a 1.8 percent decrease in Medicaid, and a .3 percent decrease in private pay, since 1996.[5]

Medicare – The Balanced Budget Act of 1997 calls for the implementation of a prospective payment system for nursing facilities to begin in Rhode Island on January 1, 1999. Nursing facilities that have the expertise to keep up with the technological requirements of this new system may thrive under the new reimbursement schedule. Conversely, smaller homes (under 100 beds) and those that lack the technology for electronic submittal of the required minimum data set may not remain in the Medicare program.

Medicaid In 1998, nursing home payments accounted for over 30 percent of all Rhode Island Medicaid spending, which is higher than regional and national averages (Fig. 7).

Figure 7 - State Medicaid Expenditures on Nursing Facilities



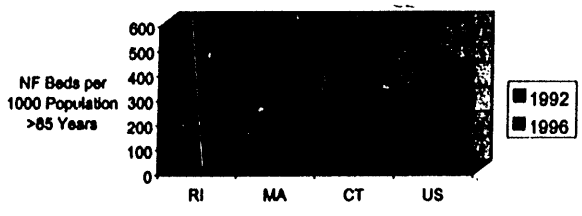
Source: HCFA, Medicaid Budget and Expenditure System

Supply

There are 107 nursing facilities in Rhode Island with an average 102 beds per facility (10,898 beds total). Nursing facility bed rates (number of nursing facility beds per 1,000 population over age 85) vary substantial from state to state, but as a general matter have been decreasing. The national average bed rate in 1996 was 407 beds per 1000 population over age 85, down from 443 in 1992. The 1996 bed rate in Rhode Island was 493 per 1000, considerably above the national average, but comparable to Massachusetts and Connecticut. All three states have displayed similar reductions over recent years (Fig. 8).

[5] http://www. Ahca.org/research/f22.htm. These figures are consistent with those maintained by the RI Health Care Association.

Figure 8 - Number of Nursing Facility Beds per 1000 Age 85 and Over

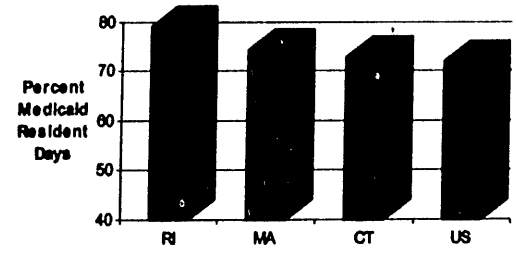


Source: US Bureau of the Census, Census of the Population, 1990

The average occupancy rate in Rhode Island nursing facilities in 1997 was 94 percent, considerably above the national average of 89.9 percent. Slight declines in occupancy rates over recent years may be attributable to the increased availability of less-costly alternatives, such as home care and assisted living.

The number of nursing home residents per 1,000 population over age 65 is higher in Rhode Island than nationally, at 57.6 per 1,000 compared to 43.7 per 1000. Similarly, the number of Medicaid recipients in nursing facilities per 1,000 Medicaid recipients is almost twice the national average. There are approximately 55.5 per 1,000 in Rhode Island as compared to an average 28.6 per 1,000 across the nation.[6] The percent of Medicaid resident days as a proportion of days paid by all payment sources is somewhat higher in Rhode Island than in either the United States as a whole or in neighboring states (Fig. 9).

Figure 9 - Percent of Medicaid Resident Days in 1995

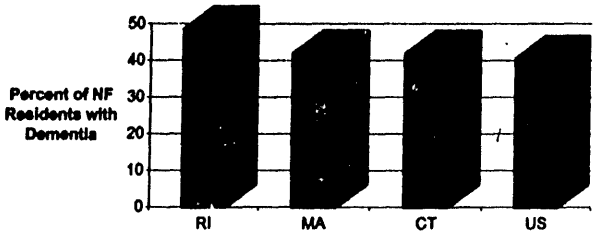


Source: HCIA and Arthur Andersen L.L.P., 1997

[6] Across the United States: *Profiles of Long-Term Care Systems*, AARP Public Policy Institute, 1998.

Rhode Island nursing facility residents appear to be slightly less impaired across all ADLs than residents nationally. However, the percentage of nursing facility residents in Rhode Island who have been diagnosed with some form of dementia is among the highest in the nation (Fig. 10).

Figure 10 - Percentage of NF Patients Reported with Dementia, 1995



Source: Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991 through 1995, Harrington et al.

As Medicare prospective payment and managed care encourage earlier hospital discharges of patients with more complex medical needs, nursing facilities are being called upon to provide a greater volume of short-stay post acute care services. Thirty-two of Rhode Island's nursing facilities have special care units, mostly for rehabilitation and Alzheimer's. Hospitals also are entering the nursing facility market by establishing "sub-acute" units to care for complex medical and rehabilitation patients after hospital discharge. Rhode Island has two such hospital-based facilities.

Home Health Care – Rhode Island home care agencies are licensed by the Department of Health as "home nursing care providers" (41) or "home care providers" (32). Twenty-seven of the home nursing care providers are Medicare certified, and these agencies (excluding those that are hospital-based) employ nearly 1,600 full-time equivalent staff and contract workers.[7]

While Medicare is the largest payer of home health services, out-of-pocket expenditures and private insurance both account for a greater proportion than does Medicaid, which pays only 14 percent of all home health expenditures.

[7] Rhode Island Certified Home Health Agency Statistical Analysis, Year-End 1997.

Medicare– According to HCFA's Office of the Actuary, the number of HHA visits per beneficiary and per beneficiary costs are somewhat lower in Rhode Island than in adjoining states, while average per visit payment is somewhat higher

Table 4 - Medicare Home Health Visits: 1996

	RI	MA	CT	US
Persons Served	20,637	122,000	61,000	3,559,600
Percent of beneficiaries Served	12.2	14.1	11.7	10.3
Visits Provided	1,348560	12,090,000	5,046,000	263,140,000
Visits Per Person Served	65	99	83	74
Charges Per Visit	$82	$65	$68	$86
Payments Per Visit	$65	$52	$58	$63
Program Payments	$88,987,000	$603,963,000	$294,506,000	$16,679,449
Program Payments per Person Served	$4,423	$5,186	$4,834	$4,691

Source: HCFA Financing Review, Medicare and Medicaid Statistical Supplement, 1998

Until 1998, Medicare reimbursed home health providers for "all reasonable costs" for covered home health visits. However, the BBA'97 calls for the development, by October 2000, of a prospective payment system for home care, under which providers will receive payments based on a specific procedure or diagnosis (e.g., physical therapy after hip replacement). Until HCFA develops the prospective system, Medicare has established an Interim Payment System that essentially places all Medicare home health care and services under an annual agency cap. The result has been across-the-board reductions in agency budgets and compounded staffing challenges in an already tight labor market.

Medicaid – Medicaid coverage of home health services is available to individuals who, on the basis of income or functional ability, would be otherwise eligible for nursing facility services. In FY 98, Medicaid paid $4,558,643 for skilled nursing/therapy services and $10,998,326 for home health, homemaker, and personal care services under various waiver programs. (Table 5)

Table 5 -Hours of Care by Visit type, Medicaid Home Health Services FY 1998

	Homemaker Only	CNA/HHA Only	CNAH/HHA Combined Homemaker
DHS Aged & Disabled	18,475	69,845	594,110
DEA Waiver	3,379		126,962

Source: Medicaid Fiscal Office and Department of Elderly Affairs

State –Funded Programs – Home care agencies also receive some funding from the Department of Elderly Affairs under programs funded exclusively with state dollars.

Private Sources – Scant data are available to characterize services furnished via private revenue sources. Beginning in January 1999, the Department of Health will require both Home Nursing and Home Care Providers to furnish statistical information as part of their license renewal applications

Managed care – Thirty percent of Medicare beneficiaries are in managed care plans. There is no Rhode Island data on home care utilization in Medicare HMOs; however, home nursing providers report that this is a highly "managed" service, with one plan authorizing only four initial visits.

Residential Care/Assisted Living - The growing number of elderly people combined with the high cost and more intense care needs of nursing facility residents has stimulated the development of new models for supportive living. The fastest growing residential alternative is assisted living, which is usually a combination of housing and supportive services for persons requiring help with ADLs and IADLs.[8] Rhode Island uses an institutional model called "residential care/assisted living" or RC/AL.

There are 58 licensed RC/AL facilities in the state, with a capacity of 2,106 units, up by 61 percent from 29 facilities with a licensed capacity of 1,116 beds in 1991[9]. Eight assisted living facilities with a total of 393 units are located within nursing facilities.[10] Four assisted living facilities have special Alzheimer's units.[11]

Thirty (30) residents are in experimental Medicaid waiver program administered by DEA, which transfers residents from a nursing home to one of twenty participating assisted living facilities. Rhode Island also has just received approval from HCFA for Medicaid participation in the development of 200 new low-income assisted living beds, to be financed by Rhode Island Housing Authority.

Adult Day Care - There are 17 adult day centers in Rhode Island with a capacity of 563 client days. The average daily census per center is 26. Most centers have not reached capacity. Total 1997 spending for adult day care services in Rhode Island approximated $4.04 million. Of this amount, state sources (public programs operated by the Department of Human Services or the Department of Elderly Affairs) accounted for just under 25 percent.

Hospice – There are nine hospice organizations in Rhode Island. The utilization of hospice services by Medicare beneficiaries in Rhode Island has been consistent with the national average (Table6), and slightly higher than other New England States.

Table 6 - Hospice Services Used by Medicare Beneficiaries: 1996

	RI	MA	CT	US	1997 RI
Number of Hospices	9	43	28	2125	8
Persons Served	1,555	7,205	3,397	345,133	1,716
Medicare Covered Days of Care	65,773	355,798	120,964	17,990,578	87,264
Average Covered Days Per Person	54	45	40	54	51
Medicare Program Payments	$8.610 M	$34.184M	$19.839M	$1,991M	9,130,074
Payments Per Person Served	$5,537	$4,746	$5,842	$5,716	5,321

Source: HCFA Financing Review, Medicare and Medicaid Statistical Supplement, 1998

[8] Coopers and Lybrand, p. 6.
[9] Arthur Palona, Rhode Island Department of Health, October 16, 1998.
[10] Ibid. (Beechwood at Laurelmead 97 beds, Cortland Place, 64; John Dugan, 26; N. Bay Manor, 20; Scandinavian Home, 40; Pavillion at the Summit, 50; Tockwotton, 30; United Methodist, 26)
[11] Arthur Palona, RI Department of Health (Beechwood at Laurelmead, Village at Waterman Lake, Village at Elmgrove. Village at Hillsgrove.

Meals on Wheels - The Meals on Wheels program delivers hot, nutritious noontime meals to frail, homebound seniors five days per week. There are 165 routes covered primarily by volunteer drivers (Table 7).

Table 7 – Rhode Island Meals on Wheels Program

	1993	1997	1998
Meals served	504,889	558,278	600,000
Clients		4,290	4,400
Meals per day			2,500

Federal funding for meals on wheels has declined slightly over the past three years, while state funding has risen (Table 8).

Table 8 – Rhode Island Meals on Wheels Program Costs

1997 Meal Costs	$1,528,666
1998 Program Revenue	
Federal Title IIIc	$499,482 (1997)
State	$320,929
USDA	$314,634
Project Income	$820,289
Donations	$31,128
Other	$95,543

In 1997, there were 21 percent of clients were in poverty. There were 405 people on the waiting list as of October, 1998.

Senior Companions - Senior Companions is a volunteer program for limited income persons age 60 and over. Companions provide clients with social support (not homemaking) and visit an average of 4 - 6 clients per week. The program is funded by the Federal Corporation for National Service.

Chore Services - The Department of Elderly Affairs has initiated a chore service by awarding $2,000 to 25 senior centers. The program provides minor modifications of homes, including minor repair, renovation, and routine care and maintenance

Respite Care - A DEA-sponsored respite care program provides grants to subsidize up to half of hourly in-home respite care. The program is available to caregivers who live with someone age 60 or older who is in need of personal care assistance. In the first three months of FY 1999, there has been a 40 percent increase in applications for respite care over last year. The increase is attributable to the reductions in home health utilization under Medicare.

Quality Assurance - A major challenge facing long-term care providers is how to ensure the quality of care in a rapidly changing health care environment. As the focus of quality assurance has shifted toward outcomes, payers are increasingly seeking performance measures from the providers with which they contract. Unlike indicators of capacity, performance outcomes are the result of long chains of events influenced by multiple players (Table 9).

Table 9 - Illustrative Framework of a System to Improve the Quality of Home and Community-Based Long-Term Care

Activity	Key Questions	Possible Goals or Measures
Define quality	What Goals and outcomes can be identified? Who should be involved in identifying goals and outcomes? To what extent do these goals and outcomes apply across disability categories, functional needs, and diagnostic groups? How are goals and outcomes articulated to stakeholders?	Maintain functional capacity Optimize autonomy and mobility Ensure safety Optimize health Prevent inappropriate institutional placement Satisfy clients Improve quality of life Reduce informal caregiver burden Reduce public costs
Identify indicators of quality	Based on the goals and outcomes identified, what indicators of program implementation or performance can be identified, and what additional information is needed to properly interpret these?	Structural indicators Caseload per worker per day Staff certification level Staff knowledge Staff turnover at consumer level Process indicators Frequency of supervision Compliance with medication orders Time between service request and provision Appropriateness of care plan Prescription of inappropriate medications Availability and frequency of informal care Outcome indicators Functioning Change in ADL and IADL status Ability to toilet as needed Safety Falls Burns Financial exploitation Health Appearance of decubitus ulcers Infections Adverse drug reactions Symptom distress Weight gain or loss Client satisfaction Client perception of unmet need Perceived quality of meals Freedom from fear Comfort Sense of control Freedom from unwanted disruption Preference for current living arrangement Duration of preferred living arrangement
Establish review of system and implementation feedback	What processes are used for periodic or on-going review of quality indicators? How are review findings used to correct or prevent problems?	Presence of a quality assurance and improvement plan Checks on implementation of plan Evidence of enhanced achievement of desired goals and outcomes

PHYSICIANS AND PHYSICIAN TRAINING PROGRAMS

-- Overview --

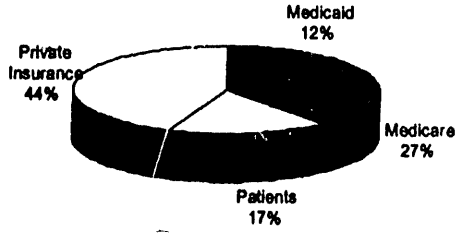
Eighty percent of health care expenditures are influenced by physicians' clinical decisions, including the type and place of treatment, the number of tests, the intensity of services, and so on. In recent years the growing cost-consciousness of health care payers and a greater sophistication among managing intermediaries (health plans, third party administrators, UR firms) have challenged the physician's fundamental control over health care resources. This fundamental change in the health care delivery system has precipitated changes in utilization of physician services, physician income, the organization of physicians practices, and the demand for various types of physician specialties, and the mix of other professionals who provide services once wholly within the domain of physicians' practice.

Unfortunately, there are few primary data available on physicians in the medical marketplace in Rhode Island, other than that collected as part of the state's licensure process or as part of much larger national census or industry surveys. Therefore, the information presented here, is drawn largely from published national sources.

At just over $220 billion per year, physician services are the second largest component of national health care spending. Physicians' share of national health spending has consistently hovered between 18 percent and 20 percent for the last three decades.[1]

Physician Income - The payer distribution for New England physicians is not significantly different than the distribution for physicians nationwide. Overall, the largest portion of physician revenue (43 percent) comes from private insurance. Medicare, Medicaid and individual out-of-pocket spending represent 27.4 percent, 11.8 percent and 17.0 percent of physician revenue, respectively.[2]

Figure 1 - Sources of Physician Practice Revenue



Source: Physician Marketplace Statistics, 1996, American Medical Association

[1] Sheila Smith, Mark Freeland, and the National Health Expenditures Team "The Next Ten Years of Health Spending: What Does the Future Hold?" Health Affairs, September/October 1998.
[2] Ibid

Physician Fees - Surveys of physician practices indicate that the New England region in general, and Massachusetts in particular, rank just behind New York and California for the highest office visit fees in the nation.[3] It has been widely asserted that Rhode Island physicians are lower-paid than their regional colleagues, owing to a combination of coding practices, service mix, utilization, and reimbursement per unit of service by major payers. Definitive state-level data to permit such a comparison is currently lacking, in part because Rhode Island's contribution to the survey samples is too small to be statistically valid.

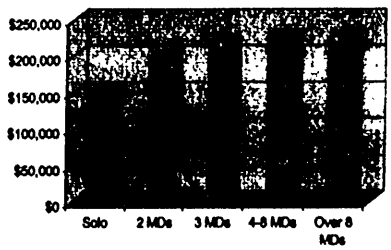
Managed Care Participation – Similarly, the extent to which Rhode Island physician practices are dependent upon managed care revenues has not been documented in any systematic way. According to national data, close to 95 percent of all physicians in New England participated in at least one managed care contract by 1996. However, because many physicians participate in preferred provider organizations (PPOs), in which compensation is based on reduced fee-for-service reimbursement rather than on shared financial risk, only about 50 percent shared some financial risk. A smaller number of physicians are salaried employees of staff model HMOs.

Practice arrangements - Ten years ago, the medical profession represented one of the last cottage industries in America. In 1965, just over 10 percent of physicians belonged to a group practice. By 2000, analysts predict that figure will rise to 56 percent. Older physicians are more likely to persist in solo practice, with nearly half those aged 55 and older practicing in such settings.[4] However, as these physicians retire from the workforce, they are being replaced by younger doctors who prefer a less entrepreneurial, more predictable and collectivized practice environment.

In general, medical practice costs consume between 35 and 45 percent of gross practice revenue[5]. In addition to the practice's relationship with managed care, practice costs vary slightly with geographic region, medical specialty, practice size, years in practice, and physician age. For example, practice expenses are slightly higher, as a percentage of gross revenues, for the primary care specialties. Practice costs tend to fall off sharply when physicians reach age 55 years. Economies of scale begin to appear when group size reaches 10 physicians.

Not surprisingly, physician net income tends to increase with practice size (Fig. 2).

Figure 2 - Median Net Physician Income by Size of Practice 1995



Source: Physician Marketplace Statistics, 1996, American Medical Association

[3] American Medical Association. Socioeconomic Characteristics of Medical Practice 1997/98.
[4] Ibid
[5] Joel Goldberg, "Practice Expenses creep Back UP", Medical Economics, November 25, 1996, and Physician Marketplace Statistics, 1996

There is no detailed information available on physician participation in group practices or other organizational arrangements in Rhode Island. However, observation suggests that compared to the rest of the nation, Rhode Island physicians have been slow to organize themselves into practice arrangements that have real market leverage. Among those Rhode Island doctors who are in full, active practice, the Rhode Island Medical Society estimates that about 30 percent are employed by hospitals or hospital foundations. Of the remaining 70 percent, roughly half are in solo-practice and half are in practice with at least one other partner (medical groups of 2-40 doctors). Most (90 percent) of this group are also involved in one or more affiliations with other physicians or health care providers (Physician-Hospital Organizations (PHO), Independent Practice Associations (IPA), Provider-Sponsored Organizations (PSO), Management Service Organizations, (MSO), etc.). However, with some very notable exceptions, these affiliations tend to be loosely drawn. Many of these contractual arrangements exist essentially on paper and have yet to result in significant marketplace consolidation.

Exceptions do exist. Three years ago, about 40 of the state's primary care internists and pediatricians joined together to form Coastal Medical Group, a true medical group practice now 60-plus physicians strong. Medical groups can be extremely effective clinical and economic performers because they generally handpick their members. This selectivity makes such groups extremely attractive to purchasers of physician services. Rhode Island has also recently witnessed the formation of two active IPAs –Rhode Island Primary Care Physicians and ProMedica – both now including more than 100 physicians. IPAs provide a range of administrative services to physician practices for an annual fee. As important, IPAs provide a structure under which independent physicians can exert a collective force in the marketplace.

Another recent national development is the growth of physician management companies, which provide administrative and operational services and systems to medical groups. In general, these companies help physicians reduce practice overhead, improve productivity, and increase earnings, in exchange for long-term service agreements with predetermined fees and/or a percentage of practice revenue.

Physician supply –

As of January 1, 1998, there were approximately 3,382 physicians licensed to practice in Rhode Island. Approximately 70 percent of the state's total physician workforce is located in the Providence area.[6] Physician practice sites are many and diverse, including hospital inpatient and outpatient departments, group and private practices, community health centers, federal facilities, as well as teaching and administrative positions in a variety of organizations. Table 1, which is based on AMA data, provides a breakdown of physicians in Rhode Island by specialty and professional activity as of January 1, 1997. AMA data provide information regarding professional activities that is not available in the Rhode Island licensure database.

[6] Physician Characteristics and Distribution in the US, 1996, American Medical Association.

Table 1 - Physicians in Rhode Island 1997

Specialty	Total Physicians	Patient Care				Other Professional Services			
		Total Patient Care	Office Based	Hospital Based		Admin	Med. Teach	Research	Others
				Resid/ Fellows	Phys. Staff				
Total Phys	3,325	2,221	1,875	561	264	74	65	78	16
Fam Prac	162	151	110	32	9	4	6	1	
Gen Prac	35	33	30	-	2	1	--		1
Cardiol	110	102	81	15	6	2	3	2	1
Int Med	710	650	409	190	51	14	16	28	2
Pediatrics	277	246	167	56	23	7	8	14	2
Surgical									
Gen Surg	188	181	127	44	10	2	3	2	
Ob/Gyn	170	161	120	28	13	4	4	1	
Other Spec.									
Anesth	88	87	76	2	9				1
Emerg	97	92	43	29	20	2	2	1	
Psychiatry	205	185	121	38	26	13	3	4	
Radiology	37	35	32		3	2			

Source: Physician Characteristics and Distribution in the U.S., 1997-98, American Medical Association

Nationally, the physician/population ratio is 1 patient care physician for every 461 civilians. In Rhode Island the ratio is 1 per 363, placing the state 6th in the nation in ranking of physician supply. Although physician/patient ratios may suggest availability or shortage, the ratios should not be construed as constituting an adequate measure of the quantity or quality of health care received by the public. For example, Rhode Island's higher physician/patient ratio may be due to that fact that the state has a larger proportion of small, independent practices, hospital-based sub-specialists (especially internal medicine physicians) and academic/partial FTE-patient care physicians.

As shown below, population-per-physician ratios have been steadily decreasing over the past decade, suggesting that the growth in physician supply is outpacing the growth in the general population. This trend is evident nationally and in Rhode Island.

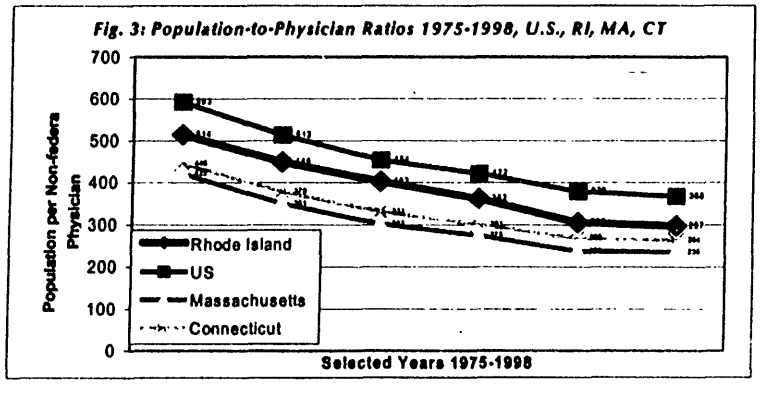
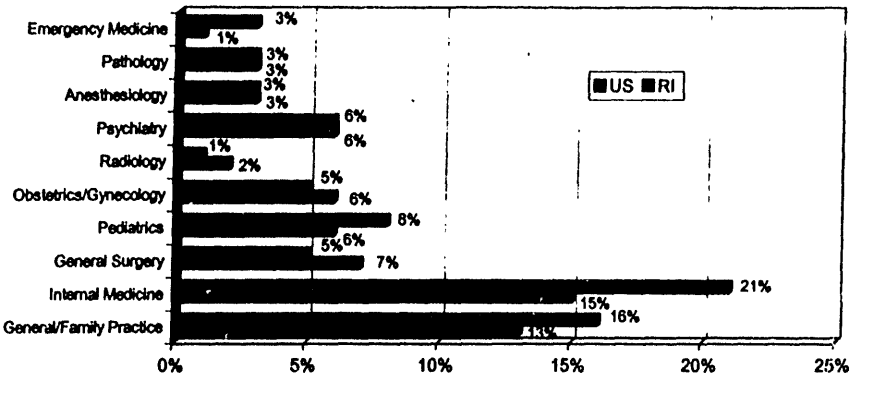


Figure 4 illustrates the percentage of physicians by selected specialties nationally and in Rhode Island. As indicated, Rhode Island maintains a higher proportion (21 percent) of internal medicine physicians than the national average (15 percent). Rhode Island also has a slightly higher proportion of general/family practice physicians and pediatricians than the rest of the United States. On the other hand, Rhode Island has a lower percentage of general surgeons, radiologists and Ob/Gyns than the nation.[7]

Figure 4 – Percentage of Physicians by Specialty



Source: Physician Marketplace Statistics, 1996, American Medical Association

There are 871 active primary care physicians in Rhode Island, or 39.1 percent of all active physicians, which equates to 1 primary care physician for every 1,145 people. Counting only those internists who have no secondary specialty reduces the number of primary care internists to 307 (224 board certified) and this lowers the total primary care physician supply to 676, or 30.4 percent of all physicians, and the ratio of primary care physicians to population changes to 1:1,476. These numbers are slightly higher than the population-based requirement estimates derived from most national physician workforce planning models.

Rhode Island has fourteen community health centers spread over 23 sites throughout the state. In 1996, 29 full-time and 46 part-time physicians delivered primary care services to roughly 68,000 patients. The health centers' physician distribution is described in Table 2.

Table 2 - Community Health Center Physician Status, Full-Time

	1993	1994	1996
Family Practice	13	13	14
Internal Medicine	8	7	6
Internal Med/Pediatric	1	1	0
Pediatrics	8	7	7
Ob/Gyn	3	3	1
General Practice	0	0	1
Total	**33**	**31**	**29**

Source: Rhode Association of Community Health Centers, 1996 Annual Report

[7] Physician Characteristics and Distribution in the US, 1996, American Medical Association.

Non-physician providers (NPPs) - Substitution in health professions is an active issue, particularly in today's practice environment, which seeks a cost-effective mix of provider inputs. The federal government has played a role in determining the workforce mix through explicit grant support of physician and allied health education and through its reimbursement policies. The private sector's role in workforce management has been relatively minor until recently. Except for large HMOs (e.g., Kaiser) there hasn't been much consideration in the private sector about what constitutes optimal provider input mix.

Approximately 150 PAs practice in Rhode Island, predominantly in single-specialty groups, hospitals, and HMOs.[8]

The scope of practice of PAs and APNs overlaps largely with that of physicians. Both groups provide a limited scope of physician services with one or more physicians providing overall supervision. Whether within a primary care or subspecialty setting, APNs and PAs tend to provide routine patient care services, thereby freeing the supervising physician to attend to more complex patient problems. Studies have tended to show that physician practices employing NPPs achieve overall gains in productivity and efficiency. In regard to the physician supply, the related issue is to what extent NPPS can substitute for physicians in evaluating population need for physician services. No precise studies of the substitutability of NPPs for physicians have been conducted. The conventional wisdom is that one NPP can be substituted for .6-. 8 physicians in the primary care setting where adequate physician oversight is available.

Performance measurement - Physician accountability for the cost, quality, and outcomes of services they deliver and authorize will continue to be a major priority for health care purchasers. Although physician fees account for only about a fifth of overall health spending, a physician's decision to hospitalize a patient, order a test, or prescribe a drug is a significant driver of health costs. Since physicians control most of the health care dollars, they will continue to play a central role in determining overall health care spending patterns, and purchasers will continue to look for ways to hold the line. However, in addition to well-managed patient care and contained costs, health care buyers now are increasingly demanding evidence of effective clinical processes and documented patient outcomes.

Medicare payment - In 1998, Medicare physician payment provisions of the federal Balanced Budget Act will once again affect physician revenue. Changes in the amount Medicare pays physicians for each work unit, as well as the way those units are distributed across physician specialties, will mean that some physicians will see significant increases in their Medicare payments, while others (again, predominantly the surgical specialties) will face reductions of up to 10 percent in their Medicare revenue. In addition, HCFA has begun to formulate a resource-based system for the practice expense component of the fee schedule, which historically has accounted for about 41 percent of charges. Because they represent such a large part of charges, these changes have met with a good deal of controversy within the physician community and beyond. Once again, the likely result of this shift will be large changes in overall income across physician services and the specialties that deliver them.

Beyond simple payment policy, the Medicare program exerts a major influence on all facets of medical practice, and on the medical marketplace in general. It is the program through which federal lawmakers and regulators can influence many aspects of physician behavior and certain elements of practice organization and financing. By virtue of the sheer volume of revenue and patients that Medicare represents to physicians and health systems, its rules, mandates, and prohibitions influence the entirety of medical practice.

[8] American Academy of Physician Assistants. 1997 AAPA Masterfile. Arlington, VA

Direct contracting - More and more physicians are seeking contracts directly with employers to provide health care services to employees. Physicians who contract directly cite potential for eliminating payments to insurers and the recovery of practice autonomy as motivating factors for such contracts. Nationally, an estimated 19 percent of physicians have direct contracts with employers. In New England 18 percent of physicians have such contracts. In a similar vein, the Balanced Budget Act provides physicians with the opportunity to form health plans and enroll Medicare beneficiaries.

Physician training in Rhode Island –

Brown University School of Medicine

The current annual cost of all undergraduate and graduate medical education activities at Brown University and its affiliated teaching hospitals is approximately $250 million. However, only about $30 million of this figure actually flows through the medical school. Of this later amount, the largest portion derives from restricted income grants and contracts, a smaller portion comes from tuition and the remainder from indirect cost recovery on grants, private giving, and investment return on endowment. The majority of medical education costs (faculty salaries) are covered directly by participating teaching hospitals.

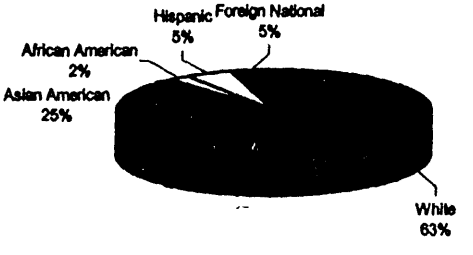
Table 3 and Figure 5 illustrate the gender and nationality breakdown of Brown University School of Medicine's graduates in 1997.

Table 3 - Breakdown of Graduates by Gender, 1997

	Number of Graduates	% of Total
Male	45	51%
Female	43	49%

Source: Stephen R. Smith M.D., Hillary Sweigart, & Alexandra Morang, "Brown University School of Medicine, Class of 1997," Medicine and Health, Rhode Island, Volume 80, No. 8, August 1997.

Figure 5 – Breakdown of Graduates by Nationality 1997

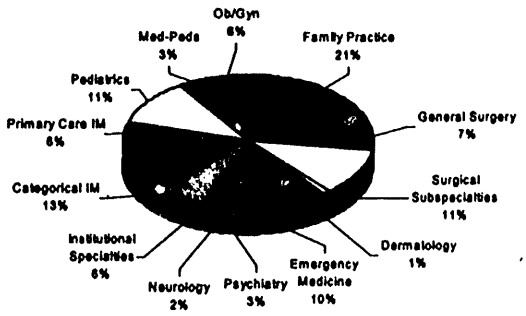


Source: Stephen R. Smith, M.D., Hillary Sweigart, & Alexandra Morang, "Brown University School of Medicine, Class of 1997," Medicine and Health, Rhode Island, Volume 80, No. 8, August 1997.

Figure 6 illustrates the specialty choices of the Brown University School of Medicine Class of 1997. The proportion of the class electing specialties in primary care (internal medicine, pediatrics, family practice,

and Ob/Gyn) hovers around 60 percent, with family practice ranking first this year. The actual percentage of graduates who will eventually practice primary care after completing their graduate medical education training will be smaller. Based on historical trends for Brown graduates, over half of all internal medicine residents and a third to a half of pediatrics residents will go on to subspecialize in fields such as cardiology and pediatric oncology. Including Ob/Gyn specialists in the primary care fold, it is expected that about 47 percent of graduates from this year's class will ultimately practice as primary care physicians. Excluding Ob/Gyn, the percentage falls to 41 percent. In either case, the percentage of Brown graduates expected to assume primary care careers is above the national average of approximately 36 percent.

Figure 6 - Specialty Choices of Brown University School of Medicine Class of 1997



Source: Stephen R. Smith, M.D., Hillary Sweigart, & Alexandra Morang, "Brown University School of Medicine, Class of 1997," Medicine and Health, Rhode Island, Volume 80, No. 8, August 1997.

Of the 1997 graduating class, 23 medical students (26 percent) matched to residency positions in Rhode Island. There are 249 doctors in Rhode Island who graduated from Brown University School of Medicine, or about 7 percent of Rhode Island physicians. This works out to an average of 11.8 physicians per graduation year of Brown who are currently licensed in Rhode Island.

Teaching Hospitals

Rhode Island hosts eight teaching hospitals, seven of which are affiliated with Brown University School of Medicine, and one of which (Roger Williams Medical Center) is affiliated with Boston University (Table 4). A list of the residency programs, sponsoring hospitals, and number of resident positions (whether filled or not) is shown in Table 5. According to data from the Liaison Committee on Medical Education, a substantial number of medical and surgical subspecialty positions are currently unfilled, especially in the first post-graduate year.[9]

[9] Liaison Committee on Medical Education, Annual Medical School Questionnaire, 1997-1998.

Table 4 - Teaching Hospitals in Rhode Island

Hospital	City	Number of Beds
Butler Hospital	Providence	101
Emma Pendleton Bradley Hospital	East Providence	60
Memorial Hospital of Rhode Island	Pawtucket	215
Miriam Hospital	Providence	247
Rhode Island Hospital	Providence	677
Roger Williams Medical Center	Providence	145
Veterans Affairs Medical Center	Providence	108
Women and Infants Hospital of RI	Providence	197

Source: Brown University School of Medicine, Department of Public Relations, 1998.

Trends in Medical Education

Physician training programs and the institutions that sponsor and support them are experiencing significant challenges as they respond to a changing health care delivery system. As previously discussed, hospital-based teaching programs, in particular, are facing an increasingly challenging operating environment:

- Managed care organizations are reluctant to pay higher rates to support graduate medical education programs. As managed care penetration continues to increase, it is likely financial support for teaching and training programs will continue to decrease.
- Managed care also will continue to shift patients out of hospitals and into community based settings. This trend decreases hospital revenues and results in fewer hospital-based training opportunities for residents by reducing patient volume and changing patient mix available for teaching.
- The fate of teaching programs is tied to the fortunes of larger hospital systems and the agreements those institutions make in the course of their affiliations and acquisitions. For example, Lifespan contributes payments of $50-$60 million for residents' salary and benefits as well as for faculty support.
- Medicare and Medicaid payment policies further influence hospitals' ability to maintain inpatient residency programs. The Balanced Budget Act of 1997 placed significant limits on Medicare's support for graduate medical education programs. These cuts will take several million dollars out of the system.
- Changes in the practice environment are affecting the knowledge and skills that residents must master in order to practice cost-effective, state-of-the-art healing.

The Balanced Budget Act contains several provisions that encourage training in primary care and ambulatory settings. For the first time, GME payments can be made to non-hospital organizations that participate in physician training programs, including health centers and Medicare Choice organizations. Also, the BBA extends the direct graduate medical education payment for an additional year for combined residency programs in primary care. Ob/Gyn programs that are combined with primary care programs will also be eligible under this policy. Moreover, the BBA creates a consortia demonstration authority, under which GME payments will be made to consortia instead of to individual teaching hospitals. Consortia are composed of a teaching hospital with one or more medical schools, other teaching hospitals, which may be a children's hospital, FQHCs, medical group practices, managed care entities, entities furnishing outpatient services or other entities authorized by the Secretary. Rather than having GME payments restricted to hospitals, a consortium will be able to support medical education in a variety of settings and determine among its members the division of payment.

Table 5 – Graduate Medical Education Programs in Rhode Island

Specialty	Sponsoring Institution	Length (Years)	Number of Positions
Dermatology	Roger Williams Medical Center	3	10
Emergency Medicine	Rhode Island Hospital	4	24
Family Practice	Memorial Hospital of Rhode Island	3	39
Internal Medicine	Memorial Hospital of Rhode Island	3	30
	Roger Williams Medical Center	3	40
	Rhode Island Hospital & The Miriam	3	133
Cardiovascular Disease	Roger Williams Medical Center	3	14
	Rhode Island Hospital	3	8
Interventional Cardiology	Rhode Island Hospital	1	2
Critical Care Medicine	Miriam Hospital	2	3
	Rhode Island Hospital	1	3
Electrophysicology	Rhode Island Hospital and The Miriam Hospital	2	4
Endocrinology	Rhode Island Hospital	2	2
Gastroenterology	Rhode Island Hospital	2	6
HematologyOncology	Roger Williams Medical Center	3	10
Infectious Diseases	Roger Williams Medical Center	2	4
Nephrology	Rhode Island Hospital	2	6
Pulmonary Medicine	Roger Williams Medical Center	2	7
Rheumatology	Roger Williams Medical Center	2	2
Internal Medicine/Pediatrics	Rhode Island Hospital	4	14
Neurological Surgery	Rhode Island Hospital	5	6
Neurology	Rhode Island Hospital	3	9
Child Neurology	Rhode Island Hospital	3	2
Clinical Neurophysiology	Rhode Island Hospital	1	3
Obstetrics and Gynecology	Women and Infants Hospital of Rhode Island	4	28
Ophthalmology	Rhode Island Hospital	3	6
Orthopedic Surgery	Rhode Island Hospital	4	17
Pathology	Rhode Island Hospital	4	17
Forensic Pathology	Rhode Island Office of State Medical Examiner	1	1
Neuropathology	Rhode Island Hospital	2	3
Pediatric Pathology	Women and Infants Hospital of Rhode Island	1	2
Pediatrics	Rhode Island Hospital	3	48
Neonatal-Perinatal Medicine	Women and Infants Hospital of Rhode Island	3	7
Pediatric Endocrinology	Rhode Island Hospital	3	3
Pediatric Hematology/Oncology	Rhode Island Hospital	3	3
Pediatric Gastroenterology	Rhode Island Hospital	3	3
Plastic Surgery	Rhode Island Hospital	3	6
Psychiatry	Butler Hospital	4	40
Child and Adolescent Psychiatry	Rhode Island Hospital	2	10
Radiology-Diagnostic	Rhode Island Hospital	4	19
Vascular and Interventional Radiology	Rhode Island Hospital	1	2
Surgery-General	Rhode Island Hospital	5	40
Surgical Critical Care	Rhode Island Hospital	1	1
Pediatric Surgery	Rhode Island Hospital	2	1
Urology	Rhode Island Hospital	3	8
Transitional Year	Miriam Hospital	1	3

Source: American Medical Association, Graduate Medical Education Directory 1997-1998.

A number of other federal programs provide financial support for health professions students and medical resident training in the primary care specialties and ambulatory sites. Most of these programs are authorized under Title VII of the Public Health Service Act and all of them emphasize training in underserved communities. Residency and undergraduate programs in family practice, general internal medicine, and general pediatrics are eligible for a several different types of federal funding. Similarly, funding is available for nurse practitioner and physician assistant training. The Area Health Education Centers Program supports health professions and residency education, recruitment of minority and disadvantaged students into the health professions, continuing education for providers serving vulnerable populations, and a variety of other related activities. The National Health Service Corps fellowship program exposes health professions' students to community health centers and other underserved sites.

MENTAL HEALTH

-- Overview --

This chapter is the Council's initial attempt to gain a better understanding of the mental health care delivery system in Rhode Island: who and what constitute the system; how the components of the system and their interrelation; the nature and magnitude of the financial, institutional, and professional resources involved; evolving marketplace dynamics and their impact on patterns of practice and utilization; the resulting match, or mismatch, between the supply and demand for care provided in different sites or different systems; changes in the clinical management of mental illness that have significant implications for the organization of treatment; purchaser expectations; and the evolving state of the art in performance monitoring.

The mental health services sector in Rhode Island is evolving.[1] As elsewhere, mental health services have come under managed care, which sets provider payments, establishes provider networks, and develops practice guidelines. Mental health care organizations are forming networks and partnerships with which to better compete in the changing health care environment. Mental health advocates and families of persons with mental illness are advocating for parity in coverage, greater coordination of mental and physical health care services, more explicit consumer protection laws and consumer benefit standards, and better ways to measure and assess quality of services.

The Council has been hampered in its analytic approach to mental health services by the existence of multiple "systems" that often relate only peripherally to each other. This fragmentation occurs along several dimensions: a "specialty" mental health services sector versus the "general" service sector, a publicly supported mental health system versus a privately funded system, and a further stratification of providers and payers and populations served. Moreover, the Council's efforts have been challenged by a profound unevenness in data. Data on the services provided and populations served by the public system are readily available. However, information about services provided by private sector organizations or under private payment arrangements is more difficult to obtain.

The lack of data on private sector expenditures for the mental health services makes it impossible to construct a complete picture of the state's mental health care system. Nevertheless, the Council finds sufficient evidence to be concerned about mismatches between supply and demand in different parts of the system. A number of studies continue to demonstrate that a substantial portion of mental illness goes untreated.[2] Few data exist to estimate the relative contributions of stigmatization, inadequate insurance coverage, and the lack of a coherent system of care.

Extrapolating from national data, the Council estimates that fully half of mental health service expenditures are made by public payers.[3]

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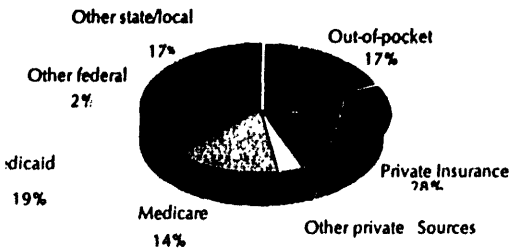
[1] National Association of Psychiatric Health Systems, *1997 Annual Survey Report*. Washington, DC. p. 15
[2] National Mental Health Association, *Mental Illness in the Family - Mental Health Statistics*. NMHA Information Center (1997)
[3] McKusick, David, et.al. "Spending for Mental Health and Substance Abuse Treatment, 1996," Health Affairs, Vol. 17, No. 5, p. 150. 1998

Figure 1.

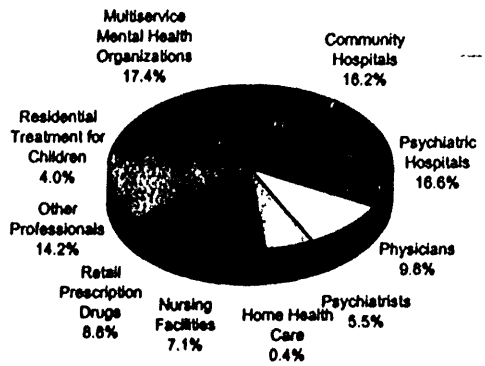
Mental Health Care Expenditures by Source of Payment, US, 1996



Source: McKusick, David etal, Spending for Mental Health and Abuse Treatment, 1996, Health Affairs, 17(5) 1998.

Nationally, nearly 45 percent of mental health treatment dollars flow to specialty providers (psychiatric hospitals, psychiatrists, multiservice mental health organizations, and residential treatment facilities) (Fig. 2). Community and psychiatric hospitals combined account for the largest share of mental health spending (about 33 percent). Individual practitioners (general service physicians, psychiatrists, and other specialty professionals) combined account for slightly less (29.5 percent).

Figure 2 – Mental Health Spending by Type of Provider, U.S., 1996

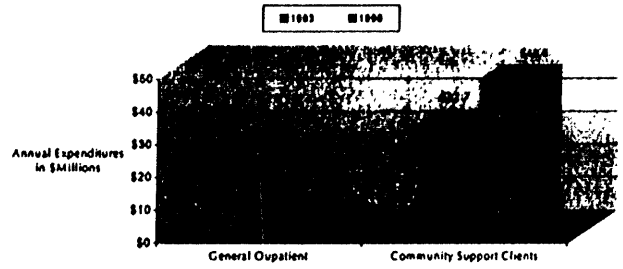


Source: McKusick, David et al, Spending for Mental Health and Substance Abuse Treatment, 1996. Health Affairs, 17(5). 1998

Rhode Island's public mental health system for adults consists primarily of a network of eight community mental health centers, and the Eleanor Slater Hospital and is supported almost entirely by the Department of Mental Health, Retardation and Hospitals. The state's public mental health system for children consists of the services and facilities contracted through the Department of Children, Youth, and Families, and the providers under contract with the RiteCare health plans.

The care provided within the public system is tightly managed and characterized by aggressive therapies. The bulk of the $77.2 million in public funds spent on adults in 1998 are on services for individuals with severe and persistent mental illness (Community Support clients).[4]

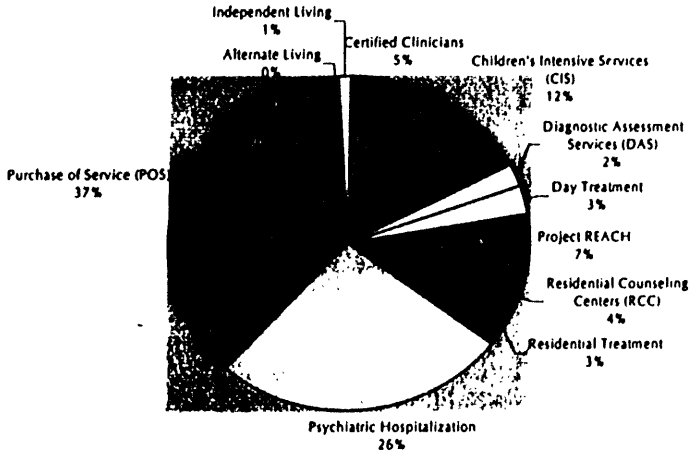
Figure 2- RI Community Mental Health System Expenditures for Non-Inpatient Services by Client Type: 1993 vs. 1998



Source: Department of Mental Health, Retardation, & Hospitals, 1997.

Similarly, the bulk of public funds for children's mental health are on spent on intensive, inpatient or specialty services for seriously ill children.

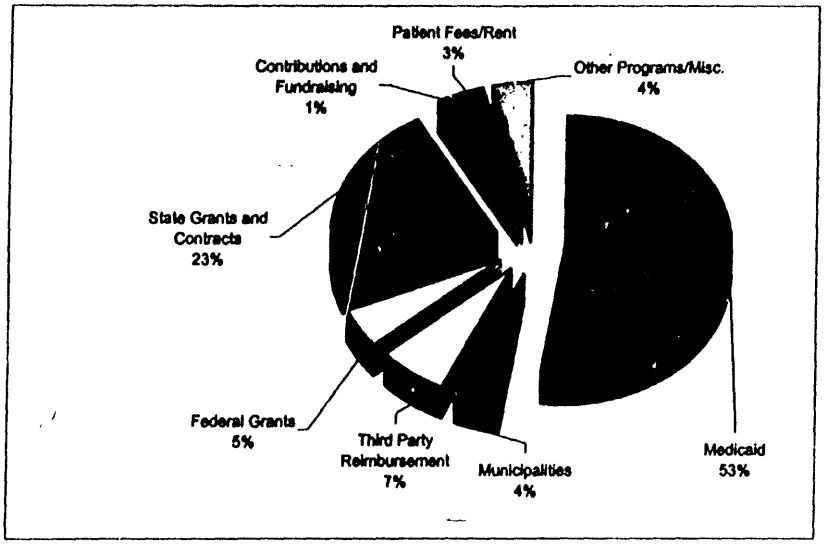
FY1998 Children's Mental Health Services (Does Not Include RIteCare In-plan benefits)I



[4] Department of Mental Health, Retardation, & Hospitals, 1997.

As noted, Rhode Island's community mental health centers are the backbone of the public mental health system. There are eight CMHC's in Rhode Island, plus three additional entities that contract with the State to serve persons with SPMI. Combined, these organizations employ 1,827 staff members with a total salary of $53.4 million.

Breakout of Revenue Sources for Community Mental Health Centers
Figures Based on the CMHCs FY '97 Year-End Audit Reports



Funding Source	*Average Percent to Total Revenue*	*Range of Percents to Total Revenue*
Medicaid	51.6%	36% to 66%
Municipalities	4.4%	1% to 12%
Third Party Reimbursement	6.6%	2% to 12%
Federal Grants	5.1%	9% to 12%
State Grants and Contracts	23%	23%
Contributions and Fundraising	1.1%	.1% to 3%
Patient Fees/Rent	3%	2% to 7%
Other Programs/Misc.	3.8%	3.8%

Other components of Rhode Island's mental health system include state and private psychiatric hospitals (Eleanor Slater, Butler, and Bradley hospitals, respectively); seven general hospitals with psychiatric units, consultations delivered in nursing facilities; and over 2,500 licensed, mental health professions who practice in a variety of settings.

Table 1 – Mental Health Professionals Licensed in Rhode Island, 1998

Profession	Number Licensed
Psychiatrists	285
Psychologists	422
Independent Social Case Worker	1,103
Clinical Social Worker	267
Marriage and Family Therapists	61
Mental Health Counselors	95
Chemical Dependency Professional	166
Chemical Dependency Supervisor	29
Psychology Trainee	17

Source: Rhode Island Department of Health, 1998

Beyond the "specialty" mental health sector, an enormous volume of mental health care is delivered in private physicians' offices and general hospitals without specialized psychiatric units.

In the private sector, mental health benefits were traditionally excluded by third party payers because of fears of uncontrolled utilization and costs and the belief that the treatment of mental illness was the sole responsibility of the public. However, the efforts of mental health advocates and the emergence of mental health parity laws have expanded the availability of mental health insurance coverage and employee assistance programs.

Coincident with the expanded coverage has been the increased use of managed behavioral health care organizations to administer mental health benefits.[5, 6] The impact of managed care on the utilization of mental health services by commercially-insured individuals in Rhode Island is unknown. Utilization data, including the sites of care for privately-insured individuals, is not yet available. National data indicate that commercial insurance paid under 29 percent of mental health care costs.[7] Furthermore, over a third of private mental health care expenditures are paid out-of-pocket. Although the state's community mental health clinics are available to privately-insured individuals, the aggressive treatment services typically provided in these facilities are often not covered by private insurance plans; and privately insured patients are rarely able to access these facilities. The extent to which the costs of care are shifted to public payers because of inadequate private coverage is also unknown.

As mental health services are an important component of overall health care spending, the need for information about this service sector is compelling.[8] Next year, data will be available which should facilitate review of mental health coverage and services in managed care organizations.[9] However, there is still no mechanism to cull from the non-publicly financed components of the delivery system information about the cost and organization of practice across provider types; financing sources; manpower needs; service utilization patterns; or patient outcomes.

Extrapolating from national data, mental disorders cost the Rhode Island economy more than $600 million each year for treatment for the costs of providing social service and providing disability payments to patients and for lost productivity and premature mortality.[10] Untreated depression alone costs an estimated $176 million each year with employers bearing more than half this cost through employee absenteeism and reduced productivity.[11]

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[5] Oss M. *Managed Behavioral Health Market Share in the United States*. Gettysburg, Pa: Open Minds; June 1994.
[6] Alliance for Health Reform (1998). Managed Care & Vulnerable Americans: Mental Health Care Coverage. Washington, DC.
[7] Ibid, McKusick, David, *et.al.*
[8] Ibid. McKusick, David, *et.al.*
[9] Under the Health Care Accountability and Quality Assurance Act.
[10] Substance Abuse and Mental Health Services Administration (SAMHSA), Public Health Service, U.S. Department of Health and Human Services. Costs of Addictive and Mental Disorders and Effectiveness..
[11] Ibid. Alliance for Health Reform.

Two out of three cases of major depression will never be diagnosed or treated. In light of the economic impact of mental illness, the Council seeks to know that:

- Rhode Island employees with mental health problems are quickly identified and have easy access to appropriate and effective services. (How are mental health care problems handled when encountered in private general practice? Are illnesses recognized?)
- Workers are returned to full productivity in the shortest period of time, and the relapse rate of Rhode Island workers treated for mental health problems is as good or better than the industry standard;
- Benefit limitations, coverage provisions (utilization review, etc.) are controlling costs without compromising the quality of care, measured in terms of patient satisfaction, best-practice outcomes, and return to full productivity.

The Council concludes that much more comprehensive, state-specific information is essential in order to be able to understand the dynamics of this rapidly changing but little understood sector of Rhode Island's health care industry.

SUBSTANCE ABUSE

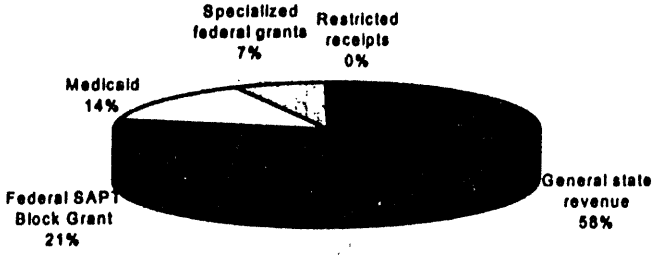
--Overview--

Within Rhode Island state government, the Division of Substance Abuse is responsible for substance abuse prevention and treatment services. Formerly within the Department of Health, the Division was moved to the Department of Mental Health, Retardation and Hospitals by legislative action in the 1998 General Assembly. **The contents of this report reflect information and activity prior to the transfer of the Division.**

Like other health care sectors, understanding the treatment of substance abuse is hampered by the existence of multiple systems, mostly defined along the line of public versus private funding. Information regarding expenditures and utilization of publicly-funded substance abuse services is readily available, but the lack of data on privately-funded and provided services makes it difficult to construct a complete picture and to understand the role of publicly-funded programs within the overall system.

Substance abuse treatment services comprise only about one percent of overall personal health care costs. However, the Council is concerned about the non-treatment costs of substance abuse. Extrapolating data from the National Institute on Drug Abuse, the estimated economic costs of alcohol and drug abuse in Rhode Island were nearly $1 billion in 1992. According to the NIDA study, alcohol abuse generated about 60 percent of these costs, and illicit drug abuse accounted for about 40 percent. The distribution of drug and alcohol costs differed markedly. Most of the alcohol-related costs were due to lost productivity, alcohol-related illness, and premature death. In contrast, the costs related to drug abuse were mostly due to drug-related crime. Crime-related costs may be a particular concern in Rhode Island, where the incidence of injection drug abuse is relatively high.

A systematic analysis of the funding for substance abuse treatment in Rhode Island is not available. The cost of care in Rhode Island's acute care hospitals for admissions related to substance abuse is unknown. Audits from publicly-funded substance abuse providers typically do not provide more detailed information. Average costs of services are not available for comparison within the state or against national norms. Categorical public funding for substance abuse services in Rhode Island during FY 1998 totaled approximately $22.4 million and administered by the Department of Health. Of the treatment admissions reported to the Department of Health, only eight percent were funded by private insurance.

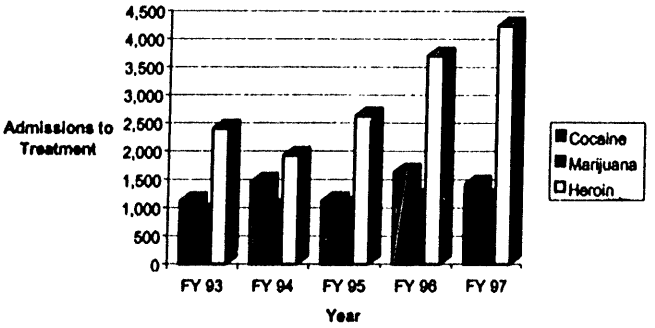


Private insurance coverage for substance abuse treatment is substantially more restricted than coverage for general medical care. However, like insurance coverage for mental health services, the proportion of insured workers with substance abuse coverage has increased over the 1990s. Despite wider availability of substance abuse treatment coverage, formal limits on care are applied almost universally. The types of limits include caps on number of inpatient and outpatient treatments per year, maximum lifetime costs of substance abuse treatment, special medical necessity review procedures, and carved-out provider networks.

HMOs and health insurers in Rhode Island are required by State law to provide medically necessary treatment for substance dependency up to certain limits. However, these laws do not apply to ERISA-protected self-funded plans or to those with only supplemental (e.g., Medigap) or single disease (e.g., cancer coverage) health insurance policies. These "mandated benefits" often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full. The conditions and restrictions noted above often apply and are not covered by law or regulation.

In the absence of direct evidence on the prevalence of adult drug abuse in Rhode Island, data from national studies can be extrapolated and modified based on information derived from treatment admission data. In 1996, an estimated 5 percent of the population were current drug users (used an illicit drug in the past month), which was down from a peak of 11 percent in 1979, and relatively unchanged since 1992. Of concern is the fact that heroin use has increased. Injecting drug users (and their sexual partners) are at high risk for contracting HIV and AIDS, as well as tuberculosis and hepatitis.

In Rhode Island, one-third of the primary drug caseload involved injection drug use; and a significant proportion of primary alcohol clients report secondary heroin or other opiate use. Rhode Island's treatment admission data reflects a significantly higher rate of heroin use (59 percent of all primary drug admissions) than the national average. Injection drug use accounts for the single highest proportion of reported HIV seropositive test results in Rhode Island (39 percent).



The Council is concerned about potential imbalances in the supply and demand for substance abuse treatment. The high non-treatment costs of substance abuse are a drain on the Rhode Island economy. Because a large proportion of drug abusers is not receiving treatment, there is potentially a high payoff to getting more abusers into treatment. Furthermore, evidence suggests that drug abuse treatment is effective. Clients report decreased drug use and less criminal activity. Assessed one year after treatment, drug use

declined when clients received any of three treatment types: Long-term residential, outpatient drug free, or methadone maintenance.

As of January, 1998, there were 55 licensed substance abuse treatment facilities in Rhode Island, including 40 additional certified services for a total of 90 programs over seven levels of care. The total estimated "static" treatment capacity for these facilities is 446 (excluding outpatient programs where capacity is not limited by overnight living space requirements). Since length of stay differs by facility and program, the annual "dynamic" capacities of these facilities varies widely.

The most comprehensive source of data on the utilization of substance abuse treatment is the Client Information System (CIS) maintained by the Department of Health. The CIS includes all admissions to community-based substance abuse detoxification and treatment providers funded in whole or in part by the Department, as well as all methadone maintenance/detoxification programs. The data does not include admissions to the one or two private treatment centers that receive no state categorical funding, hospital admissions for substance abuse treatment, out-of-state admissions, and an unknown number of admissions to outpatient therapy by independent, private practitioners. Only a portion of the substance abuse related treatment received by patients with severe and persistent mental illness (dual diagnosis) seen at community mental health centers is reflected in the CIS.

According to CIS data, in FY 1997 there were a total of 11,972 alcohol and other drug admissions to detoxification and treatment facilities included the CIS database (Table 1). The number of admissions has been relatively stable over the past five years (Table 2). Of overall admissions, 7,200 (60 percent) were for primary drug use; 4,772 (40 percent) were for primary alcohol use. Thirty percent of all primary drug users were injecting drug users (down by 3 percent over the prior year). Within the primary drug caseload, 59 percent of admissions were for heroin addiction; 20 percent for cocaine or crack; 16 percent for marijuana abuse.

Table 1 - Substance Abuse Admissions by Facility Type, Rhode Island, FY97

Type of Facility	Number	Percent
Free standing (non-hospital) residential detoxification	3,701	31
Residential Treatment (non-hospital) (Short-term = 53; Long-term = 1055)	1,108	9
Outpatient	4,728	39
Intensive Outpatient/Day Treatment	230	2
Methadone Maintenance and Detoxification	2,205	18
TOTAL	**11,972**	**100**

Source: RI Department of Health, Substance Abuse

Table 2 – Admissions to Treatment Services, FY93 to FY97

Total Treatment Services	FY 93	FY 94	FY 95	FY 96	FY 97
Detox/Social Setting Inpatient	-	-	-	-	100
Detox-Free Standing Medical Inpatient	4,136	4,077	3,082	4,901	3,601
Residential/Short Term	436	196	216	125	53
Residential/Long Term	1,038	1,022	1,161	1,190	1,055
Intensive Outpatient (Day Treatment)	296	172	187	366	230
Outpatient	4,450	4,132	4,775	5,054	4,728
Outpatient Methadone	1,083	1,427	1,506	1,353	1,667
Outpatient Methadone Detox	148	210	277	140	538
TOTAL	**11,587**	**11,236**	**11,204**	**13,129**	**11,972**

Acute care hospitals in Rhode Island are not separately licensed as substance abuse facilities and do not submit data as such. However, all but two hospitals regularly report on discharges. Because the two non-reporting institutions are voluntary mental health hospitals for adults and children, this gap in data may be significant. Furthermore, it is estimated that 25-40 percent of all US hospitalizations is related to alcohol and other drug abuse but are not designated as substance abuse by the discharge diagnosis. Discharges related to substance abuse (alcohol and drugs) totaled 1,275, which, when added to the number of other treatment admissions, constitutes only 10 percent of the total.

National data suggest that only a small portion of substance abusers enter treatment each year. According to the National Institute on Drug Abuse, in fiscal year 1995, there were nearly 1.9 million admissions to publicly funded substance abuse treatment programs, constituting less than 20 percent of the estimated 13 million current drug users. The number of current drug users who seek but are unable to receive treatment each year is unknown. To the extent that there is an unmet demand for substance abuse treatment, the causes for the failure to receive treatment are also unknown. Failure to receive substance abuse treatment could be due to the inability to pay for services, the unwillingness to enter treatment, or the lack of availability of an appropriate treatment slot.

Although there is anecdotal evidence of waiting lists, particularly for adolescent residential substance abuse treatment, no current data on the unmet need for substance abuse treatment in Rhode Island exists. However, the Rhode Island Division of Substance Abuse has contracted for an updated needs assessment using the Unified Needs Assessment Protocol; and the results are expected within the next year. The Council is pleased to note that an adolescent-specific study is part of this project.

Drug abuse prevention programs are widely distributed throughout Rhode Island and funded by a variety of public and private sources. The Division of Substance Abuse alone administers 60 subcontracts for the delivery of substance abuse prevention services. These services include: 35 municipal prevention task forces; student assistance services in junior and senior high schools; Safe and Drug Free Schools and Communities initiatives; private agency-based programs; a statewide prevention training and resource center; and a crisis intervention hotline. The National Institute on Drug Abuse has found that prevention programs are cost-effective. For every $1 spent on drug use prevention, communities can save $4 to $5 in costs for drug abuse treatment and counseling.

THE NURSING PROFESSIONS AND EDUCATION

- - *Overview* - -

The nursing profession is one of the largest and most diverse segments of the health care workforce, ranging from nursing assistants/aides and licensed practical nurses (LPN) to registered nurses (RN) and advanced practice nurses (APN).[1]

Supply - As of December 31, 1996, there were approximately 31,000 licensed nursing caregivers in Rhode Island, of which 50 percent were RNs, 10 percent were LPNs, 38 percent were Nurses Aides (NAs), and 1 percent were APNs (Table 1).

Table 1 - Trends in the Number of Licensed Nurses in Rhode Island by Category

	1992	1994	1996	% Change 1992 – 1996
RN	14,240	15,318	15,646	10%
APN				
CRNA	N/A	N/A	117	N/A
NP*	N/A	174	212	22%
CNM	27	36	43	59%
Aides	8,368	11,308	12,051	44%
LPN	3,370	3,318	3,234	-4%

Source: Rhode Island Department of Health

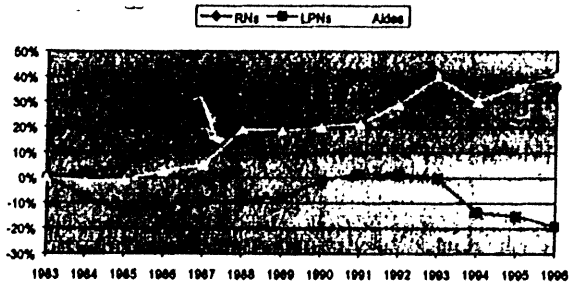
The total number of licensed nursing caregivers in Rhode Island increased 20 percent between 1992 and 1996. The majority of this increase is attributable to a 44 percent growth in the number of NAs. The number of RNs increased by 10 percent, while the number of licensed LPNs decreased over the same time period by 4 percent. There was also a large percentage increase in the number of professionals seeking licensure as a CRNA, NP, or CNM, although the actual number of persons licensed in these categories is small.

Employment Trends - Over the period between 1992 and 1996, US Census Bureau data showed a slow down in the rate of employment growth for RNs, a decline in employment for LPNs, and an increase in employment rates for NAs (Fig. 1).[2]

[1] Advanced Practice Nurses include Nurse Practitioners (NP), Certified Registered Nurse Anesthetists (CRNA), and Certified Nurse Midwife (CNM).

[2] Managed Care and the Nurse Workforce, Buerhaus and Staiger, November 13, 1996.

Figure 1 - FTE Employment growth of RNs, LPNs and Aides since 1983



Source: Managed Care and the Nurse Workforce, November 13, 1996

Compared to the New England region and the nation, Rhode Island has a higher rate of RNs who are employed in nursing as well as a higher number of nurses per 100,000 population (Table 2).

Table 2 - Supply of Registered Nurses (RNs) By Employment Status

	Total Registered Nurses*	% Employed in Nursing	% Not Employed in Nursing	Employed FTEs per 100,000 population
Rhode Island	16,117	86.5%	13.5%	1,128
New England	176,951	83.2%	16.8%	1,103
United States	2,558,874	82.7%	17.3%	798

** Includes registered nurses with advanced degrees (NP, PA, CRNA, and CNM)*
Source: The Registered Nurse Population, March 1996 HRSA

However, as compared to the rest of New England and the nation, Rhode Island has a slightly higher rate of RNs employed on a part-time basis (Table 3).

Table 3 - FTE Employment Status of RNs

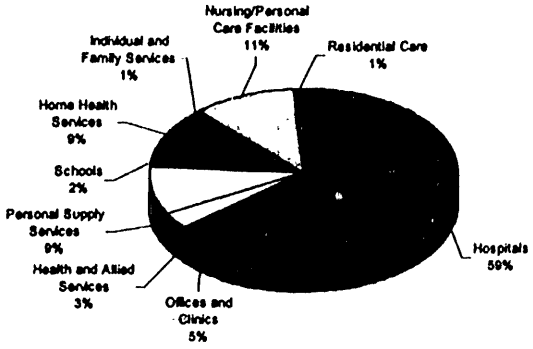
	Percent Employed Full-time	Percent Employed Part-time	Estimated Full-time Equivalent (FTE)
FTE Employment Rhode Island	60.4%	39.6%	12,926
New England	62.3%	37.7%	119,482
United States	71.4%	28.6%	1,813,067

**Includes registered nurses with advanced degrees (NP, CRNA, and CNM)*
Source: The Registered Nurse Population, March 1996 HRSA

Racial and ethnic minorities are under-represented in Rhode Island's nursing workforce. Hispanic individuals constitute 6.2 percent of Rhode Island's population, but only 0.5 percent of Rhode Island's employed RNs. Approximately 4.6 percent of Rhode Island's general population is African-American, while just 0.7 percent of employed RNs in the state are African-American.

Practice Location The distribution of nurses within hospitals has shifted away from inpatient units to outpatient hospital settings. Consistent with national statistics[3], approximately 59 percent of all Rhode Island RNs practice in hospital settings (Fig. 2). Physician practices and home health agencies employ approximately 14 percent of Rhode Island's RNs, while nursing homes and other extended care facilities account for approximately 12 percent.

Figure 2 - 1994 Employment Settings for Registered Nurses State of Rhode Island



Source: Occupational Information Coordinating Committee, December 1997

Staffing ratios of various levels of nursing care providers within hospitals and extended care facilities can serve as barometers of changing functions in the marketplace.[4] In states with high managed care penetration nursing salary increases are lower, employment growth is slower, and the role of the RN in the hospital setting is greatly altered. In future reports the Council will track the impact of changing market forces on nurse staffing ratios across a variety of practice settings.

Nursing Education - RN training occurs in a two-year associate program, a three-year diploma program, or a four-year university program. Over the past 20 years, there has been a significant change in the model for basic nursing education. In the 1970's, 75 percent of all RNs graduated from diploma programs. In the 1990s, the associate degree is the most common basic nursing education. Approximately 14 percent of all licensed RNs in Rhode Island had master's degrees and/or doctorate degrees, as compared to the national average of 10 percent. The percentage of RNs with a bachelor's degree is approximately 35 percent compared to the national average of 32 percent (Table 4).

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[3] Ibid

[4] *The Digest of Managed Health Care*, "Managed Care Shifts Nurses Away from Hospital Setting, Study Finds," Vol. 1, No. 3, December 1997.
Citing a study: Buerhaus, Peter I., and Douglas O. Stauiger, "Managed Care and the Nurse Workforce," *The Journal of the American Medical Association*, Vol. 276, No. 18, 1996.

Table 4 - Highest Educational Preparation of Employed Registered Nurses

	Diploma	Associate Degree	Baccalaureate	Master's and Doctorate
Rhode Island	26.7%	26.2%	34.6%	13.5%
New England	30.9%	24.4%	32.4%	12.2%
United States	23.8%	34.6%	31.8%	9.8%

Source: The Registered Nurse Population, March 1996 HRSA

Several Rhode Island schools offer associate-to-doctorate degree nursing programs: The University of Rhode Island, Rhode Island College, Salve Regina University, and Community College of Rhode Island. There is also a hospital-based diploma program at St. Joseph Hospital and a nurse anesthetist program at Memorial Hospital. From 1987 to 1995, there was a 14 percent overall increase in the number of graduates from these programs (Table 5).

Table 5 - Graduates of Rhode Island Public Sector Nursing Programs by Degree

Degree	87-88	93-94	94-95	% Change
Ph.D.	0	3	5	-
MS & Practicum	30	27	21	-0.3%
B.S.	177	201	213	20%
A.S./LPN	215	219	242	13%
TOTAL	422	450	481	14%

Source: Rhode Island Hospital Association

Within the nursing profession, there is a great deal of debate over which of the three types of entry level nursing programs best provides the essential knowledge and skills required to provide appropriate care in a changing health care environment. While the National Advisory Council on Nurse Education feels that the bachelor's degree best prepares students for meeting these requirements, the question is far from resolved. It is generally assumed that a higher proportion of the RN population will continue to be trained in associate degree programs. The debate would greatly benefit from a better understanding of the relationship between different nursing education programs and market, demographic, and technological demand for specific nursing skill sets.

Compensation - In 1996, the national average salary for RNs was approximately $42,000, an increase of approximately 11 percent over 1992.[5] Reliable normative wage and/or compensation analyses for nurses practicing within the State of Rhode Island are not available. However, as shown in Table 6, the Rhode Island Occupational Information Coordinating Council provided a 1995 wage range for nurses practicing in Rhode Island. Absent averages and/or medians, it is unclear how compensation for nurses in Rhode Island compares regionally or nationally.

Table 6 - 1995 Wage Range

1995 Wage Range	Low	High
RN	$21,210.00	$65,000.00
LPN	$19,000.00	$37,440.00
Aides	$12,480.00	$24,770.00

Source: Rhode Island Occupational Information Coordinating Committee

[5] Health Resource and Services Administration, Bureau of Health Professions, Sept 1997.

As noted above, the number of graduates of Rhode Island nursing programs has increased in recent years. Although there is anecdotal evidence of higher nursing wages in the Boston market, no significant out-migration of recent nursing school graduates to border states has been observed; and, other than Rhode Island College, nursing schools in Rhode Island have not limited enrollment.

Changing Roles - The need for well-trained professional nurses in nursing homes, community-based centers, and other non-hospital settings has grown dramatically. This trend is expected to increase in the coming years as utilization in non-hospital settings increases and the needs of elderly patients become more complex. Reduced inpatient hospitalization rates, the increased acuity of patients who are admitted, and the shift to care in community-based settings have significant implications for the education and training of nursing professionals. According to the Institute of Medicine, "In the future, nurses may be called upon increasingly to fill roles that require increased professional judgment, management of complex systems that span the traditional boundaries of service settings, and greater clinical autonomy."[6]

Because Rhode Island has a relatively young managed care market, it is in a position to draw upon the experiences of more competitive markets in order to anticipate future issues and challenges for nursing. At a minimum, efforts to ensure an adequate and appropriately trained supply of professional nurses require an understanding of:

- Future nurse FTE counts across all nursing levels and in each employment setting;
- Nursing skill-mix requirements, corresponding educational level requirements, and projected enrollment in different types of nursing programs;
- Normative wage and compensation trends in Rhode Island and competing markets such as Boston; and
- Financial assistance programs for nurse education and the incentives within each program in regard to the type of nursing education program.

In future reports, the Council will attempt to gather and present consistent data for all levels across all major practice settings.

[6] Ibid.

ALLIED AND COMPLEMENTARY HEALTH PROFESSIONALS

-- *Overview* --

The term "allied health" identifies a cluster of health professions encompassing as many as 100 occupational titles, exclusive of physicians, nurses, and a handful of others. Approximately two million allied health professionals are employed in the United States.

Complementary and alternative medicine (CAM) covers a broad range of healing philosophies, approaches, and therapies. It generally is defined as those treatments and health-care practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies. Some approaches are consistent with physiological principles of Western medicine, while others constitute healing systems with a different origin.

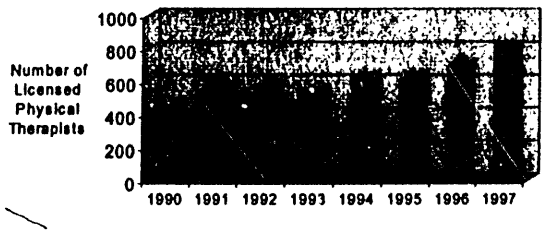
The demand for the services of allied health and CAM professions has steadily increased over the past decade and is expected to continue upward for the next several years. Two major factors will contribute to the continued growth. First, the aging of the US population will result in greater utilization for the specialized rehabilitative therapies offered by the allied health professions. Second, a growing public acceptance of CAM practices may lead to increased insurance coverage of and, therefore, great demand for alternative therapies.

Allied Health Professionals - The most widely utilized allied health services in Rhode Island and across the country are physical therapy, occupational therapy, speech therapy, podiatry, and psychology.

Beyond the income statistics reported by their respective professional organizations, there is little data with which to estimate the number or source of health-care dollars spent on the services of allied health providers. The Council believes it important to understand per capita utilization and expenditures related to these "cost centers" within the major health care sectors (hospitals, ambulatory care, nursing facilities, and home health care) according to health insurance coverage (Medicare, Medicaid, and private insurance) and for certain patient groups (e.g., the elderly). The transition from fee-for-service to managed care has brought a radical shift in the financial incentives surrounding the delivery of allied health services. Expenditures for these services have come under much more intense scrutiny. In addition, the federal Balanced Budget Act of 1997 substantially reduced Medicare coverage for these services in home health care and nursing facilities. Because it is the largest of all health plans, changes in Medicare coverage policies have a profound impact on the entire market. Assessing the impact of changing market forces requires utilization and expenditure data heretofore unavailable to the Council. In its first report, the Council is therefore left to frame questions that beg the gathering of additional data. Within the allied health chapter itself, these questions take the form of blank tables.

Physical Therapy - Approximately 115,000 physical therapists were employed in the U.S. in1996.[1] As of December 1997, there were approximately 575 physical therapists practicing in Rhode Island. The number of licensed physical therapists in Rhode Island has increased by nearly 50 percent over the past seven years (Fig. 1).

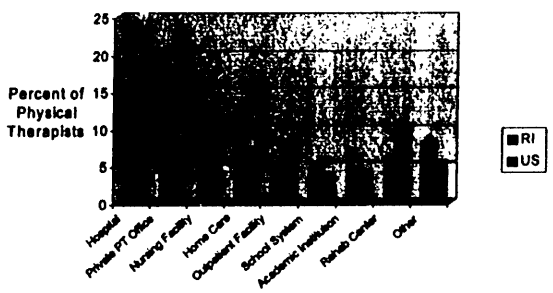
Figure 1 - Number of Licensed Physical Therapists in Rhode Island, 1990 – 1997



Source: American Physical Therapy Association Service Center, December 1997

Physical therapists practice in a variety of locations, although almost half practice in either the hospital or private office setting (Fig. 2).

Figure 2 - Physical Therapy Practice Locations



Source: American Physical Therapy Association Service Center, December 1997

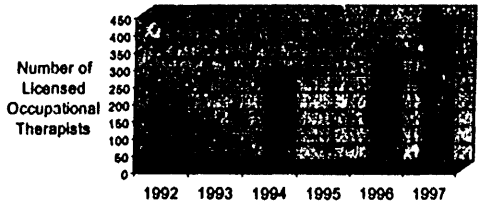
Medicare and Medicaid cover physical therapy treatments, although Medicare provides the most benefits for rehabilitative therapy There is anecdotal evidence of a current, severe shortage of physical therapists to practice in long-term care settings.

Currently there is only one accredited educational program for the physical therapy profession in the state of Rhode Island. The University of Rhode Island in Kingston offers a Professional Master's Degree Program.

[1] Bureau of Labor Statistics, US Department of Labor, 1998-99 Occupational Outlook Handbook

Occupational Therapy - Occupational therapists provide rehabilitation services to individuals with physical, psychological, or developmental impairments. The number of licensed occupational therapists in Rhode Island has increased significantly over the past decade (Fig. 3), and now stands at 227..

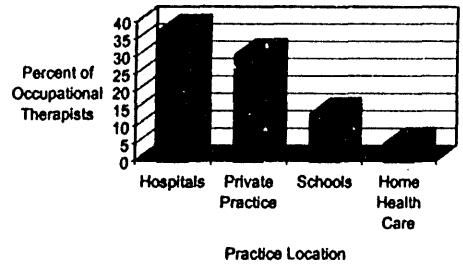
Figure 3 - Trends in the Number of Licensed Occupational Therapists in Rhode Island



Source: Rhode Island Department of Health, Profession Regulations and Licensing

Currently, most licensed occupational therapists in Rhode Island are employed by hospitals (Fig. 4).

Figure 4 - Distribution of Occupational Therapists in Rhode Island by Employment Location - 1994



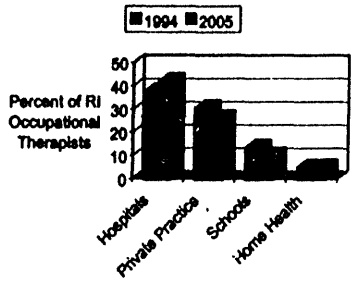
Source: Rhode Island Occupational Information Coordinating Committee, Statewide Projections Report, December 16, 1997.

Currently, Medicare and Medicaid are the principal public purchasers of occupational therapy services, although the Balanced Budget Act reduced substantially Medicare coverage of occupational therapy services in home health care and nursing facilities. Over the next year, the Council will carefully evaluate the effect of this reduction on patterns of service delivery.

Like physical therapy, occupational therapy is considered one of the fastest growing allied health professions. Rhode Island is expected to experience significant growth in occupational therapy over the next several years. Over the 11-year period of 1994 to 2005, there will be a projected 47.3 percent overall growth rate for occupational therapy.

It is anticipated that by 2005, an even larger percentage of all occupational therapists in the state will be working in the hospital setting (Fig. 8).

Figure 5 - Distribution of Occupational Therapists in Rhode Island by Employment Location

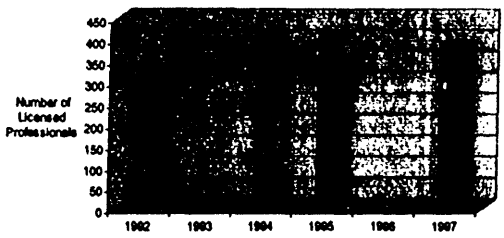


Source: Rhode Island Occupational Information Coordinating Committee, Statewide Projections Report, December 16, 1997.

There are no occupational therapy teaching programs in Rhode Island.

Speech-Language Pathology and Audiology - Speech-language pathologists assess and treat speech, language, voice, and fluency disorders, while audiologists diagnose and treat hearing deficits. The number of speech-language pathologists and audiologists employed in Rhode Island has remained relatively stable (Fig.9).

Figure 6 - Number of Licensed Speech Pathologists and Audiologists In Rhode Island, 1992-1997



Source: Rhode Island Department of Health, Profession Regulations and Licensing, 1997

Over half of speech-language pathologists and audiologists work in schools. More than 10 percent practice in the hospital setting, and the remaining number are employed in private practice, specialized speech and hearing centers, home health care agencies, and other facilities.[2] There is anecdotal evidence of a shortage of speech therapists practicing in long-term care settings.[3] Because of the association of speech and hearing problems with age, the number of speech-language pathologists and audiologists practicing in hospitals, nursing homes, and other settings that serve the elderly is expected to increase.

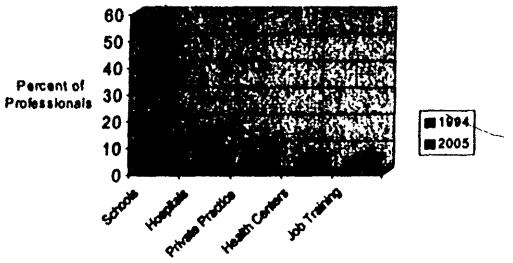
The University of Rhode Island is the sole training institution in the state offering an accredited master's degree program as well as an undergraduate training program for speech-language pathology and

[2] Ibid.
[3] Need citation here

audiology. The number of students completing the undergraduate program at URI has more than doubled in less than a decade.

As a function of an older population and declining school enrollments, the distribution of speech-language pathologists and audiologists is expected to shift slightly toward hospital settings and away from elementary and secondary schools (Fig. 7).

Figure 7 - Speech-Language Pathology and Audiology Practice Locations in Rhode Island – Current and Projected



Source: Rhode Island Occupational Information Coordinating Committee, Statewide Projections Report, December 16, 1997.

Podiatry - Podiatrists diagnose and treat diseases and deformities of the foot. Currently, there are 102 licensed podiatrists in State of Rhode Island, a number that has not changed significantly over the past six years.[4] Similarly, employment trends are characterized by slow growth (Table 2).

There are seven podiatric medical colleges in the United States graduating an average of 612 new podiatric physicians yearly.[5] The nearest colleges of podiatric medicine to Rhode Island are in New York and Philadelphia.

Factors creating additional demand for podiatric services include the aging of the population (the incidence of foot problems increases with age) and injuries resulting from more active lifestyles. Managed care is expected to exert a moderating influence on the utilization of podiatric care, as health plans seek to control the costs of specialty care.

[4] American Podiatric Medical Association, *Summary of Information on Foot and Ankle Problems, Foot Care, and Podiatric Physicians: Graphs and Maps*, May 1996.
[5] American Podiatric Medical Association, *Summary*, May 1996.

Complementary and Alternative Medicine

In the absence of a generally accepted notion of what constitutes complementary and alternative medicine, it is usually defined as treatments and health care practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies. There are approximately 202 so-called "alternative therapies" currently practiced in this country. These include naturopathy, reiki, Alexander technique, chiropractic, acupuncture, yoga, T'ai Chi, herbalism, massage therapy, shamanism, Trager, colon hydrotherapy, shiatsu, kinesiology, reflexology, feldenkrais, homeopathy, rolfing, ayurveda, Chi Kung. The federal Office of Alternative Medicine categorizes CAM into the six fields of diet-nutrition-lifestyle changes, mind-body interventions, bioelectromagnetic applications, alternative systems of medical practice, manual healing, pharmacological and biological treatments, and herbal medicine. Many of these therapies are practiced in Rhode Island without available licensure or certification, and there is scant guidance available to help consumers sort through these therapies.

Nearly two-thirds of people who visited alternative therapy practitioners pay the entire cost out-of-pocket. Conservatively estimated, Americans spent $21.2 billion on out-of-pocket expenditures for the services of alternative therapy practitioners in 1996, up from $14.6 billion dollars in 1990. Including expenditures for all unconventional therapies, Americans spent $27.0 billion out-of-pocket for alternative therapies in 1997. This figure compares to $9.1 billion in non-reimbursed expenses for all hospitalizations and $29.3 billion in out-of-pocket expenses for physician services.[6] From 1991 to 1995, overall sales of over the counter alternative drug remedies grew by 73 percent, compared to a 31 percent overall increase of prescription drug sales.[7]

Over 42 percent of Americans report using at least one unconventional therapy in the past year, up from 34 percent in 1990. Extrapolated to the entire US population, this suggests that Americans made approximately 629 million visits to providers of CAM therapy during 1997. This number exceeds the estimated number of visits to all primary care physicians by 243 million.[8] Studies of the reasons why patients utilize CAM yierld varying results. In general, the middle aged and baby boomers are leading the way. Use is more common among women, less common among African Americans. [9]

Although most health insurance plans do not cover alternative treatments, the number that do is increasing (Table 1). In January, 1997, Oxford Health Plan established the first alternative medicine program in the country after a survey indicated that 75 percent of its members were interested in adding unconventional treatment options to their current plan.

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[6] Eisenberg DM, et al. Trends in alternative medicine use in the United States, 1990-1997. JAMA. 1998; 280: 1569-1575.
[7] K. Day, *"Finding a Prescription for Economic Pain,"* Washington Post, January 16, 1997, pp. E1, E4.
[8] Eisenberg et al., 1998
[9] Richard A. Cooper & Sandi J. Stoflet, "Trends in the Education and Practice of Alternative Medicine Clinicians," *Health Affairs,* Fall 1996, 15 (3).

Table 1 - Alternative Therapy Coverage of Selected Health Plans

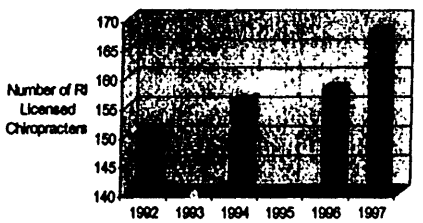
HMO Company	Therapies Covered	Coverage Provisions
Oxford Health Plans	Chiropractic, acupuncture, yoga, clinical nutritionists, massage therapy, and naturopathic physicians	Group clients purchase optional rider; members make copayments. Even without rider, members may visit any alternative medicine provider in the network at contracted rate.
Prudential Health Care Plans	Acupuncture, biofeedback, hypnotherapy, massage therapy, naturopathy, and chiropractic	Services part of standard benefit plan.
United HealthCare Corp.	Chiropractic. Some coverage of acupuncture, massage therapy, and herbal remedies.	Either as optional rider or as core benefit
Anthem Health Plans	Some chiropractic coverage	Alternative therapies available as options with some benefit plans and as a core benefit.
Kaiser Foundation Health Plans	Chiropractic	Many alternative therapies not spelled out. Doctors allowed to decide which treatments are most effective.

Source: Atlantic Information Services, 1998.

Chiropractic - Chiropractic is concerned with the relationship between the structure of the spinal cord and the function of the nervous system. In the State of Rhode Island, there are 168 licensed chiropractors, and approximately 140 of these are in actual practice (Fig. 8). There has been a slow but steady growth in the number of licensed chiropractors in Rhode Island over the past several years. Currently, there are 16 accredited chiropractic colleges in the United States. None of these are in Rhode Island; the nearest schools are located in Bridgeport, Connecticut and Seneca Falls, New York.

Although there is no federal requirement for HMOs to provide chiropractic coverage, almost two-thirds of plans now cover such services for some portion of their members, and approximately 51.5 percent cover chiropractic for all of their members.[10] Medicare covers chiropractic care in the State of Rhode Island. Although Medicaid does cover chiropractic in some states, it does not in Rhode Island.

Figure 8 - Number of Licensed Chiropractors in Rhode Island, 1992-1997



Source: Rhode Island Department of Health, Profession Regulations and Licensing

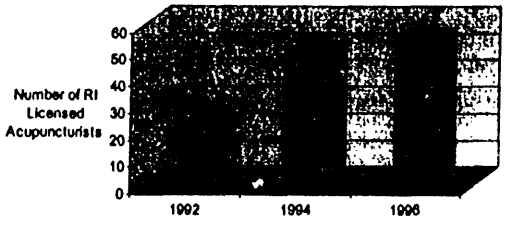
Acupuncture - Acupuncture is the gentle insertion of very thin needles into specific locations of the human body for the purpose of treating a wide range of health problems. In November 1997, a National Institutes of Health consensus panel concluded that acupuncture is an effective treatment for nausea caused by

[10] Palsbo, Susan E., The American Chiropractic Association, *Chiropractic Online: Chiropractic Care in Health Maintenance Organizations*. Available: http://www.amerchiro.org/managed/chir-hmo.htm/, December 17, 1997.

cancer chemotherapy drugs, surgical anesthesia, and pregnancy; and for pain resulting from surgery and a variety of musculoskeletal conditions. Little data exists regarding the utilization of acupuncture in the U.S. In 1996, there were 55 individuals with acupuncturist licenses in Rhode Island. This is a 48 percent increase from 26 licensed acupuncturists in the state in 1992 (Fig. 9). In 1994.

Currently, there are six states that require private insurers to cover visits to acupuncture. Neither Medicare nor Medicaid currently covers individual acupuncture treatments unless such treatments are recommended by a physician and are part of a patient's treatment plan for an illness. No data on expenditures for acupuncture is available.

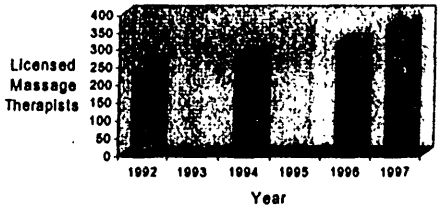
Figure 9 - Trends in the Number of Licensed Acupuncturists in Rhode Island, 1992-1997



Source: Rhode Island Department of Health, Profession Regulations and Licensing

Massage Therapy - Massage therapists seek to release tension in the body's muscles through specialized soft tissue manipulation techniques. According to the American Massage Therapy Association, consumers spend between $2 and $4 billion annually on visits to massage therapists. Most health care insurance companies do not cover massage therapy. However, the number of companies that do is increasing. Neither Rhode Island Medicaid nor Medicare reimburses for massage therapy treatments unless recommended as part of an individual's overall treatment plan by a covered provider such as a physician or physical therapist. There are currently 371 individuals with massage therapy licenses issued by the state of Rhode Island (Fig. 10).

Figure 10 - Trends in the Number of Licensed Massage Therapists in Rhode Island



Source: Rhode Island Department of Health, Profession Regulations and Licensing

There are currently 65 accredited or approved massage therapy schools in the nation. The nearest massage therapy schools are located in Connecticut, Massachusetts, New Hampshire, and Maine.

Indications for the Future - The use of complementary and alternative therapies is fairly widespread, and the, acceptance of CAM by the traditional medical profession appears to be increasing. The National Institutes of Health has established an Office of Alternative Medicine, which will subject many alternative therapies to rigorous testing for safety and effectiveness. Those alternative therapies judged to be effective are likely to move from the world of alternative medicine into mainstream medicine.

PHARMACY, PHARMACISTS AND PRESCRIPTION DRUGS

-- *Overview* --

The growth in managed care has resulted in substantial changes in the retail channel of distribution for pharmaceuticals. Community pharmacies' numbers and profit margins have declined, and market share has shifted to mail-order pharmacies as MCOs and pharmacy benefit managers are setting the terms of reimbursement. Community pharmacies have consolidated to increase negotiating power and efficiency and have become more involved in direct patient care. The success of both MCOs and community pharmacies may depend on their ability to provide cooperative services that improve patients' health outcomes.

The retail pharmacy market has experienced many important changes over the last decade. The numbers and types of pharmacies, and their ownership, have changed. Community pharmacy profit margins have declined, and pharmacy benefit managers (PBMs) have emerged as dominant influences on retail pharmacies.

Pharmaceuticals account for approximately 12 percent of national health care expenditures. Drug costs are projected to be more than $81 billion in 1998, a 13 percent increase over 1997. This increase is attributable to a combination of price inflation and higher utilization. In 1996, there were approximately 2.2 billion prescriptions filled annually in the United States, a 4 percent increase from the previous year.

Because of rapid cost increases, payers have focused attention on pharmaceutical utilization and outcomes. HMOs experienced drug cost increases of approximately 15 to 20 percent in 1996, more than double the rate of increase from three years earlier. While drugs account for only 10 percent of total HMO medical budgets, they accounted for 50 percent of their cost increases between 1995 and 1996. To address pharmaceutical cost increases, HMOs and pharmacy benefit managers (PBMs) have implemented a number of strategies:

- Closed or partially closed formularies:
- Prior authorization;
- Therapeutic interchange;
- Restrictions on certain classes and types of drugs;
- Passing risk to provider; and
- Generic substitution.

Funds Flow - A total of 2.2 billion prescriptions were filled in the United States in 1996, an increase of 4 percent from the previous year.[1] The total cost of these prescriptions was $72.7 billion, which translates into an average retail price of $33.09, a 9.6 percent increase over 1995. The average citizen received 8.3 prescriptions in 1996, an increase of 0.3 prescriptions over 1995. Compared to nearby states, Rhode Island's per capita utilization of prescription drugs is higher, cost per prescription is lower, and per capita spending is slightly higher than average (Table 1).

[1] 1997 Novatis Pharmacy Benefit Report, derived from IMS America's Retail "Method of Payment" report developed from data submitted by 34,000 retail pharmacies.

Table 1 - Prescription Volume, Spending, and Cost, 1996

STATE	Total Retail Dollars	Per Capita Spending	Total Prescriptions	Prescriptions Per Person	Average Cost Per Prescription
Connecticut	$1,055,633	$322	30,051	9.2	$35.00
Maine	$342,391	$275	9,610	7.7	$35.71
Massachusetts	$1,693,532	$280	49,769	8.2	$34.15
New Hampshire	$302,514	$260	9,088	7.8	$33.33
New Jersey	$2,819,621	$353	68,421	8.6	$41.05
New York	$5,795,724	$319	148,030	8.1	$39.38
Pennsylvania	$3,965,729	$329	115,280	9.6	$34.27
Rhode Island	**$323,119**	**$326**	**10,045**	**10.1**	**$32.28**
Vermont	$144,512	$245	4,451	7.6	$32.24
United States	$72,702,934	$274	2,197,334	8.3	$33.01

Nationally, more than 55 percent of prescriptions filled were paid for by third parties (HMO's and other insurers), and 58.5 percent of prescription costs were covered by third parties. Only 29.3 percent of the prescription retail dollars paid were cash payments from patients to pharmacists.

Rhode Island's third party share of prescription drug spending (69.4%) was the highest percentage in the Northeast and more than ten percentage points above the national average. The share paid directly by patients (18.9%) was over 30 percent lower than the national average. Medicaid paid 12.3 percent of prescription costs nationally and 11.7 percent in Rhode Island. (Table 2).

Table 2 - Source of Payment, 1996

State	Cash Share	Medicaid Share	Third Party Share
Connecticut	29.9%	106%	59.5%
Maine	28.3%	11.7%	60.0%
Massachusetts	21.1%	15.9%	62.9%
New Hampshire	29.4%	9.3%	61.4%
New Jersey	24.7%	17.2%	58.1%
New York	21.5%	20.0%	58.5%
Pennsylvania	21.1%	12.0%	66.8%
Rhode Island	**18.9%**	**11.7%**	**69.4%**
Vermont	34.3%	22.3%	43.4%
United States	29.3%	12.3%	58.5%

Source: Novartis, Pharmacy Benefit Report 1997 Edition

DRUG UTILIZATION STATISTICS: THIRD PARTY AND PUBLIC PROGRAMS

Over 95 percent of managed care enrollees had a pharmacy benefit as part of their HMO health plan. Overall PMPM drug expenditures for 1995 reached $11.63 decreasing from $12.12 PMPM in 1994. In mature managed care markets, the average 1995 PMPY costs were almost $40.00 lower than in immature markets.

Nationally, antibiotics were the most utilized drug therapy category in HMOs accounting for 231.7 million prescriptions. Antidepressants became the second highest class of drug spending in HMO's reaching 1.1 billion dollars in sales and 21.2 million HMO prescriptions. Antidepressants cost HMOs $19.63 per member on average. Gastrointestinal products were the third most expensive class in spending terms. Tables 3 and 4 provide indices of spending and prescription numbers per state resident compared to the national average. An index of 1.0 indicates equivalence to the national average in either spending or use within that state and drug class. According to these data, in Rhode Island, both spending and use of anti-depressants (1.54/1.55), cholesterol reducers (1.5/1.48), and ace-inhibitors (1.56/1.46) exceeds the national average by roughly half.

Table 3: 1996 National and State Retail Pharmacy Utilization Index Figures – Selected Therapy Areas

STATE	ANTIBIOTICS	GASTROINTESTINAL AGENTS	ANTIDEPRESSANTS	CALCIUM CHANNEL BLOCKERS	CHOLESTEROL REDUCERS
CONNECTICUT	1.12/1.15	1.03/0.98	1.34/1.22	1.12/0.96	1.29/1.07
MAINE	0.76/0.79	1.17/1.07	1.30/1.34	0.92/0.87	1.25/1.15
MASSACHUSETTS	0.84/0.98	1.05/1.00	1.35/1.27	0.87/0.85	1.26/1.14
NEW HAMPSHIRE	0.81/0.94	0.86/0.82	1.40/1.39	0.80/0.78	1.20/1.14
NEW JERSEY	1.40/1.13	1.23/1.04	0.93/0.74	1.41/1.07	1.34/0.99
NEW YORK	1.22/1.05	1.12/1.00	0.94/0.78	1.28/1.14	1.19/1.06
PENNSYLVANIA	1.08/1.04	1.26/1.24	1.13/1.07	1.33/1.32	1.35/1.30
RHODE ISLAND	1.03/1.13	1.25/1.29	1.54/1.55	1.30/1.22	1.50/1.48
VERMONT	0.73/0.91	1.00/0.98	1.34/1.44	0.73/0.74	0.77/0.86

Index comparison to 1.0/1.0 national average for dollars/prescriptions per state resident.
Source: Novartis, Pharmacy Benefit Report 1997Edition

Table 4: 1996 National and State Retail Pharmacy Utilization Index Figures – Selected Therapy Areas

STATE	ACE INHIBITORS	NSAIDS	ANTIHISTAMINES	ORAL CONTRACEPTIVES	ESTROGEN PRODUCTS
CONNECTICUT	1.23/1.07	0.87/1.01	1.13/1.18	1.39/1.47	0.92/0.80
MAINE	1.09/1.03	1.030.94	0.82/0.74	0.94/0.92	0.94/0.86
MASSACHUSETTS	1.07/1.03	0.69/0.93	0.98/0.96	1.33/1.36	0.69/0.74
NEW HAMPSHIRE	1.00/0.97	0.84/0.95	1.05/1.00	1.35/1.34	0.82/0.78
NEW JERSEY	1.31/1.01	1.08/0.95	1.32/1.28	1.12/1.09	0.64/0.55
NEW YORK	1.26/1.11	0.96/0.96	1.16/1.10	0.97/0.86	0.62/0.56
PENNSYLVANIA	1.33/1.32	1.21/1.12	1.17/1.12	1.13/1.13	0.77/0.79
RHODE ISLAND	1.56/1.46	0.93/1.15	1.02/1.12	1.59/1.67	0.82/0.88
VERMONT	1.00/0.97	0.98/0.98	0.74/0.73	0.84/0.82	0.75/0.74

Source: Novartis, Pharmacy Benefit Report 1997 Edition

Rhode Island State Purchasing - The State of Rhode Island purchases prescription drugs in a number of different programs and through a number of different and uncoordinated mechanisms (Table 5).

Table 5 - State Pharmacy Purchases in Millions of Dollars

	1994	1995	1996	1997
Medicaid		23.9	21.9	26.0
DMHRH				6.7
RIPAE	5.8	6.2	6.9	
Employee Benefits			11.8	
Total				

Medicaid – Rhode Island Medicaid expenditures for prescription drugs in 1997 totaled $52 million, of which the state's share is approximately 50 percent. Table 4 shows Rhode Island Medicaid pharmacy expenditures by age during fiscal years 1995, 1996, and 1997. The Council will analyze pharmaceutical expenditures on a per beneficiary basis (represented by the empty cells in Table 6) in future reports.

Table 6 - Medicaid Pharmacy Expenditures by age and fiscal year- Rhode Island

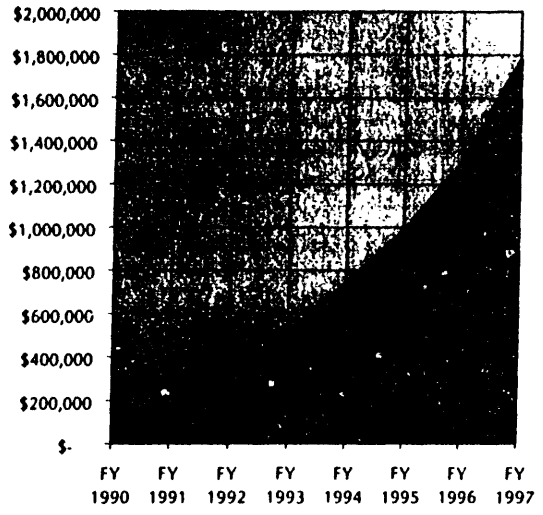
Age Category	1995		1996		1997	
	Total	Per Ben.	Total	Per Ben	Total	Per Ben.
Under 1	140,660		14,652		28,587	
1 – 5	1,147,883		357,966		327,510	
6-14	1,558,661		1,136,103		1,178,361	
15-20	937,693		777,692		692,267	
21-44	12,269,100		10,910,246		14,183,457	
45-64	12,091,435		12,087,577		14,475,354	
65-74	6,789,547		6,471,050		7,145,359	
75-84	7,153,049		7,341,581		7,717,193	
85 & Over	5,720,580		6,500,356		6,296,962	
Unknown			82,419			
Total	47,808,611		45,679,642		52,045,054	

Source: U.S. Department of Health and Human Services – Medicaid Drug Unit

DMHRH - The Department of Mental Health, Retardation and Hospitals purchases prescription drugs for the state hospital system, the Eleanor Slater Hospital, and for the Division of Integrated Mental Health Services (DIMHS). DMHRH provides pharmaceutical services through a warehousing distribution center called the Central Pharmacy. Medications are provided in bulk to two institutional pharmacies at the Eleanor Slater Hospital, approximately 55 other state agencies, and 13 community mental health clinic pharmacies. In addition, the Central Pharmacy distributes non-legend medication and medical/surgical supplies to 50 group homes and three skilled nursing facilities operated by the Division of Developmental Disabilities. During the 1997 fiscal year, $6.7 million of medication and medical/surgical supplies were distributed; approximately sixty-six percent went to the pharmacies and agencies within DMHRH.

DIMHS administers the Community Mental Health Medication Assistance Program (CMAP) which provides medications to approximately 1,600 clients. CMAP spent approximately $2 million dollars of the Central Pharmacy medications for mental health patients living in the community in 1997.

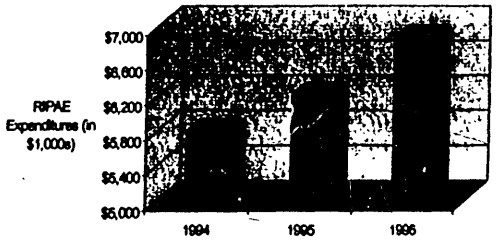
Figure 1: DMHRH -DIMHS CMAP Spending



Source: RI Department of Mental Health, Rehabilitation and Hospitals, Division of Integrated Mental Health Services

RIPAE - The State also purchases drugs through the Rhode Island Pharmaceutical Assistance to the Elderly Program (RIPAE). RIPAE pays 60 percent of the retail cost of drugs used to treat 10 chronic conditions and the RIPAE consumer is responsible for the balance. As of December, 1997, RIPAE had an enrollment of 28,924 limited income members over age 65. Approximately 62 percent utilized RIPAE benefits. There was a 6.6 percent increase in enrollment in calendar year 1997 as compared to the previous calendar year.

Figure 2 - State of Rhode Island RIPAE Expenditures



Source: RIPAE

Employee Benefits - The state purchases prescription drug products in its capacity as employer through its health benefit administrators. The group of traditional insurers, HMO's, and other managed care organizations report significant levels of expenditures for prescription drugs used by state employees and retirees. In 1996, employee drug benefit expenditures reached nearly $12 million (Table 7).

Table 7 - State of Rhode Island Employee Drug Benefit Expenditures - 1996

Plan Name	Total Prescription Drug Costs	Per Beneficiary Costs
United Health(1)	$1,268,172	
Harvard-Pilgrim Health Care (2)	$645,613	
Blue Cross & Blue Shield (3)	$9,897,821	
Total	$11,811,606	

Sources: Letters to B. Keehler, OPA (1) 1/28/96 from B. Shea, (2) 1/9/98 from B. Bjerke, (3) 1/21/98 from R Knowles

Pharmacies -

As of November 1997, there were 204 in-state pharmacies and 66 non-resident pharmacies licensed in Rhode Island (Table 8 and Fig. 3).

Table 8 - Number of Pharmacies Licensed

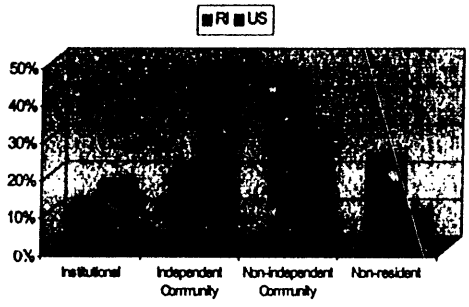
State	Total	Hospital/ Institutional	Independent Community	Non-Independent Community	Out-of- State or Non-Resident
Connecticut	650	58	275	375	55
Maine	282	42	Not reported	not reported	116
Massachusetts	1,209	158	361	669	not reported
New Hampshire	256	45	59	143	not reported
New Jersey	2,227	156	1,076	946	not reported
New York	4,444	523	2,305	1,616	not reported
Pennsylvania	3,070	314	Not reported	not reported	not reported
Rhode Island	**203**	**24**	**58**	**121**	**26**
Vermont	153	17	136	not reported	not reported
Total United States	**72,935**	**8,586**	**22,492**	**14,486**	**4,639**
% Reported Type	. N = 50,203	17%	45%	29%	9%

Source: National Association of State Boards of Pharmacy, 6/30/97.

Fifty-seven (21 percent) of the resident pharmacies were independent community pharmacies. Chain pharmacies constituted 123 (more than 60 percent) of the pharmacies in Rhode Island. Twenty-four licenses were granted to "institutional" pharmacies which serve hospitals or other institutional settings such as long-term care facilities.[2]

[2] Memo to R. A. Yacino, Chief, Division of Drug Control November 21, 1997

Figure 3 - Distribution of Various Pharmacy License Types.



Source: National Association of State Boards of Pharmacy, 6/30/97

In 1960, there were 312 independent and 14 chain store pharmacies in Rhode Island.[3] By 1975, the total number of stores had shrunk to 248, with 38 chain outlets. Between 1989 and 1994, 55 independents closed and 28 chain pharmacies opened. Since 1994, an additional 46 independent pharmacies have closed.

Pharmacists

In 1997, approximately 210,500 pharmacists were licensed in the US. This estimate includes all active licensees in ambulatory/community pharmacy practice, hospital pharmacy practice, manufacturing and wholesale practice, teaching and government, and other capacities. Of this number, approximately 175,000 practice in the traditional community and hospital pharmacy areas.

Table 9 - Licensed Pharmacists in the Northeast

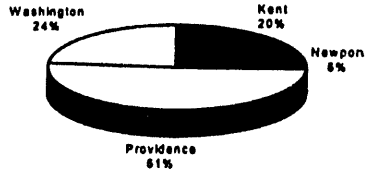
State	Pharmacists with In-State Addresses (Per 1000 Population)
Connecticut	2,760 (0.85)
Maine	not available
Massachusetts	not available
New Hampshire	811 (0.70)
New Jersey	not available
New York	15,451 (0.85)
Pennsylvania	12,182 (1.01)
Rhode Island	**907 (0.92)**
Vermont	381 (0.65)
Total United States	**201,084 (0.76)**

Source: National Association of State Boards of Pharmacy, 6/30/97

The Board of Pharmacy within the Department of Health reports 1,601 active pharmacists in Rhode Island. Nine hundred sixteen of the registrants have Rhode Island or "in state" licenses (Fig. 4).

[3] Providence Journal -Bulletin based on records maintained at the Rhode Island Pharmaceutical Association,

Figure 4 - Distribution of Licensed Pharmacists in Rhode Island (N=916)



Source: RI Department of Health, Board of Pharmacy

There are 79 schools of pharmacy in the United States, four of which were accredited for the first time in 1997.[4] Over the last five years, schools of pharmacy have been transitioning from five-year baccalaureate programs to a six-year Doctor of Pharmacy degree. Currently, 64 schools offer the Pharm.D. as the first professional degree. After the year 2000, all schools of pharmacy must offer only the Pharm.D. in order to maintain their accreditation from the American Council of Pharmaceutical Education

The college of pharmacy at the University of Rhode Island was established in the 1940's. Over the last decade, the college has enrolled and graduated its capacity of students, approximately 100-155 per year. Graduates earn a BS in Pharmacy or a Pharm.D. degree. The college is transitioning its classes to an all Pharm.D. degree.

New Practice Roles - The growth of managed care has generated new opportunities for pharmacists to play an expanded role on the health-care team. Increasing pressures to control costs, the rapid rise in drug related expenditures, the potential for some drug therapies to substitute for more expensive treatment regimens, and rapid advances in drug therapy have led payers to explore expanded roles for pharmacists. The term "pharmacy care" encompasses patient counseling, tracking of medications, improving drug therapy outcomes, and monitoring patients' health status. "Disease management" programs try to manage the care of patients with high-risk and high-cost diseases by integrating, coordinating, and monitoring the various components of health care treatment, including compliance with drug therapies. Approximately 70 percent of health maintenance organizations have some type of disease management program in place.

Pharmacy Benefit Managers - Payers utilize a variety of strategies to control and manage prescription drug costs. These include drug utilization review programs, restrictive supplier networks, restrictive formularies, mandatory generic substitution, and customer cost-shifting approaches (i.e.; co-payments and deductibles). However, even with these approaches, pharmacy costs continue to increase. The use of pharmacy benefit managers (PBMs) is another strategy used by payers to control pharmacy costs. PBMs manage prescription drug coverage on behalf of health plan sponsors.

Direct To Consumer Advertising - Recent changes in FDA regulations have led to significant increase in direct-to-consumer (DTC) advertising. Pharmaceutical manufacturers are channeling billions of dollars into print, television, radio, and Internet advertising. DTC is the industry's response to restrictive formularies and is intended to place pressure on the system through informed consumers seeking advertised treatments.

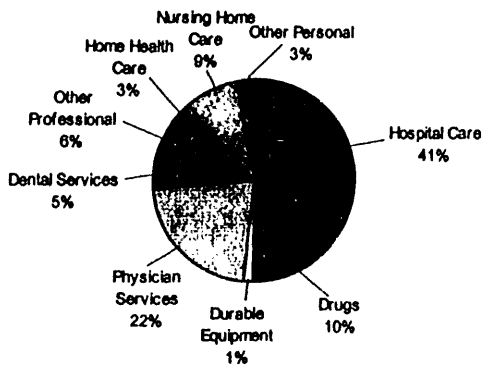
[4] American Association of Colleges of Pharmacy: Academic Pharmacy's Vital Statistics, Updated November 1997

ORAL HEALTH

– Overview –

Dental care services accounted for 5.2 percent ($47.6 billion) of all United States spending on personal health care services in 1996 (Fig. 1).[1]

Figure 1 - U.S. Personal Health Care Expenditures by Type, 1996

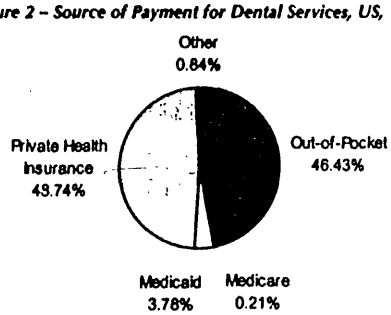


Source: HCFA, Office of the Actuary, National Health Statistics Group

Current data on total and per capita expenditures for dental services in Rhode Island is unavailable. Rhode Island Medicaid expenditures for dental services totaled $6.8 million in 1996, which averages $46 per Medicaid recipient, but $142 per recipient receiving dental services.

Nationally, approximately half the cost of dental care is covered by insurance, and a similar portion of the total cost of dental care is paid out-of-pocket (Fig. 2).

Figure 2 – Source of Payment for Dental Services, US, 1996



Source: HCFA, Office of the Actuary, National Health Statistics Group

[1] Health Care Financing Administration, US Department of Health and Human Services, "1996 National Health Expenditures."

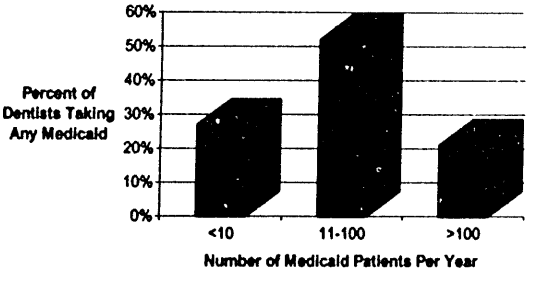
Dental Insurance – Consistent with national statistics, the Council estimates that about one half of Rhode Islanders (approximately 540,000 people) have dental insurance coverage, including 144,000 Medicaid eligibles. One half of Rhode Island employer-sponsored health plans include dental benefits.[2] The largest private dental insurers in Rhode Island are Blue Cross/Blue Shield of Rhode Island and Delta Dental of Rhode Island. Delta Dental and BC/BS Dental each have approximately 10,000 accounts with employer benefit plans and administer dental benefits for more than 200,000 Rhode Islanders. Each has carrier contracts with approximately 90 percent of the practicing dentists in the state.

One survey indicated that 44 percent of Rhode Island businesses pay all of their employees' dental premiums, while 13 percent of businesses required the employees to pick up the entire cost of the dental premium. The remaining businesses split the costs with their employees.[3]

Medicaid - Medicaid is required by federal law to provide dental benefits to children, but dental benefits are only offered at state option to adults. The Rhode Island Medicaid program provides coverage for adults and, when compared with other Medicaid adult dental programs, offers a relatively extensive benefit package. Children have can receive dental services through the EPSDT program. In addition, Rhode Island State Law (16-21-9) requires that school children receive dental examinations regularly. The Medicaid dental benefit is operated under a fee-for-service system for all Medicaid recipients, including those enrolled in RiteCare, and costs approximately $6.8 million per year.

Approximately 370 (62 percent) of practicing dentists in the state accept Medicaid patients. However, the majority of private dentists who take any Medicaid clients limit their practices to less than two Medicaid patients per week (100/year) (Fig. 3).

Figure 3 – Annual Number of Medicaid Patients of Dentists Taking Any Medicaid Recipients



Source: National Center for Health Statistics. Health, United States, 1998 With Socioeconomic Status and Health Chartbook. Hyattsville, Maryland: 1998.

[2] The Borah, Providence Business News "Annual Survey of Employee Benefits and Compensation", May 1993. AND Bloom, B, Gift, HC, Jack, SS. Dental services and oral health: National Center for Health Statistics, 1992.
[3] Ibid.

Rhode Island Medicaid dental reimbursement rates are approximately 45 percent of dentists' usual, customary and reasonable (UCR) fee levels.[4] This places Rhode Island roughly in the middle of the range of payment rates for Medicaid dental programs.

Medicare does not cover most dental procedures. However, some Medicare HMOs offer dental benefits. Currently four Medicare HMO's provide coverage for diagnostic and preventive services (oral exams, cleanings, and x-rays) with varied co-payments for procedures[5]

Dentists - In the state of Rhode Island, there are 780 licensed dentists, of which 650 are in active practice.[6]. This figure has remained relatively constant over the past several years. Ninety-one percent of dentists are in private practice, and 79 percent practice general dentistry. The remaining 21 percent are specialists and practice in fields of dentistry such as orthodontics and oral and maxillofacial surgery.[7]

Statewide, the ratio of dentists to the general population is consistent with the national average. However, the availability of dental services varies considerably between localities. In some areas of Rhode Island, there are shortages of dentists. (See below).

There are currently 55 accredited dental schools in the U.S., down from a peak of 60 in 1985. Between 1990 and 1995, the first-year enrollment in U.S. dental schools increased slightly from 3,938 to 4,078; but the number of annual graduates decreased from 4,233 to 3,840. The American Dental Association projects a further decrease in the number of graduates to 3,242 by the year 2000. There are no dental schools in Rhode Island, but there are dental schools in the Boston area (Tufts University, Boston University, and Harvard University) and at the University of Connecticut (Farmington).

A projected increase in demand for dental services is not expected to translate into a proportionate increase in demand for dentists. Forces pushing demand for dentists up over the next 5 - 10 years include a large number of dentists who are expected to retire and the dental needs of the aging baby-boom generation which will enter retirement with teeth largely intact. Moderating the growth in demand for dentists are larger enrollments in dental schools, the success of preventive measures, and the expanded use of dental hygienists and dental assistants.

Dental Hygienists – Dental hygienists clean teeth and provide other preventive dental care. In Rhode Island, there are 790 licensed dental hygienists.[8] There is one clinical training program for dental hygienists at the Community College of Rhode Island on the Lincoln campus. The University of Rhode Island offers a baccalaureate degree program in dental hygiene, but no longer has a clinical program (students from CCRI may matriculate into the URI program). There are approximately 12 graduates a year from the URI program. This number may decrease over time due to the termination of the clinical aspect of the program.[9]

Dental Assistants - Dental assistants perform a variety of patient care, office, and laboratory duties. Most areas of the U.S. are reporting shortages of dental assistants. In Rhode Island, approximately 800 dental assistants are employed. Because dental assistants do not need to be licensed, an exact figure is not available. Of these 800, about 350 are Certified Dental Assistants (CDAs).[10] CDAs pass a national certification exam and have a wider scope of practice than non-certified dental assistants. CCRI also has a

[4] William M. Mercer, Inc. Medicaid Dental Program Survey Results, April 1998.
[5] "It's Your Choice" Guide to Health Plans for Medicare Beneficiaries. Aging 2000, Feb. 1998.
[6] Per Robert McClanaghan, Chief, RI Department of Health, Division of Health Services Regulation, Dental Board.
[7] ADA, "Dental Education and Career Information", via ADA web page, updated December 21, 1997).
[8] Per Robert McClanaghan, Chief, RI Department of Health, Division of Health Services Regulation, Dental Board.
[9] Per Professor Barbara Brown, Dental Hygiene Program, URI.
[10] Estimates provided by Jennifer Carriao, President of RI Association of Certified Dental Assistants

training program for dental assistants. Following this one-year program, graduates can sit for the national certification exam. There are about 20 graduates a year from this CCRI program.[11]

Dental laboratory technicians fill prescriptions from dentists for crowns, bridges, dentures, and other dental prosthetics. There are currently more than 60,000 active dental laboratory technicians in the United States. In Rhode Island, there are 50 dental laboratories and approximately 150-200 individuals practicing as dental laboratory technicians. Because these workers are not licensed and the field is not regulated by the state, exact numbers practicing in Rhode Island are not available.

Dental Clinics - According to the Rhode Island Department of Health, as of January 1997, there were five "Dental Health Professional Shortage Areas" (DHPSAs) in Rhode Island (Table 1).[12]

Table 1 - Rhode Island Dental Health Professional Shortage Areas (HPSAs)

Location	Population Group Studied	Last[13] Reviewed
Newport County (Newport, Portsmouth, Middletown, Tiverton, Little Compton, Jamestown)	Low Income Population (i.e., ratio of dentists to number of low-income individuals)	1994
Central Falls/Pawtucket (Census Tracts 108-111,149, 151-153, and 161)	Low Income Population	1994
Providence (Census Tracts 1-23, 25-33, and 35-37)	Low Income Population	1994
East Washington County (South Kingstown, North Kingstown, Narragansett)	Low Income Population	1994
Northwest Woonsocket (Census Tracts 172, 174, 176, and 178-183)	Low Income Population	1995

Source: Office of Primary Care, Rhode Island Department of Health, 1997.

Seven community health centers in Rhode Island currently provide dental services: Each of these seven clinics serves between 2,000 and 4,000 dental patients. Approximately 20 percent of Medicaid recipients receive dental services at these safety net providers, which receive approximately $420,000 per year out of the $6.8 million spent by Medicaid on dental services. In addition to care at the health center clinic, Blackstone Valley Community Health Care operates a dental clinic at Central Falls high school two days a week as part of its school-based clinic. The two hospital-based dental clinics in the state are located at Rhode Island Hospital and St. Joseph's Hospital.

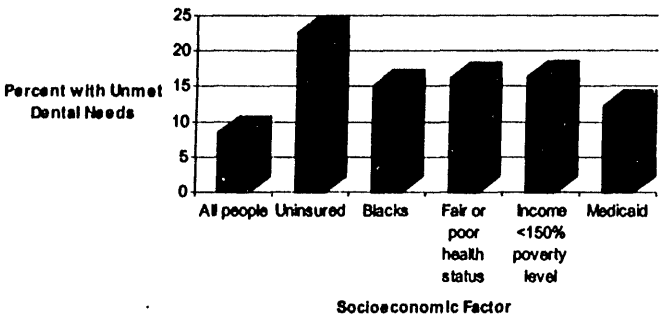
Utilization - National health surveys indicate that about 60 percent of the general population see a dentist each year. Data on the percent of the Rhode Island general population seeing a dentist at least once a year are not available. In 1996, 33 percent of Medicaid enrollees in Rhode Island received dental services, which compares to a national average fewer than 20 percent. However, within that population, 62 percent of children enrolled in RIteCare saw a dentist for fluoride treatments.[14]

Certain sub-populations, including low-income families, individuals with disabilities, and members of some minority groups, utilize dental services at lower-than-average rates.[15] Less likely to have visited a dentist in

[11] Per Donna Medas-Patton, Dental Assistants program at CCRI
[12] Ibid.
[13] Dental HPSA's last reviewed in 1994 are being re-evaluated in accordance with federal regulations to determine current compliance with standards for continued designation.
[14] RI Department of Health, Office of Health Statistics, Health Survey from 1990, c/o Jay Buechner.
[15] Ringelbert, M., Gilbert, G. Antonson, D. Et al., "Root caries and root defects in urban and rural adults: The Florida dental care study." Journal of the ADA, vol. 127, 196, p. 885-891.
Rizk, S. And Christen, A. "Falling between the cracks: oral healthy survey of school children ages five to thirteen having limited access to dental services." Journal of Dentistry for Children, Sept/Dec. 1994, p. 356-360.

the last year are the aged over 75 years, Blacks and Hispanics (versus whites), those living below the poverty level, and those with less than 12 years of education.[16] Blacks, those living below the poverty line; and those with public or no insurance are more likely to report unmet dental care needs.[17] Similar patterns are noted for children under age 17 years.

Figure 4 - Estimated Percentage of People with Unmet Dental Needs By Demographic Characteristics



Source: Mueller, CD; Schur, CL; and Paramore, LC. Access to dental care in the United States: estimates from a 1994 survey. Journal of the American Dental Association, Vol. 129, April 1998.

Having dental insurance, particularly public insurance, does not guarantee utilization of dental services. The lack of utilization by publicly-insured individuals may be due to lack of transportation, lack of childcare, fear of dentists, lack of awareness about the need for regular dental care, low priority given to oral health care, or other factors. However, the reasons for unmet dental needs are primarily financial. Over 70 percent of those with unmet dental needs attributed their lack of care to inability to afford the care, a lack of dental insurance, or having a dentist who did not accept their insurance.[18]

One major reason for this low utilization, as cited by dentists, is the low Medicaid reimbursement rates. Rhode Island Medicaid dental reimbursement rates are approximately 45 percent of dentists' usual, customary, and reasonable (UCR) fee levels.[19] Many dentists feel that Medicaid reimbursement rates for dental services are inadequate. As a result, many dentists are unwilling to accept Medicaid patients, at least to any significant degree.

In addition to low reimbursement rates, the reasons cited by Rhode Island dentists for not participating in the Medicaid program include an excessive number of patients who fail to keep appointments, excessive paperwork, payment delays, poor communication with the state agencies, and patients with complicated medical, social, and behavioral problems.

Watson, M. and Brown, L. "The oral health of U.S. Hispanics: evaluating their needs and their use of dental services." Journal of the ADA, 126:6, 1995, p. 789-796.

[16] Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Health Interview Statistics. Data from the National Health Interview Survey, 1993.

[17] Bloom, B; Simpson, G; Cohen, RA; and Parson, PE. Access to health care. Part 2: Working-age adults. National Center for Health Statistics. Vital Health Stat 10(197). 1997.

[18] Mueller, CD; Schur, CL; and Paramore, LC. Access to dental care in the United States: estimates from a 1994 survey. Journal of the American Dental Association, Vol. 129, April 1998

[19] William M. Mercer, Inc. Medicaid Dental Program Survey Results, April 1998.

PUBLIC HEALTH

-- *Overview* --

The mission of public health is to generate organized community effort in applying scientific and technical knowledge to disease prevention and health promotion. It links many disciplines, rests upon a science core of epidemiology, and encompasses activities undertaken within the formal structure of government and the associated efforts of private organizations and individuals. Public health functions within the province of several governmental agencies at federal, state, and local levels, but it is generally the responsibility of the State Department of Health to ensure that the major elements of public health are in place and that the public health mission is adequately addressed.[1]

The goals of public health are to:

- Prevent epidemics and the spread of disease;
- Protect against environmental hazards;
- Prevent injuries;
- Promote and encourage healthy behaviors;
- Respond to disasters and assist communities in recovery; and
- Ensure the quality and accessibility of health services.

Essential public health services include:

- Monitoring health status and identifying community health problems;
- Diagnosing and investigating health problems and health hazards in the community;
- Informing and educating the public about health issues;
- Establishing community partnerships for identifying and solving health problems;
- Developing policies and plans that support individual and community health efforts;
- Enforcing laws and regulations that protect health and ensure safety;
- Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable;
- Ensuring a competent public health and personal health care workforce;
- Evaluating effectiveness, accessibility, and quality of personal and population-based health services;
- Conducting research supporting innovative solutions to health problems.

Ideally, public health is not so much defined by any given set of institutions or services as it is defined by the prevailing disease patterns in the population and the pragmatic opportunities for prevention that exist at any given point in time.

The organization and operations of the federal public health agencies under the Surgeon General and the Assistant Secretary for Health over the past thirty years has had an enormous influence on the development of public health in Rhode Island and all the States. The U.S. Public Health Service and its constituent agencies (such as the Centers for Disease Control & Prevention (CDC), the Health Resources & Services Administration (HRSA), and the Substance Abuse & Mental Health Services Administration (SAMHSA), have provided state and local health departments with guidance, funding, and technical assistance. These federal efforts have had a profound impact on public health resources, priorities, competencies and directions at the state and local levels.

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[1] Institute Of Medicine, The Future of Public Health, Washington, DC: National Academy Press, 1998.

Funds Flow

The U.S. Department of Health & Human Services (DHHS) is a major source of funding for public health services in Rhode Island. The two main sources of funds from within DHHS are the Centers for Disease Control & Prevention (34 percent) and the Health Resources and Services Administration (30 percent) (Figure 1). The major recipients of these funds in Rhode Island are the Department of Health (62 percent) and Community Health Centers (15 percent) (Figure 2).

Figure 1 – U.S. DHHS Public Health Funding in Rhode Island by Donor Agency, FY 1997

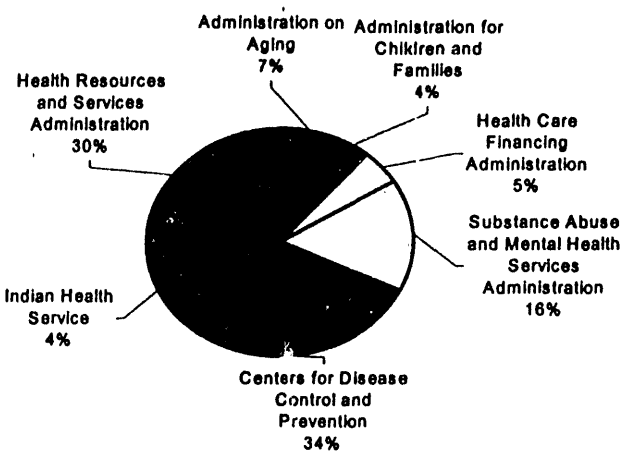
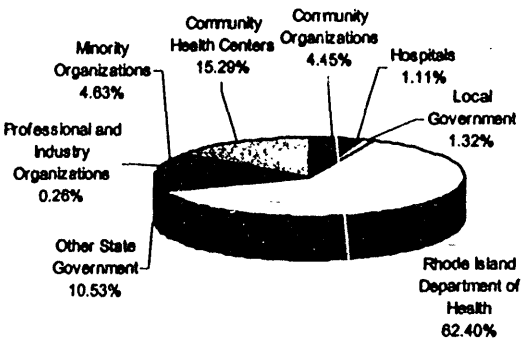


Figure 2 – U.S. DHHS Public Health Funding in Rhode Island by Recipient, FY 1997



Rhode Island Department of Health

Rhode Island is unique in having a single statewide Department of Health, and one that contracts with other agencies to provide many of its non-regulatory services, rather than deliver these services directly. For example, the Department purchases certain services from private, non-profit Community Health Centers rather than run its own public health clinics. Over half the department's total funds are used to provide grant support of private sector community-based agencies (Table 1 & 3)

Table1 - Department of Health FY 1998 Enacted Budget by Category of Use

Category	Spending	Percent
Grants	$49,023,402	53.3
Personnel	$29,456,324	32.0
Operating	$11,968,930	13.0
Debt Service	$1,472,220	1.6
Total	$91,920,876	100.0

The Department of Health has three primary sources of funds: State general revenue, state restricted receipts, and federal funds. In Fiscal Year 1998, the Department's budget totalled $91.9 million of which $38.5 million (42 percent) was state general revenue, $3.3 (4 percent) was state restricted receipts, and $50.1 million (55 percent) was federal funds. Over the past eight fiscal years, the proportion of the Department's budget that is state funded has declined from 60 percent to 42 percent (Table 2).

Table 2 - Department of Health Expenditures Fiscal Years 1990-1998 (In Millions)*

Fiscal Year	State Funds	Federal Funds	Total Funds
1990	27.9 (66%)	14.6 (345%)	42.5
1991	21.8 (55%)	18.1 (45%)	39.9
1992	22.3 (55%)	18.2 (45%)	40.5
1993	24.7 (52%)	22.6 (48%)	47.5
1994	27.8 (54%)	23.9 (46%)	51.7
1995	26.1 (47%)	28.9 (53%)	55.0
1996	39.3 (50%)	39.8 (50%)	79.1
1997	40.8 (42%)	56.4 (58%)	97.2
1998	41.8 (45%)	50.1 (55%)	91.9

Note: State funds include general revenues and restricted receipts

Table 3
Grants and Assistance Funding by Type of Agency and Program Activities
Rhode Island Department of Health, Fiscal Year 1998

	Breast & Cervical Cancer Screening	Cancer Registry	Developmental Disability	Diabetes Education & Screening	Family Planning	HIV/AIDS Prevention & Control	Immunization & Vaccine	Lead Screening & Abatement	Maternal & Child Health
Academic Institutions									
Community Action Programs									
Community Organizations	86,530					728,045	10,000	897,298	
Community Health Centers	108,997			55,764	389,782	22,499	122,515		
Developmentally Delayed Agencies			3,035,384						
Health Maintenance Organizations				18,215					
Hospitals	367,263		485,647	75,903	52,418	47,623	128,900	117,615	52,860
Local Governments									
Minority Organizations					66,501				
Professional & Industry Organizations		201,017							
Substance Abuse Agencies									
State Agencies								1,674,575	
Visiting Nurse Agencies	4,667		345,250		41,710			100,000	200,000
Voluntary Health Organizations									
TOTAL	**567,457**	**201,017**	**3,866,281**	**149,882**	**550,411**	**1,106,731**	**261,415**	**2,789,488**	**563,746**

Agency Type / Program Activities	Medical Education	Minority Health Promotion	Newborn Screening	Sexual Abuse & Assault Prevention	Sexually Transmitted Disease	School & Adolescent Health	Substance Abuse Prevention	Substance Abuse Treatment	Tobacco Control	Tuberculosis Clinical Services	WIC Supplements / Food	TOTAL
Academic Institutions	$75,000	0	0	0	0	0	0	0	0	0	0	$75,000
Community Action Programs	0	0	0	0	0	$124,765	$55,583	$383,501	0	0	0	563,849
Community Organizations	0	$51,290	0	$184,162	0	0	0	0	$32,166	0	0	2,041,868
Community Health Centers	0	21,000	0	0	$196,668	283,804	0	0	0	0	$13,299,820	14,803,641
Developmentally Delayed Agencies	0	0	0	0	0	0	0	0	0	0	0	3,205,384
Health Maintenance Organizations	0	0	0	0	0	0	0	0	0	0	0	18,215
Hospitals	0	12,000	$487,823	0	18,778	0	0	0	0	$216,000	1,766,464	3,961,294
Local Governments	0	15,000	0	0	0	0	1,676,834	0	224,624	0	0	1,916,458
Minority Organizations	0	104,420	0	0	0	124,765	276,265	297,323	65,789	0	0	922,896
Professional & Industry Organizations	0	0	0	0	0	0	0	29,817	10,406	0	0	241,240
Substance Abuse Agencies	0	0	0	28,825	0	0	2,378,832	10,871,311	0	0	0	13,403,736
State Agencies	0	0	0	0	0	0	0	0	0	0	0	1,848,371
Visiting Nurse Agencies	0	0	668,164	0	0	0	0	0	4,307	0	0	1,364,098
Voluntary Health Organizations	0	0	0	0	0	0	0	0	93,718	0	0	93,718
TOTAL	$75,000	$233,710	$1,155,987	$212,987	$217,446	$533,134	$4,387,514	$11,581,952	$431,010	$216,000	$15,058,390	$44,159,568

Year 2000 Health Objectives

Healthy People 2000: National Health Promotion and Disease Prevention Objectives contains three overall goals:[2]

- Increase the span of healthy life for all Americans;
- Reduce health disparities among Americans; and
- Achieve access to preventive services for all Americans.

In 1996, the Department of Health measured progress toward the achievement of the Rhode Island health objectives with publication of the *Mid-Course Review.*[3] The results of this analysis are summarized in Table 4. Overall, the Department of Health calculated that in 1995 Rhode Island was only 30 percent of the way toward reaching its Year 2000 Health Objectives.

Table 4 - Progress Toward Achieving Year 2000 Health Objectives for Rhode Island - 1996

	Substantial Improvement	Some Improvement	No Improvement	Negative Direction	Insufficient Data
Increase physical activity		✓			
Increase healthy diet				✓	
Reduce tobacco use		✓			
Reduce alcohol and other drug related problems				✓	
Reduce unintended pregnancies			✓		
Reduce suicides and injurious suicide attempts	✓				
Reduce the prevalence of mental disorders					✓
Reduce homicides and assault injuries	✓				
Provide quality school health education					✓
Reduce unintentional injuries	✓				
Reduce work-related diseases and injuries		✓			
Reduce children's blood lead levels	✓				
Reduce exposure to environmental tobacco smoke		✓			
Reduce risk to health from radon			✓		
Reduce risk to health from drinking water	✓				
Reduce infections due to foodborne pathogens		✓			
Improve oral health		✓			
Reduce poor birth outcomes	✓				
Reduce high blood pressure					✓
Increase screening for breast & cervical cancers		✓			
Limit the prevalence of HIV infection	✓				
Reduce risk from communicable diseases			✓		
Increase childhood immunization levels		✓			
Increase access to primary care					✓
Reduce disabilities due to chronic conditions					✓

The Council notes that progress on several important objectives has not been measured for lack of the necessary epidemiologic data. Without such data, neither the state nor any of its partners or contractors can create targeted interventions, evaluate health program impact on population health status, or establish meaningful performance criteria.

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[2] Public Health Services, "Healthy People 2000 National Health Promotion and Disease Prevention Objectives," Washington, DC: U.S. Department of Health and Human Services, 1990.
[3] "Healthy Rhode Islanders 2000, Mid-Course Review," Rhode Island Department of Health, 1996.

Year 2010 Health Objectives

The U.S. Public Health Service has initiated the process for establishing Year 2010 Health Objectives for the nation.[4] Rhode Island will have the opportunity to participate in the formulation of these national health objectives and to utilize the national health objectives to develop Year 2010 Health Objectives specifically for Rhode Island. This will be an opportunity for the Rhode Island community to come together and articulate an effective public health strategy for the first decade of the 21st century.

Federal Retrenchment

The elimination of federal support for public health planning and statistics has resulted in the loss of $2 million per year to Rhode, and has severely limited public health statistical and planning capacity.

To help compensate, in 1993, the Rhode Island Public Health Foundation was created to insure that Rhode Island maximizes opportunities for federal (and private foundation) funding of public health research and development projects.

Human Resources

The Department of Health is working with the University of Rhode Island and Brown University to establish a Master's in Public Health program that will be conducted on nights and weekends in order to respond to the need for graduate level education and training in public health for employed professionals. Brown University also is developing a Public Health Program.

Future Trends

Demographic Shifts

Demand for public health services will be driven by two major demographic shifts taking place in Rhode Island. First, the fastest growing segments of the population are African-Americans, Native-Americans, Asian-Americans, and Hispanic-Americans. These groups suffer a disproportionate share of mortality, morbidity and health care access barriers. Second, the population is aging. As with minority populations, the elderly experience a disproportionate share of mortality and morbidity; requiring greater attention be paid to health promotion/disease prevention strategies for this cohort. These sizeable demographic shifts will require significant changes in the way we approach the public's health.

[4] Developing Objectives for Healthy People 2010, U.S. Department of Health and Human Services, September 1997.

Epidemiology

Many of the contemporary leading causes of death and years of potential life lost (YPLLs) are rooted in personal and social behavior patterns such as tobacco use, diet, activity, substance abuse, and injuries (see Figures 3 and 4).[5,6,7] Thus the practice of public health will be increasingly directed at promoting healthy lifestyles through a variety of education and communication media[8]

Figure 3 - Major Causes of Death - U.S. Residents

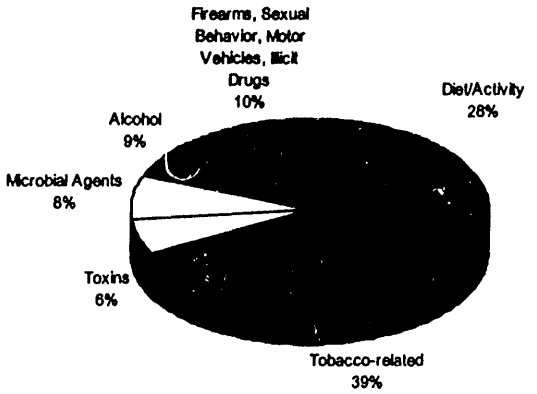
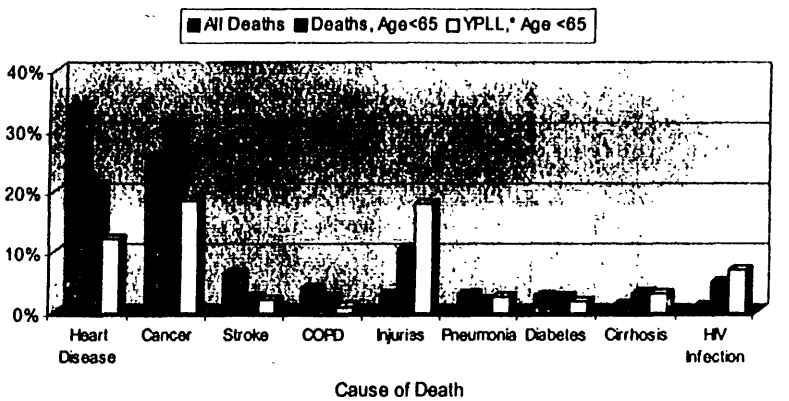


Figure 4 - Deaths, Premature Deaths, and YPLL's for Leading Causes of Death, Rhode Island Occurrences, 1995*



**Years of Potential Life Lost, defined as [65 years – age at death]*
Source: Prevention Report, "A Time for Partnership, Report of State Consultations on the Role of Public Health," U.S. Public Health Service, December 1994/January 1995.

[5] J. Michael McGinnis & William Foege, "Actual Causes of Death in the United States," JAMA, November 1993.
[6] Prevention Report, "A Time for Partnership, Report of State Consultations on the Role of Public Health," U.S. Public Health Service, December 1994/January 1995.
[7] Meyer J.A., Regenstein M., How To Fund Public Health Activities, Partnership for Prevention, 1994.
[8] Health Promotion and Disease Prevention Venues for Making It Happen, Rhode Island Department of Health, 1997.

New Opportunities

On the assumption of sustained trends toward market consolidation and capitated payment, the opportunities for the public health community to collaborate with the managed care industry will grow. Such collaborations hold the potential of shifting resources that might have traditionally gone to the delivery of personal health care services into population-based public health programs.

For example, as health insurance markets consolidate, experience suggests that health plans become increasingly concerned about the health of the population in general. A health plan's interest in community-wide efforts to reduce gun violence is much greater if there is a one-in-two chance that any particular shooting victim will turn out to be a plan member than if there is only a one-in-ten chance.

The financial incentives of capitated payment place a higher premium on disease prevention and health promotion services, at least to the extent that these services are shown to be cost-effective relative to curative care. Health promotion and disease prevention is, of course, the core of public health functions. As the evidence supporting the cost-effectiveness of disease prevention services grows, so too increases the stake of managed care plans in supporting these programs, at least for their own members if not the community at large.

Quality Assurance

Oversight of quality is a traditional role of public health through the licensure process and has been expanding in Rhode Island with the addition of responsibilities to certify Health Maintenance Organizations (HMO's), Utilization Review (UR) Organizations, and Health Plans (Health Care Accessibility And Quality Assurance Act of 1996). In addition, the Rhode Island General Assembly has recently (1996 and 1997 sessions) given the Department of Health substantial responsibility for oversight of hospital charity care and hospital conversions (change of ownership), and in 1998, for gathering specific data on plan and provider performance under the Rhode Island Health Quality Performance Measurement and Reporting Program. As always, the challenge facing a regulatory authority is that of safeguarding the public's health, safety, and access to care without blunting the vitality and innovation of the marketplace.

The Rhode Island Department of Health has a long history implementing its programs through collaborations with other public and private institutions. This history should serve the Department well as the opportunities to collaborate with the managed care industry emerge in the coming years

HEALTH STATUS/VITAL STATISTICS

- - *Overview* - -

Objective, quantitative measurements of health status are drawn from ongoing surveillance and data systems maintained by the Rhode Island Department of Health, many in compliance with national disease and vital statistics surveillance requirements. These systems have been developed to provide "information on morbidity, mortality, and disability from acute and chronic conditions; injuries, personal, environmental, and occupational risk factors associated with illness and premature death; preventive and treatment services, and costs. This information is used to understand the health status of the population and to plan, implement, describe, and evaluate public health programs that control and prevent adverse health events."[1] The data presented in this chapter is the most recent available data.

Highlights include:

- Declining mortality rates for heart disease, cancer, overall. But rates for lung cancer are increasing due to an increase rate of lung cancer among females.
- Population projections for the state indicate that the proportion of minority residents in core urban areas of the state (Providence, Central Falls) will continue to increase dramatically compared with the remainder of the state, i.e. Providence is projected to be 44% minority by the year 2010. If the disparities in health which currently exist persist into the future, the health care system which serves these urban areas will be faced with particular challenges in meeting the needs of this growing minority population.
- Areas where particular disparities exist between the white majority population and the states minority groups, with higher rates occurring in minority populations:
  Elevated blood lead in children,
  Infant mortality (which decreased overall), and associated risk indicators including low birthweight, lack of prenatal care in first trimester of pregnancy, and teen pregnancy,
  Elevated mortality rates among blacks for heart disease, cancer and stroke.
- The high proportion (19%) of children ages 1-5 with elevated lead levels is of particular concern because of the impact which lead has on the developing cognitive and physical abilities of children.
- The increasing prevalence of tobacco use among teens and young adults has major health implications for the state since tobacco use is the leading preventable cause of death among adults.
- The trend to an increasing proportion of adults and children who are overweight which is strongly associated with increase mortality and morbidity.
- RI has levels of alcohol use higher than the national average, and is associated with tremendous social, economic and health care costs.
- Growth of elderly population, and increases in life expectancy, will pose growing challenges to the health care system since this population has a higher proportion of disability and chronic disease conditions than younger persons. 38% of those over 65 have some kind of limitation, and 24% have severe limitations.
- Rising asthma rates, especially among children.
- Emerging and re-emerging infectious diseases such as HIV/AIDS, and Lyme Disease pose new health threats, and require expansion of the state's infectious disease surveillance capacity.

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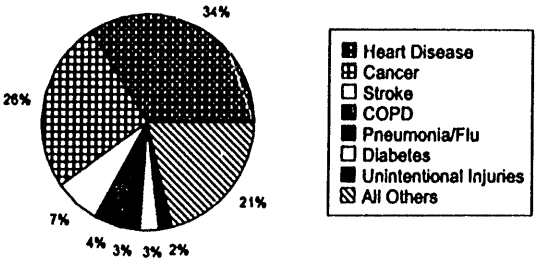
[1] Healthy People 2000. National Health Promotion and Disease Prevention Objectives. Washington, D.C.: United States Department of Health and Human Services. DHHS Pub. No. (PHS) 91-50212, 1990.

Figure 1
Leading Causes of Death
Rhode Island Residents, 1995



Mortality

The leading causes of death in the U.S. and in Rhode Island are diseases of the heart and cancer, accounting for more than half of all deaths (Figure 1). Other leading single causes include stroke, chronic obstructive pulmonary disease (COPD), pneumonia/influenza, diabetes, and unintentional injuries. While Rhode Island's mortality rates for heart disease, stroke and COPD are lower than national rates, Rhode Island's cancer mortality rate is higher that it is nationally.

Source: Rhode Island Department of Health, Rhode Island Vital Records Death File, 1995

Figure 2
Leading Causes of Death, 1993 - 1995
Rhode Island and United States

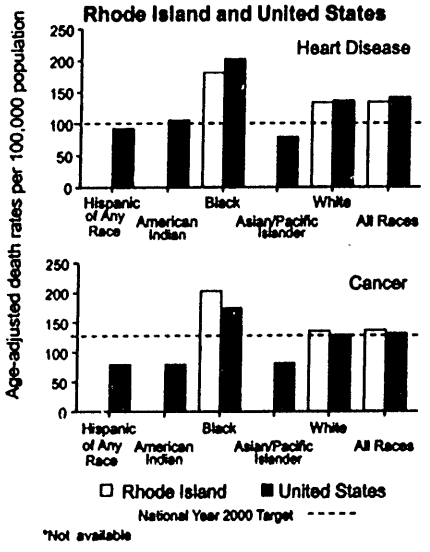
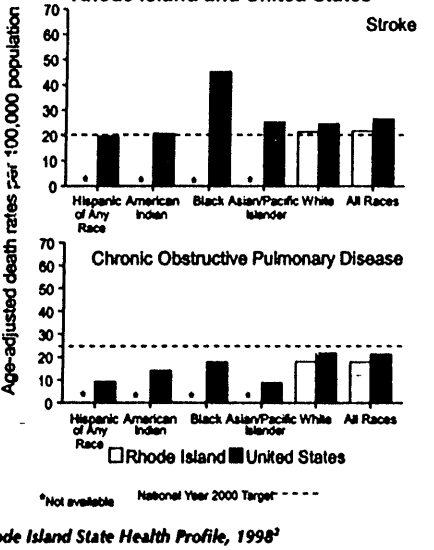


Figure 3
Leading Causes of Death 1993-1995
Rhode Island and United States



Source: Rhode Island State Health Profile, 1998[1]

[1] All graphs and maps are derived from the *Rhode Island State Health Profile, 1998*, unless indicated otherwise.

Years of Potential Life Lost

Years of potential life lost (YPLL) is a measure of premature mortality, which has been defined as the number of years between the age at death (for those who die before age 75) and age 75. The younger the person at the time of death, the greater the number of YPLL.[3]

YPLL for Rhode Island for the 5 leading causes of YPLL are lower than national estimates, with the exception of YPLL due to cancer. Overall, Rhode Island has one of the lowest age-adjusted YPLL before age 75 in the nation.

Figure 4
Leading Causes of Years of Potential Life Lost (YPLL) Before Age 75 Rhode Island and United States, 1995

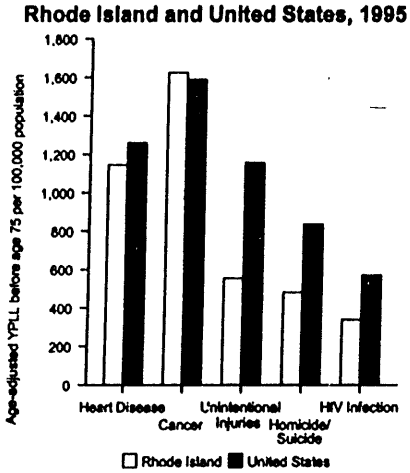
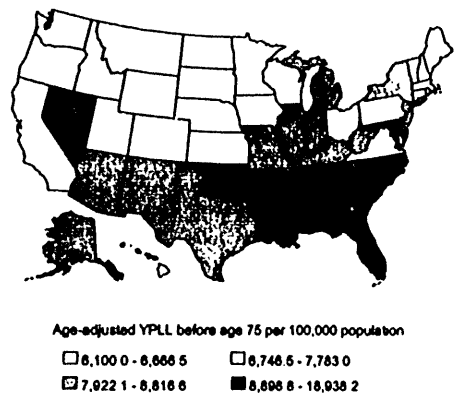


Figure 5
Rates for Years of Potential Life Lost (YPLL) Before Age 75, 1995



[3] RI State Health Profile, 1998.

Childhood Health Concerns

Prenatal Care

The proportion of women who do not receive prenatal care in the first trimester of pregnancy is much lower in Rhode Island than nationally.

Figure 7
Birth Rates for 15- to 19-Year-Old Females
by Race and Hispanic Origin
Rhode Island and United States, 1993-1995

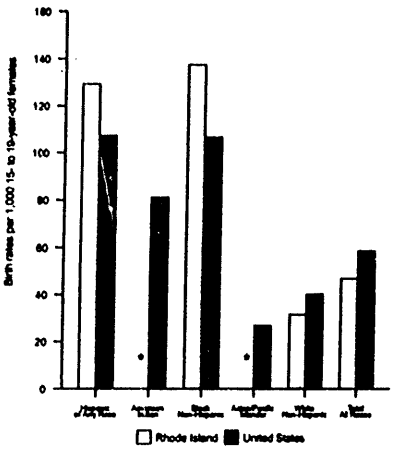
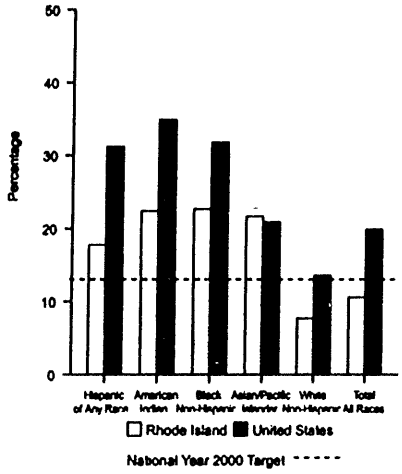


Figure 6
Women Who Did Not Receive Prenatal Care
in the First Trimester of Pregnancy
by Race and Hispanic Origin
Rhode Island and United States, 1993-1995



Births to Adolescents

"Births to adolescents is a marker for other social and behavioral risk factors and represents a group with barriers to health care."[4]

Birth rates for 15 -19 year old females are lower overall in Rhode Island than nationally. However, the birth rate among adolescent black and Hispanic females in Rhode Island is much higher than national rates for these groups.

[4] Consensus Set of Health Status Indicators for the General Assessment of Community Health Status, 1991.

Low Birth Weight

The percentage of low birth weight infants is lower in Rhode Island than nationally and has remained stable for all race and ethnic groups over the past decade. However, the rate of low birth weight babies is higher among minority infants than among white infants. For the period 1991 - 1995, 5.8% of white infants, 10.8% of black, 7.8% of Asian, and 6.8% of Hispanic infants were low birth weight.[5]

Infant Mortality

Rhode Island's infant mortality rate has improved over the past decade, from 8.6 infant deaths per 1,000 births to 7.0, and is among the lowest in the nation. Over the past ten years, infant mortality rates for all racial groups in Rhode Island have declined. Despite this progress, the black infant mortality rate continues to be twice that for white infants.[6]

Figure 8
Infant Mortality Rates and Number of Death
by Race and Hispanic Origin
Rhode Island and United States, 1995

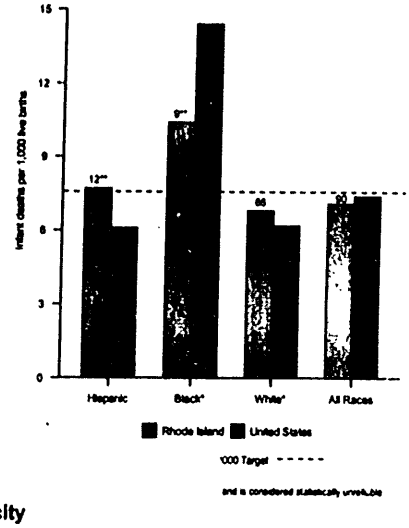
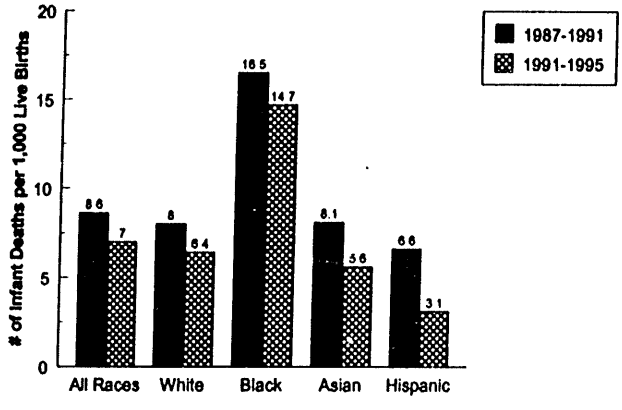


Figure 9
Infant Mortality by Race/Ethnicity
Rhode Island, 1987-1991 and 1991-1995



Source: Rhode Island Department of Health, Maternal and Child Database
Data for 1994 and 1995 are Provisional

[5] Rhode Island Kids Count Factbook, 1998. Rhode Island Kids Count, Providence, Rhode Island.
[6] Rhode Island Kids Count Factbook

By specific cause, Rhode Island infant mortality rate due to birth defects is higher than the national rate, while rates for Sudden Infant Death Syndrome (SIDS) and Low Birth Weight (LBW) are much lower than national rates.

Lead Poisoning

Lead poisoning is a major health problem for Rhode Island's youngest, those ages 1 - 5. The proportion of Rhode Island children ages 1 - 5 years with elevated blood lead levels (> = 10ug/dL) is almost five times national prevalence. More than one-third of African American children, and close to one-third of Hispanic children in Rhode Island have elevated blood lead levels. These children tend to be concentrated in Rhode Island's oldest and poorest urban areas – Providence, Pawtucket, Central Falls, Woonsocket, and Newport. Elevated blood lead levels can have significant impact on learning, cognitive ability, and neuro-behavioral development.

Table 1
Elevated blood lead levels in children aged 1-5 years: Rhode Island and United States, 1996

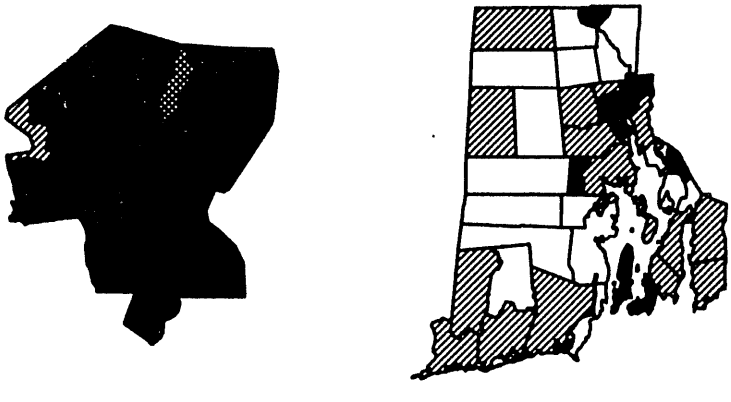
	Percent of children at 10ug/dl or higher	
	RI	USA
All children	19%	4%
By child's ethnicity:		
White	14%	2%
African-American	36%	11%
Hispanic	29%	4%*

* Includes Mexican-Americans only

Source: Rhode Island Department of Health, 1996
U.S.A. – 1991-1994 NHANES Survey Data

Figure 10

Prevalence of elevated blood lead (>=10 ug/dl) among children age five or less in FY 1996

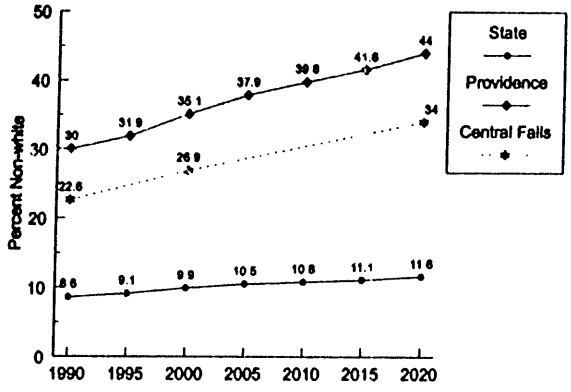


Source: Rhode Island Department of Health, 1996 Rhode Island Lead Test Data

Growth in Minority Population

Projected continued growth in the size of Rhode Island's minority population, while low for the state as a whole, will be dramatic in those cities where a substantial proportion of Rhode Island's minorities reside, for example, in Providence and in Central Falls. If disparities in health persist, the health care burden in the state's urban areas will grow disproportionately.

Figure 11
RI Minority Population Projections, 1990 - 2020
for State, Providence, and Central Falls



Source: Rhode Island Population Projections by Age, Sex, and Race, Rhode Island Office for Economic Development, 1996

Substance Abuse

For a detailed report on substance abuse in Rhode Island, see Chapter "Substance Abuse Prevention and Treatment" in this report. While current data on the prevalence of adult drug use in Rhode Island is not available, there is recent data on substance use among adolescents. Data from Rhode Island's 1997 Youth Risk Behavior Survey indicate high levels of cigarette, alcohol and marijuana use among Rhode Island high school students (grades 9 - 12). Rhode Island results are comparable to national data for 1995.[7],[8]

Table 2 Substance Use Among High School Students, Rhode Island and United States

	Rhode Island, 1997	United States, 1995
Ever used alcohol	78%	79%
Ever smoked cigarettes	69	70
Ever sniffed or breathed the contents of aerosol spray cans or inhaled any paint sprays to get high	21	16
Ever used marijuana	47	47
Ever used any form of cocaine	7	8
Ever used crack or freebase	5	5
Ever used illegal steroids	6	3
Ever used any other type of illegal drug, such as LSD, PCP, ecstasy, mushrooms, speed, ice, or heroin	17	17

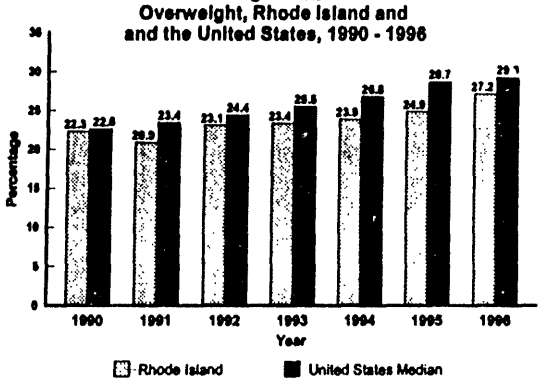
Source: Rhode Island Youth Risk Behavior Survey 1997 and Youth Risk Behavior Surveillance – United States, 1995 MMWR, September 27, 1996/Vol.45/No. SS-4

[7] 1997 Youth Risk Behavior Survey, Rhode Island 1997
[8] Youth Risk Behavior Surveillance – United States, 1995 MMWR, September 27, 1996/Vol.45/No. SS-4

Overweight

While Rhode Island was consistently below the U.S. median for prevalence of overweight from 1990 through 1996, the proportion of adults who are overweight has increased.

Figure 12
Overweight, Rhode Island and and the United States, 1990 - 1996

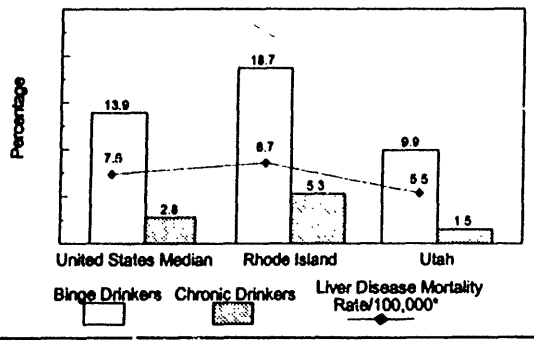


Source: Rhode Island Department of Health, Behavioral Risk Factor Surveillance System.

Alcohol Use

The prevalence of both binge and chronic drinking in Rhode Island are consistently higher than the U.S. medians. While the prevalence of binge drinking has declined nationally, it has increased in Rhode Island from 1990 - 1995. Rates for chronic drinking have remained stable. Rates for both binge and chronic drinking are higher among men than among women, and among younger than older persons.

Figure 13
Binge and Chronic Drinkers and Chronic Liver Disease/Cirrhosis Mortality United States, Rhode Island, and Utah, 1995



Sources: Behavioral Risk Factor Surveillance System Summary Report, 1995 and National Center for Health Statistics Mortality Data

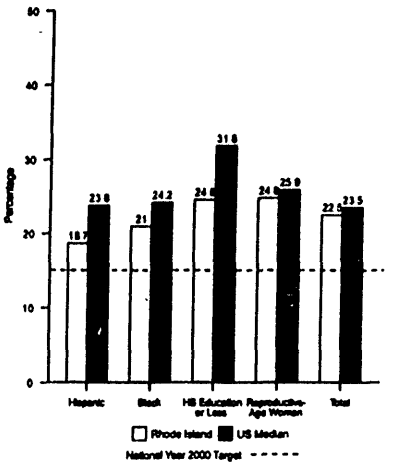
Cigarette Smoking

From 1990 through 1996, the prevalence of current smokers in Rhode Island decreased from 25.5% to 22.4%. Rhode Island's smoking rate in 1996 was lower than the U.S. median. However, in 1995, smoking among reproductive age women in Rhode Island was higher than for women in that age group nationally, and smoking rates among adolescents has increased in recent years (see substance abuse chapter for more detailed information).

Definition – Current smokers are defined as those who have smoked at least 100 cigarettes in their lifetime and who smoke cigarettes now.

Figure 14

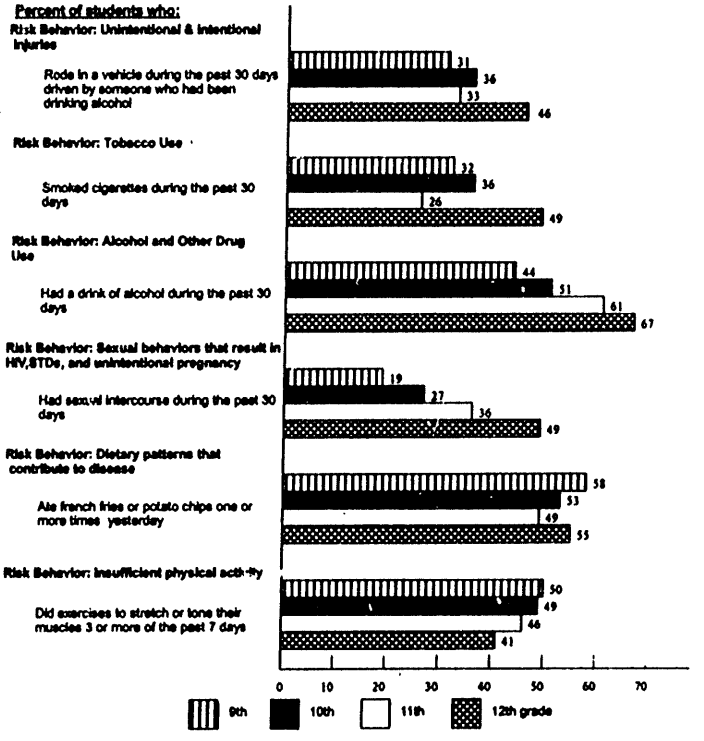
Smoking in Selected Demographic Groups Rhode Island and US Median,* 1996



Adolescent Risk Behaviors with Long-Term Health Implications

Among persons aged 5 - 24 years, approximately 72% of all deaths are due to only four causes: motor vehicle crashes, other unintentional injuries, homicide, and suicide. Each year an estimated 1 million teenage girls become pregnant and 86% of all STD cases occur among 15 - 29 year-olds. One out of every five persons diagnosed with AIDS in the U.S. is 20 - 29. Given the 8 - 10 year incubation period between HIV infection and AIDS diagnosis, many of those 20 -29 year olds with AIDS may have been infected as adolescents. A limited number of behaviors contribute substantiallyto these causes of mortality and morbidity.

Figure 15
Health Risks Among Rhode Island High School Students by Grade, 1997



Rhode Island Department of Health, 1997 Rhode Island Youth Risk Behavior Survey (n = 1528)

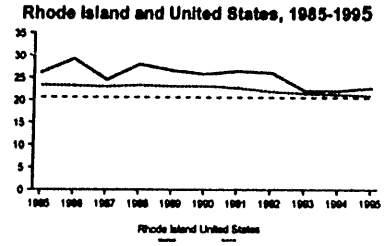
Breast Cancer Deaths

The breast cancer death rate in Rhode Island has been higher than the national rate since 1984. 3,372 cases were diagnosed between 1989 and 1993; and the breast cancer mortality rate, 29.3/100,000, was ranked 6th in the U.S.

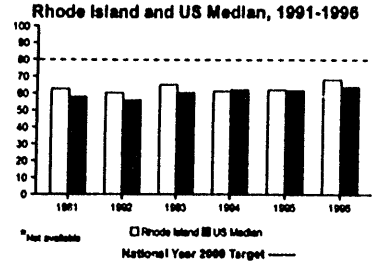
The proportion of Rhode Island women ages 50 and over who have had a clinical breast exam and mammogram within two years has exceeded the national median each year but one from 1991 to 1996.

Figure 16

Breast Cancer Deaths Among Women
Rhode Island and United States, 1985-1995



Women at Least 50 Years of Age Who Have Had a Clinical Breast Examination and a Mammogram Within the Past 2 Years,
Rhode Island and US Median, 1991-1996



Cardiovascular Disease Deaths

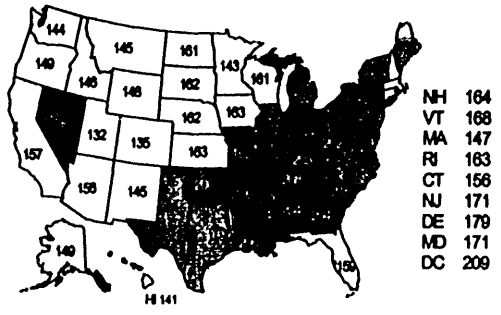
*Over the past 15 years, the death rate for cardiovascular diseases (diseases of the heart and blood vessels) has declined dramatically.[9] Still, cardiovascular disease is the leading cause of death in the United States and in Rhode Island, killing nearly as many persons as all other diseases combined.

The heart disease death rate in Rhode Island is below the national rate, and is among the lowest of the eastern and mideastern states.

[9]National Healthy People 2000

Figure 17

Total Cardiovascular Disease Deaths, 1995

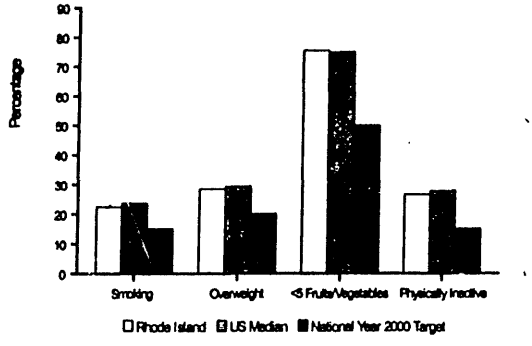


Age-adjusted death rates per 100,000 population from total cardiovascular disease

☐ 132 - 149 ☐ 150 - 164 ▨ 165 -191 ■ 192 - 242

United States - 176

Behavioral Risk Factors for Total Cardiovascular Disease Rhode Island and US Median, 1996

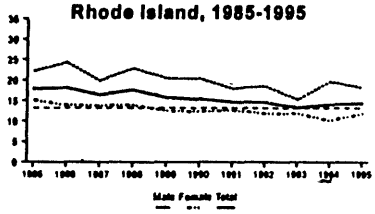


Colorectal Cancer Deaths

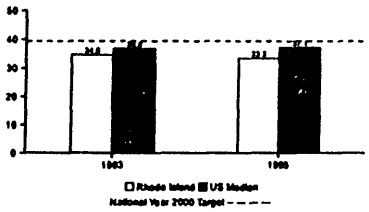
Rhode Island's colorectal mortality rate historically has been higher than the national rate, but has declined and approached the national rate in recent years.

Proctoscopic examination for adults ages 50 and older is an important screening procedure for early detection of colorectal cancer. Early detection improves survival rates. Rhode Island lags behind the U.S. median in the proportion of adults who have ever had a proctoscopic examination. Males are almost twice as likely as females to report having had such an examination.[10]

Figure 18
Colorectal Cancer Deaths
Rhode Island, 1985-1995



Adults at Least 50 Years of Age
Who Reported Having a Proctoscopic Examination
Rhode Island and US Median, 1993 and 1995

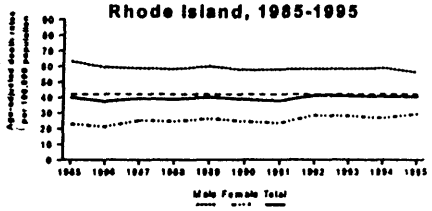


Lung Cancer Deaths

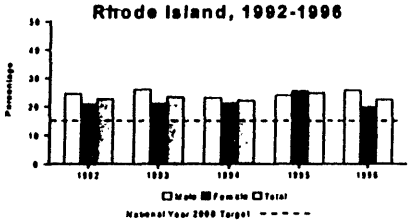
Lung cancer mortality has risen over the past 10 years, both nationally and in Rhode Island, primarily due to an increase among women.

Cigarette smoking is the single most important cause of lung cancer. Though smoking rates have declined since the 1980's, they have remained relatively stable over the past decade around 22-23% in Rhode Island's adult population.

Figure 19
Lung Cancer Deaths
Rhode Island, 1985-1995



Current Cigarette Smoking Among Adults
Rhode Island, 1992-1996

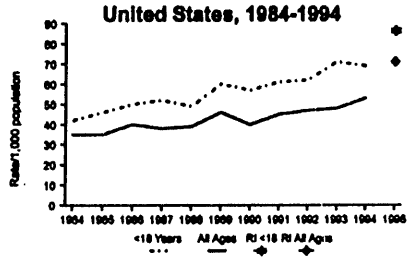


[10] Behavioral Risk Factor Surveillance System 1996 Summary Report.

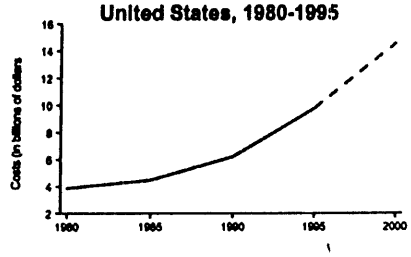
Asthma

Results of Rhode Island's 1996 Health Interview Survey indicate that 7.1% of Rhode Islanders self-report asthma, and 95% of those reporting asthma have been told by a doctor that they have asthma. Overall, 8.7% of those 18 and under are reported as having asthma and 6.6% of those over the age of 18. The self-reported prevalence of asthma in Rhode Island is higher than the national prevalence rates.[11]

Figure 20
Prevalence Rates for Asthma by Age and Year, United States, 1984-1994



Estimated Costs of Asthma, United States, 1980-1995



Source: :Rhode Island Department of Health, Behavioral Risk Factor Surveillance System.

[11]Rhode Island Health Interview Survey, 1996. Office of Health Statistics, Rhode Island Department of Health.

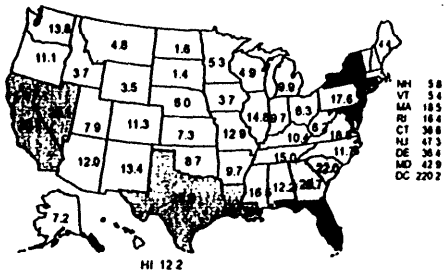
Infectious Diseases

Acquired Immunodeficiency Syndrome (AIDS)

"This is a major public health problem with changing risk groups."[12]

Rhode Island's case rate for AIDs (16.4) in 1996-97 is below the national average.

Figure 21
Acquired Immunodeficiency Syndrome (AIDS)
July 1996-June 1997

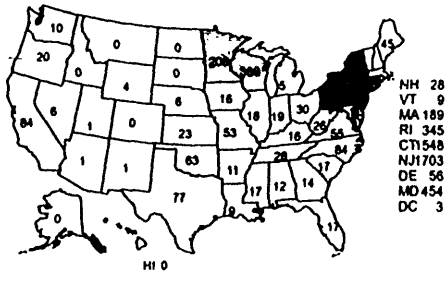


Lyme Disease

In 1995, Rhode Island reported one of the highest number of Lyme disease cases in the nation (345) exceeded only by Michigan, NY, Conn., Mass, NJ, and MD, all states with much larger populations.

Per population, Rhode Island has the second highest case rate of any state (34.5 per 100,000), exceeded only by Connecticut (47 per 100,000). Rhode Island reported 2.5% of all cases nationally, with 0.3% of the U.S. population. Reported cases most likely underrepresent the true prevalence of the disease.

Figure 22
Lyme Disease Case Reports by State, United States, 1995



[12] Consensus Set of Health Status Indicators, 1991.

Appendix A

COUNCIL MEMBER BIOGRAPHIES

Governor's Advisory Council on Health

Governor Lincoln Almond
Chairman

Director Christine C. Ferguson,
R.I. Dept. Of Human Services
Co-Vice Chair
Lt. Governor Charles J. Fogarty
Co-Vice Chair

Members

Nancy Edmonds Paull serves as Executive Director of SSTAR of Rhode Island, which provides detoxification services for medically indigent Rhode Islanders. More than 7,000 Rhode Islanders have gone through the SSTAR program since it was contracted to provide its services on behalf of the state in 1995. Ms. Paull's career in the human service arena spans nearly three decades, involves several states, and includes work with high risk adolescents, alcoholic women and their children, and pregnant addicted women. She is the recipient of numerous awards including the Fall River Chamber of Commerce's Outstanding Service to the Community Award; Bristol County's Distinguished Citizen of the Year (1994); and the YWCA's Achievement Award in 1995, to name just a few.

Michael Follick, Ph.D. is founder and CEO of the Abacus Management Group, which develops and manages health and workers' compensation insurance purchasing alliances for small business and industry groups. Dr. Follick, having served on the staff of the Miriam Hospital and faculty of the Brown University School of Medicine, has done therapy, taught, researched, written and presented for 20 years. Dr. Follick has successfully worked over the past decade to develop health care cost-containment models for business and industry including programs for some of Rhode Island's largest employers. He was the first in the State to conceptualize the potential of self-insured workers' compensation groups, bringing several such groups into fruition in the early 90's during the midst of the State's workers' compensation cost crisis.

John J. Hynes, Esq. was named President and CEO of Care New England Health System in February of 1996. Care New England, the parent organization for Kent County Memorial, Women & Infants and Butler Hospitals, employs approximately 3,600 people, has an operating budget of $299 million and represents a total of 733 hospital beds statewide. Prior to his appointment, Mr. Hynes served as President and CEO of Kent County Memorial Hospital. He has also served in numerous other health care capacities including Chairman of the Hospital Association of Rhode Island, a Trustee of Vector Health systems, and Trustee and President of Health Advantage of Rhode Island. He is a member of the American College of Health Care Executives, and the Rhode Island and American Bar Associations.

H. Denman Scott M.D. is Associate Dean of Medicine and Professor of Community Health and Medicine at Brown University's School of Medicine. He is responsible for enhancing primary care education and research at the medical school and the Brown affiliated hospitals. In 1997 he assumed direction of the newly formed Brown University Center for Primary Care & Prevention. He also serves as Chief of Medicine at the Memorial Hospital of Rhode Island. Dr. Scott's previous professional positions include Senior Vice President for Health and Public Policy at the American College of Physicians for three years during which time he led the College's health reform agenda, and as the Director of the Rhode Island Department of Health (1984-1991) where he was responsible for statewide public health policy and administration and health regulations.

Reverend Paul Bliss is actively involved in numerous senior organizations in Rhode Island on behalf of our state's aging population. He serves on the Rhode Island Forum on Aging, and is Vice Chair of the Rhode Island Advisory Commission on Aging of which he is Chairman of its Legislative Committee. He is

also a member of the New England Regional Advisory Council on Aging, the Community Council of the Washington County Aging 2000, and is State Coordinator Emeritus of AARP/VOTE.

Maryanne I. Harmsen is Executive Vice-President of Marketing and Sales for Blue Cross & Blue Shield of Rhode Island. Prior to her appointment as Chief Marketing Officer, she had been a consultant to BCBSRI in the area of HMO marketing and integrated marketing capabilities. In this capacity, Ms. Harmsen developed and implemented new product distribution channels; most noteworthy, being the establishment of effective working relationships with the broker community. Prior to her affiliation with BCBSRI, she worked for Metropolitan Life as Regional Sales Director. Ms. Harmsen is a member of the Boards of Directors of the Alzheimer's Association and of the Rhode Island Film Commission. She is also a member of the Providence Preservation Society and serves in the President's Circle on Habitat for Humanity.

Elizabeth Burke Bryant is Executive Director of Rhode Island KIDS COUNT, a children's policy and information organization which provides comprehensive data and analysis on the health, economic well-being, safety and education of Rhode Island children. The KIDS COUNT Factbook, published annually in partnership with Brown University's Taubman Center of Public Policy and the Rhode Island College School of Social Work, offers a detailed, statistical portrait of children in the state as a whole and by community. Prior to her work with KIDS COUNT, Ms. Bryant served with the Rhode Island Foundation and in various other positions including Director of Policy for the City of Providence and as Deputy City Solicitor at the Providence Housing Court.

Donald I. Marsh, M.D. is Dean of Medicine and Biological Sciences at Brown University. Dean Marsh has a scientific interest in many areas including health care policy and has lent his professional expertise to various organizations including the National Science Foundation, the National Institute of Health, the American Heart Association and the American Medical Association. Prior to his affiliation with Brown University, Dean Marsh served in a number of capacities with the University of Southern California, including chairman of both the university research committee and the academic program review committee, and as a member of the faculty executive committee. He has published nearly 100 research papers and has received international recognition for his work.

Vincent Mor, Ph.D. is Director of the Center for Gerontology and Health Care Research, Professor of Medical Science, and Chair of the Department of Community Health at the Brown University School of Medicine. Dr. Mor has been the Principal Investigator on more than 12 National Institutes of Health grants and other contracts related to aging and long term care, including: Medicare funding of hospice, patient outcomes in nursing homes, and a national study of residential care facilities. He received a MERIT award from NIA for his research on nursing home organizational factors related to residents' outcomes. He has published more than 150 peer reviewed articles and several books and book chapters on hospice, long term care and cancer treatment patterns among the elderly as well as the organization of AIDS health services.

Edward J. Quinlan is President of the Hospital Association of Rhode Island. His previous professional background includes Press Secretary to Rhode Island Senator John H. Chafee in Washington, D. C.; Director of Corporate Communications for Gilbane Company which is consistently ranked as one of the nation's top construction and real estate development firms; Director of Public Relations and Development for Kent County Memorial Hospital; and Director of Public Relations and Development for North Miami General Hospital.

Elizabeth V. Earls is the Director of The Rhode Island Council of Community Mental Health Centers and is Chief Executive Officer of Community Treatment Affiliates. In both capacities, Ms. Earls is responsible for working to strengthen and develop strong systems of community-based care for persons with mental illness. She is a member of the Medical Assistance Advisory Committee, Co-Chair of the Children's Policy Coalition and immediate Past Chair of the Coalition for Mental Health. Ms. Earls is very involved in issues relating to the delivery of behavioral health care in Rhode Island.

Kenneth N. Kermes is a partner in BayView Equity Partners, which is engaged in the acquisition and development of mid-scale businesses in the $20 – $100 million range. He is also a partner in the investment banking firm, Riparian Partner, LTD. For the past four years, he has served as Vice President of Business and Finance at the University of Rhode Island. Mr. Kermes is also the Chairman of the Board of South County Hospital and has served on the Board of Bradley Hospital prior to its acquisition by Lifespan. He possesses a unique blend of corporate financial and strategic planning expertise. His past professional positions include Treasurer of Monsanto Company, CFO of Ralston Purina Company, Lone Star Industries

Corporation, Black and Decker Corporation and most recently, SmithKline Beecham. After retiring from SmithKline Beecham, Mr. Kermes participated in the start-up and funding of new businesses in the New England area, helping to raise approximately $25 million in new capital.

Elaine Clemm is the parent of three children, two of whom were born with a genetic defect which has left them severely disabled and medically involved. They require 24-hour care with skilled nursing services in the home. When Christopher and Heather were very young, they lived in a pediatric nursing facility. Elaine and her husband, Donald, fought very hard for and succeeded at winning the right to have their children cared for in their own home. Elaine has become a very active advocate for the disabled community in Rhode Island and contributes her time not only to her children, but to the Developmental Disabilities Council, the Division of Family Health at the Department of Health, the Cranston Center, and RIARC. She is currently employed part-time with United Cerebral Palsy of Rhode Island as a family outreach coordinator and is committed to helping families navigate the often complex system of health care for children with special needs.

Dorothee D. Maynard/Rogers is President and founder of The Good Neighbor Alliance Corporation, which is engaged in providing employee benefits. The Alliance also serves as a valued benefit information resource for the small business community of Rhode Island and parts of Massachusetts and Connecticut. Ms. Maynard/Rogers is also very active with various small-business related organizations and associations including the United Health Plans Constituency Advisory Committee, the United Health Plans Board of Arbitrators, and the Governor's Council on Insurance. She also served as a delegate to the White House Conference in Small Business in both 1986 and 1995, as an advisor to the U. S. Senate Subcommittee on Health and Human Services, and as a member of the Society of Professional Benefit Administrators and the National Female Executive Association.

Deborah A. Smith has more than twenty years experience in corporate banking, serving most recently as senior vice president of civic and community affairs for the former Old Stone Bank. Ms. Smith is also widely known as a civic and community leader, participating in a variety of causes and lending her time and expertise to many organizations including the Governor's Leadership Summit on Diversity of which she is Chair of its Subcommittee on Health; the Board of Governor's of Higher Education, the Rhode Island Human Resource Investment Council, and the Rhode Island Commission on Criminal Justice. She is Past President of the Urban League of Rhode Island, a Trustee of the National Conference on Christians and Jews, and was appointed to serve on a number of committees of the Rhode Island Catholic Diocese. She is a member of the Board of Directors of Harvard Pilgrim Health Care of New England and Chairs the Members Appeal Committee. In addition, she is a member of the Board of Directors of Kent County Memorial Hospital and the Kent County Physician Hospital Organization. Ms. Smith has been honored with numerous awards and commendations in recognition of her many works on behalf of the community.

Barbara B. Colt has served as Director of the Rhode Island Health Center Association for thirteen years. In that capacity, she has been responsible for administrative management and community relations. She represents the Association on the National and New England Association of Community Health Centers, and a variety of regional, state and community organizations and has been a strong advocate of community health centers and has been involved in the formulation and development of related legislation and policy. Ms. Colt has been involved in a number of other organizations including the Women's Development Corporation, the Rhode Island Council on Domestic Violence, and Planned Parenthood of Rhode Island

Arthur R. Colby was named Chairperson of the Governor's Commission on Disabilities May of 1997. In this volunteer capacity, Mr. Colby will be responsible for presiding over the 24-member commission, coordinating its activities, and organizing compliance of all state agencies and quasi-governmental corporations with the Americans with Disabilities Act and other laws. Mr. Colby was Director of Work Force Diversity at Shawmut Bank, Director of Human Resources for the City of East Hartford, and Manager of Equal Opportunities Programs and Personnel Manager at United Technologies Corporations/Pratt & Whitney Aircraft. He is a lecturer at the Hartford Graduate Center, an adjunct professor at Quinebaug Community College and Assumption College, and is the recipient of the US Dept. of Labor's Eve Award, Individual Achievement Award and was named the 1984 National Rehabilitation Association's Switzer Scholar. Mr. Colby was National Chair of the Literacy Volunteers of America.

Alfred Santos serves as Executive Director of the Rhode Island Health Care Association, Vice President of the National Association of Health Care Executives, and is a member of the Governor's Long Term Care Coordinating Council – Planning Committee. He also serves in numerous other health-care related

capacities, which include a member of the American College of Health Care Administrators and an advisor to the Southeastern Gerontological Society. He is also very active with Catholic Social Services of Rhode Island, the St. Vincent's Children Center, and the American Red Cross. He devotes much of his time to a variety of civic organizations, including the Rhode Island Jaycees, and is the recipient of a number of awards and commendations, including those from the RI Jaycees and the American Heart Association.

Marta V. Martinez is current Chair and Co-Founder of the Governor's Commission on Hispanic Affairs. Additionally, she is a member of the Rhode Island Department of Health (DOH) Minority Health Advisory Committee, and has served on other DOH boards including the Health Services Council, and the Minority AIDS Advisory Committee. She is active with the Warwick Human Rights Commission, and is a Co-Founder of the Juanita Sanchez Community Fund and the Hispanic Heritage Committee. Ms. Martinez is Director of Publications at the Rhode Island Historical Society and former Director of the Center for Hispanic Policy and Advocacy.

J. Jeffery Bandola, M.D. is President of the Rhode Island Medical Society, an organization for which he has served in various leadership capacities over the years. Dr. Bandola serves as Vice President for Medical Affairs for South County Hospital, Medical Director of South County Hospital Home Care, and a member of the Board of Directors of Rhode Island Quality Partners. He is Past Medical Director of Lafayette Nursing Home, South County Nursing Center, and High Point Alcohol Treatment Center. Dr.Bandola is board certified by the American Board of Internal Medicine and is affiliated with the American Medical Society.

Jeanette S. Matrone, R.N., Ph.D. is a consultant for nursing excellence in private practice. She was formerly Vice President for patient care services/Nurse-in-Chief for Lifespan's Academic Medical Center where she is responsible for patient care services at The Miriam Hospital, a 247-bed acute care hospital, and select areas of Rhode Island Hospital, both major teaching hospitals of Brown University's School of Medicine. Prior to her Lifespan appointment, Dr. Matrone had served with The Miriam for more than twenty years. She is an adjunct assistant professor at the University of Rhode Island and is President-Elect for the Rhode Island State Nurses Association. She has served as President for the Board of Nurse Registration and Nursing Education and is currently an Appraiser on the panel for Magnet Hospitals for the American Nurses Credentialing Center Commission on Accreditation.

Reverend Sammy Vaughan is the former Corporate Director of Community Relations/EEO for Lifespan Hospitals. His past professional experience also includes serving as Director of Community Relations/EEO and as Director of Affirmative Action programs for Rhode Island Hospital. Reverend Vaughan is Minister of the St. James Baptist Church of Woonsocket and is a member of the Rhode Island Ministers Alliance. He is a dedicated community and civic activist who has served on numerous boards and commissions over the years, including the Urban League of Rhode Island, the Providence Plan Commission, the NAACP of Woonsocket, the Visiting Nurses of Rhode Island, the Corporation of Women & Infants Hospital, and the Opportunity Industrialization Center of Rhode Island.

Ronald P. Jordan, RPh. has an outstanding professional career in pharmacy and related consulting. He is a Past-President of the Rhode Island Pharmacists Association, and President of HCaliber Consulting Corporation of East Greenwich, RI - an international health care informatics consulting firm. He is Senior Vice-President and Treasurer of Hospice Pharmacia, Inc. of Philadelphia, a pharmacy group specializing in delivery and management of drug therapy and pharmaceutical care in the hospice arena. Ron has two decades of experience in community pharmacy management, long-term care practice, medical and pharmacy information system consulting, and health benefit program design and administration. He is President of the American Pharmaceutical Association.

Steven D. Baron is President of Lifespan Rhode Island, a major operating division of the Rhode Island-based Lifespan health system. Prior to assuming this position, Mr. Baron served as President and CEO of Miriam Hospital where he introduced TQM principles to guide that organization. Mr. Baron has served as Chairman of the Board of the Hospital Association of Rhode Island, President of the Board of the Rhode Island Magnetic Resonance Imaging Network, a member of the Board of the New England Healthcare Assembly, and a member of the American Hospital Association's Regional Policy Board.

Robert P. Moretti is Administrator of the New England Laborers' Health and Safety Fund, a post he has held since 1994. The NELHSF focuses on developing occupational health and safety programs, health promotion and education programs, and research programs concerning the health and safety of laborers and their families. Prior to assuming this position, Mr. Moretti was Program Director for Laborers'AGC

Education and Training Fund. Before joining the Laborers', Mr. Moretti served as the Director of Economic Development for the City of Cranston, and subsequently, as Magistrate of Municipal Court, Cranston.

Stephen C. Schoenbaum, M.D., MPH is Senior Vice President for Regional Operations, Southern New England Region of Harvard Pilgrim Health Care, and President, Harvard Health Care of New England, a wholly owned subsidiary of Harvard Pilgrim Health Care. In this role he is responsible for all regional operations of a mixed staff and network model HMO with approximately 145,000 members. From 1993-1998, he was Senior Vice President and Medical Director of Harvard Pilgrim Health Care of New England. He has had a long interest in immunization activities and policies on a local and national level, is the author of over 100 scientific articles and papers, the editor of a recent book on Measuring Clinical Care, and has a faculty appointment as Associate Professor of Ambulatory Care and Prevention at Harvard Medical School.

Amy K. Knapp is the President and Chief Executive Officer of United HealthCare of New England, Inc. and acting President and Chief Executive Officer of United HealthCare Northeast. United HealthCare of New England serves more that 325,000 members in Rhode Island and Massachusetts through a broad range of quality, affordable, health care products and services. Ms. Knapp has been in the health care industry over 20 years. She most recently led health plan operations at Prudential HealthCare in South Florida. Previously, she held a national policy role and was a ranking executive for Prudential's southern California plan. Under her leadership, Prudential's South Florida plan became a leading performer, earning two consecutive three-year NCQA accreditations and the Sachs Honor Role Designation.

In addition to Christine Ferguson, several other cabinet members participate in the Governor's Advisory Council on Health.

Patricia Nolan, MD, *Director, RI Department of Health*
Jay Lindgren, ***Director***, *RI Department of Children, Youth and Families*
Barbara L. Rayner, MSW, CLSW, *Director, RI Department of Elderly Affairs*
A. Kathryn Power, *Director, RI Department of Mental Health, Retardation and Hospitals*
Robert Carl, Jr., PhD, *Director, RI Department of Administration*
Barry Hittner, *Director*, *RI Department of Business Regulation*
John Swen, ***Director***, *RI Department of Economic Development*

PREPARED STATEMENT OF RICHARD S. FOSTER, F.S.A.

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of the our aged and disabled populations.

The financial outlook for the Medicare program has improved dramatically since 1997 as a result of the Balanced Budget Act of 1997, together with recent strong economic growth, moderate increases in health costs generally, and continuing efforts to combat fraud and abuse. Even so, there remains a serious imbalance between long-range income and expenditures for the Hospital Insurance (HI) trust fund and growth rates for Supplementary Medical Insurance (SMI) benefits are expected to continue to exceed growth in the nation's economy.

BACKGROUND

Chart 1 summarizes the enrollment, covered services, and financing provisions of the Medicare program. Information is shown separately for the HI and SMI programs, also known as "Parts A and B," respectively. As indicated, roughly 39 million people were eligible for Medicare benefits in 1998. HI provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth.

Only about 22 percent of HI enrollees received some reimbursable covered services during 1998, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only $100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums ($45.50 in 1999) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

The HI tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and general revenue payments are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 1999 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

SHORT-RANGE FINANCIAL OUTLOOK FOR HOSPITAL INSURANCE

Chart 2 shows past income, expenditures, and trust fund assets for the HI program and projections through 2015. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities.

[1] Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

The Board of Trustees has recommended maintaining assets equal to at least one year's expenditures as a contingency reserve.

During 1990–97, HI expenditures increased at a faster rate than HI income. Expenditures exceeded income by $2.6 billion in 1995, $5.3 billion in 1996, and $9.3 billion in 1997. Prior to the Balanced Budget Act, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6 percent. The 1995–97 shortfalls were met by redeeming trust fund assets, but in the absence of corrective legislation assets would have been depleted in about 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation and, as indicated in chart 2, these changes significantly reduce the growth rate in HI expenditures during 1998–2002. In 1998, income exceeded expenditures for the first time in 4 years. The trust fund is estimated to continue to experience modest surpluses through about 2006. Thereafter, however, expenditures are projected to again exceed income. Assets would be drawn down to cover the resulting shortfalls but would be exhausted by about 2015 under the Trustees' intermediate assumptions.

The depletion date estimated in the 1999 Trustees Report represents a significant improvement compared to the estimate in last year's report (2008). The improvement arises from higher payroll tax revenues in 1998 than had been estimated, together with lower benefit expenditures and adjustments to projected income and expenditure growth for the future based on this experience. The higher payroll taxes in 1998 resulted from robust economic growth, particularly the rapid growth in employment. Lower HI expenditures reflected the implementation of the Balanced Budget Act, low increases in health care costs generally, and continuing efforts to combat fraud and abuse in the Medicare program.

The improvement in the HI depletion date also reflects a subtle but important shift in the near-term operations of the trust fund. As shown in chart 3, the HI trust fund was previously projected to experience small deficits during 1998–2002, and large and growing deficits thereafter. The improvements described above, however, were sufficient to result in modest surpluses during this period, instead of small deficits. As a result, under the Trustees' intermediate assumptions, the trust fund would not begin to draw down assets for another 7 or so years. Thus, the impact of the favorable experience in 1998 is magnified because the transformation of small deficits to small surpluses significantly delays the onset of the fund's depletion.

LONG-RANGE FINANCIAL OUTLOOK FOR HOSPITAL INSURANCE

The interpretation of dollar amounts through time is very difficult over extremely long periods like the 75-year projection period used in the Trustees Reports. For this reason, long-range tax income and expenditures are expressed as a percentage of the total amount of wages and self-employment income subject to the HI payroll tax (referred to as "taxable payroll"). The results are termed the "income rate" and "cost rate," respectively. Projected long-range income and cost rates are shown in chart 4 for the HI program.

Past income rates have generally followed program costs closely, rising in a stepwise fashion as the payroll tax rates were adjusted by Congress. Income rate growth in the future is minimal, due to the fixed tax rates specified in current law. Trust fund revenue from the taxation of Social Security benefits increases gradually, because the income thresholds specified in the Internal Revenue Code are not indexed. Over time, an increasing proportion of Social Security beneficiaries will incur income taxes on their benefit payments.

Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Future cost rates are projected to initially decrease as a result of the Balanced Budget Act provisions. After 2002, however, cost rates would increase steadily and accelerate significantly with the retirement of the baby boom, beginning in about 2010. Closing the HI deficit over the first 25 years would require either an 11–percent reduction in benefits or a 12–percent increase in income, or some combination, starting immediately. Over the full 75–year period, the adjustments would have to be considerably greater. The good news is that, as a result of the Balanced Budget Act and the favorable experience of recent years, the long-range actuarial deficit is only one-third of the level projected prior to the BBA. The bad news is that, even so, the remaining imbalance is considerable.

The effect of the baby boom's retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 25 years. Basically, by the time the baby boom cohorts have retired, there will be roughly twice

as many HI beneficiaries as there are today. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary, as shown in chart 5. Currently, this ratio is 3.9 workers per beneficiary. With the advent of the baby boom's retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.3 in 2030 and 2.0 in 2050 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.4 years currently, with an estimated further increase to over 20 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

The key factors underlying past and projected increases in HI expenditures are summarized in chart 6. Aggregate cost increases have been factored into (i) growth in the number of beneficiaries, (ii) increases in general inflation, as measured by the Consumer Price Index, and (iii) all other factors, reflecting per capita increases in the utilization of health services and in the "intensity" (or average complexity) of such services. Through the early 1980s, general inflation was a major contributor to growth in HI costs. The "all other" category has seen major swings in the past, from average annual increases of as much as 6 percent to as little as 0.7 percent.

Under the intermediate projections, the impact of the baby boom's retirement clearly shows up in its effect on beneficiary growth rates. The Trustees project a fairly constant rate of inflation at about 3.3 percent annually. Projected growth in the "all other" category varies significantly, reflecting the net impact of several factors. Initially, residual growth rates are low due to the impact of the Balanced Budget Act. After 2002, utilization is expected to reaccelerate, although not as severely as in past years, due to the new prospective payment systems mandated by the Act. Future demographics will also play a role: as an influx of 65-year-old baby boomers arrives, average per capita utilization will actually decrease temporarily, as the average age of beneficiaries declines. As the baby boom generation ages, however, their utilization will increase and drive up residual HI growth rates overall.

A final factor affecting the residual growth rates shown in chart 6 is an assumption that health costs cannot continue to grow indefinitely at the high rates frequently experienced in the past. A simple extrapolation of the past quickly leads to a situation where Medicare alone would represent a substantial portion of total gross domestic product—an untenable and unrealistic situation. For this reason, residual growth rates are purposely assumed to gradually moderate toward the end of the first 25-year projection period. This assumption has been used for many years and has been found appropriate in the past by independent panels of expert actuaries and economists. More recently, however, it has received considerable criticism. Accordingly, I have asked my staff to carefully review the long-range Medicare growth assumptions. In addition, the Board of Trustees is convening a new expert panel for the purpose of reviewing the Medicare trust fund projections. We will also ask this group to review the long-range growth assumptions.

FINANCIAL OUTLOOK FOR SUPPLEMENTARY MEDICAL INSURANCE

Chart 7 presents estimates of the short-range outlook for SMI and is generally similar to the information presented in chart 2 for the HI program. Two key differences stand out: First, the income and expenditure curves for SMI are nearly indistinguishable in the future. As noted previously, SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends. The second difference is the relative level of trust fund assets. Since financing is reset frequently, a lower level of assets can suffice for contingency reserve purposes.

The primary concern for SMI is the rapid rate of growth in benefits. SMI costs grew by 41 percent over the last 5 years, exceeding the growth in the nation's gross domestic product (GDP) by 9 percent. Similar growth is projected for the short-range future. Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact is more than offset by other factors. First, the Act specified that home health services not associated with a prior stay in an institution were to be converted to Part B benefits and

paid for by the SMI trust fund (phased in over several years). In addition, the Act provides for several significant new preventive or "screening" benefits, such as colorectal examinations, not previously covered by Medicare, and it gradually corrects an excessive level of beneficiary coinsurance for outpatient hospital services. As a result, SMI costs are estimated to increase somewhat as a result of the Balanced Budget Act.

The increase in SMI costs is offset by additional premium revenue under a provision to maintain the SMI premium at the level of 25 percent of expenditures. Prior to the Balanced Budget Act, premium increases would have been limited to the Social Security cost-of-living adjustment (COLA) and, over time, would have represented a declining share of total costs. The Balanced Budget Act makes permanent the current relationship between premium revenue and total costs.

The long-range cost of SMI (shown in chart 8 as a percentage of GDP) is expected to follow the same general pattern seen previously for HI. In contrast to HI, these costs will automatically be met through enrollee premiums and general revenues of the Federal government. Policy makers remain concerned about continuing rapid growth in SMI expenditures.

CONCLUSIONS

In their 1999 report to Congress, the Board of Trustees notes the substantial improvements in the financial outlook for Medicare that have come about as a result of the Balanced Budget Act of 1997, together with recent strong economic growth and relatively slow growth in health costs generally. But they emphasize the continuing financial pressures facing Medicare and urge the nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. Today's relatively favorable conditions could change, accelerating the expected return to deficits in the HI trust fund. Moreover, the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

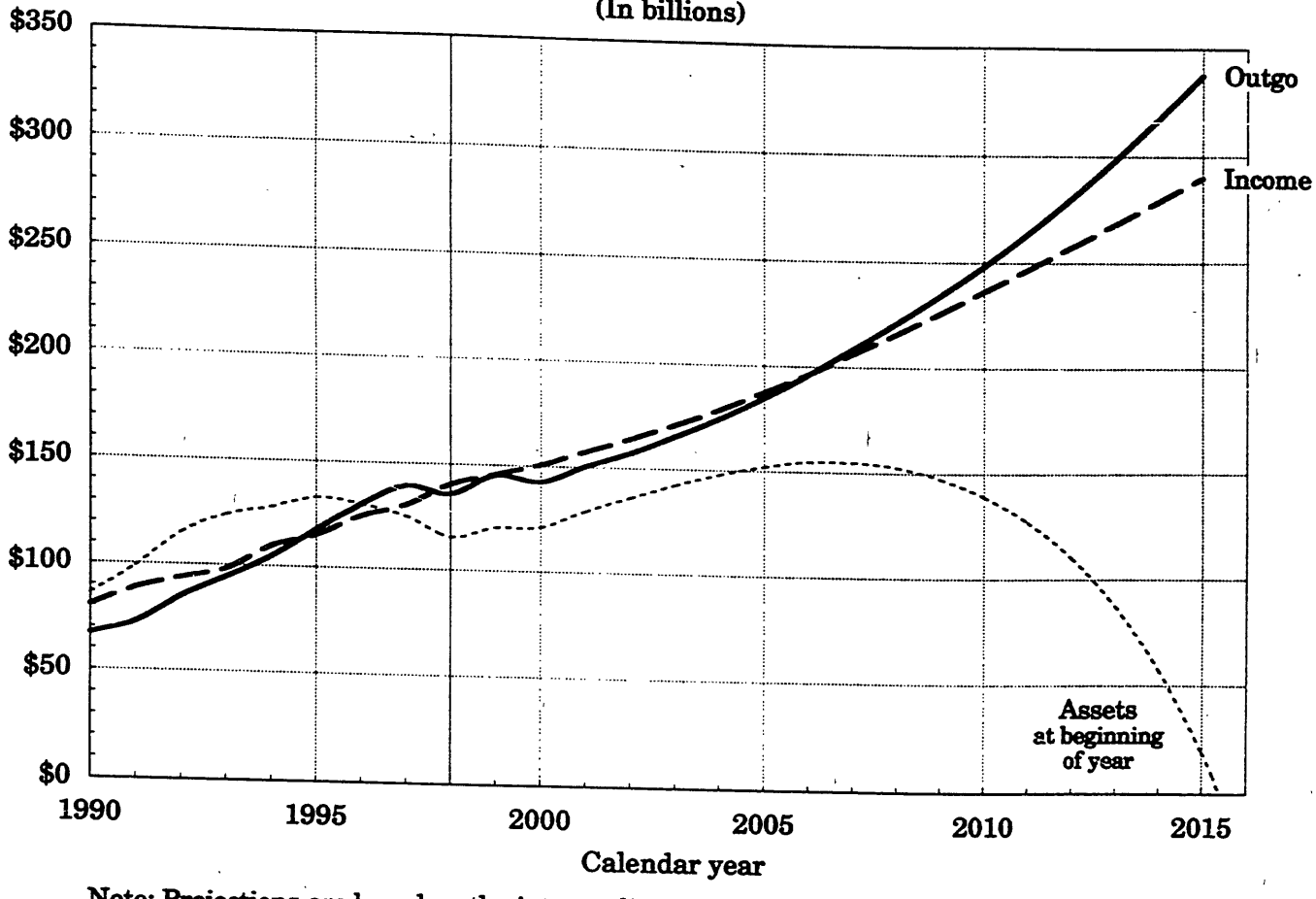
I concur wholeheartedly with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the remaining financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial issues.

Chart 1—Medicare enrollment, benefits, and financing

	Hospital Insurance (HI)	Supplementary Medical Insurance (SMI)
Enrollment in CY 1998:		
Total	39 million	37 million
Proportion with services...	22%	87%
Benefits* * Subject to certain deductible and coinsurance requirements	Inpatient hospital care Skilled nursing care Home health care (post-institutional) Hospice care	Physician services Outpatient hospital services Home health care (general) Other services, e.g. • Diagnostic tests • Medical equipment • Ambulance
Financing	HI tax on covered earnings: • 1.45% payable by employees and employers, each • 2.90% payable by self-employed • Following elimination of HI contribution base (effective 1994), HI tax applies to all earnings in covered employment Revenue from taxation of OASDI benefits (portion between 50% & 85%)	Premiums paid by enrollees in 1999: • $45.50 per month for all enrollees • Covers 25% of costs General revenue transfers in 1999: • $139.10 per month for aged persons • $160.50 per month for disabled • Covers remaining 75% of costs

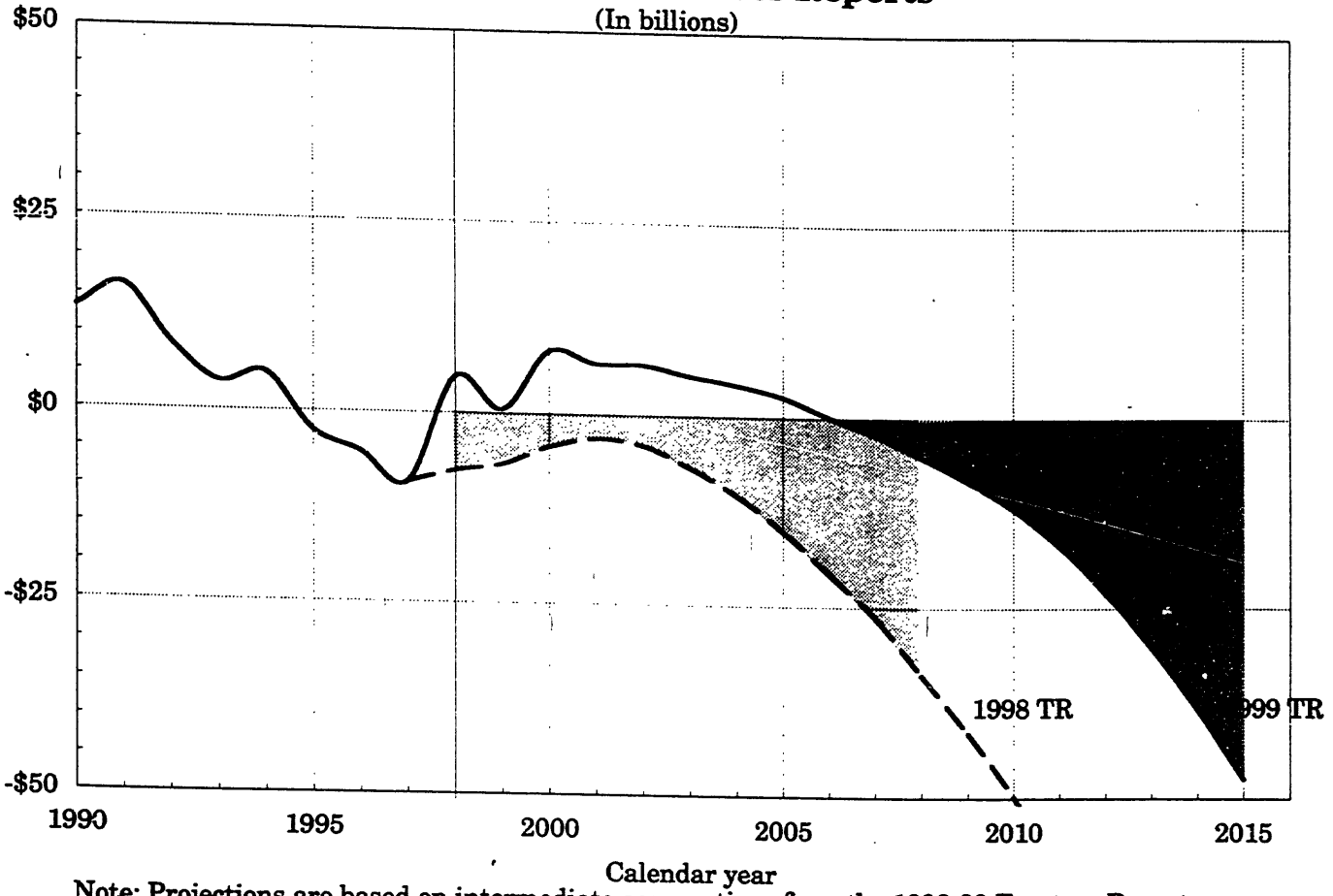
Chart 2—HI income, outgo, and trust fund assets

(In billions)



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

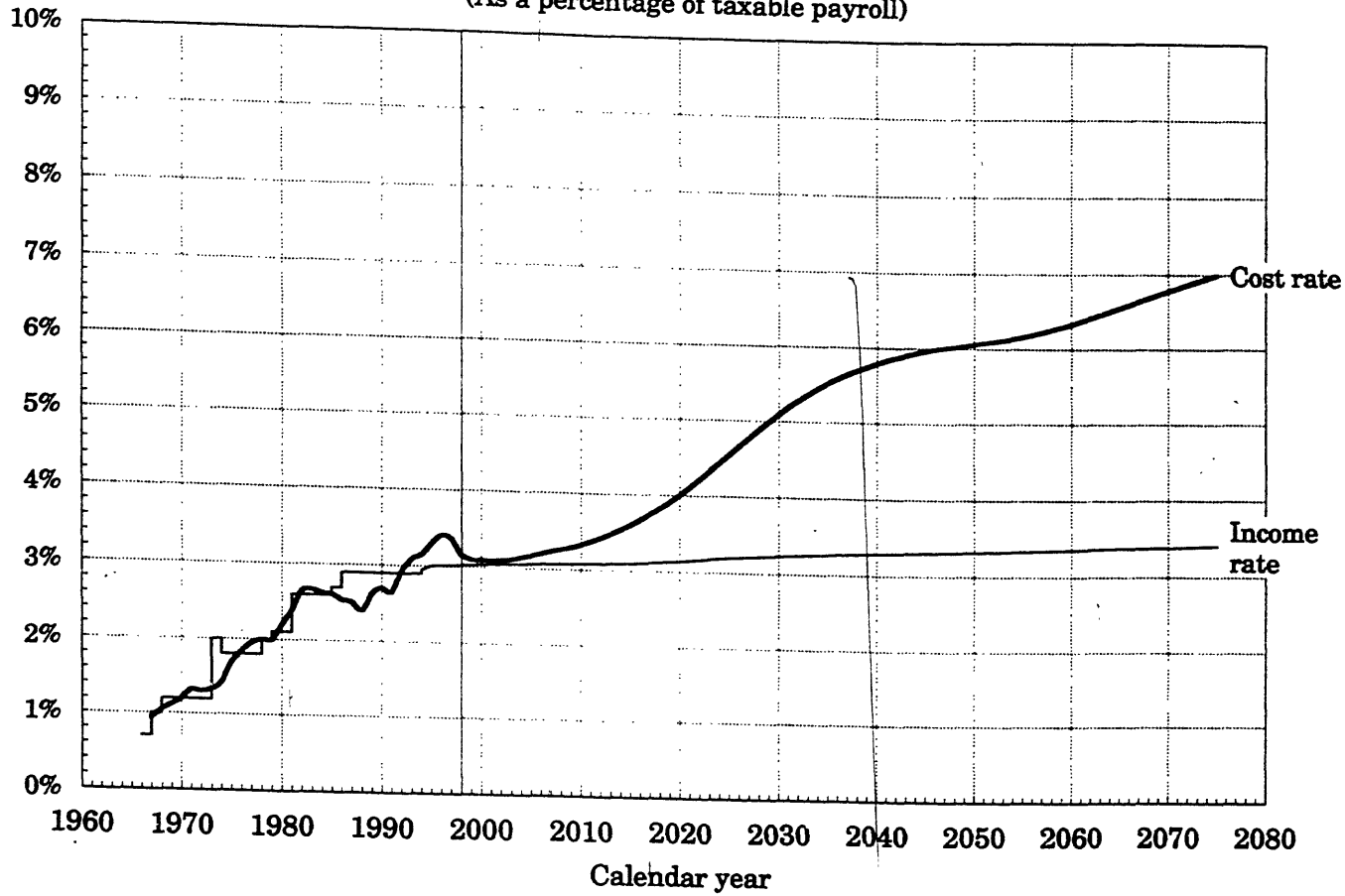
Chart 3—Net increase in HI trust fund assets, 1998 vs. 1999 Trustees Reports



Note: Projections are based on intermediate assumptions from the 1998-99 Trustees Reports.

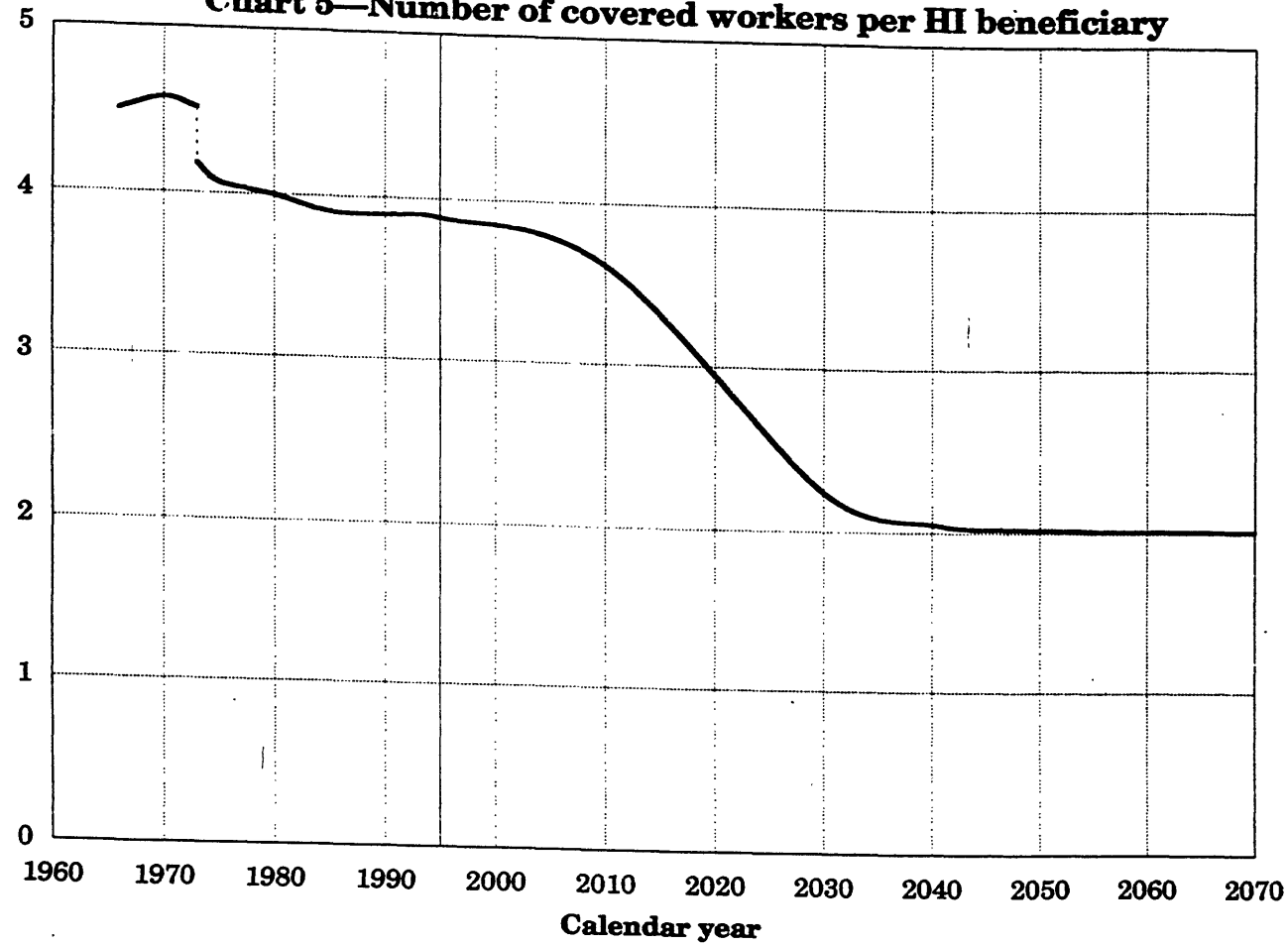
Chart 4—Long-range HI income and cost rates

(As a percentage of taxable payroll)



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

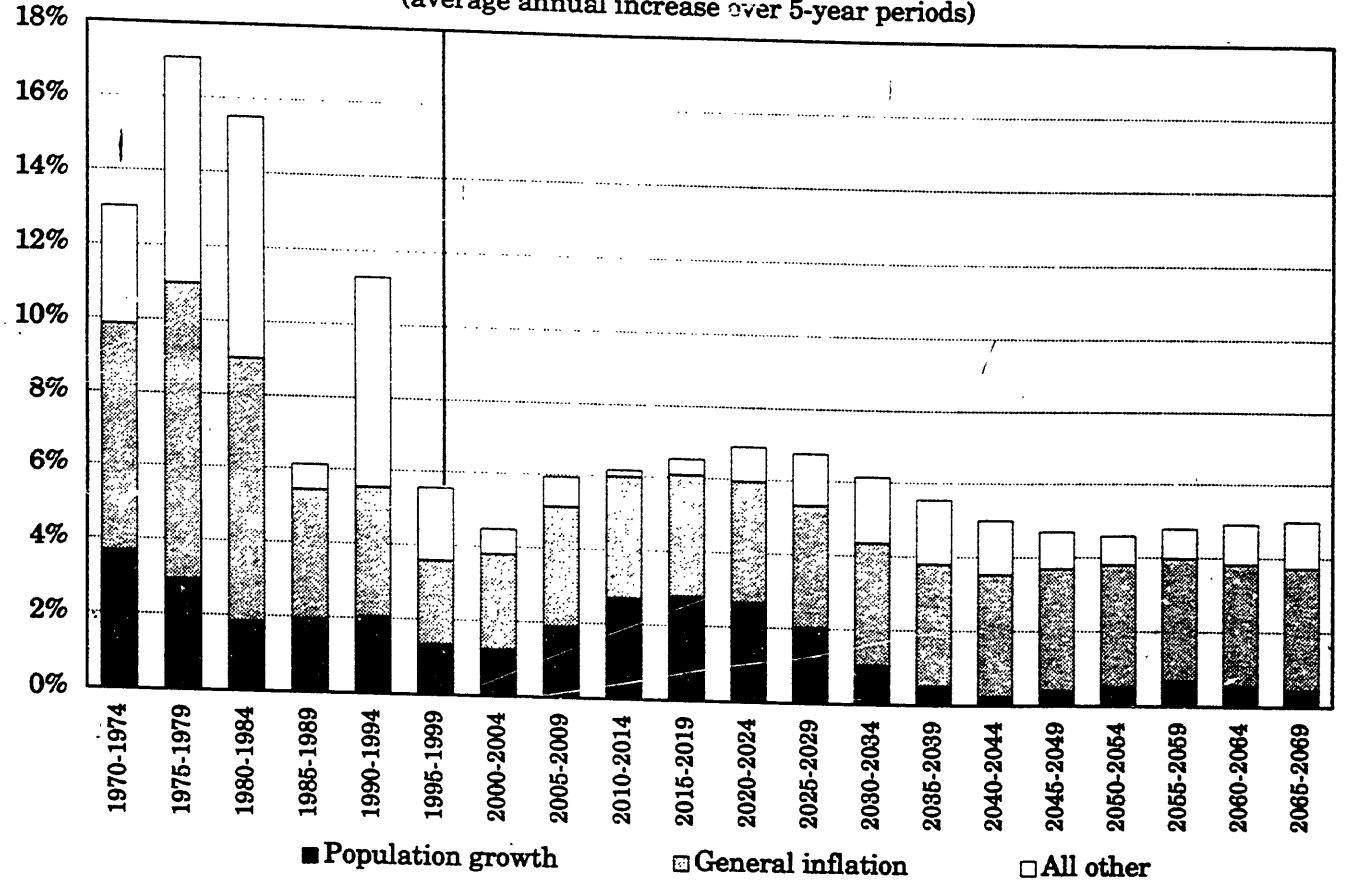
Chart 5—Number of covered workers per HI beneficiary



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

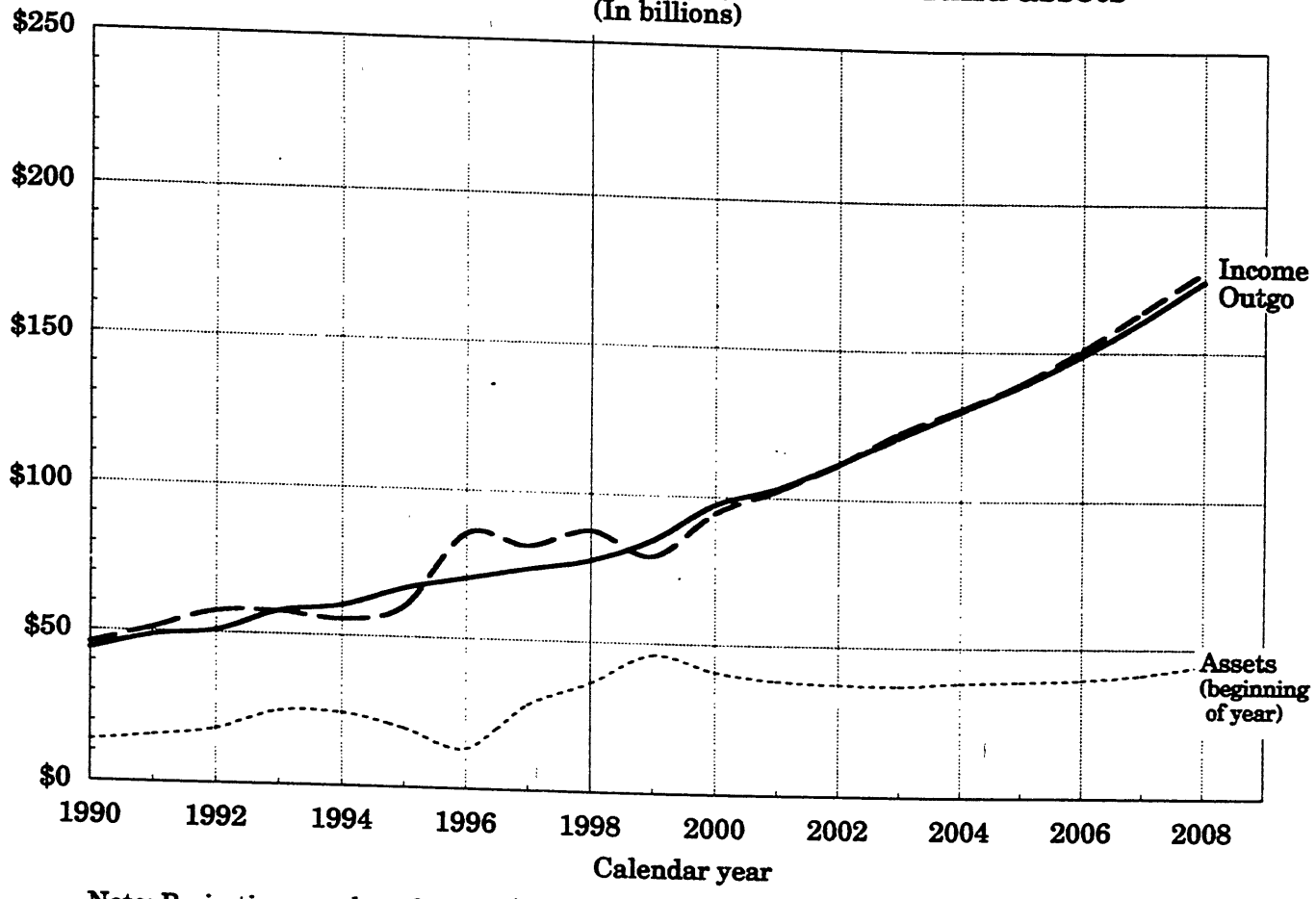
Chart 6—HI expenditure growth factors

(average annual increase over 5-year periods)



Note: Projections are based on the intermediate set of assumptions from the 1999 Trustees Reports.

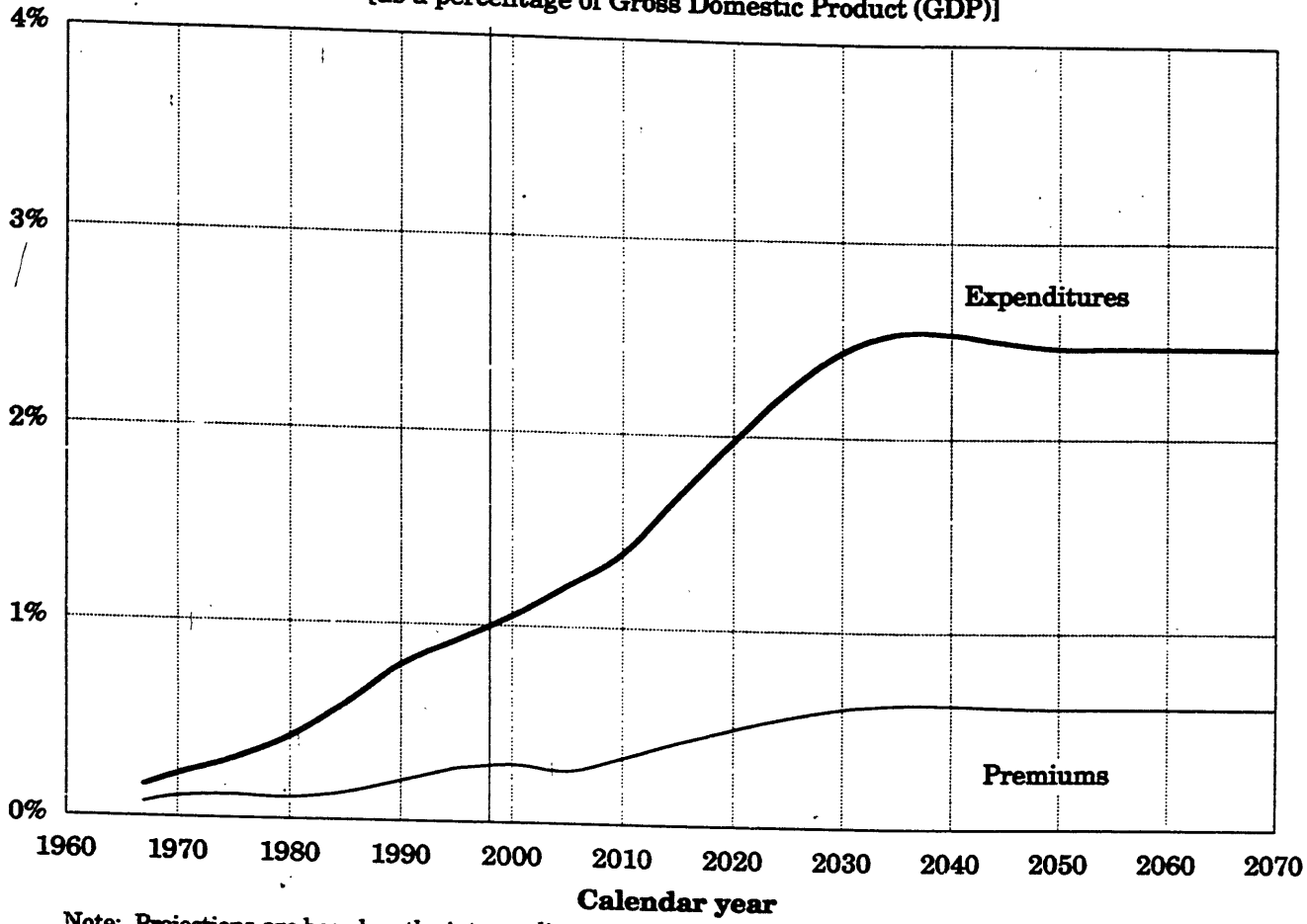
Chart 7—SMI income, outgo, and trust fund assets



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

Chart 8—SMI expenditures and premium income

[as a percentage of Gross Domestic Product (GDP)]



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

RESPONSES OF DR. FRECH TO QUESTIONS FROM SENATOR GRASSLEY

Question: You discuss the economic incentives Medigap insurance creates for beneficiaries to utilize more services. Is it possible that people who purchase Medigap insurance need more medical care so that is why they purchase Medigap insurance and that these same people would still be greater users of services even if we reform Medicare fee-for-service and the Medigap market?

Answer: Researchers have paid a lot of attention to the possibility that purchasers of Medigap insurance were sicker and therefore would have used more medical care with or without Medigap. If this were true, Medigap would not be causing high use. This is sometimes called the selection or adverse selection problem. In this case, researchers are reasonably sure that this problem in not important and that Medigap is actually causing the higher use. Here a few reasons for this belief:

1. The measured effect of Medigap is roughly the same as the effect of copayments in the Rand Corporation's Health Insurance Experiment. In the Health Insurance Experiment, people were randomly assigned to different plans, thus this sort of selection problem does not affect the results.

2. Those with supplements are actually less sick than those without supplements. This suggests that selection (the decision to purchase supplements) is not primarily driven by a need or demand for medical care.

3. One would expect relatively little selection bias form employer-provided supplements, since they're based on a long-term employment history before retirement. Yet, there is a large effect of these supplements on utilization.

For recent discussions of these issues, see: Christensen, Sandra and Judy Shinogle. "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," [Health Care Financing Review 19 (1) (Fall 1997): 5-17, especially pp. 15, 16.

Physician Payment Review Commission (PPRC). *Annual Report to Congress 1997.* Washington, D.C.: PPRC, 1997, especially p. 292.

Question: Your testimony highlights the problem with the cost-sharing structure of Medicare. The large deductibles and coinsurance encourage beneficiaries to purchase Medigap insurance, which in turn increases their utilization of services. You propose several possible ways to address this problem with Medigap coverage. You advocate taxing Medigap plans or prohibiting certain ones from being offered, but could Congress adjust the cost-sharing structures within the Medigap coverage policies we enacted in OBRA 90? Would that address the overutilization problem you describe?

Answer: Medigap problems could be reduced by changing the allowed Medigap plans under OBRA 90, but not eliminated. I would suggest the following reforms:

1. Individual Medigap plans could be prohibited from covering the physicians' Part B deductible and the hospitals' Part A deductible.

2. Medigap coverage for Part B coinsurance could be prohibited entirely or prohibited unless a particular stop-loss amount had been met (say $1,000 or $2,000 per year of covered out-of-pocket expenses).

These Medigap reforms would go a long way towards improving incentives and reducing costs for individual medigap coverage. I would strongly support such reforms.

However, these reforms would have no effect on the group supplemental insurance provided as a retirement benefit by employers. The group of beneficiaries with this group coverage is slightly bigger than those with individual medigap coverage.

Congress could extend the reach of OBRA-type regulation and limit the allowed benefits in group supplements in exactly the same way as it does for Medigap. This, of course, would require a new level of federal regulation of group insurance.

PREPARED STATEMENT OF LARRY S. GAGE

I am Larry Gage, President of the National Association of Public Hospitals & Health Systems (NAPH), which represents over 100 of America's metropolitan area safety net hospitals. These hospitals and systems are uniquely reliant on governmental sources of financing to support care to Medicare, Medicaid, and uninsured patients. They also provide many preventive, primary and costly tertiary services to their entire communities, not just to the poor and elderly. These services include a wide variety of around-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters. Finally, most NAPH members also serve as major teaching hospitals.

I am pleased to have this opportunity to testify before the Finance Committee on the issue of long term Medicare reforms. NAPH members on average serve fewer

Medicare patients, and far more Medicaid and uninsured patients, than the average community hospital in America. However, Medicare payments—especially Medicare teaching and disproportionate share hospital (or "DSH") adjustments—are important sources of support for safety net hospitals. Moreover, the Medicare patient population of NAPH members is disproportionately drawn from among low income elderly residents in urban areas. We therefore feel that our members have a special interest in the debate over future reforms to the Medicare program.

I would like to accomplish three things in my testimony this morning. First, because it has been some time since NAPH last testified before this committee, I would like to take this opportunity to bring you up to date on the situation of America's safety net hospitals and health systems. Second, I will provide you with a number of specific comments on long term Medicare reform generally and on the premium subsidy proposals discussed during the deliberations of the Medicare Commission in particular. Finally, as part of my prepared testimony submitted for the record, I would like to comment briefly on several other issues of concern to NAPH members. These include the impact of the 1997 Balanced Budget amendments, dramatic recent changes that have occurred in Medicaid eligibility and reimbursement policies, and a proposed new Safety Net initiative currently under consideration by the Senate Appropriations Committee.

SITUATION OF URBAN SAFETY NET HOSPITALS AND HEALTH SYSTEMS

The last decade has seen a dramatic transformation of the role of the hospital in our nation's health system, with a profound impact on every important element of that system. From the way we purchase and pay for health coverage, to where and how we provide needed care, the metamorphosis has been swift and intense. New systems and networks spring to life overnight, mergers and acquisitions dramatically shrink the number of players, and traditional payment mechanisms turn upside down in a heartbeat.

While all hospitals are affected by these trends, safety net hospitals and health systems have felt their impact disproportionately. The pressure for change is especially acute for those providers who rely most heavily on federal, state and local governmental funding to pay for their wide range of primary, acute and public health services. For such systems, marketplace pressures are intensified by a variety of other factors. These include the growth in the uninsured, reductions in Medicaid funding and local support, greater competition for Medicaid patients, the explosion in managed care, and the need to provide public health and community-wide services.

As a result of these challenges, safety net hospitals and systems face major threats to their future survival. The health of many millions of low income patients, and the viability of the health system for rich and poor alike in many metropolitan communities, are likely to be in danger if these threats are not adequately addressed.

In describing the situation of safety net systems, I will draw in part on new 1997 data collected by NAPH in its annual Hospital Characteristics Survey, augmented by data from the American Hospital Association's Annual Survey and other sources. Please note that this is the first time this new 1997 NAPH data has been released.

The mission of NAPH members, and other safety net health systems, includes a willingness, to the extent of their financial ability, to serve all individuals, regardless of insurance status or ability to pay.

This mission is reflected first and foremost in the tremendous volume of patient care services provided to all patients in safety net hospitals. In 1997, NAPH members averaged 17,200 inpatient admissions and over 340,000 outpatient and emergency room visits annually.

However, these numbers tell only part of the story. For most safety net systems, this volume reflects an even more significantly disproportionate provision of services to the elderly and the poor, especially by those hospitals which also serve as academic medical centers. In 1997, NAPH members provided, on average, 83% of their services to Medicare, Medicaid and "self-pay" patients. Most "self pay" patients represent, in effect, the uninsured (who typically pay little or nothing for their care). NAPH members provided, on average, 28% of their services (as measured by gross charges) to such self-pay patients in 1997.

Most of these self pay patients end up as bad debt or charity care for NAPH member hospitals, and the costs of these patients must be covered from a variety of other payment sources. Just 67 NAPH members provided over $3.9 billion in uncompensated care in 1997, or an average of $58 million per hospital.

The situation is projected to worsen over the next several years. Even since efforts to enact national health reform failed in 1994, the numbers of uninsured have

grown to nearly 44 million today, and are projected to continue to grow for the foreseeable future. The University HealthSystem Consortium recently estimated (using HCFA data) that we would have 53 million uninsured by 2003. A recent study by the National Coalition on Health Care predicts that if an economic downturn occurs, as many as 61.4 million non-elderly Americans—one in four—could be uninsured by 2009.

It is ironic that the pressures on the safety net have been increasing at a time of unprecedented economic prosperity in America. Unemployment is at a 28-year low. The federal budget was balanced last year for the first time in decades. And many states are seeing larger budget surpluses than at any time in recent memory. Why do we face this paradox of an extraordinarily robust economy and increasing number of uninsured? There are several likely reasons, including:

- Many of the new jobs being created are in small businesses or service industries that do not provide adequate insurance coverage;
- Many lower-income workers, especially younger individuals, faced with rising costs, are giving up coverage or refusing to accept optional personal or dependent coverage;
- Welfare and immigration reforms have led to reduced eligibility for Medicaid and other programs among some low-income and vulnerable populations;
- In most states a large proportion of those eligible for Medicaid and other programs are simply never enrolled, or at least not until they fall seriously ill;
- Incremental reforms—such as the 1995 Kennedy-Kassebaum legislation and the 1997 Child Health Insurance Program (CHIP)—have been slow to bear fruit and will likely end up helping far fewer uninsured individuals than originally anticipated.

One major characteristic that defines NAPH member hospitals is how they finance the provision of high volumes of charity care. In 1997, NAPH members on average received just 19% of their net operating revenues from Medicare and 19% from commercial insurance and managed care plans. With another 27% in Medicaid patient care revenues, that left 35% of costs to be covered by alternative sources.

The primary sources of financing for uncompensated care in NAPH member hospitals are the Medicaid and Medicare Disproportionate Share Hospital (DSH) programs. In 1997, Medicaid DSH payments covered 35% of the costs incurred in treating the uninsured and underinsured and Medicare DSH covered another 8% for all NAPH members nationally. State and local subsidies made up most of the difference, accounting for 52% of total payments for uncompensated care. Such subsidies accounted for 28% of net patient revenues for NAPH members in 1997.

Safety net health systems also face increased competitive pressures, including competition for privately insured patients, and for selected Medicaid patients as well. In the area of obstetrics, for example, NAPH members have seen a dramatic reduction in the number of deliveries, as private providers have increasingly sought to compete for the simpler, less complicated Medicaid patients. In particular, between 1990 and 1996, the number of births has declined by over 35% (or nearly 1200) at the average NAPH member hospital.

This trend in obstetrics is just one example of the more aggressive competition driving the need for dramatic changes in the way safety net hospitals do business. A significant part of this is driven by the shift to managed care for Medicare, Medicaid and privately insured patients alike. The ability to contract with managed care plans and compete for both physicians and managed care patients is becoming more essential to survival in today's competitive marketplace.

In addition to eliminating cost shifting, managed care and competition have had other effects on health care providers in ways that will impact their provision of uncompensated care. States have used managed care to contain costs in their Medicaid programs and, in some instances, have attempted to expand coverage to the uninsured with some of the savings. However, many such states have been forced to cap or reduce such expanded eligibility. This has further increased pressure on safety net providers serving the uninsured and underinsured.

NAPH COMMENTS ON MEDICARE REFORM

NAPH members understand and appreciate that long term structural reforms will be essential if the Medicare program is to be preserved and improved for current and future generations. Fortunately, the hard work previously undertaken by Congress and the President allows this Congress more time to step back and take a thoughtful and measured approach to reform. The life of the Trust Fund has been extended by the reforms already enacted and by improvements in the U.S. economy. We also believe the Congress can further extend the life of the Trust Fund by adopt-

ing the President's proposal to dedicate 15 percent of the budget surplus to that purpose.

Because the program has thus been protected for the near future, NAPH believes that your baseline principle for considering major reforms should be "first, do no harm." In that regard, first and foremost, we counsel caution and careful deliberation. Efforts at reforming the Medicare program should not be taken lightly or precipitously. For this reason, NAPH neither endorses nor opposes the premium support proposals deliberated (although not formally endorsed) by the Medicare Commission. Rather, we prefer to provide you with some suggested principles for undertaking a cautious and careful approach to reform. Those principles are:

Medicare care must continue to guarantee coverage and benefits

The Medicare program has been extremely successful in ensuring that our nation's elderly and disabled have access to meaningful health care coverage. Meaningful coverage means guaranteeing beneficiaries that their costs for a defined set of health care benefits will be paid for (or substantially paid for), subject only to clearly defined and commonly understood copayments. The premium support proposals discussed to date do not make it clear that beneficiaries would continue to be entitled to coverage for a defined benefits package. NAPH's support for future reform proposals will be contingent upon continuing the guarantee of coverage and benefits to all Medicare-eligible individuals.

Medicare must be affordable for low-income beneficiaries

Currently, Medicare's premiums and cost-sharing are strictly limited by law. Low-income beneficiaries are further protected from unaffordable cost-sharing through dual Medicaid-Medicare coverage. Such cost-sharing protections, particularly for low-income beneficiaries, must be preserved in any reform proposal. Unless low-income beneficiaries retain equal access to the full gamut of Medicare options, we will wind up with a two-tiered Medicare system which channels poorer beneficiaries into second-rate plans, while the more wealthy enjoy better coverage.

Medicare reform must protect beneficiaries from adverse selection

Currently, only around one in six beneficiaries is in a Medicare HMO and the rest remain in the "traditional" Medicare fee-for-service system. HMO enrollees on average have been a healthier and less costly population to serve than their fee-for-service counterparts. Current Medicare benefits and marketing requirements to some extent limit the ability of HMOs to attempt to attract a specific sub-set of beneficiaries, such as those who are healthier or lack certain chronic conditions. However, to date, HCFA is currently in the process of designing a risk-adjusted HMO payment system to remove the incentive for such "cherry-picking." Any reform must ensure that participating plans are prohibited and financially discouraged from avoiding high-risk, high-cost cases. Otherwise, the traditional fee-for-service Medicare system will be left with only the more expensive beneficiaries, becoming prohibitively expensive both for the beneficiaries and for the government

Medicare reform should ensure that beneficiaries have meaningful choices in both their plans and providers

As Medicare seeks to move more and more beneficiaries into managed care as a way of controlling costs and providing more benefits, reform should ensure that these choices are real for all beneficiaries, not just those who are healthy or live in certain communities. The premium support proposal that has been outlined by Senator Breaux calls for establishing a "Medicare Board" to oversee the program. This Board would be given broad powers to negotiate premiums, approve the benefits package, safeguard against adverse selection, and ensure quality standards. The proposal gives no boundaries within which the Board would wield these powers—it does not even give any details on how the Board would be constituted. These questions must be answered before NAPH could support such a proposal with confidence that such a Board would protect beneficiary interests.

Protection of essential medical education and DSH payments

Currently, Medicare hospital reimbursement includes explicit adjustments to pay for graduate medical education (GME) and care for the poor (through the disproportionate share hospital, or DSH, program). Medicare's role in funding these payment adjustments has been debated, and some have called for the removal of these payments from the Medicare trust fund. We strongly oppose these efforts. Medicare pays only for its share of medical education and other uncompensated costs. These adjustments must be properly viewed as a legitimate component of Medicare reimbursement, not an inappropriate subsidy that should be paid for through general revenues. We do agree, however, that Medicare should not be the only payer sup-

porting medical education and care for the poor, and that the structure of these payments might possibly be subject to reform within the context of broadening support by other payers.

At the same time, a reformed Medicare system must ensure that DSH and GME payments reach their intended recipients—providers that care for a disproportionate number of low-income patients and that train our nation's future health care work force. The current program does this for GME by carving it out of the payments to managed care entities and paying it directly to the providers that teach residents. A reformed program must likewise ensure that both GME and DSH payments are not folded into the premiums paid to plans but are paid directly from the federal government to the providers that they are intended to support.

Medicare reform must not increase the ranks of the uninsured

Proposals to raise the eligibility age from 65 to 67 years of age will increase the number of near-elderly who cannot get health insurance coverage. Given the rising number of uninsured and the particular problems for individuals who are over 55 years old to access coverage, no federal policy should be undertaken that decreases access to health insurance coverage.

NAPH supports adding a prescription drug benefit to the Medicare program

Some proposals would effectively limit availability of this benefit to the very poor and only those who can afford high option plans. Consistent with these principles, we urge that it be made accessible to all beneficiaries and not financed in ways that undermine other aspects of the program.

Finally, Medicare reform must ensure that managed care plans protect beneficiaries' health

The reforms of the Balanced Budget Act and those discussed by the Medicare Commission envision an expanding role for managed care plans in Medicare. This expansion comes at the same time that Congress is concerned enough about managed care abuses to debate seriously patient protection legislation. Moreover, many private sector plans participating in Medicare+Choice have demonstrated a lack of long-term commitment to the program and have dropped out, causing disruptions and access problems for thousands of beneficiaries. Meanwhile, providers, many of whom already are struggling under BBA cuts, are finding their reimbursement slashed further under managed care, not only through low rates but less overtly through payment denials and delays. We caution you to consider seriously the myriad problems wrought by Medicare (and Medicaid) managed care and to find ways to address them before moving too swiftly to expand the role of managed care further. NAPH would be happy to assist you in this process.

This set of principles is by no means exhaustive, but represents concerns that have grown out of the deliberations of the Medicare Commission as it considered a model of Medicare reform based on premium support. The public descriptions to date of this model have been short on details and left many of these concerns unanswered. Without more details, it is impossible to say whether or not Medicare will remain an entitlement under a premium support model or whether beneficiaries will be guaranteed the same set of benefits currently available. We will employ our principles as we evaluate more specific forthcoming proposals.

We thank you for your work on these difficult issues. Because of the scope and reach of the Medicare program, efforts at reform must be taken carefully. "Fixing" one set of problems may result in creating others—affecting not just Medicare, but the entire health care system. We caution you and your Senate colleagues to consider carefully the effect of any proposed reforms, not just on the elderly and disabled who are beneficiaries, but on all segments of our society which may be affected. NAPH stands ready to assist you in your efforts.

NAPH COMMENTS ON OTHER IMPORTANT ISSUES

In this third section of my prepared statement, I would like to take this opportunity to comment on several other issues that are important to NAPH members.

IMPACT OF 1997 BALANCED BUDGET ACT

It is becoming increasingly apparent that the cuts initiated in the Balanced Budget Act of 1997 (BBA) are much deeper than anyone anticipated at the time and are threatening the viability of hospitals and other providers. Several recently released studies detail the impact of BBA cuts on hospitals. The most recent study, done for the American Hospital Association (AHA) by the Lewin Group, projects that BBA Medicare cuts will reduce hospital spending by as much as $71 billion over five years—$18 billion more than originally estimated—and that those cuts will cause

70 percent of all hospitals to have negative Medicare profit margins by 2002. Another study, done by Ernst & Young, projects that total hospital margins will decline 48 percent in five years, from 6.9 percent in FY 1998 to 3.6 percent in FY 2002. The Association of American Medical Colleges (AAMC) has found that the impact will be especially hard on our nation's teaching hospitals, reducing total margins for typical large teaching hospitals by as much as half or more—to about 1 percent—by 2002.

NAPH wants to thank those members of this Committee who recognize the BBA's impact on hospitals, especially teaching hospitals, and we appreciate your introduction and support of legislation to mitigate this impact. In particular, NAPH wishes to express our support for the "Graduate Medical Education Payment Restoration Act of 1999" (S. 1023), introduced by Senator Moynihan, with the co-sponsorship of Senator Kerrey and others. That act would freeze the indirect medical education (IME) adjustment at the FY 1999 level of 6.5 percent, rather than reduce it to 5.5 percent by FY 2001 as required by the BBA. We would strongly urge the authors of this proposal to extend this freeze to DSH payment adjustments.

We also support Senator Moynihan's "Managed Care Fair Payment Act of 1999" (S. 1024), which would carve DSH payments out of the payments made to Medicare+Choice organizations and pay them directly to the DSH hospitals that provide the care. We also commend Senators Chafee and Kerrey for their support of this bill. We further support the "Nursing and Allied Health Payment Improvement Act of 1999" (S. 1025), to carve out Medicare funding for the training of nurses and other allied health professionals from Medicare+Choice rates and pay them directly to the hospitals that provide their training. As Medicare relies more and more heavily on managed care, the loss of DSH and nurse training payments for Medicare managed care enrollees will have a greater and greater impact on the safety net and teaching hospitals that rely on these payments. Congress should therefore do for DSH payments what you have already seen fit to do for GME payments and pay them directly to the hospitals for which they were intended. Once again, we thank Senator Moynihan and his cosponsors for their leadership on each of these important healthcare issues.

IMPACT OF MEDICAID, IMMIGRATION AND WELFARE REFORMS

Medicaid absorbed significant cuts in the Balanced Budget Act of 1997, particularly in the Disproportionate Share Hospital (DSH) program, which is the lifeblood of many NAPH members. Further cuts, even those purportedly coming from administrative expenditures, ultimately impact Medicaid recipients and the providers that serve them. NAPH urges Congress to continue to hold the line on future cuts to the program.

A recent report released by Families USA estimates that 675,000 low income individuals became uninsured as a result of welfare reform (either because they were diverted from applying for cash assistance and never got enrolled in Medicaid even though they were eligible, or because they found jobs that do not have health insurance). Medicaid enrollment declined by 1.25 million between 1995 and 1997 as a result of welfare reform.

With the number of uninsured at 43 million and rising, NAPH supports any and all efforts to expand Medicaid to those without adequate health care coverage. These efforts include the following:

- Restoration of Medicaid and CHIP coverage to certain legal immigrants.
- Passage of the Work Incentives Improvement Act to allow disabled persons to return to work without fear of losing Medicaid (or Medicare).
- Expanded eligibility and enhanced outreach for the State Children's Health Insurance Program (CHIP).
- Coverage for low-income women without health coverage diagnosed with breast or cervical cancer.

We would like to commend Senators Jeffords, Roth, and Moynihan for your leadership on the "Work Incentives Improvement Act" (S. 331) and applaud the Committee's approval of this important legislation.

In addition, Medicaid cuts in the disproportionate share hospital program have begun to impact hospitals. The impact will worsen as those cuts are fully phased in by 2002. Several states, like Minnesota, Wyoming, and New Mexico, had caps in their DSH allotments that were set too low in error. These errors have been corrected in the annual appropriations process, but they require more than one-year fixes, which should more appropriately be addressed by authorizing committees, and several other states may also require relief. Some safety net hospitals are also losing additional Medicaid DSH funds due to the hospital-specific DSH caps established in OBRA 93. Such hospitals are financing their states' entire DSH program and they

are experiencing a significant and unfair loss of DSH funds due to imposition of the caps.

The 1996 welfare reform law eliminated benefits for many legal immigrants, creating a crazy-quilt patchwork of eligibility requirements that is confusing to immigrants and providers. NAPH supports the passage of Senator Moynihan's Fairness for Legal Immigrants Act of 1999 (H.R. 1399/S. 792) which would clarify eligibility requirements and restore many of the benefits taken away by the 1996 legislation. In particular, the Fairness for Legal Immigrants Act would:

- Permit states to provide Medicaid and CHIP eligibility to legal immigrant pregnant women and children, regardless of date of entry.
- Permit states to provide Medicaid eligibility to legal immigrants who are blind or disabled, regardless of date of entry.
- Restore SSI and Medicaid eligibility for elderly poor legal immigrants who entered the US prior to August 22, 1996.
- Restore SSI and Medicaid eligibility for legal immigrants who become disabled after entry to the US.

SUPPORT FOR NEW SAFETY NET INITIATIVE

Finally, we also urge your support for a new national safety net initiative included in the Administration's FY 2000 budget request for the Department of Health and Human Services. Specifically, $25 million has been requested through the appropriations process as seed funding for the coming fiscal year, and $250 million per year for each of the next four years to finance safety net reforms in up to 100 communities around the country. This funding would support grants to local communities to enhance collaboration and cooperation among safety net clinics and hospitals, helping to produce a more efficient and seamless health care system for the uninsured.

Currently many very important federal programs provide reimbursement or direct support to providers of health care services for uninsured and underinsured populations. These programs play a vital role in their communities and need additional funding in their own right to serve the growing number of people who are seeking their care. While such funding will strengthen the foundation of care for uninsured and vulnerable people in many communities, safety net providers could be even more efficient and cost-effective if given the resources to work together and coordinate care for their patients. Currently, there is no federal support for communities wishing to integrate the programs and services they already provide into a cohesive system of care for uninsured patients. While safety net providers are committed to providing the best possible coordinated services, they face significant obstacles in doing so. Their patients typically have much greater and costlier medical and social needs than more affluent populations, sapping these providers of any disposable resources to devote to coordinating care among themselves. The safety net initiative would help fill service gaps, building upon existing programs by encouraging coordination and efficiency and thereby significantly stretching federal dollars invested in direct services.

Moreover, the initiative would allow for significant innovation and experimentation at the local level, with local consortia of providers proposing the most effective use of the funding for their communities. By focusing on the most pressing service gaps in their communities and targeting true safety net providers—those who currently serve large numbers of low-income and uninsured patients—communities can guarantee that existing charity care is expanded, and not supplanted or replaced. Successful models already in existence could be replicated or adapted, or communities could design completely new approaches. In addition, communities could use the relatively modest federal investment to leverage even greater local public and private funding, eventually becoming self-sustaining.

This concludes my prepared testimony. I would be pleased to answer any questions you may have at this time.

PREPARED STATEMENT OF PAUL B. GINSBURG, PH.D.

I am here today to discuss with you the differences between the traditional Medicare program and private insurance. The latter includes insurance products that are obtained through public purchasers, such as the Federal Employees Health Benefits Program (FEHBP) and the California Public Employee Retirement System (CALPERS). I draw heavily on my work with three organizations: the Center for Studying Health System Change (HSC), where I serve as president; the Study Panel on Fee-for-Service Medicare sponsored by the National Academy of Social Insurance

(NASI), which I chaired; and the former Physician Payment Review Commission, where I served as executive director.

When the Medicare program was designed and implemented in the 1960s, many aspects of it were modeled after the leading private insurance plans. But the two have diverged over time. Medicare, which has had the market power to pay providers on the basis of administered prices, developed sophisticated mechanisms to determine payment rates for different classes of providers. Some elements of the administered pricing systems were oriented towards influencing the delivery of care, for example the encouragement of shorter hospital stays. Private insurers, which had less market power, developed mechanisms to purchase services competitively through limiting provider panels and an array of administrative tools to influence how care is delivered.[1] I refer to these tools as "care management."

PROVIDER PAYMENT

Although Medicare initially paid providers on a passive basis—what hospitals costs were and what other providers generally charged—it developed more aggressive systems over time. Medicare developed hospital prospective payment and a physician fee schedule in order to pay less than under the passive payment systems and to provide some incentives for more cost conscious delivery of care. The overall level of payment has been influenced greatly by Congress' desire to reduce the federal budget deficit. Thus, substantial payment cuts were enacted as parts of various budget reconciliation bills throughout the 1980s and 1990s. In this process, interests of providers compete politically with interests of beneficiaries, the interests of groups benefiting from other federal spending, and the interests of taxpayers. My observation has been that overall federal budget policy has been a much more important driver of these changes than the anticipated shortfall of the Medicare trust fund.

Medicare has also successfully used its administrative pricing system to change provider incentives. Thus, paying hospitals on a per admission basis provided incentives to shorten lengths of stays. The physician fee schedule shifted physician incentives away from the provision of medical and surgical procedures towards the provision of evaluation and management services.

Often at the behest of employers, private insurers have evolved their provider payment mechanisms in the direction of competitive purchasing. By establishing networks of hospitals, physicians, and other providers that enrollees could access with less out-of-pocket expense, private plans have been able to negotiate payment rates with providers. The stronger the ability of the plan to influence the choice of providers by its enrollees, the greater the price concessions that it is able to achieve. Thus, HMO products often pay providers at lower rates than preferred provider organization (PPO) products.

Private insurers have also used payment mechanisms designed to influence how care is delivered, mostly in HMO and point of service (POS) products. For example, primary care physicians are often paid on the basis of capitation for primary care services—that is, a fixed amount per enrollee per month. An HSC physician survey shows that 72 percent of primary care physicians are in practices that accept capitation and for those with some capitation, it accounts for 32 percent of practice revenue.[2] Bonuses are often paid to physicians whose patients are most satisfied with their care. Less common, but seen as a cutting edge practice, a capitated payment for all services (referred to as "global capitation") is negotiated with an organization that includes hospitals and physicians.

Private insurers now typically use the Medicare fee schedule as a benchmark in physician payment. Thus, the conversion factor may be higher or lower than used by Medicare in the area, but the relative values are the same. Private insurers tend not to use per case payment of hospital care, preferring instead to use administrative controls to limit lengths of stay.

CARE MANAGEMENT

Private insurers have done much more than Medicare in the use of administrative mechanisms to influence how care is delivered. For example, private insurers routinely require authorization for hospital admissions. Although such requirements originated in managed care products, they are now common in traditional plans as well. In many cases, authorizations are required for major procedures as well, such as MRI or CAT scans. Managed care plans often require enrollees to see a primary care physician for referral to a specialist. HSC data show that in 1997, 46 percent of persons with private insurance had such a "gatekeeper" requirement.[3] In some

Footnotes at end of statement.

plans, the primary care physician must obtain an authorization to make a referral. Financial incentives to primary care physicians are also used to limit referrals to specialists. None of these tools are used extensively in Medicare.

These care management mechanisms are not used as frequently by health plans when providers are "at risk" for spending. In the extreme, where providers are paid on the basis of "global" capitation, the responsibility for limiting care is transferred from the health plan to the provider organization. The plan's activities dealing with care delivery are limited to monitoring quality. In intermediate situations, such as contracting with a provider on the basis of an episode of care, such as for coronary artery bypass graft surgery (CABG), the plan's only role might be in approving the procedure, with the balance delegated to the provider of services. Through a demonstration project, Medicare is also experimenting with episode-based payment for CABG.

Managed care is in a period of widespread experimentation with respect to influencing the delivery of care. Much is being done in the area of prevention. Health plans send reminders to enrollees to schedule appointments for preventive services, such as mammograms.

The most innovative plans identify persons with certain chronic diseases, such as diabetes, and prescribe a regimen of preventive services, education, and self care. Often referred to as "disease management," secondary prevention activities have also been applied to asthma and congestive heart failure. Some insurers have developed or disseminated practice guidelines to physicians to help them practice in a manner that research has shown to be most effective. Some have used data on physician practice patterns to limit their networks to those practitioners who practice more efficiently. Some have programs of high-cost case management, in which extra benefits, such as modifications to the patient's home, can be provided to improve outcomes or lower costs. But other plans have focused exclusively on obtaining discounted payment rates from providers and have not invested in these care management mechanisms.

Many of these mechanisms are still evolving and must be considered "experimental." Although few have a research literature to vouch for their cost effectiveness, the fact that use of these tools is becoming widespread is an indication that plans—and in some cases, employers—believe that they are worthwhile and may become more effective in the future.

CONSTRAINTS FACING MEDICARE PROGRAM

Why has Medicare done less in the areas of selective contracting with providers and administrative tools for care management? Two key reasons come to mind. First, government programs operate according to different rules than private enterprises. These rules limit flexibility and make changes slower. Second, in many areas, Medicare beneficiaries have few, if any, alternatives to the traditional Medicare program. The inability of beneficiaries unhappy with a practice to go elsewhere leaves the traditional plan with the responsibility to attempt to meet the needs of all beneficiaries.

The size of the Medicare program, in conjunction with its status as a government program, limits its ability to interact with providers in various ways. Since the program is so important to hospitals and to physicians in certain specialties, political constraints bar it from excluding from the program a provider who, while not committing fraud, has a highly inefficient practice style. Because Medicare payment rates are so critical to providers, they are decided through a political process in which the welfare of providers is weighed against the needs of taxpayers and beneficiaries. On a number of occasions, Medicare demonstrations of a new payment mechanism have been blocked by lobbying of constituencies that might lose out.

The process of government also makes it difficult for Medicare to pursue innovations in payment or care management. Since society is reluctant to allow government officials the level of discretion that managers of private entities enjoy, procedures to make decisions are cumbersome and time consuming. Government officials must demonstrate the rationale for their decisions and must provide affected parties an opportunity to express their concerns. Sunshine laws restrict the ability of government officials to negotiate with providers behind closed doors in the manner that their private plan counterparts are able to.

The report of the NASI panel that I chaired described particular problems experienced by HCFA with innovations tested in demonstrations.[4] When demonstrations are successful, it lacks the authority to implement the tools widely. When demonstrations are not successful, political constraints sometimes make it difficult to stop them.

Medicare faces an additional problem that results from the way in which the Congress provides the funds for the program. As an entitlement program, funds to pay providers are not subject to the appropriations process. But the funds to administer the program are and Medicare's administrative needs must compete with more glamorous activities, such as biomedical research. The result has been that Medicare has long underinvested in administrative activities and cannot afford many of the care management activities described above, even when there is an expectation of substantial savings in benefit payments.

The lack of choice of program by many beneficiaries constrains the program in many ways. It means that mechanisms that restrict beneficiaries cannot be implemented except on a volunteer basis. For example, if a gatekeeping requirement were added, those who value direct access to specialists would feel a significant loss. A private plan could include such a requirement with the knowledge that those unwilling to deal with it could switch to another (presumably more expensive) plan without such a requirement. This lack of choice means that even if a private organization were retained to administer Medicare on an incentive basis, as has been proposed on a number of occasions in the past, Medicare's being the sole choice for many would lead to severe constraints on its flexibility.

This may become less constraining over time. With increasing options through Medicare+Choice for plans that resemble what most of the younger population is enrolled in, there may be less need for traditional Medicare to meet the needs of all beneficiaries.

POLICY DIRECTIONS

Congress can pursue two courses to bring additional care management activities into the Medicare program. One is to encourage greater enrollment in private health plans. Congress took some steps in this direction in 1997 when it established the Medicare+Choice program. Under Medicare+Choice, HCFA has the opportunity to further the use of private plans by innovating as a purchaser, but it also must guard against retarding the development through being too interventionist. Proponents of premium support proposals also seek to further encourage enrollment in private plans.

The second course is to take steps to make it easier for the traditional Medicare program to incorporate innovations in care management. The NASI panel developed a series of recommendations to encourage and facilitate innovation in the traditional Medicare program.[5] These included a directive to HCFA to innovate by adapting the best practices of private health plans, authority for HCFA to waive certain statutory requirements in order to experiment and move from demonstrations to implementation like private organizations, and requirements for frequent reporting on how this authority is being used. The panel felt that improving traditional Medicare was compatible with continued development of private health plan options in the program. Its work was in response to forecasts that even if private plans have great success in attracting Medicare beneficiaries from the traditional program, that enrollment in the traditional program would be substantial for many years to come and that beneficiaries and taxpayers should benefit from innovation in management.

In sum, the Medicare structure has led to valuable innovations in provider payment but much less in the way of innovations in care management. The program needs to innovate in order to contain costs and to pursue opportunities to improve the quality of care for beneficiaries. Additional enrollment in private plans and more innovation in the traditional Medicare program are both viable options to accomplish this important and laudable goal.

NOTES

[1] In this statement, I do not discuss differences in benefit structure, which will be covered by another witness on this panel.

[2] Unpublished data.

[3] Robert St. Peter, Gatekeeping Arrangements are in Widespread Use. Center for Studying Health System Change, Date Bulletin #7, Fall 1997.

[4] From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare. (Washington, DC: National Academy of Social Insurance, January 1998).

[5] See From a Generation Behind to a Generation Ahead, 1998.

PREPARED STATEMENT OF P. ANTHONY HAMMOND, ASA, MAAA

Good morning, Mr. Chairman and members of the Senate Finance Committee. My name is Tony Hammond. I am the Senior Actuarial Fellow for the Institute for

Health Policy Solutions and an independent actuarial consultant. It is an honor to speak with you today. My testimony concerns the differences in benefits between Medicare and conventional employer-sponsored health insurance plans.

Medicare covers many of the same benefits that any employer-sponsored health insurance plan would cover. However, there are differences which Medicare beneficiaries may find surprising when they switch from their employer-sponsored plans to Medicare coverage.

The first and most obvious difference is that Medicare does not cover outpatient prescription drug benefits. This Committee has been considering the issue of prescription drugs for quite a while now, so I will not go into great detail on the impact of this benefit difference. I will note, however, that nearly all employer-sponsored health insurance plans provide prescription drug benefits.[1] Thus, new Medicare beneficiaries coming from employer-sponsored plans will be unprepared for the costs they have to pay for prescription drugs, and most private Medicare supplement plans cover little or none of this expense.

Next, recent Medicare beneficiaries may notice that their single combined deductible of, say, $250 has changed to a $100 deductible for physician (or Part B) services combined with a $768 deductible (1999) for inpatient (or Part A) services. Thus, the deductible a Medicare beneficiary would have to pay for an average hospital stay would be $768 versus a maximum of $250 under a conventional plan. If the beneficiary incurred more than $100 of Part B (medical) costs prior to hospitalization, the beneficiary would also pay an additional $100 deductible on the Part B benefits, bringing the combined deductible to $868.

More than 81% of conventional employer-sponsored plans pay 80% of the cost of care after the deductible is paid, leaving 20% for the employee to pay. The 20% the employee pays is called coinsurance. Medicare uses a 20% coinsurance rate for beneficiaries, but the coinsurance only applies to medical (Part B) benefits after the deductible. That is, Medicare does not apply the coinsurance rate across all benefits, including hospital, as a conventional plan would. In addition, Medicare increases the coinsurance rate to 50% for outpatient mental health benefits. This higher coinsurance rate for outpatient mental health is consistent with many conventional plans.

Employer-sponsored plans limit the total share of the health insurance cost paid by their employees (called an out-of-pocket limit). Over 90% of conventional plans limit out-of-pocket costs (deductibles plus coinsurance) to less than $2000 annually for single employees.[2] Thus, even if an employee had to stay in a hospital 90 days or incurred more than $10,000 of Part B expenses, the most the employee would pay would be equal to the out-of-pocket limit. Medicare does not limit the total out-of-pocket cost a beneficiary must pay.

Medicare generally covers up to 90 days of inpatient treatment[3] whereas most employer-sponsored plans cover the entire year, 365 days. In truth, this difference may be more one of appearance than cost because hospitalizations of more than 90 days are rare. However, the difference in days covered can make it look like a much more limited benefit is being offered.

About a quarter of conventional employer-sponsored plans offer vision or hearing services. 40% offer some degree of dental services.[4] Medicare offers neither.

New Medicare beneficiaries would also notice a difference in their contribution toward the premiums for health insurance. Employees contributed $22–35 per month toward their employer-sponsored coverage (1998 figures).[5] In 1999, Medicare beneficiaries contribute $45.50 monthly toward their Medicare coverage (Part B premium).

Managed care concepts are also finding their way into conventional fee-for-service plans. For example, almost a third of conventional plans have carved out the prescription drug coverage and provide this benefit under a separate prescription drug card program to reduce costs. Mental health benefits may also be provided in this manner. Also, under conventional plans, inpatient visits must be precertified as medically necessary. Medicare does not use these approaches for these benefits.

Medicare uses several other managed care techniques that new Medicare beneficiaries will find familiar. Medicare sets payment rates for services and restricts payments to physicians who agree to accept Medicare's rates. Participating Medicare providers are also prohibited from billing patients for the difference between the provider's normal charge for the service and what Medicare pays (balance bill-

[1] KPMG's 1998 Annual Survey of Employer-Sponsored Health Benefits, Table 28.
[2] KPMG's 1998 Annual Survey of Employer-Sponsored Health Benefits, Table 26.
[3] Up to 60 days of additional coverage may be used for inpatient stays over 90 days over one's lifetime.
[4] KPMG's 1998 Annual Survey of Employer-Sponsored Health Benefits, Table 28.
[5] KPMG's 1998 Annual Survey of Employer-Sponsored Health Benefits, Table 19.

ing). This approach to paying providers—sometimes called managed indemnity—is similar to the approach Blue Shield plans and commercial PPOs have used.

Although there may be more similarities than differences between benefits covered under Medicare and benefits covered under employer-sponsored health insurance plans, there are important differences. Some of these differences may surprise retirees who are changing from employer-sponsored plans to Medicare. In sum, the major differences are:

- Prescription drug benefits are not covered under Medicare;
- Medicare does not have a combined hospital and medical deductible;
- The coinsurance rate of 20% is consistent with many conventional plans, but Medicare only applies the coinsurance rate to medical services, not hospital services.
- Medicare does not have an explicit out-of-pocket limit; and
- Medicare's basic hospital benefit is only 90 days versus 365 days in conventional plans.

Typical employer-sponsored health insurance plan [6]

The typical conventional (fee-for-service) health insurance plan includes the following cost-sharing provisions and benefits:

Cost sharing

- Aggregate annual deductible of $250 for single employees; [7]
- 80–20 coinsurance (plan pays 80%, employee pays 20% of costs after the deductible);
- $1,000 maximum out-of-pocket limit for single employees;
- $1,000,000 lifetime maximum.

Hospital inpatient services

- Up to 365 days of semi-private accommodations for acute care
- Up to 30 days of mental health or substance abuse treatment
- Up to 180 days of hospice care
- All inpatient services require precertification of services.

Hospital outpatient services

- Surgery
- Diagnostic Lab and X-ray
- Chemotherapy and Radiation Therapy
- Mental Health
- Emergency

Physician services

- Office visits
- OB/Gyn visits
- Allergy visits
- Inpatient visits
- Surgery
- Preventive care
- Mental health—50% coinsurance

Other medical services

- Chemotherapy and radiation therapy
- Home care
- Private duty nursing
- Physical/Speech/Occupational Therapy
- Durable medical equipment
- Ambulance
- Chiropractic

Ancillary services

- Prescription Drug
- Vision-exams but not lenses
- Dental-preventive care

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[6] Based on data and information from KPMG's 1998 Annual Survey of Employer-Sponsored Health Benefits, Congressional Research Service (from Hay Group data), and Greenwood Consultants.

[7] Includes deductible carryover: any deductible paid in the last quarter of the year carries over into the next plan year.

PREPARED STATEMENT OF HON. ORRIN G. HATCH

Thank you, Mr. Chairman. Allow me to commend you for your leadership on the critically important issue of Medicare reform.

Today, we begin a series of five hearings in which we will consider the numerous and complex issues associated with reforming one of the most important programs of the federal government—the Medicare program.

I am particularly pleased with the comments of both Chairman Roth and our Ranking Minority Member, Senator Moynihan, who have publicly announced their intention to conduct "a thorough, bipartisan review of Medicare issues, including the status of the current program, and possible reform options including but not limited to the work of the National Bipartisan Commission on the Future of Medicare."

It is clear to me that if Congress is going to pass any kind of Medicare reform legislation this year, or even next year, that it must be bipartisan. Moreover, success will depend on the level and commitment of leadership we receive from President Clinton.

We cannot do this task alone; and, without the President, it will not be done.

It is my understanding, Mr. Chairman, that at the completion of these hearings you will then consult with all Senators on the committee to determine whether there is strong bipartisan support for either a comprehensive or a more focused piece of reform legislation.

We know from our experience on the Balanced Budget Act of 1997 that there are no easy solutions to saving the Medicare program. Indeed, many of the solutions are not going to be popular with our constituents or with health care providers for that matter.

We may not be able to truly reform Medicare until the American people are fully versed on the financial instability of the program and the daunting problems that lay ahead as we enter the next millennium.

In this regard, let me also commend my colleagues on the committee, Senator Breaux, for his leadership as cochairman of the commission as well as Senators Gramm, Kerrey and Rockefeller, whose expertise and knowledge of these complex issues made them extremely valuable resources to the work of the commission.

Mr. Chairman, once again, I commend you and the ranking member for beginning this process today.

Let me also welcome our witnesses whose testimony I look forward to reviewing.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF KAREN IGNAGNI

I. INTRODUCTION

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

Our plans have had a longstanding commitment to Medicare and to the mission of providing high quality, cost effective services to beneficiaries. Today, more than 16 percent—or 6.1 million beneficiaries—are enrolled in health plans, up from only 6.2 percent five years ago. Recent research indicates that health plans are attracting an increasing number of older Medicare beneficiaries, and that Medicare beneficiaries are remaining in health plans longer. In addition, near-poor Medicare beneficiaries are more likely to enroll in health plans than higher-income beneficiaries. These health plans offer Medicare beneficiaries many benefits that are not covered under traditional Medicare, such as prescription drug coverage.

With passage of the Balanced Budget Act (BBA) two years ago, Congress took significant steps toward the goal of providing Medicare beneficiaries with expanded choices similar to those available in the private sector and toward ensuring the solvency of the Medicare trust fund. The establishment of the Medicare+Choice program was supported by AAHP and regarded as the foundation for moving forward with a program design that can be sustained for baby boomers and future generations of Medicare beneficiaries. Unanticipated events, however, have endangered this foundation and created structural issues that must be resolved quickly. Without Congressional action this year, the promises made to beneficiaries with the passage of the BBA will remain unfulfilled thus preventing the successful implementation

of virtually every long-term solution, including premium support, that this Committee might examine.

We appreciate this opportunity to share with the Committee our members' thoughts on reforming Medicare for future generations of seniors and disabled and will comment on several topics, including:

- AAHP's Medicare principles;
- The Medicare Fairness Gap and its effect on beneficiaries; and
- The premium support approach to reforming Medicare.

II. AAHP'S MEDICARE PRINCIPLES

The Medicare program was enacted 34 years ago and was a reflection of private sector insurance coverage at that time. Much has changed since then—but prior to the enactment of the Balanced Budget Act of 1997, Medicare had taken few dramatic steps to modernize the program. In the past 34 years, health plans have learned how to organize and deliver health care services in ways that improve coverage and quality while better controlling costs. But Medicare had been slow to take advantage of these improvements. As a result, while more than 80 percent of working Americans with health insurance coverage now receive their care through health plans, only one out of every six Medicare beneficiaries is a health plan member.

Given the challenge of addressing the current Medicare problems and moving toward the goal of sustaining the program for future beneficiaries, our members believe that there are six principles that ought to guide the Committee's work:

- Strengthen Medicare Through Expanded Choice. Ensuring a strong Medicare program requires that beneficiaries have an expanded range of health care choices. Consumers in the private sector have benefited from access to affordable, comprehensive coverage due to the widespread availability of health plan options. However, broader choice for Medicare beneficiaries, a central goal of the Balanced Budget Act, has not yet been realized. The promise of the BBA and the foundation for future reform should be fulfilled through midcourse corrections that will make the Medicare+Choice program fair, stable, and predictable for beneficiaries, health plans, and providers;
- Provide More Information. Beneficiaries should receive accurate information that allows them to compare all options and select the one that best meets their needs. We are concerned that with its beneficiary information campaign last year, HCFA got off to a very rocky start. The agency conducted a costly campaign that did not meet congressional expectations. Many seniors received incorrect or confusing information and, in fact, information about options other than the traditional Medicare program did not appear in the "Medicare+You" brochure until page 17, some plans were left out altogether, information was inaccurate and the subliminal message to beneficiaries was "don't switch";
- Ensure Payment Adequacy, Accuracy, Predictability, and Stability. Federal contributions to Medicare+Choice organizations should be adequate and predictable to promote expanded choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established. As is now apparent, the BBA payment formula, in combination with the Administration's risk adjustor, will not achieve this goal. New options generally are not developing, while communities across the country with high concentrations of seniors are seriously threatened. This experience is completely contrary to what Congress intended and is an unstable basis from which to proceed to address long-term structural reform;
- Mechanisms to improve payment accuracy should ensure that Medicare+Choice organizations are reimbursed appropriately for the broader benefits, better out-of-pocket protections and coordinated care provided to enrolled beneficiaries. Furthermore, implementation of the new risk adjustment mechanism required under the BBA should move forward on a spending neutral basis, as Congress intended; when it is clear that risk adjustment is consistent with objectives of promoting a system that provides high quality cost effective care and disease management; when the risk adjuster accurately measures health status, rather than producing results that are artifacts of data problems or fee-for-service utilization patterns; and when benefits offered to Medicare beneficiaries will not be adversely affected. An accurate, well-implemented risk adjustor will be a critical component of any premium support model or alternative that builds on a competitive model;
- Ensure Payment Parity and Fair Regulation. A key component of a stable Medicare program is payment parity and regulatory fairness across all options available under the Medicare program. The rate of growth in reimbursements

for beneficiaries under the Medicare+Choice program should be comparable to the rate of growth in spending to serve beneficiaries under the Medicare fee-for-service program. Likewise, the regulatory structure for health plans should not be based on the erroneous view that fee-for-service Medicare is inherently superior to Medicare+Choice. In fact, there is much evidence of better care being provided in the Medicare+Choice program, yet Medicare regulation continues to emphasize micromanaging Medicare+Choice plans over improving care for the 85 percent of beneficiaries in fee-for-service Medicare. In short, Medicare+Choice organizations should not receive disproportionately low government payments on behalf of beneficiaries or be subject to disproportionately extensive regulatory requirements;

- Establish Consistent Standards and Meaningful Regulation. Beneficiaries should have confidence that all options, including both Medicare+Choice plans and the Medicare fee-for-service program, meet standards of accountability that ensure that they will have access to all Medicare benefits and rights regardless of the choice they make. All Medicare+Choice options offered to Medicare beneficiaries should be required to meet comparable standards in such areas as quality of care, access, grievance procedures, and solvency. These standards should be implemented through regulatory requirements that make the best use of Medicare+Choice organization resources to ensure that beneficiaries receive the maximum value from the program. This means that when requirements are established, their benefits must outweigh their costs. In a reformed Medicare system, consistent standards are essential to the creation of a level playing field of choices; and
- Promote Responsive Government. To foster increased consumer confidence in all aspects of the Medicare program, HCFA should take immediate steps to improve administration of the Medicare+Choice program by: providing consumer-friendly educational information to current and prospective beneficiaries about all types of choices available to them through an equitably financed program; reducing unnecessarily burdensome regulatory requirements that do not add value for beneficiaries and streamlining and stabilizing program administration to permit expanded choice; and improving consistent implementation of HCFA Central Office policies throughout HCFA regional offices and minimizing variation in policy interpretation and administrative determinations across these offices.

III. THE MEDICARE FAIRNESS GAP

The BBA limited the annual rate of growth in payments to health plans, producing $22.5 billion in savings from the Medicare+Choice program. In addition, the BBA reduced geographic inequities in the payment formula to encourage the development of choices in lower payment areas of the country. We supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund.

We are deeply concerned, however, that unintended consequences of higher than anticipated inflation, 900 pages of new regulations, and the growing gap in funding of the two sides of the program does not serve the best interests of beneficiaries and was not intended by Congress. In 1998 and 1999, because of the low national growth percentage and the inability to achieve budget neutrality, no counties received blended payment rates. Furthermore, HCFA has chosen to implement its new risk adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated additional $11.2 billion over a five-year period. This is an administratively imposed 50 percent increase in the $22.5 billion savings Congress anticipated from the payment methodology as enacted in the BBA of 1997. In fact, the Congressional Budget Office (CBO) recently stated that it had "previously assumed" that risk adjustment in the Medicare+Choice program would be budget neutral.[1]

AAHP analysis of PricewaterhouseCoopers projections of Medicare+Choice rates in each county over the next 5 years shows that a significant gap opens up between reimbursement under the fee-for-service program and reimbursement under the Medicare+Choice program.[2] This Medicare+Choice Fairness Gap will be at least $1,000 for two-thirds of Medicare+Choice enrollees living in the top 100 counties,

[1] "An Analysis of the President's Budgetary Proposals for FY 2000," Congressional Budget Office.

[2] AAHP's analysis of the PricewaterhouseCoopers payment model used assumptions that produced conservative estimates of the Fairness Gap. For example, although county-level Medicare+Choice payments were actually lower than FFS per capita payments in 1997, AAHP's analysis assumes that county-level Medicare+Choice and FFS payments were equal.

as ranked by Medicare+Choice enrollment. This same Fairness Gap will exceed $1,500 in major Medicare+Choice markets, including Chicago, Los Angeles, Miami, New York, Boston, Pittsburgh, Cleveland, St. Louis City, Dallas, and Philadelphia. In Miami, the Fairness Gap will be $3,500 in 2004 and in Houston the gap will exceed $2,500 in 2004. In New Orleans, the Fairness Gap will exceed $2,600 in 2004.

For nearly half of Medicare+Choice enrollees living in the top 100 counties, the Medicare+Choice reimbursement will be down to 85 percent of traditional Medicare payments in 2004, significantly exceeding any estimates of so-called overpayment due to favorable selection by plans. When AAHP examined the top 101–200 counties ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be $1,000 or more in 2004.

A large percentage of the Fairness Gap is attributable to HCFA's risk adjuster. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk adjustment methodology will be to restrict new market entrants and leave beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs. AAHP has found that the impact of HCFA's risk adjuster on Medicare+Choice payments to rural and urban counties is similar—rural areas with Medicare+Choice beneficiaries are cut by about 6 percent, while urban areas are cut by about 7 percent.

Finally, we also are concerned that only health plan beneficiaries are funding the Agency's beneficiary education campaign. Given concerns about the effectiveness of this effort and at a time of growing instability in the Medicare+Choice program, we strongly urge that the program be scaled back and realistic goals set. In addition, we urge that the cost of a newly developed effort be distributed proportionally across the entire system.

We have summarized the crisis in the Medicare+Choice program because we believe its success will determine the nation's ability to move to broader reforms. We look forward to a future opportunity to present our analysis and our proposals for addressing these challenges to the Committee when it convenes its hearings specifically on Medicare+Choice.

IV. PREMIUM SUPPORT APPROACH FOR MEDICARE

In order to protect and preserve the Medicare program for future generations of beneficiaries, a national conversation should proceed about the need for structural change and future preparedness. The premium support approach that was examined by the National Bipartisan Commission on the Future of Medicare could be the platform for examining how to fundamentally change the way Medicare finances coverage to beneficiaries, offering seniors a wide variety of choices with the anticipation also of curbing long-term spending growth. Since a premium support program would represent a significant change not only for beneficiaries, it will be crucial to consider the best means of structuring the program so that the fee-for-service program continues to be available.

Changing the Medicare program along these lines raises a number of important design issues that should be explored thoroughly. To that end, as the Committee considers fundamental changes to Medicare, it needs to evaluate what has occurred in the Medicare+Choice program. Virtually all stakeholders supported the concept of expanding choice, but many have been disappointed by problems in implementing Congress' intent. Through this prism, our members have developed the following principles for your consideration.

- Establish a Core Set of Benefits and Allow for Competition Around Additional Services. The program should require a core set of benefits, while allowing plans flexibility in offering other benefits. To help beneficiaries compare different plan offerings, benefit descriptions could be standardized.
- Government Contribution Must Be Actuarially Sound. Determining the amount of the government contribution will be a critical decision in the design of a premium support program. The level of the government's contribution should be a fixed proportion of an amount necessary to adequately meet the needs and costs of the benefits package for Medicare beneficiaries.
- Include the Fee-For-Service Program. In order to allow for a level playing field that promotes effective competition and a broad array of choices, all options, including fee-for-service, should be required to operate under the same premium support rules.
- Let the Beneficiary Choose. The federal government's premium contribution should not vary according to the type of program or delivery system selected.

• Establish Equivalent Quality Standards for Coverage Options. Health plans have been the frontrunners in meeting quality, access and consumer protection standards. All coverage options, including Medicare fee-for-service, should be governed by equivalent quality and consumer protection standards. Equivalent standards should be flexible enough to recognize that a given quality or consumer protection objective might be achieved in a number of different ways.

• Develop a New Administrative Framework. Health plans and other options participating in a reformed Medicare program should be administered under a new framework that focuses on promoting quality medical care, rather than on micromanaging plan and practitioner operations. The new framework should seek to minimize the conflicting objectives evident under HCFA's current role as both purchaser and regulator.

• Pilot Testing and Phase-In. A premium support approach—including the traditional program—should be pilot tested on a limited basis. Subsequently, the program should be phased-in to allow time to make necessary adjustments.

In addition, there are two very specific lessons from the current Medicare program that should provide context for your discussion of premium support.

• Tensions Between HCFA's Role as Purchaser and Regulator. HCFA's dual roles as purchaser and regulator are, at times, in conflict. Nowhere has this conflict been more evident than in HCFA's implementation of the BBA. The situation plans faced in the Fall of 1998 serves to illustrate the inherent conflict between HCFA's traditional role as a regulator and its changing role as a purchaser. Given all of the uncertainty surrounding the program and the unrealistic compliance timetable, plans across the country and across model types became deeply concerned last Fall about their ability to deliver benefits promised under the originally mandated filing schedule. This led our members to make an unprecedented request to HCFA to allow plans to resubmit parts of their adjusted community rate proposals. In some service areas the ability to vary copayments—even minimally--meant the difference between a plan's staying in or pulling out of a market.

While this request presented HCFA with a difficult situation, AAHP strongly believes that an affirmative decision would have been better for beneficiaries. As a purchaser, HCFA had a strong motivation to maintain as many options as possible for beneficiaries by responding to health plans' concerns and adopting a more nimble approach to Medicare+Choice implementation. As a regulator, HCFA would have had a difficult time coping with the predictable political fallout from reopening bids.

These role conflicts remain unresolved, even largely unaddressed. Until ways are found to reconcile them, however, they will stand in the way of designing and delivering a Medicare+Choice program that really works. One of the features of the Bipartisan Commission's premium support proposal was that it addressed this conflict by establishing a separate administrative board to oversee the restructured program. We recommend that the pros and cons of such an approach be thoroughly investigated and stand ready to participate with the Committee in a discussion of these issues.

• Lessons from the Competitive Pricing Demonstration Project. Many issues raised by a premium support approach are similar to those experienced under the controversial competitive pricing demonstration projects proposed in recent years for Baltimore and Denver, and HCFA's current efforts to implement similar demonstrations in Phoenix and Kansas City. Successful competitive pricing models in the private sector include all options available to enrollees; HCFA's competitive pricing demonstrations have not and do not include the fee-for-service Medicare program as an option alongside health plans. From the first proposed demonstration site, AAHP consistently has recommended that both sides of the program be included in a model to test competitive bidding.

The competitive pricing demonstration projects proposed for Kansas City and Phoenix would continue to experiment only on seniors who have chosen Medicare+Choice. These projects will lead to benefit reductions and disruptions for the provider community, which explains why in every community coalitions of physicians, hospitals, health plans, employers, and beneficiaries have joined together to raise seniors' concerns about these proposals. This experience provides important lessons for consideration of a premium support model.

V. CONCLUSION

For well over 10 years, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these choices are at risk. Congress and the Administration should

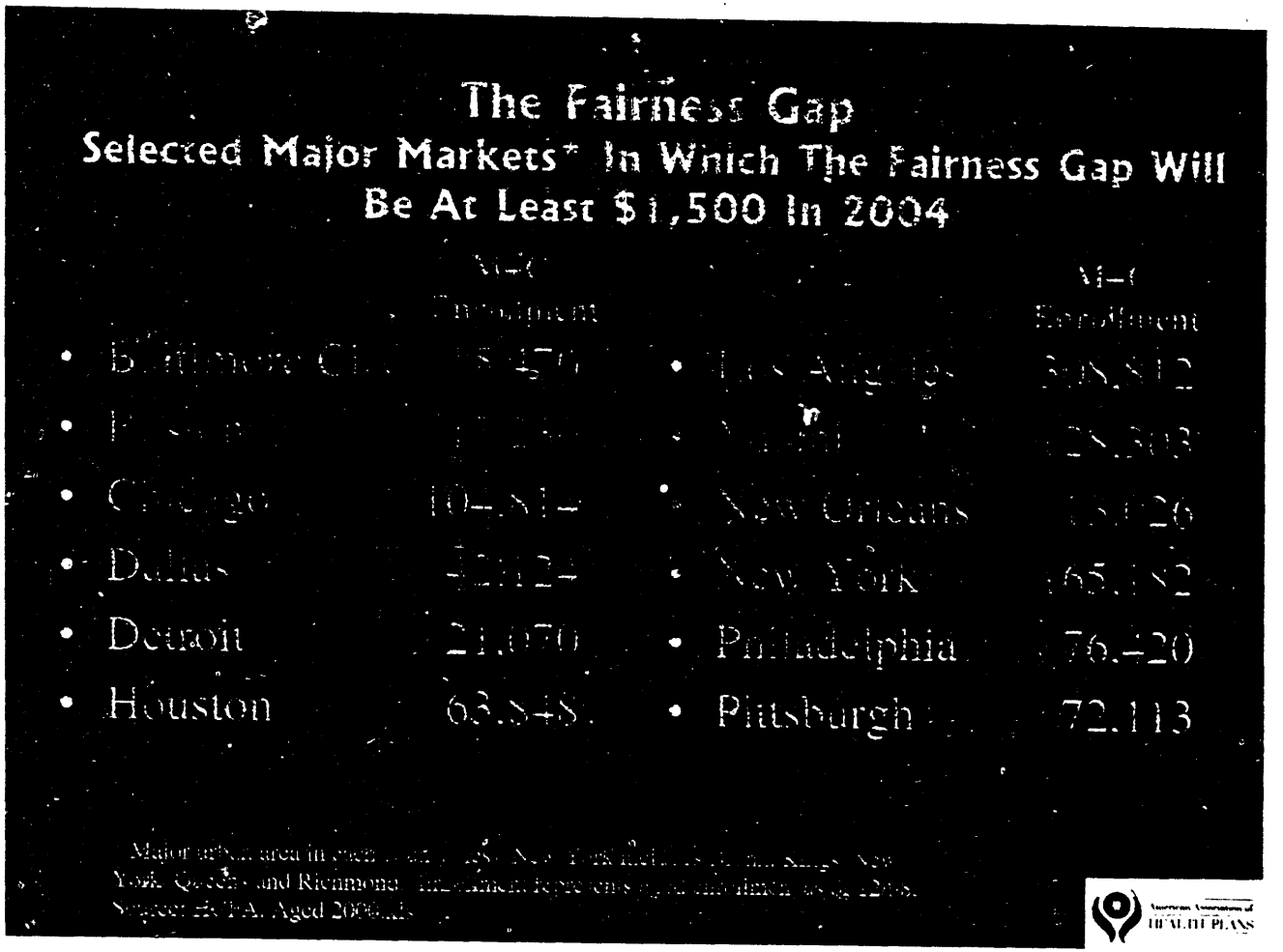
act immediately to create a level playing field between the Medicare+Choice program and fee-for-service, and a regulatory environment that holds Medicare+Choice organizations and providers in the Medicare fee-for-service program equally accountable. We are in the process of conferring with the members of the Committee and your staff about our specific suggestions for solving these problems.

Without action this year, beneficiaries may find access to their health plans jeopardized and beneficiaries may find few choices available to them. In addition, employers and unions who have depended on health plans as a source of comprehensive and affordable retiree health care may find their choices severely limited. Finally, if the Medicare+Choice program erodes it will seriously set back discussions in the Committee, and throughout the Congress to preserve Medicare for future generations.

The Medicare+Choice
Fairness Gap
HEALTH PLANS

The Fairness Gap--Top 100 Counties By Enrollment
Two-Thirds of M+C Enrollees Live In Areas Where The Fairness Gap Will Be $1,000 Or More In 2004
Percent of Enrollees
20
15
10
5
0
12.2%
14%
25.3
5.3%
2.6%
M+C growth more than FFS
M+C growth less than FFS
American Association of HEALTH PLANS

The Fairness Gap --Top 100 Counties By Enrollment
Nearly Half of M+C Enrollees Live In Areas Where The
Fairness Gap Will Be 15 Percent Or More In 2004


The Fairness Gap
Selected Major Markets* In Which The Fairness Gap Will Be At Least $1,500 In 2004
M+C Enrollment
• Baltimore CL 5,457
• P 1,[illegible]
• Chicago 10,[illegible]
• Dallas 12,12[illegible]
• Detroit 21,070
• Houston 63,5[illegible]
M+C Enrollment
• Los Angeles 308,512
• [illegible] 28,303
• New Orleans 13,126
• New York 165,182
• Philadelphia 76,220
• Pittsburgh 72,113
Major urban areas in each [illegible] New York Bronx, Kings, New York, Queens and Richmond [illegible]
Source: HCFA, Aged 2004
America's Health Plans

PREPARED STATEMENT OF CHARLES N. KAHN III

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Charles N. Kahn III, President of the Health Insurance Association of America (HIAA). HIAA is the nation's most influential advocate for the private, free market health care system. HIAA's 269 member companies provide health, long-term care, supplemental, and disability income coverage to more than 115 million Americans.

HIAA places a high priority on preserving a vibrant Medicare program for the baby boom generation and beyond, and I believe we have a unique perspective on the issues under consideration by this committee. Association members include companies currently serving as Medicare+Choice managed care contractors, companies who are considering offering new Medicare+Choice options, and companies that have recently withdrawn from their Medicare+Choice products from a handful of markets. Along with the Blue Cross Blue Shield Association, we also represent the lion's share of carriers providing Medicare Supplemental insurance and Medicare Select coverage to over 12 million Medicare beneficiaries.

In addition, I served from 1995 to 1998 as Majority Staff Director to the House Ways and Means Subcommittee on Health. In that role, I was deeply involved in drafting the Medicare reform provisions of the Balanced Budget Act of 1997, as well as the precursor to those reforms contained in the 1995 Balanced Budget Act.

The Balanced Budget Act of 1997 (BBA) helped put in place the basic building blocks necessary to transform the Medicare program from a passive payer to a more dynamic, market-based health care system. HIAA congratulates Chairman Roth, Ranking Member Moynihan and the rest of the members of this Committee for the role you played in enacting these bold Medicare reforms which have the potential to increase choices and improve Medicare coverage for beneficiaries.

While the BBA provides an important foundation, it alone will not ensure that the program remains solvent for the baby boom generation and beyond. According to the latest report of the Medicare Trustees (released March 30, 1999), the BBA reforms and a healthy economy have pushed the Medicare Part A Trust Fund insolvency date until 2015. This clearly gives Congress sufficient time to thoughtfully consider a series of long-range reform options.

Last fall, I was invited to testify before the Bipartisan Commission on the Future of Medicare. Central among the principles I outlined for the Commission was the need to expand and improve choices for Medicare beneficiaries by fostering true competition among private health plans. The program can be improved for seniors by harnessing for Medicare both the savings and the substantial health benefits consumers have realized in the private sector.

As the past several months have made clear, the success of any long-term structural reform also will depend in large part on the successful implementation of the building blocks put in place through the BBA. Therefore, it is critically important that Congress immediately revisit the Medicare reforms enacted in 1997 to remedy structural problems in the Medicare+Choice program related to the formula for determining private plan payments. Left unattended, this structural flaw will not only thwart Congress' intent to increase beneficiaries' coverage options. It will undermine the foundations of private plan involvement in Medicare upon which Congress must build to carry a viable Medicare program into the next century. Moreover, failure to address these issues in the short-term could seriously undermine beneficiaries' confidence in future reforms.

BACKGROUND

Medicare has been one of the most successful federal programs in our nation's history in terms of ensuring access to health care for millions of seniors who otherwise would be unable to meet staggering health care costs. In terms of its structure and financing, however, the program clearly has not been successful. Total Medicare outlays mushroomed from $14.8 billion in 1975 to over $200 billion this year. And, even after the spending reductions effected by the BBA, Medicare costs are predicted to double over the next decade. These unsustainable costs have led to increased reliance on administered pricing and cost controls that have led to significant market distortions.

Moreover, beginning in 2011, when the first baby boomers reach retirement age, to 2030, when the last reach age 65, the ratio of workers paying into Medicare will fall from 3.6 taxpayers to 2.3 for each retiree. It is this combination of unsustainable cost growth and immutable demographic trends that brings us here today.

If Medicare is to serve succeeding generations, Congress will have to examine three basic approaches:

- Controlling program costs;
- Asking beneficiaries to contribute more; and
- Raising taxes.

Whether adopted alone or in combination, these approaches have different consequences and are not equally viable or effective. Raising taxes will increase revenue, yes, but this in turn would fuel the Medicare program's appetite for spending, thus contributing to further growth. In addition, many of those under 65 who pay taxes to finance Medicare either lack access to health coverage or pay a significant amount each year toward their own coverage.

Increasing beneficiary responsibility through greater out-of-pocket costs would help offset program costs and, if structured properly, could enhance program efficiencies. However, asking seniors to shoulder an increased burden should not be done without ensuring that those with more limited incomes have access to high quality health care. Any reforms that move in this direction would need to be accompanied by well-fortified safety net protections for the poorest elderly.

Controlling program costs has the most potential. To achieve limits to growth in Medicare, government-set price controls (which have been shown to be ineffective) should be eschewed in favor of structural reforms that place a much greater reliance on the private market.

While BBA put in place the basic structure necessary to sustain Medicare for a few more years, more needs to be done. Our primary recommendation, then, is to continue the restructuring process begun by the BBA so as to facilitate the delivery of high-quality health benefits to Medicare beneficiaries through private health plans, while adopting successful private-sector cost containment strategies in the traditional fee-for-service component.

DISCUSSION OF MEDICARE COMMISSION PROPOSALS

The work of the Bipartisan Commission on the Future of Medicare, and the plan developed through the leadership of Statutory Chairman Breaux and Administrative Chairman Thomas, provides a solid outline for achieving the goal of long-term Medicare structural reform. As the members of this Committee have recognized, it is critically important that we begin to more fully consider the impact of the Breaux-Thomas approach and the complicated implementation issues raised by these proposed reforms and perhaps other, competing reform models.

The eight-page reform proposal released by Medicare Commission Chairmen Breaux and Thomas in mid-March does not provide a great deal of detail. What it does is to raise a series of important structural and technical challenges, the resolution of which are key to determining whether or not the "premium support" model will work in the real world. Premium support raises a myriad of technical issues. In my testimony today, I would like to highlight for you just a few of the most salient of those issues. Mr. Chairman, these issues are not insoluble. Yet, they will require time and careful consideration.

Competition and conflict among the Commission's goals

The Breaux-Thomas Medicare reform proposal is designed to address the need for reduced growth in program spending, the desire for additional prescription drug coverage, and to provide premium and cost-sharing subsidies for low-income beneficiaries. Long-run savings reportedly would be achieved primarily through price competition among alternative Medicare plan options and extension of the Medicare eligibility age from 65 to 67. An optional outpatient prescription drug benefit would be available in every Medicare private plan option and through any Medicare Supplement policy. Federal subsidies would be provided to beneficiaries with income up to 135 percent of poverty.

Thus, the Breaux-Thomas proposal attempts to accomplish three goals simultaneously: (1) fundamentally restructuring of the Medicare program; (2) placing the program on sound financial footing for the baby boom generation; and (3) enhancing the core benefits available to beneficiaries by adding outpatient prescription drug benefits.

There is a significant potential for inherent conflict among these three goals. The attempt to enhance benefits may frustrate the achievement of cost-containment and program restructuring.

It is easy to understand why there is a desire to improve Medicare coverage for outpatient prescription drugs. While the majority of seniors have access to some drug coverage, about 35 percent do not. Pharmaceuticals clearly have become one of the most important components of a high-quality health care. They contribute to improving the lives and health of many patients and new research breakthroughs in the coming years are likely to bring even greater improvements.

At the same time, however, the rapid increase in both the price and utilization of outpatient prescription drugs (and projected increase) could make pharmaceutical coverage in particular and health insurance in general less affordable. According to a published report last week, officials from the Office of Management and Budget are encountering considerable difficulty in designing a Medicare outpatient drug benefit. An Administration official was quoted as saying that, while there are a number of drug benefit plans under consideration, "none of them are good." It has been estimated that even modest Medicare prescription drug enhancements would cost the federal government as much as $30 billion annually.

Prescription drug expenditure growth now outpaces other categories of health spending, including hospital and physician costs, and is expected to comprise over nine percent of all personal health expenditures by 2007—almost double what it was in 1980. Moreover, hospital and physician costs have continued to climb despite these increases in drug spending.

The growing costs of drugs are among the reasons that HIAA strongly opposes proposals requiring that either Medicare Supplemental Insurance products or Medicare+Choice plans cover the costs of outpatient prescription drugs. The growing cost of pharmaceuticals would force plans with mandated drug coverage to raise premiums or cost-sharing or reduce other benefits, which would be counterproductive. Mandated drug coverage could lead to greater government restrictions on private plans, such as prohibitions on the use of formularies or mandating certain levels of coinsurance.

Existing Medigap plans without drug benefits already are experiencing significant premium increases and could become unaffordable for many enrollees if they were also required to pay the additional cost of drug coverage. A recent report by HIAA demonstrates that adding pharmaceuticals to Medicare's core benefits could more than double the cost of basic Medigap coverage—putting those policies out of reach for millions of seniors.

There is no question that we need to find ways to improve the coverage of prescription drugs for Medicare beneficiaries. The real issue is where this goal should rank in relation to the other two objectives outlined by the Breaux-Thomas Medicare reform proposal. A recent HIAA poll asked Americans, more broadly, to rank their goals in reforming the nation's health care system. The survey found that 64 percent of the people polled believe that our nation's top health care reform goals should be providing basic health coverage to all Americans (32 percent) and making health care more affordable (32 percent). Providing prescription drug coverage ranked last (8 percent) below making sure people can select the doctor of their choice (16 percent) and maintaining the high quality of American health care (10 percent). Even among seniors, a strong majority believe that providing basic health coverage to all Americans is more important than guaranteeing prescription drug coverage for Medicare beneficiaries.

Regardless of these findings, I believe there are a number of ways that we can strengthen the voluntary coverage of prescription drugs under the Medicare program's current structure. For example, we can ensure that government payments to Medicare+Choice organizations are sufficient.

Achieving real competition by blending original FFS and Private Medicare+Choice program

The second major hurdle in implementing the Breaux-Thomas plan that I would like to discuss today is the role of the Health Care Financing Administration (HCFA) and, more broadly, the capacity of the original fee-for-service program under the proposed reforms.

The premium support model envisions a system of price competition among Medicare health plan options where original fee-for-service Medicare is treated as a plan option, operating on the same terms as private plans. Under this model, HCFA would act as both regulator and competitor.

As the work of the Competitive Pricing Advisory Committee (CPAC) attests, blending the original fee-for-service program into a private competitive model is as essential as it is complex. There was considerable discussion at CPAC about the artificiality of a competitive pricing system applicable only to seniors enrolled in the Medicare+Choice program. All CPAC members agreed that this was problematic; and I voted to delay the implementation of the demonstration in Phoenix, Arizona in part because of this concern. Congress cannot expect private health plans to continue offering more benefits to seniors with a shrinking proportion of program funds, while the fee-for-service program provides fewer benefits with greater resources.

The Breaux-Thomas plan attempts to address these concerns and level the playing field by integrating the original Medicare fee-for-service program into a competi-

tive model. Under Breaux-Thomas, HCFA would be required to become an aggressive purchaser of hospital, physician, laboratory, and other services. The agency would have to negotiate prices for a range of Medicare-covered benefits and services across diverse groups of providers and suppliers, while—in a sense—trying to construct a benefit package that could be offered to seniors within a localized or regionalized per-capita payment limit.

This is a monumental task that goes well beyond the implementation of prospective payment systems (such as those for skilled nursing facilities, hospital outpatient departments, long-term care hospitals, home health agencies, and rehabilitation agencies required by BBA). It is also a system that differs markedly from the current administered pricing structure. If HCFA could not stay within these per capita limits, the additional costs would presumably be passed on to beneficiaries choosing the fee-for-service option. Or, it may be possible that original fee-for-service will not be an option in certain areas of the country where it simply is not possible for the government to successfully complete this complex series of contract negotiations.

While about 15 percent of seniors currently are enrolled in private Medicare+Choice plans, Breaux-Thomas envisions a program where all Medicare beneficiaries would receive benefits through this competitive model. Therefore, the sheer volume of seniors receiving benefits under this model will add to its complexity.

Again, let me stress that the implementation issues raised by this approach are not insurmountable. Yet, the questions raised by blending private health plans and the original fee-for-service Medicare program into a unified premium support model should be very carefully examined by this Committee, and other members of Congress, before they are implemented on a broad scale.

Information dissemination challenges

If the Medicare program is to become a market-based system where all beneficiaries choose among competing health plan options, we also will need to do a much better job of collecting and disseminating meaningful and appropriate information to beneficiaries.

If at least some beneficiaries are required to pay the difference in cost between the coverage they select and the government's contribution (as envisioned by Breaux-Thomas), it is essential that they have access to meaningful health plan comparison information. To make quality measurements meaningful to beneficiaries, health plan data collection and reporting requirements should recognize functional and operational differences across delivery models. In addition, the same level of information about cost and quality should be available to beneficiaries who choose to enroll in the original Medicare fee-for-service plan in their area.

Currently, HCFA is devoting much less effort to providing meaningful information about the cost and quality of fee-for-service coverage (even though the vast majority of beneficiaries will remain in the traditional fee-for-service program for the foreseeable future). The government will have to devote much more effort (and expense) to quality measurement, data collection, and information dissemination to this effort if the premium support model is to be successful.

The need for a better risk adjustment mechanism

The implementation difficulties we are experiencing currently with the Medicare+Choice program are a useful prism through which to view any broader programmatic reforms relying on a competitive private sector model. One of the areas where HIAA's member companies have experienced significant difficulty with BBA is in the payment mechanisms and the risk adjustment methodology implementation. For example, the data collection requirements necessary to implement risk adjustment have been among the barriers preventing PPOs and other open access health plans from participating in Medicare+Choice.

In order to work correctly, the Breaux-Thomas plan would need to rely upon a more sophisticated risk adjustment mechanism than those that currently exist. There will never be a perfect risk adjuster. Yet, a much more accurate model will need to be developed, and tested, before per capita payments can be adjusted on an individualized health status basis to all Medicare beneficiaries nationwide (as envisioned under the premium support model).

After years of research and development, the current Medicare+Choice risk adjustment method proposed by the Administration will not represent a true picture of an individual's health status. Instead, it will rely initially only on inpatient hospital data. This experience suggests that members of Congress should not place significant faith in the short-term on a system dependent on a much more sophisticated risk adjustment method.

SHORING UP THE MEDICARE+CHOICE FOUNDATION BEFORE MOVING FORWARD

HIAA believes that the Medicare program must actively encourage the type of competition on price and quality that has helped stabilize costs and enhance the quality of services in private-sector health care. The Breaux-Thomas proposal would move the program substantially in that direction. Yet, before moving forward, we must first shore up the foundation upon which broader restructuring will be built.

BBA put in place significant changes to the Medicare program. The system will need time to adapt those reforms and, where necessary, to make adjustments. As noted above, beneficiaries must have confidence in the current program in order for long-term structural reforms envisioned by Breaux-Thomas to be successful.

Perhaps the greatest threat to the success of the Medicare+Choice program is the collective impact of changes in Medicare's payment methodology enacted by the BBA. In order to achieve a successful partnership between the federal government and Medicare+Choice organizations, program rules must: (1) allow payment rates that recognize and adjust for the actual costs of providing health care and permit necessary investment in clinical and operational improvements, and (2) incorporate financial incentives to reward those Medicare+Choice organizations that achieve the government's economic, clinical and operational objectives.

In order to achieve deficit reduction, BBA placed strict limits on private health plan payments. While payments in many rural areas did receive a significant one-time increase under the BBA formula, payments in most counties (those where the majority of Medicare managed care enrollees reside) will increase by only 2 percent during the next few years. This is far below the rate of payment increases that will occur in the traditional fee-for-service program during the same period.

The cumulative effect of the payment reductions in BBA will vary depending upon the relationship of the current payment, current benefits, and the number of beneficiaries enrolled. In your state, Chairman Roth, there were 8,800 beneficiaries enrolled in Medicare risk plans. We project that Medicare+Choice plans will receive only 53.6 percent of the increase per capita relative to Medicare fee-for-service increases. We also project an increase in the 65+ population from 96,900 in 1998 to 112,000 in 2003. If Medicare+Choice options are withdrawn or have less perceived value by then, a reduction of Medicare+Choice enrollment to 75 percent of existing numbers would reduce the savings from BBA for 2003 by $3.9 million from Delaware alone. The comparable figure for the state of New York is $253.2 million.

HIAA has calculated the impact of BBA's payment policies, including risk adjustment, for the states of each member of this committee. A calculation of your state's projected payments has been delivered to your office. As examples of these projections, attached to our testimony are the projections for Chairman Roth's state, the State of Delaware, and Senator Moynihan's state, the State of New York.

The future of the Medicare program clearly lies in enhancing the role of private health plans. But for private plans to continue providing quality care, including pharmaceutical benefits not available under the traditional program, Medicare pricing must become more equitable, and spending for private plans and fee-for-service coverage must grow at comparable rates over time.

ENSURING THAT MEDICARE SUPPLEMENTAL INSURANCE REMAINS A VIABLE OPTION

Traditional Medicare fee-for-service is likely to remain an important option for most seniors for the foreseeable future. Therefore, Medigap insurance, which offers valuable protection from Medicare's cost-sharing requirements, must be preserved as an option for our seniors.

Medigap policies allow beneficiaries—who are often on fixed incomes—to easily budget their monthly health care costs, protecting them from high out-of-pocket expenses, particularly when sudden unexpected illnesses strike. Moreover, Medigap coverage is the only protection from high out-of-pocket expenses for those seniors in rural geographic areas or areas whose managed care markets are less fully developed.

Almost 90 percent of Medicare beneficiaries—30 million Americans—who are enrolled in the fee-for-service program enroll in some form of supplemental coverage. Approximately 68 percent of those individuals have private coverage, either through individually-purchased insurance or an employer-provided plan; and 18 percent are covered by Medicaid.

Consumer satisfaction with Medigap products is extremely high. In a recent report entitled, "Medicare Beneficiaries with Additional Medical Insurance in 1997," the Inspector General of the Department of Health and Human Services cited the results of a 1997 survey that found almost a 90 percent satisfaction rate among Medigap consumers.

Therefore, I urge the Committee to be extremely careful in considering any type of reform that would impact on seniors with Medigap coverage. For example, a study released earlier this year by Dr. Gerard Anderson of Johns Hopkins University on behalf of HIAA found that one reform contemplated by the Medicare Commission—prohibiting Medigap insurance from covering Medicare copayments and deductibles—would hurt the oldest, poorest, and sickest Medicare beneficiaries. This type of ban would cause the most vulnerable of Medicare's beneficiaries to pay as much as $10,000 more a year in out-of-pocket costs currently covered by private Medicare supplemental insurance.

OPTIONS TO PRESERVE THE FINANCIAL VIABILITY OF MEDICARE MUST BE CONSIDERED WITHIN THE BROADER FRAMEWORK OF ENSURING ACCESS TO HEALTH COVERAGE FOR ALL AMERICANS

In searching for ways to ensure the long-term survival of the Medicare program, we must remember that our nation does not have unlimited resources. And, while we spend nearly 14 percent of our annual gross domestic product on health care (more than any other industrialized nation), over 43 million Americans do not have access to affordable health coverage. Many of these same Americans contribute payroll taxes to help guarantee health coverage to nearly 40 million Medicare beneficiaries. Therefore, we encourage the Committee to examine options for preserving the program within the broader context of making health coverage more affordable for all Americans. Any proposals involving how much the government and taxpayers should contribute toward the Medicare program during the next century and what level of benefits the government is willing to guarantee to its seniors, should be carefully balanced against the cost and quality of coverage for the nation overall.

The HIAA Board of Directors has just endorsed a major proposal for attacking the country's growing problem of uninsured Americans. I look forward to discussing our proposal with the Finance Committee and other congressional bodies in the near future.

CONCLUSION

Despite the historic changes to the Medicare program resulting from passage of BBA, the nation faces the daunting task of ensuring that Medicare remains financially viable for those seniors who will rely upon it in the next century. Provided that Medicare+Choice payment inequities are soon remedied, BBA put in place the basic building blocks necessary to achieve this goal. But difficult trade-offs must be made if the program is to survive. To accomplish this goal without dramatically scaling back benefits or increasing costs, Medicare must be further restructured to harness the innovation and energy of the private market. This will present significant implementation challenges. And, short-term adjustments to the reforms just passed in BBA will need to be considered first. HIAA stands ready to work with this Committee to ensure that the promise of Medicare remains for another generation.

PREPARED STATEMENT OF DAVID B. KENDALL

SUMMARY

The challenge before Congress is to build a consensus for improving the health care benefits of older and disabled Americans while reducing Medicare's overall spending growth: The key problems are:

- Many Medicare beneficiaries do not have adequate coverage for prescription drugs.
- Early in the next century, the rising cost of Medicare (as well as Social Security and Medicaid) will drain away funding for education, research, roads, and other pubic responsibilities.
- Past efforts to change Medicare have become politically volatile.

The proposal of Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA) is designed to change the political calculus of Medicare with three key principles:

- Older and disabled Americans should have the opportunity to obtain modern health care benefits now and in the future.
- Medicare beneficiaries should have the responsibility to choose the coverage that best suits them.

- As Medicare beneficiaries assume more responsibility for themselves, the federal government should step-up Medicare's commitment to help those who cannot help themselves.

The following design features of the Breaux-Thomas proposal would help ensure a successful implementation:

- People would have the final say over the use of Medicare funds in their community, not providers and government officials.
- The role of government as a referee in the marketplace would be separated from its role as a player.
- Budgetary accountability would be achieved by setting a solvency standard for all of Medicare spending, not just for the hospital trust fund.

Mr. Chairman, thank you for holding these important hearings on Medicare reform. The task of modernizing Medicare presents a political challenge that is large and complex. The Progressive Policy Institute believes that the proposal of Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA), developed from the Bipartisan Commission on the Future of Medicare, answers this challenge. It contains the key principles that can forge a consensus of enactment of reform and the design features necessary for a successful implementation.

THE CHALLENGE OF MODERNIZING MEDICARE

The challenge before Congress is to build a consensus for improving the health care benefits of older and disabled Americans while reducing Medicare's overall spending growth. Here are the major problems:

- Many Medicare beneficiaries do not have adequate coverage for prescription drugs. While Medicare covers drugs used in hospitals, one-third of older Americans have no insurance coverage for outpatient drugs. Another five to ten percent have only limited financial protection because they are enrolled in private, Medicare supplemental (also called Medigap) policies that have an annual limit on drug coverage.
- Early in the next century, rising spending on Medicare (as well as Social Security and Medicaid) will drain away funding for education, research, roads, defense and other public responsibilities. Without reform, Medicare spending will triple from 2.4 percent to 7.1 percent of gross domestic product and will exceed even Social Security spending by 2030 due to both the aging of the population and unchecked medical inflation.
- Past efforts to change Medicare have become politically volatile. The Medicare Catastrophic Coverage Act of 1987 that contained a prescription drug benefit was repealed. The attempts to limit Medicare spending by Democrats as part of a national health care budget during the 1994 health care reform debate and by Republicans with a fixed contribution to each beneficiary's health coverage in the Balanced Budget Act of 1995 were both dramatic failures.

A BREAKTHROUGH: THE BREAUX-THOMAS PROPOSAL

The proposal of Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA), developed from the Bipartisan Commission on the Future of Medicare, offers a road map for addressing Medicare's major problems. It won support from eight Republicans and two Democratic members of the 17-member commission. While it fell one vote short of the super majority needed to make a formal recommendation, it did receive additional partial support from two other Democratic members appointed by President Clinton.

The Breaux-Thomas proposal is based on the ideas of opportunity, responsibility, and community that new progressives both here in the U.S. and abroad are using to create a third way in politics. The third way philosophy rejects both the political left's reflexive defense of government bureaucracy and the right's destructive bid to simply dismantle it. The third way seeks to replace centralized bureaucracy with public institutions that enable people to solve their own problems.

The Breaux-Thomas proposal would establish a consumer-drive health care system in Medicare modeled after the Federal Employees Health Benefits Program (FEHBP).[1] FEHBP covers nine million workers, retirees and their dependents—as well as members of Congress and their staff—and provides a choice of health plans that compete on price, benefits, service, and quality.

FEHBP guarantees a minimum contribution to the premium costs for health care coverage of every worker and retiree based on the average prices off the major

[1] For a complete description of the Breaux-Thomas proposal, see Jeff Lemieux, testimony before the U.S. House of Representatives, Committee on Government Reform and Oversight, Subcommittee on Civil Service, May 22, 1999, available at www.dlcppi.org.

health plans, a system also known as premium support.[2] With this opportunity comes the responsibility for federal workers and retirees to choose a health plan based on their own needs, preferences, and personal budget. In addition, the Office of Personnel Management (OPM) acts on behalf of the community of workers to oversee the competition and to prevent health plans from cherry-picking healthy, less expensive enrollees.

The Breaux-Thomas proposal applies the principles of opportunity, responsibility, and community as follows:

Older and disabled Americans should have the opportunity to obtain modern health care benefits now and in the future

Medicare benefits are frozen in time because they require an act of Congress to change. While some improvements have been made since Medicare's enactment in 1965, the benefit package remains an artifact of a bygone era when insurance companies—one for hospital coverage like Medicare Part A and another for doctor coverage like Part B—acted only as bill payers for the care of the sick and injured. Nostalgia for this old and simple system may make the lack of change seem advantageous, but consider some widely-used benefits not yet adopted by Medicare: outpatient prescription drug coverage, consumer outreach programs to encourage the use of preventive care services (e.g., postcards), and disease management that integrates care for patients with a wide variety of needs.

The Breaux-Thomas proposal would modernize Medicare benefits both now and in the future by updating current benefits and encouraging innovation. All beneficiaries with incomes up to 135 percent of poverty would be guaranteed comprehensive drug coverage. Coverage for everyone else would be more broadly available as a result of new requirements that all health plans, including the traditional fee-for-service system and Medigap plans, offer optional drug coverage.

To encourage innovation, the Breaux-Thomas proposal would strengthen the incentive for beneficiaries to seek more value for every Medicare dollar in their health plan choice. Every beneficiary would be entitled to premium support worth 88 percent of the average premium of health plans competing to offer Medicare's defined benefits. This contribution is the combination of Medicare's current payments for Parts A and B, which today are 100 percent and 75 percent respectively. Beneficiaries who choose a plan with an innovative cost-saving feature would pay less than the average. Similarly, beneficiaries might choose to pay more for an innovative plan that improved health care outcomes for its members without necessarily saving money.

Under Breaux-Thomas, all health plans would have an incentive to innovate in order to stay ahead of their competition. Indeed, that is how most private health plans today have evolved to cover prescription drugs. Drugs and related products for conditions such as asthma, diabetes, and heart disease can reduce costs and improve health by preventing the need for hospital stays and trips to the doctor. A premium supports system would allow payments for such innovation to become commonplace.

Politically, the combination of a guarantee for existing Medicare benefits and an incentive for innovation distinguish Breaux-Thomas from the 1995 GOP effort to set a defined contribution for Medicare. While that proposal would also have encouraged innovation through competition, it would have let existing benefits erode if premium increases went up faster than the dollar amount set in law for Medicare's contribution to beneficiaries' coverage. Interestingly, it would have also prevented the contribution from justifiably going down if prices fell generally.

Medicare beneficiaries should have the responsibility to choose the coverage that best suits them

The key decisions about prices in Medicare are made today by legislative and regulatory fiat. These decisions often appear benign, but sometimes they have a dramatic consequence including last year's action by private health plans to drop 450,000 beneficiaries. Moreover, government control over the prices paid to providers and plans turns routine decisions about the way to provide high quality health care least expensive into highly-charged political battles involving small armies of lobbyists, lawyers, and public-relation firms.

Into the Breaux-Thomas alternative, competition would to set prices in Medicare just as in FEHBP. Federal workers have the responsibility to choose their own coverage based on their health care needs, preferences, and budget. Their choices in aggregate determine how much the government spends on their coverage. In Medi-

[2] Henry J. Aaron and Robert D. Reischauer, The Medicare Reform Debate: What is the Next Step? "Health Affairs," Winter 1995.

care, beneficiaries would be able to choose an average priced plan and pay nothing more than they would otherwise pay for the Part B premium. They could also pay more or less depending on their choice of a plan.

While it may sound counterintuitive, high quality care need not cost more. The world-famous Mayo Clinic in Rochester, Minnesota, practices medicine cost-effectively by following the precept, "do it right the first time." The cost of patient care in Rochester, which is served almost exclusively by the Mayo Clinic, has been tracked at 22 percent below the national average.

Higher costs in health care are frequently caused by the lack of information about prices and quality. The complex task of setting standards for the disclosure of information to enable consumers to make valid comparisons between plans is a key role for government. Of course, not everyone is a careful shopper. In fact, only a small fraction of people are informed consumers in any given market. But their influence multiplies as others follow their lead.

For Medicare beneficiaries, the reward of assuming more responsibility will likely be lower prices and higher quality care. Under the Breaux-Thomas proposal, the average Medicare beneficiary will not pay more than 12 percent of the total premium amount in contrast to current Medicare law in which the beneficiaries' contribution is projected to rise to nearly 14 percent.

Unlike the 1987 Medicare Catastrophic Act in which many beneficiaries were forced to pay more for benefits including some they already had, the Breaux-Thomas proposal allows beneficiaries themselves to choose how much they want to spend and only if they believe the extra amount is justified. By letting seniors have more control of their health care destiny, the Breaux-Thomas proposal is unlikely to produce the same backlash.

As Medicare beneficiaries assume more responsibility for themselves, the federal government should step-up Medicare's commitment to help those who cannot help themselves

The Breaux-Thomas proposal would strengthen Medicare's ability to help those who cannot help themselves in two ways: a strong Medicare board to ensure fair and effective competition and additional financing for lower-income beneficiaries. To these provisions, PPI recommends a third: voluntary purchasing groups to give beneficiaries more clout.

One of the Medicare board's key tasks would be to prevent plans from cherry-picking healthier, less costly beneficiaries, which could leave other health plans with higher premiums simply because they had sicker enrollees and not because they were less efficient. The board would have the power to renegotiate a plan's benefits package if, for instance, it offered health spa memberships to attract health-conscious seniors. They could also adjust the payments to health plans based on the riskiness of their enrollee's need for health care.

To give lower income beneficiaries more economic assistance, the Breaux-Thomas proposal would not only provide drug coverage for seniors up to 135 percent of poverty, but also provide additional support through Medicaid to cover other out-of-pocket costs such as the beneficiaries' portion of the premium support. One very effective use of this subsidy would be to compress the price difference between health plans for lower-income beneficiaries so they could have access to the most expensive plan at a price that reflected their means.

Finally, the federal government should catalyze the creation of voluntary purchasing groups or Medicare Consumer Coalitions (MCCs), a term coined by the National Council on Aging.[3] MCCs would give Medicare beneficiaries the purchasing clout that large employers use to demand lower prices and higher quality. They would help consumers to understand their rights and choices, to interpret data and information on quality and benefits, and to make their own decisions about their health plan choices. They would also advocate for the special needs of beneficiaries to regulators, legislators and service organizations and help handle consumer complaints with health plans.

SUCCESSFULLY IMPLEMENTING THE BREAUX-THOMAS PROPOSAL

As with any major policy change, the implementation strategy is as important as the political strategy that leads to enactment. Unless the purpose and benefits of reform are broadly understood and accepted, implementation will likely fail. The Breaux-Thomas proposal has three features that will make a successful implemention more likely:

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[3] Jim Firman et al, National Guard on the Aging, "Medicare Consumer Purchasing Coalitions: A Catalyst for the Market-Based Reform of Medicare." Report to the Bipartisan Commission on the Future of Medicare, December, 1998.

People would have the final say over the use of Medicare funds in their community, not providers and government officials

Medicare beneficiaries should have the power to vote with their feet in directing the size and direction of the health care system. The Breaux-Thomas proposal would enable local market conditions to set the prices and quality expectations. It would also enhance the participation of national plans, which can in fact have provider networks that are more readily adaptable to local markets. These plans, however, would thrive only if they met local demands.

A key example are subsidies for rural health care, of which nearly all go to hospitals and health professionals. These subsidies create a convoluted process whereby rural providers must go to Washington to lobby for arcane funding formulas that redirect money back home. A more direct way is for a large portion of these funds to be controlled by individuals in rural communities who could exercise their own choices to drive resources where they are needed more effectively than decision-makers in Washington.

The Breaux-Thomas proposal blazes a new path in rural health care by providing subsidies to those areas of the country where no competition exists. Specifically, by guaranteeing that beneficiaries would not have to pay more than the national average for their share of the premium, it takes an important step toward redirecting Medicare funds to beneficiaries themselves in order to offset the higher cost of providing high quality care in rural areas.

The role of government as a referee in the marketplace would be separated from its role as a player

Today, the Health Care Financing Administration, which runs Medicare (and Medicaid) is both a referee for all the health plans participating in Medicare as well as a player administering the traditional, fee-for-service plan. The Breaux-Thomas proposal would end this conflict of interest by creating a separate Medicare board with oversight responsibility for the whole program. HCFA would then be free to focus on creating a more competitive government-sponsored plan.

Breaux-Thomas also would end much of the micromanagement that Congress has imposed on HCFA. This new flexibility would be critical for its ability to compete and should lead to the authority for HCFA to set premium levels, benefits package, and provider reimbursements just like any private plan.

This reform, more than any other, will require a significant cultural shift by members of Congress who are used to taking a hands-on approach to Medicare. The key to success is twofold: a strong Medicare board that can earn the respect of Congress just as the Federal Reserve has done with monetary policy and the ability for consumers to hold HCFA accountable for its overall performance in terms of price, quality and access just as they would any private plan.

Budgetary discipline would be achieved by setting a solvency standard for all of Medicare spending, not just for the hospital trust fund

With the publicity surrounding the impending insolvency of the Medicare Part A trust fund, elected leaders in both parties have conspired to minimize the appearance of a problem in two ways. In the Balanced Budget Act of 1997, Congress simply shifted the cost of home health care from Part A to Part B, which added about seven years to the life of the trust fund. This year, President Clinton has proposed depositing a portion of the surplus into the trust fund. As important as that strategy is to recognize the potential need for additional revenues to preserve Medicare and to prevent the surplus from being used for tax cuts at the expense of debt reduction, such budget maneuvers undermine the political discipline established by a trust fund that has predetermined the source of financing (the hospital insurance payroll tax) and spending (hospital care).

Breaux-Thomas would rightly create a new standard for solvency that prevents budgetary game playing. It would define Medicare to be solvent as long as the portion of Medicare funding coming from general revenues—currently 37 percent—is no more than 40 percent. This standard would trigger a debate if the financing begins to consume larger amounts of general revenue and threatens funds for other public responsibilities.

CONCLUSION

Forging a consensus on Medicare reform will not be easy because any meaningful changes will be controversial. The Breaux-Thomas proposal is no different. But its strategy to make seniors a key part of the solution should have broad appeal especially with the "can-do" World War II generation and self-empowered baby boomers.

Time is needed, but so is leadership. Whether the 106th Congress enacts the entire Breaux-Thomas proposal or takes steps toward it is less important than sending

a clear signal that it intends to set a new course for Medicare. That is what the Senate Committee on Finance Committee can do this year.

PREPARED STATEMENT OF NELL LEHNHARD

Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. BCBSA represents 52 independent Blue Cross and Blue Shield Plans throughout the nation that together provide health coverage to 71.4 million Americans. I appreciate the opportunity to testify on some of the key issues in Medicare reform.

Blue Cross and Blue Shield (BCBS) Plans have a unique point of view because they are a major presence in all aspects of the Medicare program. Collectively, BCBS Plans provide Medicare HMO coverage to more than one million Medicare beneficiaries, making them the second largest Medicare+Choice (M+C) provider in the country. On the fee-for-service side of Medicare, BCBS Plans process 90 percent of Medicare Part A claims and about 57 percent of all Part B claims. Finally, BCBS Plans are a trusted source of Medigap and Medicare Select coverage, which provide supplemental coverage of Medicare fee-for-service benefits.

BCBSA supports Medicare reforms that will assure that the program remains financially stable and secure so that it can successfully serve both current and future beneficiaries. As the Finance Committee debates the future direction of the Medicare program, I would urge that you consider these key points:

- **First, any reform should harness the power of the private sector to bring Medicare beneficiaries the types of choices and innovations that working-age Americans now enjoy.** Accomplishing this will demand a fundamental change in how the government partners with private health plans.

- **Second, Congress should view the Medicare+Choice program as the foundation of any broader private sector based reform.** Congress should assure a strong working relationship between the government and the private sector by making Medicare+Choice payments more reasonable and predictable, and by reducing excessive regulatory mandates.

- **Third, because a substantial number of beneficiaries are likely to stay in fee-for-service Medicare for the foreseeable future, it is vital that Congress maintain the viability of Medigap and assure the proper administration of the Medicare fee-for-service program.**

- **Finally, Congress should look to and learn from the experience of the private sector in efforts to develop a prescription drug benefit for Medicare beneficiaries.**

I. HARNESS THE POWER OF THE PRIVATE SECTOR

Over the last two decades, a wave of innovation and vitality has swept through much of the private health care industry. Today, the market offers more choices of products and benefits than ever before. Medicare+Choice, created in 1997, was meant to infuse the Medicare program with this innovation and vitality. Unfortunately, this has not happened. Because of unnecessarily complex federal regulations, a high level of business risk, and unpredictable and inadequate payment rates, the private sector has not played as great an expanded role as the Congress envisioned when it created Medicare+Choice.

We believe the success of Medicare reform will depend on a fundamental change in the government's relationship with the private sector:

- The government must act more like a private sector purchaser and partner with plans;
- The government must provide for reasonable and predictable payments; and
- The government must assure that any reform will be fair and workable.

Model Behavior After the Private Sector

Since Congress enacted Medicare+Choice, the Health Care Financing Administration (HCFA) has issued hundreds upon hundreds of pages of regulations and literally thousands of detailed conditions, including the 800+ page "mega-reg," 98 operational policy letters, and the Quality Improvement System for Managed Care (QISMC). HCFA's massive

regulations – unheard of in the private sector – set out detailed requirements for virtually all aspects of a health plan's operations. Given the tremendous changes still to come in health care, in medicine, technology, pharmacy, electronics, and organization, the government must abandon this highly regulatory approach and act more like a private sector purchaser, partnering not micromanaging.

Private sector purchasers treat health plans as their business partners and establish clear performance expectations and payments in advance. They do not, however, become involved in every aspect of a health plan's operations. They focus on broader, critical goals such as the price they pay, the satisfaction of their employees, and the quality of service.

Let me provide you with two examples of requirements that would never be imposed by private purchasers:

- **Excessive business risks:** The Medicare+Choice program requires that health plans agree to an exceptionally high level of compliance with numerous, complex and detailed rules. The risk of unintentionally failing to comply with a particular requirement is immense. For example, health plans are asked to certify that all the data they submit, including data developed by providers, are 100 percent accurate. Penalties for non-compliance are extremely severe. These penalties could ultimately put a plan's entire corporation, including its private business, at risk and expose senior officials to the possibility of criminal penalties. This is clearly unreasonable, especially when one realizes that no claims operation is set to achieve a 100 percent accuracy rate.

- **Rigid and unreasonable "one-size-fits-all" quality standards:** In recent years, private sector purchasers have worked closely with health plans and private accrediting organizations to develop workable models for quality measures for HMOs. Instead of using these private standards, HCFA has developed their own quality standards for Medicare+Choice plans that are far more stringent, arbitrary and rigid than the "gold

standard" used in the private sector for HMOs. Moreover, HCFA unilaterally applied these HMO standards to PPOs, a very different type of health plan option, making it extremely difficult for PPOs to participate in Medicare+Choice. To date, the program offers virtually no PPO options.

Provide Reasonable and Predictable Payment Rates

Transforming the government's regulatory mindset is essential for long-term Medicare reform. But it must be be accompanied by appropriate payment rates to ensure private sector interest in Medicare. Payments to private plans should keep pace with changes in spending in the government-run fee-for-service program. If payments to private health plans fall significantly below per person spending in the Medicare fee-for-service program – as is currently projected under Medicare+Choice – plans will have difficulty attracting sufficient numbers and types of providers to their networks and in providing the Medicare benefit package.

While adequate payments to health plans are critical, stability and predictability in future year payments are just as important. Blue Cross and Blue Shield Plans are committed to a "retention strategy." In other words, our Plans place a high priority on **both** attracting new beneficiaries and keeping current beneficiaries satisfied over the long term. One of the most important ways of retaining members is to avoid large increases in premiums and instability in benefits. Significant increases in premiums can trigger "shopping" by individuals who will look for a better price. The way to avoid the disruption of this "churning" is to assure that payments do not fluctuate significantly from one year to the next.

A key element of predictability is having sufficient information in order to price premiums properly. This means that all the requirements for a given year must be spelled out in advance. It is especially problematic when the government demands big "change orders" in the middle of the year, increasing the expenses of the plan, without providing a corresponding increase in payment levels. Such actions will invariably require plans to

adjust their premiums in future years simply to catch up with the government's actions in the previous year. This is a recipe for market instability.

Assure Fair and Workable Reforms

If Medicare reform is to engender widespread private sector participation, it must assure that all players are treated fairly, the reforms are workable, and that the steps to full implementation are well designed and practical.

Today's most discussed model for reform is Senator Breaux's and Congressman Thomas' "premium-support" proposal. Fashioned, in part, after the Federal Employees Health Benefits Program, and building on the current Medicare+Choice structure, the premium-support proposal would replace the government-set formula payments now used to pay private plans with a new competitive pricing model. It would also include the traditional fee-for-service (FFS) Medicare program in the competitive pricing formula. Private plans and the government-run FFS plan would submit annual bids for the basic Medicare package. The government would contribute a set percentage of the national weighted average of all plans' bids (adjusted for geography, demographics and health status); beneficiaries would be responsible for the remaining premiums. A brand-new "Medicare Board" would oversee this process, and possibly negotiate premiums.

While the details of this proposal are now being developed, many design issues, such as the following, should be resolved to assure the success of the program:

- How can adverse selection be minimized? The premium-support proposal envisions a nationally priced government-run fee-for-service program competing against locally or regionally priced private plans (e.g., PPOs and HMOs). Private plans will have an incentive to compete in low cost areas, where they can offer lower premiums than the nationally priced fee-for-service plan. This is likely to increase the cost of the Medicare program. Alternatively, if the government fee-for-service program is locally priced, consistent with private plans, equity and political issues are raised. For

example, beneficiaries could pay twice as much for the fee-for-service program in high cost areas as in low cost areas. (For example, in 1996, Medicare fee-for-service per beneficiary costs ranged from $3,199 in rural Nebraska to $6,592 in urban Louisiana).

- How will plan bids compare to the government contribution? The proposal calls for the government contribution to be a percentage of the weighted average of all bids across the country. Actual payments to plans will be the government contribution, adjusted by a new geographic index.

- How will the new government contribution rates compare to current Medicare+Choice payments? This will be especially significant in the first year of the program, where major changes in the government contribution and, therefore, premiums to beneficiaries could cause upheaval in the marketplace.

- Can the Medicare Board handle a nationwide annual competition, all at once?

- Can the Social Security Administration, which currently handles collection of the Medicare Part B premiums, handle deducting the new premiums (that will replace the Part B premium and will vary by beneficiary) from Social Security checks and send the appropriate share to plans? (A portion of these premiums will have to be deposited in the Medicare trust fund and the balance will have to be mailed to private plans.)

- What would happen if plans' bids significantly exceed projected Medicare estimates?

- What happens if Medicare fee-for-service outlays in a given year significantly exceed the government's bid? Would beneficiaries have to pay more? How would this effect private plan payments?

Given Medicare's complexity and importance to its beneficiaries, as well as the health care system overall, the reforms should be designed carefully so that all stakeholders – beneficiaries, private plans, and providers – understand the new program and that

unintended consequences are avoided. This calls for a detailed, multi-year transition plan. Congress may want to consider phasing in the program, such as on a geographic basis or with newly eligible beneficiaries.

II. STRENGTHEN MEDICARE+CHOICE AS THE FOUNDATION FOR MEDICARE REFORM

Medicare+Choice is and must continue to be the foundation of any future Medicare reform. Medicare+Choice was designed to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options" (H.R. Conf. Rep. No. 105-217, p. 585). Unfortunately, for reasons alluded to earlier in my testimony, Medicare+Choice has fallen short of expectations. If Medicare+Choice is to serve as a stepping stone to future reform, then it is vital that Congress garner the private sector's confidence in the program.

HCFA's highly regulatory approach has not inspired confidence. Nor have current trends in payment levels for Medicare+Choice plans. As you know, in the first two years of Medicare+Choice all health plans (except for those serving "floor" counties) were capped at annual payment increases of 2 percent. A substantial number of plans (enrolling more than one-third of beneficiaries) will stay at 2 percent next year and into the foreseeable future. By 2004 this trend will open up a yawning gap, with these Medicare+Choice plans receiving less than 75 percent of the amounts spent per person in traditional fee-for-service Medicare.

Risk Adjustment

Compounding the trend in payment levels is the uncertainty introduced by HCFA's new risk adjustment methodology, scheduled to begin in 2000. In many areas, the risk adjuster could lead to severe reductions in plan payments that will result in higher premiums and reduced benefits for beneficiaries. HCFA estimates that risk adjusters will reduce payments to M+C plans by 7 percent, or $11 billion between 2000 and 2004, and by an

additional 7.5 percent from 2005 through 2009. The Congressional Budget Office has said this cumulative reduction is not sustainable for the program.

A major success of managed care has been reducing hospital costs through prevention and expansion of outpatient treatments. Yet HCFA's new risk adjustment method will penalize plans that keep people out of the hospital because it only gives "credit" for members with selected inpatient hospital stays of two or more days (i.e., the method pays plans higher amounts only for patients who have been hospitalized). It defies good medical and business planning: according to the American Academy of Actuaries, "A plan which manages care [and keeps beneficiaries out of the hospital] may be paid less than a plan which does not manage care for exactly the same type of patient."

HCFA does plan eventually to incorporate selected outpatient data, but it will be several years before this happens and the exact effects cannot be predicted. Even over the next couple of year, plans face the prospect of wide and unpredictable swings in payment because HCFA will phase in the hospital-based risk adjuster (i.e., 10 percent in 2000, 30 percent in 2001, etc.) and the switch to yet another methodology in 2004. As I mentioned earlier, significant changes in premiums will undermine efforts by plans to attract new beneficiaries and keep them satisfied over the long term.

We urge Congress to delay enactment of the risk adjuster. This step is essential to the viability of the Medicare+Choice program; it will give HCFA and industry time to develop a risk adjuster with the right incentives and time to test a new system and avoid the serious data and systems problems currently plaguing plans.

III. MAINTAIN THE VIABILITY OF MEDIGAP AND MEDICARE ADMINISTRATION

As the Congress decides to reform Medicare, it is highly likely that many beneficiaries will continue to receive coverage through Medicare's traditional, fee-for-service program, at least for the foreseeable future. That makes it important that beneficiaries continue to have

access to affordable Medigap policies, and that the administration of the fee-for-service program receives adequate support.

Medigap

As Congress debates Medicare reform, it will be important not to undermine the existing Medicare supplemental programs that serve 12 million seniors. Medigap plans offer Medicare beneficiaries valuable protection from Medicare's cost-sharing requirements, and they are very popular in the marketplace. A July 1998 report from the Department of Health and Human Services Inspector General found that 88 percent of beneficiaries are satisfied with their Medigap coverage.

One serious risk to the affordability of Medigap is the possibility of a federal mandate for all Medigap options to cover drugs. Tampering with Medigap, such as expanding guarantee issue, community rating, and prescription coverage would have the unintended consequence of significantly increasing Medigap premiums. Of the 10 current standardized Medigap packages, only three include prescription drug coverage (H, I, and J). A study recently released by BCBSA and the Health Insurance Association of America found that mandated drug coverage could increase all Medigap premiums by $1,000 or more a year. Such increases would force many Medicare beneficiaries to drop coverage, thus leaving them to bear the full cost of copays and deductibles. As you consider reforming Medicare, I would urge that you keep Medigap affordable.

Proper Administration of Medicare

Inadequate administration of fee-for-service Medicare could wreak havoc with overall reform plans. Fee-for-service Medicare will always need to pay claims timely and accurately, provide high quality customer service to providers and beneficiaries, handle numerous appeals and hearings, and fight fraud, waste, and abuse. But the contractors who

administer these activities must receive adequate financial support because they can perform required functions only when their payments for such tasks are adequate.

It takes experienced, efficient, and properly funded contractors to limit improper Medicare payments. With adequate funding, contractors can act effectively as Medicare's first line of defense against fraud and abuse. Indeed this year's Inspector General's report shows that recent strides in rooting out fraud, waste, and abuse have brought about a drastic reduction in improper Medicare payments.

In 1996, Congress strengthened contractors' ability to fight fraud and abuse by establishing a separate funding source for specific fraud and abuse initiatives through the Medicare Integrity Program (MIP). Claims processing activities continue to be funded in the program management account.

Unfortunately, HCFA is proposing to break up program management activities and fraud and abuse among different organizations. We believe this will undercut fraud and abuse detection efforts. Program management and fraud and abuse are not autonomous services; they require constant coordination and communication. Nearly all program management activities – including educating providers on how to bill correctly, determining appropriate payment amounts, and detecting duplicate claims – safeguard the Medicare trust funds and are closely integrated with fraud and abuse activities.

IV. PROCEED WITH CAUTION ON DRUG COVERAGE

The final topic I would like to address is adding a prescription drug benefit under the Medicare program, whether constructed as a government-financed program or as a mandatory offering by Medicare+Choice and Medigap plans. BCBSA shares the Congress's concern that beneficiaries have access to affordable drug coverage. We recognize that since Medicare's inception, prescription drugs have assumed an increasingly important role in improving and maintaining the quality of health care. However, we

would urge Congress to proceed with caution in developing any drug benefit because drug costs are the fastest-growing segment of health care.

High Costs

Private sector experience suggests that a Medicare drug benefit would be costly:

- Private insurance payments for drugs increased 18 percent per year over the past 3 years; overall annual growth rate in private insurance payments was less than 4 percent.

- For many health plans, prescription drugs now account for 11 percent to 14 percent of total medical expenses, up from 7 percent a few years ago.

- One Northeastern BCBS Plan experienced an increase in its prescription drug spending from just over 10 percent of premium in 1996 to more than 16 percent last year. This Plan now spends more on prescription drugs than it does on primary medical care. A Midwestern Plan spent more last year on prescription drugs than on either inpatient hospital or physician spending: 25 percent of premium versus 24 percent each for inpatient hospital and physicians.

Given the potentially high costs, any Medicare drug proposal would have to include incentives for appropriate drug utilization as well as cost management provisions. In fact, many health plans and employers have responded to double-digit increases in drug costs by redesigning their prescription drug benefits. Many health insurers are now assessing the usefulness and cost-effectiveness of prescription drugs and developing lists of drugs that they will cover (i.e., formularies). In instances where the only difference in a particular therapeutic category is that one drug costs less than the other, it makes sense for plans to free up money by covering the less expensive drug. In other instances, where studies prove that one drug is more effective than another, plans will promote those drugs even though they may be more expensive than the other drugs in the therapeutic category.

Plans are also introducing innovative three-tier benefit systems to address cost concerns, as well as consumer demands for flexible coverage. These new systems provide varying levels of coverage for generic drugs (e.g., a $5 copay), for brand-name formulary drugs (e.g., a $15 copay), and for drugs that are not on the formulary (e.g., a $30 copay).

Even with these cost-containment tools, prescription drug costs continue to rise in the private sector. Congress must confront the challenge of managing costs and an adequate benefit design if it moves toward a Medicare drug benefit.

CONCLUSION

In conclusion, reforming Medicare poses monumental challenges. First and foremost, Congress must stabilize the Medicare+Choice program. If a future Medicare program is to harness fully the power of the private sector, Congress should act now to make the Medicare+Choice program a true partnership with the private sector: this includes providing stable and predictable payment rates and sensible regulatory rules. Expanded participation by the private sector will also raise beneficiaries' confidence in the Medicare+Choice program, which is important for the program to withstand the stresses of change. In addition, Congress should support both existing Medicare supplemental programs and the contractors who administer the traditional fee-for-service program.

We look forward to working with this Committee as you craft a stronger Medicare program for the 21st century.

PREPARED STATEMENT OF MARILYN MOON

The aging of the U.S. population will generate many challenges in the years ahead, but none of them more dramatic than the costs of providing health care services for older Americans. Largely because of advances in medicine and technology, spending on both the old and the young has grown at a rate faster than spending on other goods and services. Combining a population that will increasingly be over the age of 65 with health care costs that will likely continue to rise over time is certain to mean an increasing share of national resources devoted to this group. How will the burden of that expense be shared and what role will Medicare play in meeting these needs?

Projections from the 1999 Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) from both parts of the program will reach 4.43 percent in 2025, up from 2.53 percent in 1998. This projection is lower than just a few years ago, however. For example, the estimates of the date of exhaustion of the Part A Trust fund have been pushed out to 2015. While this new date of exhaustion reduces some of the perceived urgency in addressing the issue, it is important not to underestimate the need for addressing reforms and financing issues for Medicare. This reprieve in the deadline for action offers an opportunity to engage in a careful discussion of the issues surrounding Medicare that extends beyond the budgetary focus that has thus far dominated much of the debate.

The focus on structural reforms

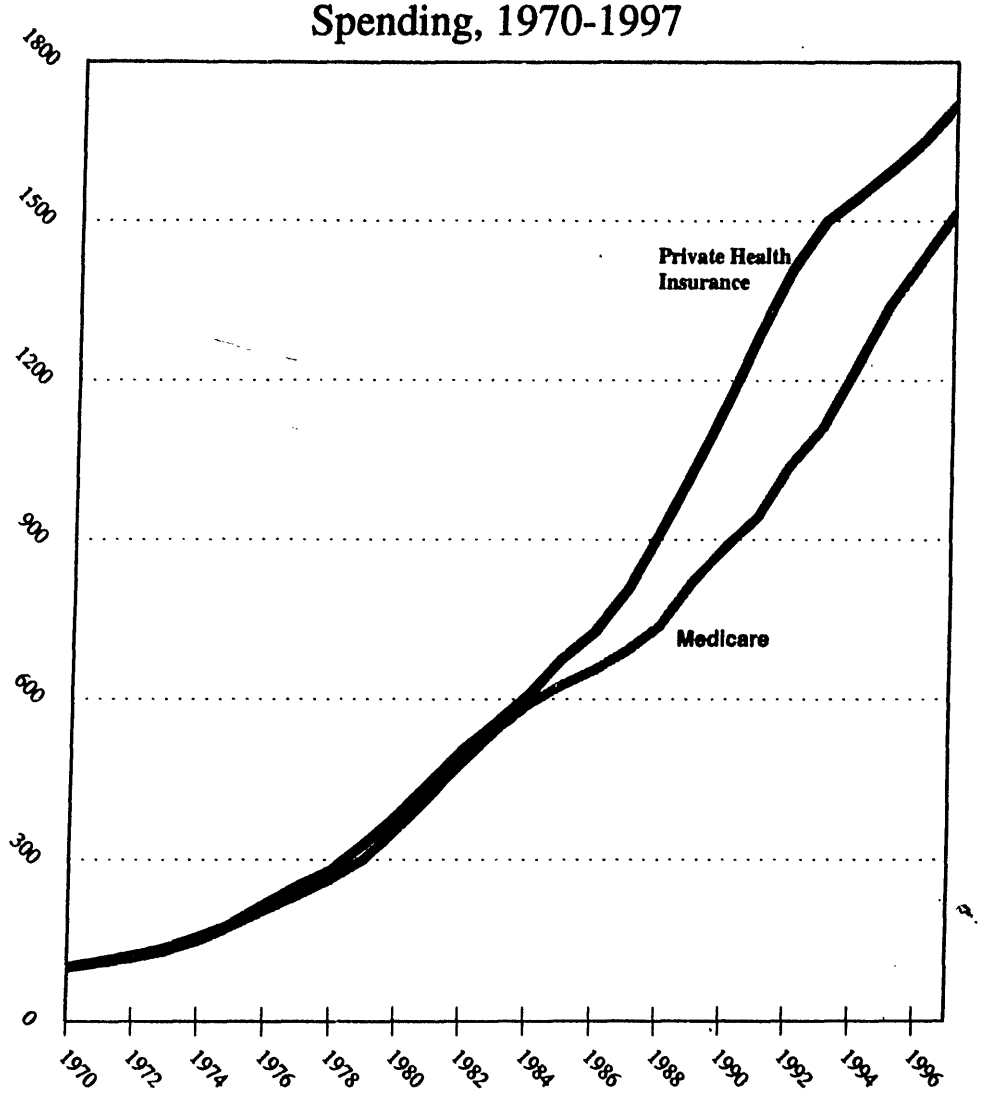
Projected increases in Medicare's spending arise because of the high costs of health care and growing numbers of persons eligible for the program. But most of the debate over Medicare reforms centers on only a piece of the cost issue. That is, changes to reduce Medicare spending through restructuring can only go so far. Technological advances that raise the costs of care are the primary reason for higher costs over time, and this phenomenon is occurring system wide, not just in Medicare. Further, a beneficiary population that is growing now because of increased life expectancy and will be exacerbated in the future by the retirement of the baby boom raises issues well beyond any restructuring options. Nonetheless, the nature of such reforms would profoundly affect Medicare's future.

Claims for savings from options that shift Medicare more to a system of private insurance usually rest on two basic arguments: first, it is commonly claimed that the private sector is per se more efficient than Medicare, and second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike. What about these claims?

Medicare vs. the Private Sector. Looking back over the last 27 years (between 1970 and 1997), Medicare's performance in terms of growth in the costs of care has been better than that of private insurance. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences (See Chart 1). By the 1980s, per capita spending had more than doubled in both sectors. But Medicare became more proactive than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay off. From about 1984 through 1988, Medicare's per capita costs grew much more slowly than those in the private sector.

Chart 1

Cumulative Per Capita Rates of Growth in Health Care Spending, 1970-1997



Source: The Urban Institute's Analysis of National Health Expenditure Data

This gap in overall growth in Medicare's favor stayed relatively constant until the early 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance thus narrowed the difference with Medicare in the 1990s, but as of 1997, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth.

It should not be surprising that the per capita rates over time are similar between Medicare and private sector spending since all health care spending shares technological change and improvement as a major factor driving high rates of growth. To date, most of the cost savings generated by all payers of care has come from slowing growth in the prices paid for services and making only preliminary inroads in reducing the use of services or addressing the issue of technology. Reining in use of services will constitute a major challenge for both private insurance and Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this.

Using Competition to Generate Savings. Reform options such as the premium support approach seek savings by allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that beneficiaries will become more price conscious and choose lower cost plans. This in turn will reward private insurers that are able to hold down costs. And there is some evidence from the federal employees system and the Calpers system in California that this has disciplined the insurance market to some degree. What is not known, however, is how well this will work for Medicare beneficiaries.

For example, for a premium support model to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? We do not know that the competition will really do what it is supposed to do.

In addition, new approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Some studies have shown that having one physician over a long period of time reduces costs of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially disadvantaged. Further, private plans by design are interested in satisfying their own customers and generating profits for stockholders. They cannot be expected to meet larger social goals; and to the extent that such goals remain important, reforms in Medicare will have to incorporate additional protections to balance these concerns as described below.

What it is crucial to retain from Medicare

The reason to "save" Medicare is to retain for future generations the qualities of the program that are valued by Americans and that have served them well over the last 33 years. This means that any reform proposal ought to be judged on principles that go well beyond the savings that they might generate for the federal government.

In this testimony I stress three crucial principles that are integrally related to Medicare's role as a social insurance program:

- The universal nature of the program and its consequent redistributive function.
- The pooling of risks that Medicare has achieved to share the burdens across sick and healthy.
- The role of government in protecting the rights of beneficiaries—often referred to as its entitlement nature.

While there are clearly other goals and contributions of Medicare, these three are part of its essential core. Traditional Medicare, designed as a social insurance program, has done well in meeting these goals. What about options relying more on the private sector?

Universality and Redistribution. An essential characteristic of social insurance that Americans have long accepted is the sense that once the criterion for eligibility of contributing to the program has been met, that benefits will be available to all

beneficiaries. One of Medicare's great strengths has been providing much improved access to health care. Before Medicare's passage, many elderly persons could not afford insurance, and others who could not obtain it were denied coverage as poor risks. That changed in 1966 and had a profound impact on the lives of millions of seniors. The desegregation of many hospitals occurred under Medicare's watch. And although there is substantial variation in the ability of beneficiaries to supplement Medicare's basic benefits that should be of concern, basic care is available to all who carry that Medicare card. Hospitals, physicians and other providers largely accept the card without question.

Once on Medicare, illness or high medical expenses no longer place enrollees in fear of losing care or battling to retain coverage with a private plan—a problem that still happens too often in the private sector. This assurance is an extremely important benefit to many older Americans and persons with disabilities. Developing a major health problem is not grounds for losing the card; in fact, in the case of the disabled, it is grounds for coverage. This is vastly different than the philosophy of the private sector towards health coverage. Even though many private insurers are willing and able to care for Medicare patients, the easiest way to stay in business as an insurer is to seek out the healthy and avoid the sick.

Will reforms that lead to a greater reliance on the market still retain the emphasis on equal access to care and plans? For example, differential premiums could undermine some of the redistributive nature of the program that assures even low income beneficiaries access to high quality care and responsive providers. Modifications in Medicare to give more power to states to deal with those dually eligible for Medicare and Medicaid may lead to such beneficiaries being treated as less desirable than "regular" Medicare patients.

The Pooling of Risks. One of Medicare's important features is the achievement of a pooling of risks among the healthy and sick covered by the program. Even among the oldest of the beneficiaries, there is a broad continuum across individuals' needs for care. While some of this distribution is totally unpredictable (because even people who have historically had few health problems can be stricken with catastrophic health expenses), a large portion of seniors and disabled persons have chronic problems known to be costly to treat. If these individuals can be identified and segregated, the costs of their care can expand beyond the ability of even well-off individuals to pay over time.

A major impetus for Medicare was the need to protect the most vulnerable. That's why the program focused exclusively on the old in 1965 and then added the disabled in 1972. About one in every three Medicare beneficiaries has severe mental or physical health problems. In contrast, the healthy and relatively well-off (with incomes over $32,000 per year for singles and $40,000 per year for couples) make up less than 10 percent of the Medicare population. Consequently, anything that puts the sickest at greater risk relative to the healthy is out of sync with this basic tenet of Medicare. A key test of any reform should be who it best serves.

If the advantages of one large risk pool (such as the traditional Medicare program) are eliminated, other means will have to be found to make sure that insurers cannot find ways to serve only the healthy population. This is a very difficult challenge that has been studied extensively; as yet no satisfactory risk adjustor has been developed. What has been developed to a finer degree, however, are marketing tools and mechanisms to select risks. High quality plans that attract people with health care needs are likely to be more expensive than plans that focus on serving the relatively healthy. If risk adjustors are never powerful enough to eliminate these distinctions and level the playing field, then those with health problems—who disproportionately have lower incomes—would have to pay the highest prices under many reform schemes.

The Role of Government. Related to the two above principles is the role that government has played in protecting beneficiaries. In traditional Medicare, this has meant having rules that apply consistently to individuals and assuring everyone in the program access to care. It has sometimes fallen short in terms of the variations that occur around the country in benefits, in part because of interpretation of coverage decisions but also because of differences in the practice of medicine. But in general, Medicare has to meet substantial standards and accountability that protect its beneficiaries.

If the day-to-day provision of care is left to the oversight of private insurers, what will be the impact on beneficiaries? It is not clear whether the government will be able to provide sufficient oversight to protect beneficiaries and assure them of access to high quality care. For example, what provisions will be in place to step in when plans fail to meet requirements or who leave an area abruptly? What recourse will patients have when they are denied care?

Further, one of the advantages touted for private plans is their ability to be flexible and even arbitrary in making decisions. This allows private insurers to respond more quickly than a large government program and to intervene where they believe too much care is being delivered. But one plan's cost effectiveness activities may translate into a beneficiary's loss of potentially essential care. Which is more alarming, too much care or care denied that cannot be corrected later? Some of the "inefficiencies" in the health care system may be viewed as a reasonable response to uncertainty when the costs of doing too little can be very high indeed.

What should be the direction for reform of the delivery of care?

Much of the debate over how to reform the Medicare program has focused on broad restructuring proposals. However, it is useful to think about reform in terms of a continuum of options that vary in their reliance on private insurance. Few advocate a fully private approach with little oversight; similarly few advocate moving back to 1965 Medicare with its unfettered fee-for-service and absence of any private plan options. In between, however, are many possible options and variations. And while the differences may seem technical or obscure, many of these "details" matter a great deal in terms of how the program will change over time and how well beneficiaries will be protected. Perhaps the most crucial issue is how the traditional Medicare program is treated. Is it just one of many plans that beneficiaries choose among, or does it remain the basic default option with private plans playing a comparable or larger role than under the current Medicare + Choice arrangement?

As is likely clear from my testimony, I am skeptical of approaches that move to place a major emphasis on private plans. The modest gains in lower costs that are likely to come from some increased competition and from the flexibility that the private sector enjoys could be more than offset by the loss of social insurance protection. The effort necessary to create in a private plan environment all the protections needed to compensate for moving away from traditional Medicare seems too great and too uncertain. And, on a practical note, many of the provisions in the Balanced Budget Act of 1997 that would be essential in any further moves to emphasize private insurance—generating new ways of paying private plans, improving risk adjustment and developing information for beneficiaries, for example—still need a lot of work.

What I would prefer to see instead is emphasis on improvements in both the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasis private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

That is, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared. Private plans can play an important role and may develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems—exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjustors. Innovative plans would likely suffer in that environment.

Finally, the default plan—where those who do not or cannot choose or who find a hostile environment in the world of competition—must, at least for the time being, be traditional Medicare. Thus, there needs to be a strong commitment to maintaining a strong traditional Medicare program while seeking to define the appropriate role for alternative options. But for the time being, there cannot and should not be a "level playing field" between traditional Medicare and private plans.

Other reform issues

While most of the attention on reform focuses on structural questions, there are other key issues that must also be addressed, including the adequacy of benefits, reforms that pass costs on to beneficiaries, and the need for more general financing. Even after accounting for changes that may improve the efficiency of the Medicare program through either structural or incremental reforms, the costs of health care for this population group will still likely grow as a share of GDP. That will mean the important issue of who will pay for this health care—beneficiaries, taxpayers or

a combination of the two—must ultimately be addressed to resolve Medicare's future.

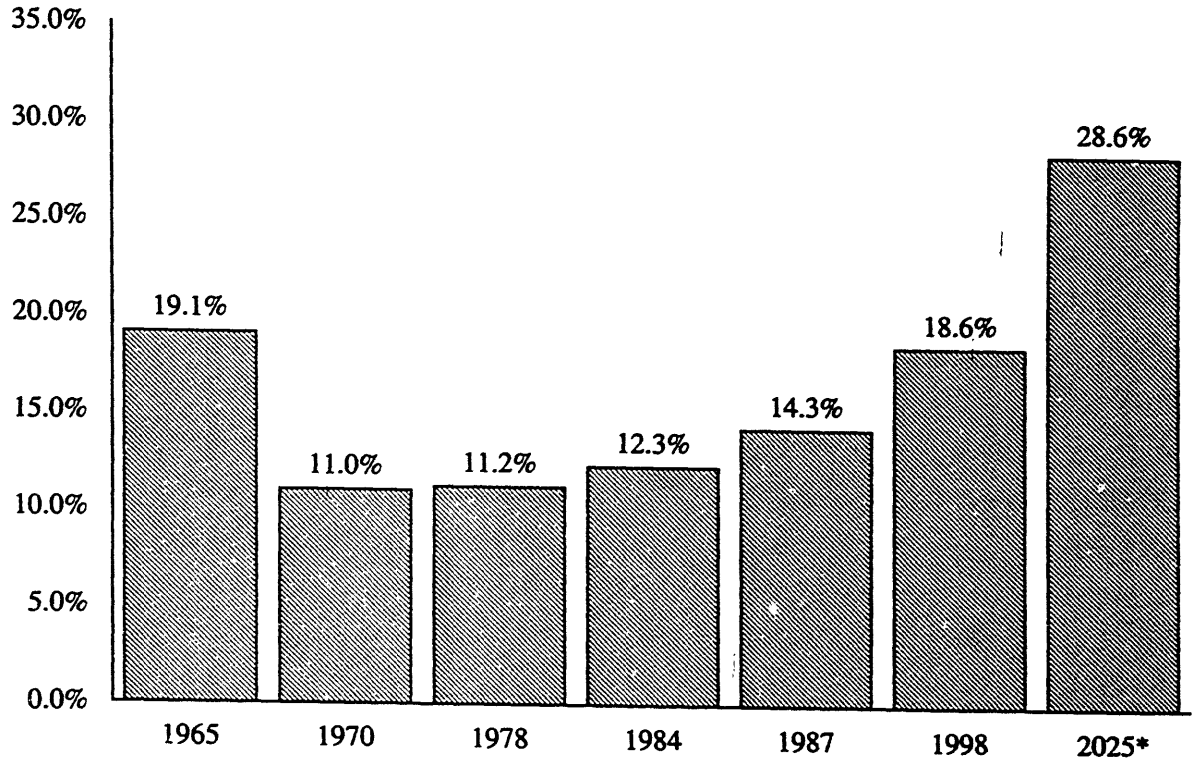
Improved Benefits. It is hard to imagine a "reformed" Medicare program that did not address two key areas of coverage: prescription drugs and a limit on the out-of-pocket costs that any individual beneficiary must pay in a year. Critics of Medicare rightly point out that its inadequacy has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. And to suggest that a change in structure, without any further financial contributions to support expanded benefits, will yield large expansions in benefits is wishful thinking. A system designed to foster price competition is unlikely to stimulate expansion of benefits.

Expanding benefits is a separable issue from how the structure of the program evolves over time. It is not separable from the issue of the cost of new benefits, however. This is quite simply a financing issue and it would require new revenues, likely from a combination of beneficiary and taxpayer dollars. A voluntary approach to provide such benefits through private insurance, such as we have at present, is seriously flawed. Prescription drug benefits generate risk selection problems; already the costs charged by many private supplemental plans for prescription drugs equal or outweigh their total possible benefits because such coverage attracts a sicker than average set of enrollees. A concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program.

Benefits and Eligibility Issues for Disability Beneficiaries. A number of special problems face the under-65 disabled population on Medicare. The 18 month waiting period before a Social Security disability recipient becomes eligible for coverage creates severe hardships for some beneficiaries who must pay enormous costs out of pocket or delay treatments that could improve their disabilities if they do not have access to other insurance. In addition, a disproportionate share of the disability population has mental health needs and Medicare's benefits in this area are seriously lacking. Special attention to the needs of this population should not get lost in the broader debate.

Beneficiaries' Contributions. Some piece of a long-term solution probably will (and should) include further increases in contributions from beneficiaries beyond what is already scheduled to go into place. The question is how to do so fairly. Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to absorb these changes. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses (see Chart 2).

Chart 2
Acute Health Care Spending by Elderly as Share of Income



* Projection
Source: Urban Institute Calculations Using NHE, CPI, and CPS

In addition, options to increase beneficiary contributions to the cost of Medicare further increase the need to provide protections for low income beneficiaries. The current programs to provide protections to low income beneficiaries are inadequate, particularly if new premium or cost sharing requirements are added to the program. And the issue of whether such protections should be housed in the Medicaid program also needs further consideration.

Financing. Last, but not least, Medicare's financing must be part of any discussion about the future. We simply cannot expect as a society to provide care to the most needy of our citizens for services that are likely to rise in costs and to absorb a rapid increase in the number of individuals becoming eligible for Medicare without taking the financing issue head on. Medicare now serves one in every eight Americans; by 2030 it will serve nearly one in every four. And these people will need to get care somewhere. If not through Medicare, then where?

PREPARED STATEMENT OF HON. DANIEL PATRICK MOYNIHAN

Mr. Chairman, we again commend and thank you for holding this series of hearings on Medicare, and especially today's hearing on the fundamental distinctions between Medicare as a social insurance program and private insurance as provided in the marketplace.

Medicare not only provides basic health care coverage to 40 million senior and disabled citizens, but it also supports the nation's health care infrastructure. For example, Medicare makes payments to teaching hospitals for graduate medical education (GME), and payments to hospitals serving a disproportionate share of indigent patients (DSH payments), many of whom are uninsured.

Medicare supports these payments because Graduate Medical Education is what economists call a public good—something that benefits everyone, but which is not provided for by market forces alone. Think of an army. Or a dam. Private insurers, including managed care plans, do not provide these payments to hospitals.

Mr. Chairman, today I am introducing three bills that will provide much needed financial support for America's 144 accredited medical schools and 1,250 graduate medical education (GME) teaching institutions. These institutions are national treasures; they are the very best in the world. Yet today they find themselves in dire financial straits as market forces reshape the health care delivery system in the United States.

To ensure that this precious public resource is maintained and the United States continues to lead the world in the quality of its health care system, I am introducing three new bills—the Graduate Medical Education Payment Restoration Act of 1999, the Managed Care Fair Payment Act of 1999, and the Nursing and Allied Health Payment Improvement Act of 1999—that will all provide critically required funding for teaching hospitals.

The Graduate Medical Education Payment Restoration Act, with a total of 13 cosponsors, will freeze the current schedule of BBA cuts in indirect GME funding, or IME. Under the BBA, the indirect payment adjustor is scheduled to be reduced from 7.7 percent to 5.5 percent by FY 2001. This bill will maintain the current payment adjustor at its current level of 6.5 percent, thereby rolling back about half of the indirect GME funding cuts in the BBA. In total, this provision restores about $3 billion over 5 years and $8 billion over 10 years in indirect GME funding for teaching hospitals.

The Managed Care Fair Payment Act, with seven cosponsors, will redirect more than $2.5 billion over 5 years of Medicare Disproportionate Share Hospital (DSH) funds from the Medicare managed care payment rates to the more than 1,900 hospitals that qualify for DSH funding, most of which are also teaching hospitals.

The third bill, which has 10 cosponsors, is the Nursing and Allied Health Payment Improvement Act. Although Congress in the BBA of 1997 recognized the need to carve out GME funding from managed care rates, it unintentionally did not carve out the funding for the training of nurses and allied health professionals. Like DSH funds, without the carve out, funding for these education programs is unlikely to reach the more than 700 hospitals that provide training to these vitally important health professionals. This bill will carve out the funding for the training of nurses and other allied health professionals, and direct them to the hospitals that provide these training programs.

Together, these three measures will strengthen our nation's teaching hospitals and ensure that the United States will continue to be the world leader in development of new cures, new medical technology, and training of the world's finest med-

ical professionals. Without this legislation, our nation's teaching hospitals and the delivery of health care in America will remain in jeopardy.

PREPARED STATEMENT OF KEITH J. MUELLER, PH.D.

Chairman Roth, Senator Moynihan, distinguished members of the Committee, thank you for inviting me to testify today about Medicare payment policies as related to the rural health care infrastructure. My comments draw on the research and analysis in which I have participated as the Director of the Nebraska Center for Rural Health Research and as Chair of the Health Panel of the Rural Policy Research Institute (RUPRI). For this hearing, I will describe the context in which to consider the impact of Medicare policies on rural health care delivery, touch on some specific Medicare payments of note, and close with guidelines and principles to follow in any redesign of current Medicare policies.

The Medicare program is based on a promise to the nation's elderly population that they will have access to health care services.[1] While a great deal of the Medicare policy debate focuses on financial access, for rural Medicare beneficiaries geographic access to essential services is at least as important. Services must be available before any insurance benefit makes them financially accessible. Hence, this Committee and members of Congress have acted, since 1966, to either affirm the principle of access by using Medicare payment to help assure availability of services, or to correct Medicare policies that had the unintended consequences of threatening availability of services. Before speaking to those policies, I will offer a few reminders of the importance of Medicare policies to the rural health care delivery system:

- According to the most recent data available from the US Census, a greater percentage of rural residents are Medicare beneficiaries, compared to urban residents (18 vs 15);
- Medicare payments account for, on average, 33 percent of practice revenues for rural physicians (27 percent for urban physicians); for many physicians in small communities Medicare payments represent over 60 percent of practice revenues;
- Medicare payments, on average, account for approximately 39 percent of rural hospital inpatient revenue (33 percent for urban hospitals); for small rural hospitals that can be as high as 90 percent;[2]
- Medicare's base payment for inpatient hospital services (before adjustment for case-mix, which would naturally increase urban payment, and before the IME/DSH factor, which also favors urban hospitals) is lower for rural hospitals ($3,416) than for urban hospitals ($3,935);[3]
- 50 percent of all patient days in rural hospitals are from use by Medicare beneficiaries; compared to 37 percent for urban hospitals;
- The smallest hospitals, with fewer than 100 beds, have the lowest operating margins (2.5 percent in 1999). These hospitals are the most vulnerable to negative swings in Medicare payment;
- Total Medicare (traditional) payment per beneficiary is nearly $1,000 less for rural beneficiaries than for urban beneficiaries, and by the way, payment is the lowest for rural beneficiaries in Nebraska.[4]

Any dialogue about the future of Medicare payment policy must begin with these facts: spending on behalf of rural beneficiaries is low, payment to rural providers is low, and Medicare payments drive the fiscal health of rural providers. Without adequate Medicare payment, the rural health care infrastructure, particularly in small town rural America, cannot survive.

Building and sustaining rural delivery systems requires both general approaches through programs targeted to rural and underserved areas and payment policies that recognize rural needs. The general programs include the National Health Service Corps, funding for health professions training programs designed to meet the needs of underserved areas, grants to safety net providers, and project grants to develop new means of delivering services such as telemedicine and integrated delivery networks. Medicare's commitment to access is met by investing in rural systems through payment policies. This approach is sensible for two reasons: (1) it links in-

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[1] A good presentation of the purposes of Medicare can be found in Marilyn Moon, Medicare Now and in the Future 2nd Edition. Urban Institute Press. 1996: pp 27–41.

[2] The data on Medicare share of provider income are 1994 data for physicians and 1993 for hospitals, as reported in Paul Frenzen, "How Will Measures to Control Medicare Spending Affect Rural Communities?" USDA Agricultural Information Bulletin Number 734. March, 1997.

[3] Medicare Payment Advisory Commission. Report to Congress. March 1998: 52.

[4] Data taken from the Health Care Financing Review Statistical Supplement for 1998.

vestment to the services being demanded by the beneficiaries; and (2) it links provider revenue to services rendered. Furthermore, this approach allows Medicare policies to define the specific providers warranting additional payments.

The following are examples of special payments reflecting Medicare investment in rural health care delivery:

- sole community hospitals: institutions isolated from any other hospital provider and therefore essential to a broad geographic area (reimbursed based on costs);
- rural health clinics: ambulatory care in health profession shortage areas, providing access to primary care services to a population that would otherwise face barriers to access related to travel (reimbursed based on cost);
- federally qualified health clinics (not uniquely rural), including community and migrant health centers: designed with particular populations in mind (low income, minority) and the safety net provider in their communities (reimbursed based on cost);
- Medicare dependent hospitals: institutions with more than 60 percent of their inpatient revenues derived from Medicare and therefore very dependent on Medicare for their fiscal solvency (reimbursed based on cost);
- critical access hospitals: redesigned institutional providers that provide limited, essential services (reimbursed based on cost);
- physicians providing services in rural underserved areas receive bonus payments;[5]
- telemedicine services are reimbursed: currently limited to services received in health profession shortage; and
- physician assistants and nurse practitioners are paid directly for primary care services in shortage areas.

These rural providers (providers serving rural beneficiaries in the case of telemedicine) are receiving special payments because they are delivering services such as primary care, emergency care, and short term hospital stays, that must be available in close proximity to the beneficiaries needing them. With that general approach in mind, this Committee may want to impose a "rural test" on all Medicare payment policies as they are developed and afterwards as they are implemented.

How will the change in Medicare payment policy affect the rural health care delivery system in precisely those communities where rural providers are the most financially vulnerable?

The rural test could be used to monitor the changes currently unfolding in the following payment streams:

- premiums paid to Medicare+Choice health plans;
- hospital outpatient payment;
- hospital inpatient payment;
- home health services payment;
- skilled nursing services payment;
- bad debt payments;
- transfer payment policy; and
- disproportionate share.

The RUPRI Health Panel and others are monitoring impacts of these changes on rural health care delivery systems, and thus far the trends seem negative, with impacts not yet fully realized. The RUPRI policy paper published in February 1999 is attached. It includes specific information about the impacts of payment changes on rural hospitals and safety net providers. Effects on Medicare beneficiaries, especially those related to choices among alternative plans, also are presented. As is always the case in RUPRI's work, the paper includes suggestions for public policy that deal with the findings in the context of present policy (Medicare as modified by the Balanced Budget Act of 1997). A study released by HCIA, using analysis completed by Ernst & Young, projects that under current payment policies, margins for small, rural hospitals will fall from 4.2 percent in 1998 to a negative 5.6 percent by 2002.[6]

If this Committee and/or others decide that for reasons of general Medicare policy changes, the current special payments for rural providers need to be replaced with

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[5] As reported by the General Accounting Office (GAO/HEHS–99–36) only a small portion of the total spending for bonus payments is for services delivered in remote areas, and a majority of spending in the program is for specialist services. The point made in this testimony is that the bonus payments that are spent for services in rural areas are consistent with objectives related to access in rural areas; the additional payment, compounded because of the higher percentage of income from Medicare payments, can be meaningful in recruiting and retaining providers in remote rural areas.

[6] "A Comprehensive Review of Hospital Finances in the Aftermath of the Balanced Budget Act of 1997." March, 1999. Available from the HCIA eb site: http://www2.hcia.com/studies/fahs/todc.htm.

a different strategy of investment in rural health care delivery systems, I would suggest the following guidelines to be sure that different approaches retain the achievements of present payment policies:

1. The investments support all essential, appropriate services for rural beneficiaries;
2. The investments are sustainable, thereby secure over time for the providers; and
3. The investments have a positive impact on services to all residents of rural communities.

Finally, Mr. Chairman and members of the Committee, I will offer two frameworks for use when monitoring current Medicare policies and considering any changes. The first framework is the one used by the RUPRI Health Panel in our work. We use three criteria when assessing the impacts of policies and programs:

1. What is the impact on rural consumers, in this specific case Medicare beneficiaries? In our work on Medicare policies this includes out-of-pocket payment, benefits available, and availability of choice.
2. What is the impact on the rural health infrastructure? Specifically included are availability of rural health services, effects on efforts to coordinate and/or integrate services, and rural involvement in decisions about the health care system.
3. What is the impact on the local rural economy?

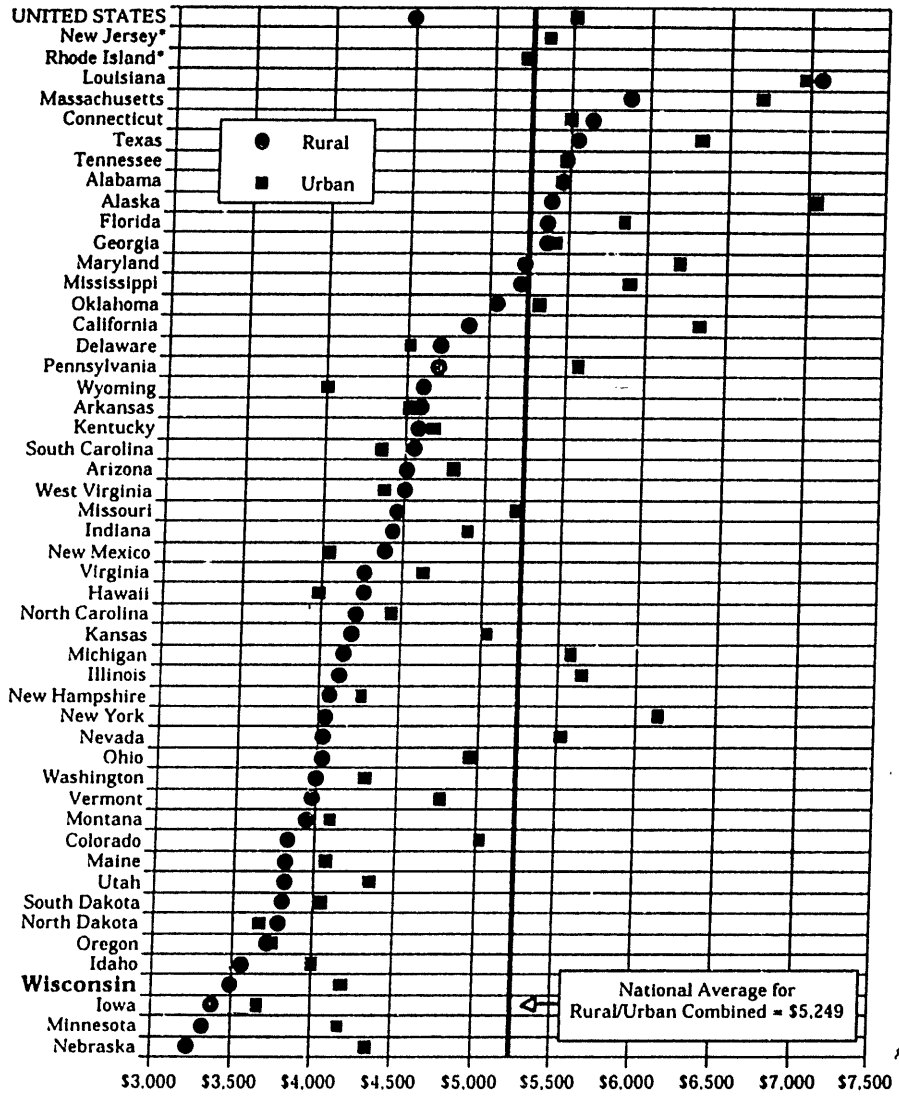
The second framework is a more subjective one and includes a series of principles I offered to the Bipartisan Commission on the Future of Medicare a few months ago:

1. Opportunities that enrich Medicare for beneficiaries should be available to all rural beneficiaries.
2. Medicare policies should be designed to help sustain the rural health care delivery infrastructure.
3. Medicare policies should help sustain the safety net in rural and underserved areas.
4. Medicare policies should contribute to the overall quality of life in rural communities.

Thank you again for this opportunity to speak to rural interests in Medicare policy. I would welcome any requests to work with the Committee as you continue to improve the Medicare program.

Special Committee on Capture of Federal Resources Public Hearing, November 11th, 1998
Presentation by Tim Size, Rural Wisconsin Health Cooperative

Medicare Program Payments per Person Served in 1995 By State & Rural/Urban County of Residence



Data: *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1997*
Note: New Jersey & Rhode Island have no rural residents. Graph: RWHC 1/98

Taking Medicare into the 21st Century: Realities of a Post BBA World and Implications for Rural Health Care

Rural Policy Research Institute
Rural Health Panel

February 10, 1999

P99-2

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The Rural Policy Research Institute provides objective analyses and facilitates dialogue concerning public policy impacts on rural people and places.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) initiated changes in the Medicare program that have significant potential to alter the landscape in rural health — changing the way care for rural beneficiaries is financed; and, subsequently, the structure of the rural health delivery system. BBA implementation is an evolving process, beginning with federal regulatory policies and eventually leading to local responses, which will require years to complete and assess. This analysis describes the likely impacts of fee-for-service payment changes, summarizes changes in Medicare plan offerings and enrollments in rural areas, and describes anticipated implications for public policy and private sector decision makers. These issues are summarized below.

General Impacts on Rural Health Care Services

Payment changes in Medicare can affect rural hospitals more dramatically than their urban counterparts, because rural hospital operating margins are lower; more rural hospitals experience negative total margins – 15.9 percent vs. 9.8 percent. Specific BBA changes in Medicare payment could have these impacts:

- Medicare outpatient payments, to become prospective payment under the BBA, represent 9.5 percent of revenues for rural hospitals, compared to 7.1 percent for urban hospitals, and changes that lower the total payment could lower operating margins.
- Shortfalls in Medicare revenues for rural hospitals include payment for a host of services, including home health, skilled nursing care, bad debt, and post acute transfers.
- The net impact of payment reductions is significant – $79 million for rural Missouri hospitals in the year 2002, 7.4 percent of anticipated revenues for rural California hospitals during 1998-2002, and 17.34 percent of net income annually for one rural Wisconsin hospital.

Other services for Medicare beneficiaries are affected by the BBA, including home health and skilled nursing care. Home health payments were reduced from a maximum of 112 percent of the national average to 106 percent. Nursing home payment will bundle previous separate payment for therapists into a single facility rate. These changes could precipitate the following changes in service delivery in rural areas:

- Home health agencies may avoid high cost patients or reduce services per user.
- Nursing homes may have difficulty recruiting physical therapists as employees of the homes.

Specific Impacts on Rural Safety Net Providers

Community and Migrant Health Centers (C/MHCs) are affected by a provision in the Balanced Budget Act of 1997 (BBA) that allows states to phase out Medicaid cost-based reimbursement.

Current reimbursement policy allows C/MHCs to include non medical enabling services in their charges, which would not be the case if new payment systems such as managed care are calculated based only on costs of medical treatment. The impacts are likely to be the following.

- Some states will likely choose to no longer use a cost-based reimbursement approach for Medicaid patients treated at C/MHCs.
- Medicaid managed care plan payments are estimated by Centers to be much less than reasonable cost rates (current basis for reimbursement) to C/MHCs.
- Thirty-three percent of C/MHC revenue is from Medicaid, seven percent from Medicare.
- Without change, current policy may reduce the ability of C/MHCs to provide care to the uninsured.

This issue could be addressed by:

1) requiring cost-based reimbursement for Medicaid patients seen at C/MHCs,
2) devising a prospective payment system that encompasses all services provided by C/MHCs and is appropriately adjusted for service utilization among C/MHC clients, or
3) increasing grant funding to compensate for reduced revenues from public payment.

Small rural hospitals (under 50 beds), which are often the safety net providers in many communities, are subject to the same payment changes that affect all hospitals, unless they are exempt because of sole community hospital or Medicare dependent hospital status. The impacts are likely to be significant because:

- forty-seven percent of rural hospital costs are paid by Medicare,
- twelve percent of rural hospital costs are paid by Medicaid,
- rural hospitals lost 3.7 percent of costs on Medicare business in1994, and
- under the BBA, PPS inpatient payment for all rural hospitals will be reduced 9.6 percent in 2002; accounting for 0.6 percent of all revenues.

This issue could be addressed by:

- extensive use of designations as critical hospitals among the smallest of the rural hospitals, and/or
- policies to protect the financial viability of small rural hospitals that serve as the local safety net provider.

Impacts on Rural Medicare Beneficiaries

The evidence on enrollment of beneficiaries into managed care plan thus far shows:

- only modest increases in the number and percent of rural Medicare beneficiaries enrolled in managed care plans;
- very few health plans being formed and/or offering managed care options in rural counties; and
- managed care plans opting to discontinue operating in 120 rural counties affecting 56,142 beneficiaries, and
- of the affected beneficiaries 15,158 are in counties there will now be no managed care plans available.

Implications

- Constraining Medicare spending by imposing continuing and significant reductions on small rural providers could jeopardize access to care for rural beneficiaries.
- Given low enrollment into managed care and limited use of any Medicare-risk plans in rural areas for the foreseeable future, the impacts of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries.
- Any changes in payment policies should include a "rural differential," accounting for different impacts on providers as a function of size and location.
- Policies designed to encourage change in the organization of health care services should include resources and suggested models that encourage rural input.
- Reductions in Medicare payment may threaten the financial viability of many rural providers.
- Rural providers might move into other options for organizing facilities, including Critical Access Hospitals, Medicare dependent hospitals, and participating in managed care networks.
- Certain rural providers, especially home health agencies and skilled nursing facilities, might reduce services offered to beneficiaries and/or be selective in who they see.
- Rural health care providers will need to find and implement measures to reduce costs of care, but they are unlikely to find sufficient savings to absorb all revenue reductions.
- Rural health care providers are likely to look increasingly to consolidation of service networks, including participating in urban-based systems.

OVERVIEW

The Balanced Budget Act of 1997 (BBA) initiated changes in the Medicare program that have significant potential to alter the landscape in rural health — changing the way care for rural beneficiaries is financed; and, subsequently, the structure of the rural health delivery system. BBA implementation is an evolving process, beginning with federal regulatory policies and eventually leading to local responses, which will require years to complete and assess. There are **opportunities to affect the substance and impact of these changes; both to alter the direction of policy and to influence developments in rural health care delivery systems.** The objectives of this analysis are to:

- describe the likely impacts of the changes made to fee-for-service payment to rural health care providers,
- provide information about changes occurring in Medicare plans offered to rural beneficiaries and enrollment in different plans, and
- describe implications for public policy and private action.

The various provisions of the BBA each affect a component of the rural health delivery system; their combined impact could lead to radical restructuring of the system. In general, the BBA is intended to:

- influence payment in traditional Medicare program (restricting fee for service reimbursement);
- encourage initiatives to change to different payment systems (changing payment policies for risk contracts, including implementing risk adjustment methodologies);
- create incentives for beneficiaries to enroll in capitated plans (presumably to enhance their insurance benefits);
- encourage changing the delivery system (enabling rules for Provider Sponsored Organizations, the rural hospital flexibility program);
- encourage an emphasis on measuring quality of services (quality assurance provisions in the June 1998 regulations); and
- expand insurance coverage for children, and redirect financial support of graduate medical education.

While each provision of the BBA should be assessed on its merits and impacts, a complete understanding of the Act's impact requires integration of clusters of provisions, and then of the entire Act. This analysis will integrate provisions related to payment in the traditional Medicare program, and provisions designed to encourage expansion of choice for rural beneficiaries.

PAYMENT POLICIES

Most of the savings in the BBA were the result of changes in reimbursement paid through the traditional Medicare program, $100 billion during the years 1998-2002.[1] Those savings were achieved by limiting annual payment increases, converting cost-based reimbursement to prospective payment systems, and changes in policy (including reducing payment for certain cases where discharges are from hospitals to other Medicare providers, capping payment to certain rural health clinics, phasing out requirements for Medicaid cost-based reimbursement, and reducing payment for certain services). Individual reductions may not lead to drastic changes in availability of services. However, when considered in total, they may threaten certain health care providers in rural areas.

Can Institutional Providers Adjust to the Changes?

The BBA achieves budget savings by constraining payment to health care providers, and specifically to institutions providing care (there is some adjustment in payment to health care professionals in Section 4502, which matches updates to the conversion factor to a "sustainable growth rate"). An important way to view the changes is to consider the effects on *services being proviaed* to Medicare beneficiaries, and *services available* to everyone in a given community. Each major change in payment, including conversions from cost-based reimbursement to prospective payment, potentially affects the abilities of providers to deliver services. Since the changes are being implemented in the context of achieving budget savings, we assume new payment levels will be set to lower expected expenditures, which of course means less than anticipated revenue for providers. When all such payment adjustments are considered together, the total impact on small rural systems serving disproportionate shares (higher percentages than most other providers) of Medicare beneficiaries and/or uninsured persons could be quite severe. Consider that each of the payment for each of the following categories was changed by the BBA:

- Hospital inpatient services
- Hospital outpatient services
- Home health services
- Skilled nursing services
- Hospice services
- Ambulatory services provided by federally qualified health centers
- Ambulatory services provided by rural health clinics
- Ambulance services
- Outpatient rehabilitation services
- Ambulatory surgical services

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[1]U.S. Congressional Budget Office. "Budgetary Implications of the Balanced Budget Act of 1997." CBO Memorandum. December, 1997.

In addition to changes in payment for services, other changes in the BBA affect payment to providers for specific purposes:

- Certain hospital discharges to post acute care (lowering hospital payment)
- Reduction in disproportionate share payments
- Reduction in capital payments for PPS hospitals
- Payment for clinical diagnostic laboratory tests
- Reductions in payments for graduate medical education
- Medical education and disproportionate payments attributable to outlier payments
- Cap on TEFRA limits (PPS-exempt hospitals)
- Reductions in allowable costs of bad debt [2]

The net impact of these changes is best illustrated by more thorough consideration of the impact on three groups of providers, which may be combined in single organizations: hospitals, skilled nursing facilities, and home health agencies. Combined, these categories account for a majority of Medicare expenditures, and home health is the most rapidly increasing component of Medicare expenditures.[3]

Impacts on Rural Hospitals

The BBA affects the major categories of payment to hospitals — inpatient and outpatient services — as well as a host of other services offered by hospitals. The impact in any given category may be absorbed as only a small percentage of any hospital's total Medicare payments, but the combined impacts could threaten the viability of providing Medicare services, and perhaps the financial security of the hospital. At this early time in the post-BBA era, we cannot be certain about the ultimate outcome in service availability, but we can develop scenarios to illustrate the potential outcome.

Changes in Medicare payment can have a ***disproportionately negative impact on many rural hospitals***, as a function of hospital size, dependency on Medicare revenues, share of Medicare business that is through the traditional program, and hospital management. In hospital fiscal year 1995 (actual months vary across hospitals), 15.9 percent of rural hospitals experienced negative total margins, as compared to 9.8 percent of urban hospitals. Among rural hospitals, only 2.5 percent of rural referral centers had negative margins, compared to 18.2 percent of sole community hospitals

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[2]For details of these provisions, see the Health Care Financing Administration web site <www.hcfa.org> and locate the summary of provisions from the Balanced Budget Act of 1997; or contact RUPRI through Keith Mueller at the Nebraska Center for Rural Health Research, <kmueller@unmc.edu> or phone: (402) 559-5260.

[3]It should be noted that prescription drugs are not included in Medicare expenditures, since the only means of collecting Medicare payment for them is when they are dispensed in the hospital.

and 15.8 percent of all other rural hospitals.[4] To be more specific to a provision of the BBA, use of prospective payment to derive savings from hospital outpatient payment, those payments account for 9.5 percent of revenues for rural hospitals, as compared to 7.1 percent for urban hospitals. All types of rural hospitals are between 9 and 10 percent dependent on Medicare outpatient payment for their revenues.[5] Further analysis shows that the smallest hospitals are the most vulnerable to Medicare outpatient revenue.

Another means of examining effects of BBA changes on hospitals is to forecast lost revenues as the difference between Medicare payment before and after the BBA provisions take effect. All hospital services are threatened if the cumulative impact of the BBA changes force decisions to cease operations or to reduce levels of services (either by dropping services or groups of patients such as the uninsured or Medicare beneficiaries). ***The impact of the changes in inpatient prospective payment can account for as little as only approximately 1/3 of the reduced Medicare revenue predicted for rural hospitals, as in the case of the example from Missouri hospitals described below; and the conversion to outpatient PPS is not yet included in these calculations.*** The net impact on rural hospitals is the sum of a number of different payment changes that affect PPS hospitals.

Some hospitals have estimated annual impacts through the year 2002. Missouri's rural hospitals estimate annual shortfalls to be $32 million in 1998, $45.3 million in 1999, $62.1 million in 2000, $70.4 million in 2001 and $79 million in 2002, from the aggregate total of reduced growth or cuts in the following payments:

- Payment for post acute transfers
- DRG payment rate of growth
- Elimination of formula-driven overpayment for certain hospital outpatient services
- Reduced capital payments
- Reduced disproportionate share payments
- Tax Equalization and Fiscal Responsibility Act (TEFRA) cap (applies to non-PPS hospitals)
- TEFRA relief payments
- TEFRA bonus payments
- TEFRA capital payments
- Bad debts
- Indirect Medical Education (IME) payments
- Home health cost limits

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[4]Penny E. Mohr, Bonnie B. Blanchfield, C. Michael Chen, William N. Evans, and Sheila J. Franco. "The Financial Dependence of Rural Hospitals on Outpatient Revenue." Working Paper. The Project Hope Walsh Center for Rural Health Analysis. July,1998.

[5]Ibid.

- Home health per beneficiary limits
- Skilled nursing facility payment [6].

Hospitals in California used the following categories to calculate impacts for the years 1998-2002, inclusive:

- Update reduction
- PPS capital reduction
- IME reduction
- Graduate medical education reduction
- Transfer payment change
- Elimination of outlier add-on
- Outpatient PPS (using preliminary estimates)
- Reduction in PPS exemption

The current payment and total impacts were calculated for each of the 52 Congressional districts in the state. The totals for eight rural districts were:

- $8043.1 million expected payment, and
- $598.7 million in reductions (7.4 percent of anticipated revenues).[7]

A rural hospital in Wisconsin estimated annual losses from the following changes:

- Reduction of DRG weights
- Reduction in Federally Driven Overpayment calculation
- Home health cost limits and per beneficiary cost limits
- Bad debt reimbursement
- Transfer rules for home health

The resulting impact on hospital income was estimated to be 6.1 percent of Medicare reimbursement, and 17.3 percent of net income.[8]

As evident from the above analyses, rural institutions can only estimate impacts since final decisions about the specifics related to new payment formulas (e.g., prospective payment) have not been made. As a result, the estimates tend to be underestimates because not all possible impacts are considered

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[6]From the Missouri Hospital Association, with assistance from the accounting firm of Baird, Kurtz & Dobson. December, 1998.

[7]California Hospital Association. December, 1998.

[8]Calculations completed by the Chief Financial Officer of the Hospital.

in any of the calculations. The important question for service delivery to rural beneficiaries and others is can these reductions in reimbursement be absorbed by rural hospitals? While only the test of time could answer the question definitively, an intuitive answer would be no, not without changes in hospital finance and/or organization.

Impacts on Skilled Nursing Facilities and Home Health Agencies

Some impact from conversion to prospective payment for these services was evident in the analysis of hospital revenues above. For skilled nursing facilities the BBA extends the cost limits already in place and requires a three-year phase-in of prospective payment. During the fiscal years 1998 and 1999 the update in the rate will be one percentage point less than the update in the market basket increase for that year. Prospective payment is also to be phased in for home health services, with a new interim payment system (IPS) to be used until PPS is operational. The IPS restricts cost-based payments to home health agencies.

For skilled nursing facilities the phase in of prospective payment has just begun, and the full impact on rural services will be evident only as the rate is determined more by the national PPS rate (only 25 percent national in the first year). The new payment system also bundles payments previously made separately into a single payment to the facility. Facilities that had contracts with providers that billed Medicare directly will now have to pay for those therapy services out of their facility rates. This could affect payment for those services. In places where there are current or potential shortages of physical therapists, the new system may affect the facility's and community's abilities to recruit and retain these health professionals.

For home health agencies, payments per visit are limited to 106 percent of the national average (reduced from 112 percent), and each agency is capped on how much payment it will receive from each beneficiary. The per beneficiary limits may induce agencies to screen the patients served, avoiding high cost patients. The per beneficiary limit may have a differential effect in rural areas where fewer beneficiaries use home health services but have more visits per user. In the absence of such changes, home health agencies, and/or their branch offices, may close.

Are Rural Safety Net Providers at Greater Fiscal Risk?

When the federal government joins other (private) health plans in the rush to find fiscal savings by reducing payment for care delivered to insured persons, the margins needed to finance care to the uninsured are threatened. Resolving what becomes a fiscal bind shared by safety net providers (those "institutions, programs, and professionals devoting substantial resources to serving the uninsured or social disadvantaged"[9]) becomes an important public policy problem, whether

[9]R J Baxter and R E Mechanic, "The Status of Local Health Care Safety Nets." Health Affairs 16 (4) July/August, 1997: 7 - 23.

addressed by changes in payment for publicly insured persons, or separately with direct assistance to safety net providers. Rural safety net providers include the following:

- Community and Migrant Health Centers
- Federally Qualified Health Centers
- Hospitals
- Physicians
- Rural Health Clinics

The burden of providing uncompensated care varies among rural providers, but all on the list are, at least in some rural communities, the primary source of care for the uninsured and therefore treat a significant proportion (above 5 percent) of non-paying patients. Rural safety net providers, because of the overall preponderance of Medicare patients for all rural providers, and because of the special niche the safety net providers occupy, are more likely than others to rely on public insurance programs for a high percentage of their patient revenues. Therefore, reductions in payment from those programs could reduce abilities to provide uncompensated care and create holes in the safety net. Two classes of rural safety net providers illustrate this point.

Community and Migrant Health Centers

Revenue dependency: 33 percent of all revenues for C/MHCs is from Medicaid
7 percent is from Medicare
29 percent is from federal grants
9 percent is from private insurance
7 percent is from patients
15 percent is from other (than Medicaid) state and local[10]

BBA Provision: Allows state government to phase out cost-based reimbursement, without requesting Medicaid waivers. If C/MHCs participate in Medicare+Choice plans, those payments would likely be reduced.

Potential Impact: Medicaid revenues would likely be reduced. One estimate is that Medicaid managed care plans, on average, pay less than 60 percent of the Centers' reasonable cost rates (basis for cost-based reimbursement).[11]

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[10]Taken from Daniel R. Hawkins, Jr. "Statement on The Effects of Managed Care and Other Health System Trends on Community Health Centers." Presented to the Institute of Medicine. May 8, 1998. Figures represent 1966 revenues.

[11]Daniel R. Hawkins and Sara Rosenbaum. "The Challenges Facing Health Centers in a Changing Healthcare System." Ch. 6 in Altman, Reinhardt and Shields, eds. The Future U.S.

Resolution: Three approaches have implications for the federal budget, but are the only solutions that would assure C/MHCs continued financial viability. First, the requirement for cost-based reimbursement could be reinstated, perhaps modified to apply only to certain services (the "wraparound" services provided by centers). Second, a separate prospective payment formula for health centers could be developed that reflects the costs of all the services they provide which would otherwise not be reflected in a formula based on costs of all ambulatory care providers. Third, federal grants could be increased to substitute for the previous margins in the public programs.

Other potential resolutions would include increasing private funding through successful competition for managed care contracts, increasing funding from state and local sources, and increasing funding from private contributions. While Centers should be expected to pursue these options and implement management efficiencies, these approaches are not certain to fill in all gaps.

Small Rural Hospitals

Rural hospitals with fewer than 50 beds are "important in the fabric of the safety net." These hospitals are disproportionately represented in the highest decile of hospitals classified according to ratio of uncompensated care costs to operating expenses.[12]

Revenue Dependency: 47 percent of all rural hospital costs covered by Medicare
12 percent covered by Medicaid
5.4 percent uncompensated care
3.7 percent loss on Medicare in 1994
4.7 percent loss on uncompensated care in 1994
1.3 percent loss on Medicaid in 1994[13]

Healthcare System: Who Will Care for the Poor and Uninsured? 1998. Chicago: Health Administration Press. Data are taken from a letter prepared by the National Association of Community Health Centers.

[12]Linda E. Fishman. "What Types of Hospitals Form the Safety Net." Health Affairs 16 (4) July/August, 1997: 215-222.

[13]Stuart H. Altman and Stuart Guterman. "The Hidden U.S. healthcare Safety Net: Will It Survive." ch 9 In Altman, Reinhardt and Shields, eds. The Future U.S. Healthcare System: Who will Care for the Poor and Uninsured? 1998. Chicago: Health Administration Press. Data are taken from the Prospective Payment Advisory Commission analysis of American Hospital Association Annual Survey of Hospitals data.

BBA Provisions:	PPS payments for *all* rural hospitals reduced 9.6 percent in 2002. Net impact of 0.6 percent on all revenues in 2002[14]
Potential Impact:	For small rural hospitals not qualifying for full cost-based reimbursement under rules of exception (such as sole community hospital designation), reductions in the PPS payment could cause financial ruin and trigger decisions to close the hospitals. While the overall impact on revenues may seem small, these hospitals operate on narrow or often negative operating margins.
Resolution:	Policies may be required to protect the financial viability of small rural hospitals that are the safety net providers in their communities.

[14]Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy Vol II: Analytical Papers. March, 1998.

CHOICES FOR BENEFICIARIES

The BBA created a new Medicare+Choice (M+C) program, intended to provide beneficiaries with a menu of options from which to select the Medicare health plan of their preference. Among the choices are to be: traditional Medicare, managed care plans (HMOs), preferred panel organization plans (PPOs), medical savings accounts (MSAs) and hybrids that combine fee-for-service payment to providers with capitation to Medicare and beneficiaries. Experience with the impact of the BBA on Medicare managed care is limited because the policies have been in place for only a few months, and some policies are still being phased in slowly over a period lasting six years. In addition, new Medicare+Choice plans could not be formed until January 1999, and so far the only one of those choices receiving response in the market is the HMO option, in large part because it existed already under earlier enabling legislation.

Payment Changes in Medicare+Choice

Much of the future growth of options in M+C is contingent on the payment rates being attractive to health plans. So far, the experience is mixed, as indicated by the data just presented concerning some plans withdrawing from certain counties.

Concerns about the BBA have focused on the implementation of the payment policy changes. In particular, although the BBA promised to eventually use a "blended" rate methodology to set Medicare capitation rates in most counties, no counties had their rates set by this method in 1998 and 1999. Instead, every county either got only a 2 percent increase over the previous year's rates, or was raised up to the payment floor (roughly $380 per person per month in 1999). This outcome occurred for several reasons, but the main reason was that the slow growth in Medicare per capita spending, slower than what was anticipated at the time of the passage of the BBA, coupled with the "budget neutrality" provision in the BBA to eliminate the funds needed to "fund the blend."

Future payments to Medicare managed care organizations will likely be significantly impacted by another provision of the BBA that will be phased in over a number of years. Recently, HCFA has announced that it will begin phasing in a "new risk adjustment methodology," which will be in effect for a small portion (10 percent) of payment rates paid in the year 2000, and phased in over a period of five years (fully phased in by the year 2004). The proposed methodology would adjust the AAPCC county rate paid to Medicare+Choice organizations, based on inpatient medical diagnoses, along with demographic factors, to predict total health spending in the following year.[15] Preliminary analysis of the published adjustments suggests that they would favor rural counties, in the sense that rural rates would be adjusted slightly upward, and urban rates slightly downward. However, it is important to note that the rate paid to a plan will depend on the characteristics of recipients who

[15]Memorandum from HCFA to Medicare+Choice Organizations and other Interested Parties, "Medicare+Choice Rates -- 45 Day Notice: Advance Notice of Methodological Changes for the CY 2000 Medicare+Choice Payment Rates," January 15, 1999.

enroll in the plans, if any enroll. Thus, even though the risk adjustment might seem to favor rural counties in the short run, that could change as experiences of enrollees change (fewer rural enrollees in the expensive inpatient treatments and/or more urban enrollees in those treatments). Thus, we cannot comment with certainty on any ultimate "windfall" for rural managed care plans.

Changes in Enrollment

Despite the slow growth of options to Medicare HMOs, some of the payment policy changes were implemented immediately as of January 1998, so current and new Medicare HMOs will be affected by these policy changes. The early evidence indicates that the percentage of rural beneficiaries in managed plans increased from 2.15 percent in December 1997 to 2.62 percent in September 1998. This translates into an increase in enrollment of roughly 45,000 enrollees in rural counties over the period.

A great deal of attention has been paid in the popular press to reports that existing Medicare HMOs are either dropping counties from their service areas, or planning to not renew their Medicare contracts altogether. In a recent report, HCFA found that 95 risk contracts (health plans paid on a prepaid capitation basis) are not renewing their Medicare contracts or reducing their service areas (with these plans continuing to serve other parts of their current service areas).[16] A total of 414,292 beneficiaries in Medicare risk plans (about 7 percent of total risk enrollment of roughly 6 million persons) are affected by non-renewals and service area reductions in 371 counties. Of these, 56,142 beneficiaries are in 120 rural counties.

HCFA notes, however, that only 11 percent of the beneficiaries affected by plan non-renewals live in counties where no other Medicare managed care option exists. No other risk (or cost) plan will be available in 72 of the 371 counties described above. This will affect 45,074 beneficiaries, less than one percent of current risk enrollment. Of the counties with no other plans available, 51 of these counties are rural counties, affecting 15,158 beneficiaries. It is worth noting that 13.6 percent of beneficiaries losing their coverage, and 33.6 percent of those without another HMO option, reside in rural counties, even though only 4.1 percent of Medicare HMO enrollees overall reside in rural counties. This indicates that the problem of Medicare HMOs not renewing is disproportionately affecting rural residents.

Although RUPRI has not completed a full analysis of the reasons why plans might be dropping out, some evidence on the reasons for change can be found from studying individual cases of plans dropping their service contracts. From that analysis, RUPRI has concluded that the counties dropped from the service area were often those counties "at the margin," either with capitation rates lower

[16]Health Care Financing Administration. (1998) "Managed Care Organization Service Termination and Service Area Reductions," message from Administrator, October 8, 1998 [downloaded on October 8, 1998, from World Wide Web at address http://www.hcfa.gov/Medicare/nonrenew.htm].

than other counties in their service area, or counties with low enrollment. In addition, the BBA, and subsequent regulation, require a single premium rate and benefit package throughout the service area of a given plan. Therefore, firms are making decisions based on *relative* payment in the same area, where the difference across counties may exceed $100 per member per month.

IMPLICATIONS AND OPTIONS

There should be little or no doubt that changes in the Medicare program introduced by the BBA are significant and will have an impact on the delivery and use of services in rural areas. The impacts will be felt by Medicare beneficiaries, and because of Medicare revenues to rural providers, by all who use the rural health care delivery system. In this section, general implications for the delivery system and beneficiaries are drawn from the specific impacts illustrated in previous sections. Responses to the changes in Medicare policy will include how providers and others respond, and how policy makers will make adjustments in Medicare policy as the implications of what was enacted in 1997 become more clear.

Implications for the Delivery System in Rural Areas

This analysis focused on the impacts of payment change on institutional providers in rural areas, community and migrant health centers, small (less than 50 beds) rural hospitals, all rural hospitals, skilled nursing facilities and home health agencies. For each group of providers, payment changes have the net effect of reducing Medicare revenues. The following fiscal realities make these reductions especially troubling:

- **Many of the rural providers affected by the Medicare payment changes operate on very narrow and sometimes negative operating margins.**
- **For many rural providers Medicare payments (for hospitals including multiple sources of payment) represent a substantial portion of their total revenues.**
- **Therefore, reductions in Medicare payment may threaten the financial "bottom line" of many rural providers.**

Absent any response from the delivery system, or change in public policy, rural providers may be forced to cease operations. Since many of these providers represent the safety net in rural communities, closures need to be carefully monitored so that rural citizens are not left without viable options for care. Other changes in the BBA should be considered in tandem with those that reduce payment in the traditional Medicare program. For example:

- **The new Rural Hospital Flexibility Program allows small (fewer than 16 acute care beds) to convert to a new Medicare certified category that enables them to reduce operating expenses and receive cost-based reimbursement.**
- **Small rural hospitals may qualify for designation as sole community hospitals or Medicare dependent hospitals, which would mean cost-based reimbursement.**
- **Rural providers could participate in Medicare+Choice plans that, based on realizing more Medicare revenues than the total of fee for service payments in traditional Medicare, pay more to providers.**
- **The new Child Health Insurance Program may result in payment for previously**

unpaid claims.

These provisions will not eliminate all of the financial concerns of safety net providers losing cost-based reimbursement from Medicaid, or those of hospitals not qualifying for exemption from prospective payment systems. Other actions are likely to be needed, as discussed below.

Implications for Rural Medicare Beneficiaries

The data concerning enrollment into Medicare managed care plans is not very promising if equity of choice among beneficiaries across urban and rural residence is a goal. However, the full effects of the changes in risk contract payment mandated by the BBA will not be evident for some time to come. Increases in managed care offerings that follow implementation of a blended formula cannot be detected until the blend has begun, at the earliest in 2000. Even though enrollment of rural beneficiaries into managed care plans is increasing at a higher percentage than in urban areas, the total number remains small, and rural counties have experienced disenrollment resulting from plans not renewing Medicare managed care contracts. Further increases in rural beneficiary enrollment into managed care plans will be related to:

- **implementation of the blended formula for payment to risk contracts,**
- **impact of any use of risk adjustment in determining payment,**
- **readiness of managed care organizations to enroll rural beneficiaries, and**
- **willingness of rural beneficiaries to enroll in new Medicare plans.**

Given low enrollment into managed care and limited use of any Medicare+Choice plans in rural areas for the foreseeable future, the impacts of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries.

The relationship of payment decisions to the welfare of rural beneficiaries is illustrated by examining the impacts of changes in payment for home health services. The current per beneficiary limits may force agencies to restrict the types of patients they serve. Under the limits, agencies will have a strong incentive to avoid high cost patients. The per beneficiary limit may have a differential effect in rural areas where fewer beneficiaries use home health services, but have more visits per use. Similar implications arise regarding services from local hospitals, skilled nursing facilities, and community and migrant health centers. If payment changes force decisions to restrict services or persons served, access to services will suffer. In a worst case scenario, if the local provider is forced out of business because of negative operating margins, local access to essential services would end.

Responses to the Changes

The payment changes included in the BBA are predicated on the assumption that health care providers and delivery systems can adjust to lower than expected Medicare payment by finding cost

savings in their operations. This approach may prove difficult for small rural providers, but not impossible. For example, one home health agency administrator offered the example of introducing "clinical pathways" for some the most frequent diagnoses, which should result in better and less expensive care. Similar approaches could reduce the costs of other types of care, particularly in skilled nursing facilities and hospitals. For safety net providers, such cost efficiencies may be more difficult to discover and implement. However, the Bureau of Primary Health Care has been providing technical assistance and funding for technical assistance to C/MHCs to help them adopt new strategies of improving cost effectiveness in service delivery. ***The point being made here is that rural health care providers can find and implement measures to reduce per unit costs of care.***

However, ***individual health care providers are not likely to find sufficient savings to absorb the full amount of payment reductions anticipated as a result of the BBA.*** Another response is to find savings through developing local networks of service providers. There are programs in place to encourage this activity; the network grant program of the Federal Office of Rural Health Policy, the network grant program of the Bureau of Primary Health Care, and the new State Rural Hospital Flexibility program. Experience with rural networks is still quite limited, and savings cannot be determined. ***Rural providers may be able to find savings through further development of local and regional networks, but this requires time and the yield is unknown.***

Another possibility for finding cost savings is to increase volume of service per provider such that economies of scale would yield savings. Individual rural providers are not likely to be able to do this, nor will small networks. Two possibilities exist: large rural networks, or consolidation of providers. ***A challenge for rural providers will be how to cooperate across a sufficient number of service locations to generate the number of patients needed to use new techniques of medical and administrative management, without sacrificing local autonomy.***

Policy Issues

Policy makers examining the Medicare program are obligated to be fiscally prudent in setting payment policies, but they are also charged with the responsibility of doing what they can to assure that services are available to the beneficiaries. These twin responsibilities pose what has become a core dilemma in recent years – meeting an obligation to finance services without spending more than is affordable in the context of the Medicare Trust Fund and the General Fund of the federal budget. ***The imperative to constrain Medicare spending cannot be met by imposing continuing and significant payment reductions on small rural providers; doing so jeopardizes access to care for rural beneficiaries.*** Those providers should be able to cut costs in a manner that contributes to savings deemed necessary for the future of Medicare, but not at the same levels as larger providers. Therefore, we close with the following considerations for public policies:

- **Any changes in payment policies should include a "rural differential," accounting for different impacts on providers as a function of size and location,**
- **Policies designed to encourage change in the organization of health care services should include resources and suggested models that encourage rural providers to participate in the changes.**

MEMBERS
RUPRI RURAL HEALTH PANEL

Andrew F. Coburn, Ph.D., is the Director of the Institute for Health Policy and Associate Professor of Health Policy and Management in the Edmund S. Muskie School of Public Service at the University of Southern Maine. Dr. Coburn is also Director of the Maine Rural Health Research Center, one of seven national centers funded by the federal Office of Rural Health Policy. He is currently directing studies of rural health insurance coverage and rural long-term care. Dr. Coburn is an active member of the National Academy for State Health Policy.

Sam Cordes, Ph.D., is Director of the Center for Rural Community Revitalization and Development at the University of Nebraska-Lincoln. He is a past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and the National Research Initiative Advisory Committee, U.S. Department of Agriculture. He has published extensively on the economics of rural health care, and served as President of the American Rural Health Association. He was the 1996 recipient of the National Rural Health Association Distinguished Researcher Award.

Charles W. Fluharty is Director of the Rural Policy Research Institute (RUPRI), a multi-state interdisciplinary research consortium which conducts research and facilitates public dialogue designed to assist policymakers in understanding the rural impacts of public policy choices. Fluharty was born and raised on a fifth generation family farm in the Appalachian foothills of eastern Ohio, where he returned following graduation from Yale Divinity School. As an educator, public policy analyst, association executive, and private consultant, his professional career has centered upon service to rural people, primarily within the public policy arena.

J. Patrick Hart, Ph.D., is President of Hart and Associates in Grand Forks, North Dakota. Before accepting his current responsibilities, Dr. Hart held faculty positions at the University of Minnesota-Duluth School of Medicine, Tulane University, the University of Oklahoma, the University of Texas Health Science Center and the University of North Dakota. He is past President of the Board of Directors of the National Rural Health Association and past Chair of the Rural Health Committee of the American Public Health Association.

A. Clinton MacKinney, MD, MS is a board-certified family physician practicing in rural Iowa. He earned his medical degree at Medical College of Ohio and completed residency training at the May-St. Francis Family Practice Program. His MS degree is in Administrative Medicine, University of Wisconsin. He has lectured and published articles regarding rural health, and has served on committees for the American Medical Association, the American Academy of Family Physicians, the Robert Wood Johnson Foundation, and the National Rural Health Association.

Timothy D. McBride, Ph.D., is Associate Professor of Economics, Public Policy and Gerontology at the University of Missouri- St. Louis. Dr. McBride's research concerns public economics, with special emphasis on the economics of aging and health. In the health policy area, Dr. McBride's research has focused on the uninsured, long-term care, and health care reform. He is the author of

over a dozen research articles and co-author of a monograph, titled The Needs of the Elderly in the 21st Century. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri- St. Louis after spending four years at the Urban Institute in Washington, D.C. He received his Ph.D. from the University of Wisconsin in 1987.

Keith Mueller, Ph.D. is a Professor and the Director of the Nebraska Center for Rural Health Research, University of Nebraska. He was the 1996-97 President of the National Rural Health Association, and the recipient of the Association's Distinguished Rural Health Researcher Award in 1998. Dr. Mueller's Ph.D. is from the University of Arizona, in Political Science. He is the author of a University of Nebraska Press book, *Health Care Policy in the United States*, and has published articles on health planning, access to care for vulnerable populations, rural health, and access to care among the uninsured. He is the Chair of the RUPRI Rural Health Panel, and in that capacity has provided expert testimony to Committees and staff of the U.S. Congress. He recently testified on rural health issues before the Bipartisan Commission on the Future of Medicare.

Dr. Mary Wakefield is Professor and Director of the Center for Health Policy at George Mason University, Fairfax, Virginia. From January 1993 to January 1996, Dr. Wakefield was the Chief of Staff for United States Senator Kent Conrad (D-ND). Prior to that she served as Legislative Assistant and Chief of Staff to Senator Quentin Burdick (D-ND). Throughout her tenure on Capitol Hill, Dr. Wakefield advised on a range of public health policy issues, drafted legislative proposals, worked with interest groups and other Senate offices. From 1987 to 1992, she co-chaired the Senate Rural Health Caucus Staff Organization. Dr. Wakefield served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. She was appointed to the Institute of Medicine's Committee on Quality of Health Care in America.

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Response to Question from Senator Grassley

Keith Mueller, Ph.D.
University of Nebraska Medical Center
January 31, 2000

What conditions would need to exist to make the premium support model work in rural America? Can plans ever make it work, or should we simply give up on that and focus instead on continuing our rural subsidies for fee-for-service insurance?

These questions encompass two related, but different models of payment suggested for the Medicare program:

1. Setting payment to health plans based on competition among plans as reflected in monthly premiums.

2. Paying health plans directly for arranging for the full array of Medicare services for enrollees – essentially promoting managed care as in the Medicare+Choice program.

Making competing plans work in rural areas

There are some sparsely populated rural areas wherein it is unrealistic to expect multiple health plans to compete for a small number of Medicare enrollees. Advocates of the premium support model have suggested that national plans will still compete for enrollment, citing the Federal Employee Health Benefits Plan (FEHBP) experience to support this argument. However, the national plans in the FEHBP are either fee-for-service plans or preferred provider panels that include all the rural providers in their panels. They do not represent choices among managed care options, as implied by those who argue, for example, that there are 19 plans to choose from in Nebraska (at least 6 of those plans, including all the managed care options, are offered only in the Omaha and Lincoln metropolitan counties).

Experience with the Medicare+Choice program indicates that health plans are not willing to add rural markets to urban service areas if doing so means offering the same benefits at a lower rate of payment. Therefore, unless the fundamentals of the payment system are changed such that rural rates are increased, a scenario of national or regional plans competing for rural enrollment is quite unlikely. If the inequity in rates was corrected, plans might compete in those rural areas

where they could foresee adding appreciable numbers to their enrollment. Even under these improved circumstances we should not expect competitive activities in frontier areas.

Could the premium support approach actually render harm in rural areas? If the payment policies were set to hold the beneficiaries harmless to any increases beyond their current member premiums for comparable benefits (e.g., their supplemental plans), the answer is no. However, if beneficiaries are told the national average premium determines the government payment and if the only option in their area is a government sponsored plan charging more than the national average, their costs will increase. The final recommendations of the Bipartisan Commission on the Future of Medicare addressed this problem with a payment set at *either* the average or the rate of the *single* plan being offered in any county. However, if there are even two plans being offered, the result may still be increased liability for the beneficiary.

Managed care plans in rural areas

To argue that sparsely populated rural areas cannot sustain competing plans is not to argue that a single managed care plan cannot succeed in those same areas. Well managed and well capitalized plans can succeed with minimal Medicare enrollment, assuming adequate payment. Such has been the case for the plan in Rugby, North Dakota for years, and more recently for plans in Oregon and Montana. However, the current payment for Medicare+Choice plans in rural areas is, in most instances, not sufficient to inspire development of managed care plans. The experience in Billings, Montana is particularly telling – they were a demonstration site that converted into a Medicare+Choice plan. Now they are withdrawing from the program, because payment is too low; had the blended rate provisions of the BBA been implemented they might have been able to stay in business. The plan in Bend, Oregon is staying in business, although it too is struggling to stay afloat fiscally at a payment rate only slightly above the "floor." In each of these two cases, a monthly payment rate close to an urban average (assuming that would be above $450 per member per month) would be sufficient. The current inequities in payment for Medicare+Choice plans are preventing a fair test of whether or not such plans could be sustained in rural areas.

Conclusion

I am not willing to say that the only approach to sustaining rural health care delivery for Medicare beneficiaries is in continuing rural subsidies through the fee-for-service model. However, even after a fair test of managed care, I can foresee reaching that conclusion in the most sparsely populated of our rural areas. Policies based on approaches such as the premium support model would need to include special arrangements for such areas. This can be done without sacrificing the integrity of the general model, as we are doing now in hospital payment by recognizing certain categories for separate payment policies. Such policy by exception also does not threaten the finances of the program, as only a very low percentage of total spending is affected.

For your further information and the record, I am enclosing a copy of a special paper regarding the premium support approach, written in June, 1999.

PREPARED STATEMENT OF HERBERT PARDES, MD

EXECUTIVE SUMMARY

Chairman Roth, Senator Moynihan and distinguished members of the Finance Committee, I appear before you today as a proponent of academic medicine. Currently, I am Vice President for Health Sciences and Dean of the College of Physicians and Surgeons at Columbia University. During the course of my career in government, as Director of the National Institute of Mental Health, and at many fine medical centers, I have seen a phenomenal progress in medical care.

When I was an intern during the early 1960s, the range of treatment options available were limited. The small black bag of that day represented the limits of available treatment and diagnosis. Today antibiotics, genetic therapy, early diagnosis and treatment, and pharmaceutical interventions have made available a far wider group of options for the diagnosis and treatment of diseases previously untreatable and the amelioration of symptoms for others previously unrecognized.

These discoveries and treatment capabilities were made possible through the support of biomedical research and the government's recognition of the uniqueness of academic medical centers.

As we look forward, we see:

- Potential for defining the nature of numerous diseases through the human genome project which will allow more targeted treatments.
- Support of biomedical research provides advances that in the long-run can reduce costs of treatment.
- Our teaching hospitals are a valuable resource for the nation.
- Medical schools and teaching hospitals provide inestimable social goods.
- Effective treatment targeted to disorders saves costs, unnecessary medical procedures, and hospitalization days.

As such, I respectfully urge you to consider the following:

- Medicare's historical promise to provide the best and most comprehensive care must be retained.
- Academic medical centers and other health facilities in New York would be devastated by proposed efforts to privatize and deregulate Medicare.
- Graduate medical education in the United States is the best in the world. Establishment of trust funds for medical education, such as those called for in Senator Moynihan's bill, S.210, will help us retain preeminence in medicine through future generations.
- At this stage we cannot know the full impact of the Balanced Budget Act of 1997. I would urge you to consider the possibility that mid-course corrections might be needed.

Thank you for this opportunity to testify.

TESTIMONY BY HERBERT PARDES, MD

Chairman Roth, Senator Moynihan and distinguished members of the Senate Finance Committee, I am honored to appear before you today to testify about changes in academic medicine over the past decades. I am Herbert Pardes, M.D., Vice President for Health Sciences and Dean of the College of Physicians and Surgeons at Columbia University. During the course of my own career, I have had the opportunity to work at many fine academic health centers and to provide service to our government as Director of the National Institute of Mental Health in both the Carter and Reagan administrations. In these capacities, I have observed firsthand the most important discoveries medical science has made. America has the highest quality of medical care and biomedical research in the world. Today's innovative new treatments are tomorrow's routine medicines. If changes to financing of Medicare are contemplated, we must preserve this great strength.

Before describing the major changes in medical care since the inception of Medicare, I thought it would be useful to highlight for you the concerns I have about payment for health services. At this stage, we do not know the full impact of the Balanced Budget Act of 1997, but my colleagues and I believe that we may need to consider mid-course corrections. Providers of service to Medicare beneficiaries are concerned about their ability to provide care in the present environment. If one were to use premium support for all Medicare services, New York's patients and providers would suffer and our glorious system of medical education would disappear. Senator Moynihan's bill (S.210) would spread the cost of medical education across-the-board.

If I could take you back to the early 1960s you will recall the doctor's little black bag. The bag was little because there was very little to put in it.

Hospitals in the early 1960s, when I was an intern, did not discriminate between Alzheimer's disease and other forms of senile dementia, merely assuming that all people deteriorated in their late 60s and beyond. The prospects were hopeless, so, many patients who came in with such conditions were put into units off to the side with the expectation that little would or could be done except eventual disposition to a nursing home or, perhaps, the demise of the individual.

For coronaries we provided pain medication and 21 days of bed rest. Add a little prayer and you had the full therapeutic prescription.

In long-stay psychiatric hospitals there were patients with general paresis (syphilis of the brain) and manic depressive disease. Large numbers of patients (close to 600,000) were hospitalized in chronic psychiatric state hospitals.

The prospect of being diagnosed with cancer was feared as an almost definite death sentence. In fact, going to hospitals in those days was a cause for great anxiety, because, by virtue of the limited therapeutic potential of the medical system, it was not unusual that anyone going to a hospital for any kind of condition or consequence might not return home.

Today we recognize Alzheimer's disease as a separate disease. There is increasing information about the genetic contributions. There is evidence that the early administration of estrogen might delay the onset of Alzheimer's disease in women. There is exciting work, which is informing us increasingly about memory and the possibility that memory deterioration, one of the most frequent causes of institutionalization of patients with Alzheimer's disease and other dementias, may prove more malleable to treatment.

Drug therapy has expanded greatly. Patients with syphilis of the brain are almost unknown today because of their effective treatment with penicillin. Manic depressive disease can now be controlled for the most part with lithium, carbamazepine, or valporate, allowing many individuals to function normally despite the illness.

The patient population of chronic psychiatric hospitals has fallen from close to 600,000 to less than 100,000 today.

Threatened myocardial infarctions (coronaries) can be prevented with rapid treatment by TPA in emergency rooms. The use of techniques of cleaning out clots, bypass surgery, anticlotting substances, prophylactic benefit from aspirin, and better diets have literally revolutionized our treatment of heart disease.

Although heart disease is one of the nation's major killers, many more patients with heart disease are surviving heart conditions and thriving. In the most serious instances of heart disease, transplants and left ventricular assist devices afford thousands of people new opportunities of life extension.

While we still have a long way to go in the treatment of cancer, for many patients treatments are definitively curative, for some, considerably life extending, and for others, dramatically relieving of symptoms and improving of function.

In a word, American medicine today has so dramatically changed that it is almost unrecognizable compared to what it was in the early 60s.

With these new methods of treatment, sites of care are also changing. Across the United States hospital occupancy rates have fallen from 64.5% in 1990 to 58.7% in 1995, despite a 7% decrease in the number of hospital beds during that period. If anything, there is a continuing decline in the use of hospital beds and hospital days.

More and more procedures are done on an ambulatory basis. Cataract surgery has become an increasingly simplified procedure. Other types of surgery have also reduced the number of hospital days. Previously a person with a heart attack was hospitalized for 21 days; today a bypass patient often leaves in 5 days.

This is a record of which the United States should be proud. The advances made by physicians and scientists all over the country highlight the leadership of American medicine which at its best has no equal.

The wisdom underlying this extraordinary set of accomplishments originates with the Congress and the American government. Medicare support has been indispensable in permitting teaching hospitals and their affiliated medical schools to claim world leadership in advanced patient care physician education, and research. Whether you read the list of the 50 best hospitals in US News and World Report or learn about the latest innovation in medical care on the evening news, the chances are that a United States teaching hospital or medical school is the setting. Teaching hospitals and medical schools fulfill an extraordinarily valuable social mission. By virtue of the blend of their functions, patients are cared for with the highest quality expertise in a setting in which new doctors can learn. Others can work with scientists to identify treatment needs and steer the research toward addressing them.

There are many things of which this nation can be proud, and one of the most potent is the distinction of its academic medical system.

What do we see when we look forward?

One result of the completion of the human genome project will be new technologies for quickly sorting out what genes are relevant to given disorders to expedite our verification of the nature of the number of diseases. Such increasingly specific genetic information allows for a corresponding development of very specific medications, which will modify the effect of genes in a tailored and highly specific fashion.

Our ability to examine the minute structure of proteins, those we use for treatment, and relate their structure to either their effectiveness or their side effects, will enable us to design and develop better medications, increasing the therapeutic effect while diminishing the side effects.

I believe the trend of reducing the kinds of conditions for which patients are hospitalized and increasingly focusing on health care in out-patient settings will continue. As we learn more about diseases, the value of educating patients with diabetes and asthma about caring for themselves should mean the reduction of hospital stays and acute crises. Those should be replaced by more steady personal care on an out-patient basis, with more and more effective prescriptions.

I am aware of the concerns that technology may cost more, but there are many examples of how new technologies have reduced major costs:

- Lithium is said to have saved more money than all the money ever spent on research at the NIMH.
- Polio vaccine eliminated expenditures for the iron lung industry and long term institutionalization.
- Fluoride has revolutionized the treatment of dental care.
- The savings from the migration toward ambulatory health care instead of costly and lengthy hospital stays are enormous.

To ensure the remarkable progress in medicine continues, I urge the following for Congress:

(1) Please continue your vigorous support of the biomedical research effort in this country. I applaud the intention to double the NIH budget and thank the Congress for its support both last year and in the years up-coming.

(2) I believe Congress should ensure that the nation's teaching hospitals continue to thrive as they have over the last several decades. As we speak there has been an acute downturn in the financial fortunes of these hospitals. They are too valuable a resource to be placed at risk.

(3) The social goods provided by medical schools and teaching hospitals, including medical research, the training of top quality physicians, the delivery of the best care often to the neediest patients should be strongly protected. Regardless of how Medicare is structured going forward, there has to be assurance that these social benefits can be achieved by the institutions that know how to achieve them.

(4) Increasingly, effective, targeted and tailored treatment can reduce unnecessary treatment days, hospital stays, complications and the like. This is true whether we are talking about diabetes, heart disease, cancer or psychiatric illness.

I want to thank you—our national leaders—here today. You have given us extraordinary support over the years.

I respectfully urge you to continue on that path in order to move America's revolution in health care even further. Insuring that elderly people have the ability to secure their care and their medications is wise, compassionate and economically sound policy.

The little black bag of the 1960s would have to be replaced by a very large black bag today. The ultimate intention is to have no condition for which we do not have an answer, whether it be a cure, a preventive strategy, or new treatments that alleviate pain and suffering.

Prepared Statement of Martha Phillips

Thank you for inviting me to appear today to discuss Medicare reform. I am representing the Concord Coalition, a nationwide, grassroots bipartisan organization dedicated to strengthening the nation's long term economic prospects through prudent fiscal policy.

Background

Concord's co-chairs are former senators, Warren Rudman (R–NH) and Sam Nunn (D–GA). They, along with our approximately 200,000 members who hail from every state, have worked for six years since the organization's founding by Paul Tsongas and Warren Rudman in 1992 to help build a political climate that encourages elected officials to make the tough choices required to (1) balance the federal budget, (2) keep it balanced during times of peacetime prosperity, and (3) prepare for the budg-

et problems that will occur as the nation's population becomes sharply older in coming decades.

Balancing the federal government's books is the single most effective policy we have to increase savings, which in turn are the key to long term economic growth. Savings provide the capital needed to increase the productivity of American workers, a concern that will become especially urgent when the retirement of the huge baby boom generation virtually halts growth in the size of the U.S. work force. With a fixed-size work force, economic growth and an improving standard of living will depend almost entirely on how much we invest in gaining additional output from each person working in our economy.

Concord believes that not only should we put the rest of the government's accounts into balance, we should also use the current economic, fiscal, demographic and political windows of opportunity to address the long-term Social Security and Medicare deficits that will accompany the aging of America. These looming and unsustainable deficits threaten to undo the hard work and fiscal discipline of recent years and undermine our nation's potential for future economic growth.

Medicare reform

As I mentioned a moment ago, the Concord Coalition believes that reforming the Medicare program to make it fiscally sustainable over the long haul should be a leading priority of our nation's political leaders. Responsible political leadership requires first admitting that a Medicare financing problem exists and then working in a bipartisan and constructive manner to address it. Any serious reform will necessarily involve tough choices, choices that people in elective office probably would prefer not to make. But "none of the above" is no solution; the Medicare financing problem will only grow worse. Therefore, we challenge those who use "Mediscare" tactics by purposely delaying action on Medicare reform to refrain from creating political wedges by attacking office-holders and candidates who are willing to make tough choices as part of an overall reform effort.

Why is the need so urgent to address Medicare now? After all, program growth not only recently has been slower than ever before and slower than expected after the 1997 reforms, but it now appears that the program for the first time in memory may not spend appreciably more this year than last year. Medicare spending in the first half of fiscal year 1999 has actually been $2.6 billion less than the 1998 comparable period. What's more, the Part A trust fund, often has been on the precipice of bankruptcy in the past, now appears to be solvent for a decade.

The reason reform should be tackled promptly is that the current period of benign Medicare financing is a deceptive lull before the storm. Every serious policy analyst who has looked at the long term situation has concluded that Medicare is on borrowed time for several reasons.

Two-part problem

Medicare cost increases have been deceptively low in recent months, so much so that no one expects the current spending slowdown to continue much longer. Part of the lower cost this year is due to a lengthening of the average processing time for Medicare claims. Eventually, the payment rate will level out, and if processing time returns to normal, there will be a surge in "catch up" payments. Second, the 1997 Medicare reform legislation has resulted in greater savings than anticipated, and payments to some Medicare providers, particularly managed care providers, skilled nursing facilities and rehabilitation therapy have been cut back more than lawmakers expected. As a result, there may be efforts to soften the impact of the 1997 legislation, which will have the effect of increasing costs in the short run.

In the long run, however, two problems combine to create a serious potential crisis for the future of the Medicare program. One problem is the massive and permanent shift in our nation's demographics that will occur when the Boomer generation becomes eligible for Medicare. This will begin in 2011, and by 2030, all the Boomers will be 65 or older. The younger generations coming along after the boomers constitute a much smaller percentage of the total population than did the boomers.

(In 1998, today's youngest "Millennial Generation" (new-born through age 18) who are now stressing public education coast-to-coast have beaten the Boomer generation's record for sheer numbers. However, total U.S. population today is larger than when the Boomers were kids. Therefore, individuals 18 and under constitute a smaller percentage of the population today (25.9%) than they did in 1960 (35.7%.)

Because birth rates have declined to barely replacement rates or even below, the population "pyramid" that existed when the U.S. was literally a young nation will metamorphose into a population "column" in which various age cohorts will be roughly equal in size. Therefore, the retirement of the Boomer generation signals

the beginning of a rapid aging of America and will mark the transition to a substantially older population:

- The number of people who are "young-old" (age 65–85) will double and those who are "old-old" (85 and older) will triple or quadruple.
- Between 2010 and 2030, the elderly population will grow three times faster than it will in the coming decade.
- In 1997, 458,000 new beneficiaries signed up for Medicare. In 2022, HCFA estimates that a staggering 1,633,000 new beneficiaries will sign up.
- Older Americans today constitute about 12 percent of our total population. By 2030 they will be 20 percent, and later on an even larger percentage.
- The working age population (aged 18–64) will grow more slowly than ever before, until by 2010, the total workforce will be increasing by only one tenth of a percent annually, compared to two percent annual increases in the past and one percent annual increases today.

When a large working age generation provides retirement support for a small retired generation, modest contributions by each worker are sufficient. But the closer the number of retirees comes to the number of workers, the greater the burden workers must carry. In the 1960's, there were about 5 workers for every retiree in the U.S. Today there are about 3, and by 2030 there will be only 2. When this happens, current program commitments to provide taxpayer-financed retirement income and health insurance benefits for the elderly—Social Security and Medicare—will become unsustainable. The sheer numbers of new beneficiaries will push costs up faster than the revenue sources committed to pay for the benefits and perhaps faster than what working age citizens, retirees' children and grandchildren, will be willing to finance.

(It's true that working age people must also bear the costs of supporting children and nonworking adults. However, government commitments to children are considerably smaller than those to the elderly. The federal government spends $9 on the elderly for every dollar it spends on children. Even after taking into account State and local education, Medicaid and other expenditures on behalf of children, the ratio is still $3 for every senior for every $1 spent on children.)

In addition to this looming increase in Medicare beneficiaries, a second factor is operating to drive Medicare costs up even faster: the rapid increase in Medicare costs per beneficiary. Medicare per-capita spending increases reflect economy-wide increases in medical costs. Due to breakthroughs in medical science, ever more intensive treatments and management of acute and chronic illnesses, medical costs are growing at a faster rate than the economy. Even if future policy-makers could find a way to finance today's level of benefits for the huge number of future beneficiaries, increased costs per beneficiary make the current Medicare program unsustainable for the long run. In fact, Medicare costs are projected to overtake Social Security costs in about a decade. Although growth in costs per beneficiary are no longer increasing at a double digit clip as they did in earlier decades, they are still growing 8 percent annually in the 1990s, and are expected to continue growing at 6 percent annually (although none of the forecasters who predict the 2 percentage point slowdown in the growth rate have any explanation as to how that slowdown will be achieved.) No one expects even a red-hot economy to produce anything like a long-term 6 percent rate of growth, much less higher rates.

Taken together, the increase in the elderly population and the increase in Medicare costs per beneficiary will drive Medicare expenditures projected under the current program from less than 3 percent of GDP today to 5 percent by 2020 and 7 percent by 2040.

It is highly unlikely that resources will be found in the future to support this level of health care spending on behalf of the elderly. Therefore, the Concord Coalition joins many others in advocating that actions be taken in the near term to bring promised future commitments into line with identifiable future sources of financing.

The Concord Coalition would urge policy makers to heed the following guideposts, or criteria for reform:

Fiscal sustainability

A fiscally responsible program is one that can reasonably be expected to operate over the long term within the resources available to finance it. A program that depends on an open spigot perpetually gushing forth additional resources at a rate faster than economic growth is not credible. If policy makers are serious about maintaining the promised level of benefits—including an escalating real cost of Medicare insurance per beneficiary—then they should identify the resources to finance these benefits. On the other hand, if policy makers are unwilling to increase the flow of resources going to the elderly portion of the population beyond the half of the federal budget devoted to seniors today (excluding net interest), then they

should begin to put in place a rational means of scaling back promised benefits to a level that stays in line with anticipated program revenues. Either course is responsible. Neither course is easy. But what is both easy and highly irresponsible is to continue to promise benefits that exceed not only the revenues identified to pay for those benefits, but also exceed anything future taxpayers conceivably will support.

Generational responsibility

Generational responsibility has several dimensions. The Concord Coalition believes that each generation should pay as much as possible of the cost of its own retirement package, including Medicare and Social Security and long-term care. This definition of generational responsibility is particularly important at time when an extremely large generation such as the baby boomers is retiring and the working-age generations (baby busters) are substantially smaller in numbers. It is simply unfair to expect a smaller generation to support the larger one, particularly when retirees on average are financially just as well off, if not better off.

In addition to the huge wave of boomer retirements, a second major reason why the number of elderly will soar dramatically as a percentage of total population is that people are living longer than ever before. Life expectancies for people reaching age 65 are continuing to climb and many experts believe that current projections may even understate future trends. (Intermediate projections count on it taking until 2050 for people in the U.S. to live as long on average as people do today in Japan.)

What does generational responsibility require with respect to lengthening lifespans? That Medicare insurance be provided at age 65 regardless of whether a 65-year-old can be expected to live for another 14.6 years as in 1965, or 17.7 years today? What about providing Medicare insurance for 20.3 years, as the program is currently expected to do by 2070? The Concord Coalition believes it is reasonable to increase the age of eligibility for benefits, particularly taxpayer-financed benefits, along with increasing lifespans.

People of all ages have problems that the government could address, ranging from prenatal care, to child development and education, to job training, to old age assistance. No generation should have an automatic claim on taxpayer resources simply because of its chronological age. Indeed, if any generation should be singled out for special attention, it should be the young who are our future citizens, workers and parents.

Means-testing

The Concord Coalition has long been on record in favor of means-testing government entitlements. We believe that entitlement programs should be viewed as universal insurance plans rather than universal annuity benefits. It is reasonable to insure everyone against the risk of not having enough cash income or access to medical insurance in old age, but given the looming age wave, it is not reasonable to award every person who crosses an arbitrary chronological age threshold a set of income and health insurance benefits regardless of income. Our demographics and future economy simply will not allow it without bankrupting everything the government does for other age groups and for the common good. Concord believes that since benefits must inevitably be scaled back, the fairest way is to protect lower-income individuals as much as possible, and ask the comfortably well off to take proportionately less from their fellow taxpayers, many of whom themselves have lower incomes. To take the most extreme example, when Bill Gates retires, why should a single mother earning minimum wage have to pay anything toward his health insurance? Why shouldn't he pay his entire premium?

Medicare means-testing should never be applied by charging some people more for their treatment than others. But, reduced to its essentials, it is reasonable to think of Medicare as a government-financed medical insurance policy for the elderly and disabled. Although as a group seniors enjoy a better income and less poverty than other age groups, particularly children, not every elderly person is economically secure. Therefore, the Medicare medical insurance "policy" should be means tested, with premiums geared to income levels. This makes more sense than means testing the deductibles and copayments; not only would that be an administrative nightmare, but it would fall most heavily on the small percentage of elderly who are extremely sick in a given year.

Converting Medicare to a FEHBP style supported premium arrangement seems to be a sensible change, and Concord generally endorses this approach. However, we doubt that it will be possible indefinitely to finance the level of benefits most Americans expect and continue to charge every enrollee the same premium. If the premium were held to a level that seniors in, say, the bottom two deciles of income

distribution could afford, the insurance coverage that could be provided would be inadequate and those who could afford it would augment Medicare by purchasing high-option and supplementary insurance. Alternatively, if universal premiums were permitted to rise along with rising medical costs, the government eventually would be forced to augment the premiums of those with lower incomes through Medicaid or in some other way. Either way, those who could readily afford to pay for a larger share (or even all) of their Medicare insurance would not be required to do so, and that's wrong from both a practical and equity standpoint.

Efficient provision of medical care

Whatever new system of medical insurance for the elderly is devised, it should contain incentives for both providers and patients to use resources in a cost effective manner. Treatments that have little or no promise of achieving any appreciable improvement in a patient's well-being should not be financed with taxpayer dollars. Fee-for-service Medicare should be permitted to use many of the same techniques available to managed care providers to deny payment for unnecessary treatment, duplicative diagnostic procedures and other practices that waste resources.

Prompt action

Changes in Medicare should be enacted promptly, so that new systems can be implemented before the boomers retire. Entitlement programs for the elderly are long term commitments between the government and the citizenry, and people base their behavior and make their plans based on current provisions. Therefore changes in the Medicare health insurance commitment should be undertaken in time to permit gradual changes and to give people time to plan and adjust.

If an FEHBP style supported premium system is the picture of Medicare in the future, then there is a second reason why prompt reform is urgent. Setting up a premium support system will require a vast amount of work to be accomplished in behind the scenes preparation. Even if people agree with the vision of a FEHBP model (which right now they do not), it would require at least a decade to implement, and even more years before it runs smoothly and seamlessly.

Medicare changes should not be made in a vacuum

Medicare is only one of the long-term commitments citizens have made to support seniors, along with Social Security and, in the case of long-term care, Medicaid. When program reforms are considered one at a time, it is possible to ignore the ripple effect of changes in the cost or financing for other programs serving the elderly.

Consider the triple whammy coming from the future costs of Social Security, Medicare Part A and Medicare Part B. Today, the three programs combined claim 6.76 percent of GDP. By 2035, they will claim nearly 11.3 percent (assuming the intermediate cost projections), and by 2070, when today's newborns are lining up for benefits, they will cost nearly12 percent of GDP. Today, The "triplets" operate on a break-even basis: The 1999 Social Security cash surplus of $70 billion was more than sufficient to cover the $4 billion cash shortfall in Medicare Part A as well as the $64 billion general revenue infusion into Medicare Part B. But in 2035, all three of the triplets are heading toward a negative cash position totaling more than half a trillion dollars annually measured in today's dollars. This short fall, under current law projections, will mount to well over a trillion dollars each and every year by 2070, again measured in today's dollars.

Any changes made in Social Security or Medicare, or the portion of Medicaid that finances medical and long-term care benefits for the elderly will have ramifications for the other programs. There is no getting around the fact that all these programs benefit essentially the same set of citizens and that working age people can be asked to bear only so much of the burden.

Back to fundamentals

According to the Congressional Budget Office, reduced to fundamentals, keeping Medicare costs down requires some combination of (1) reducing the number of people eligible for the program, (2) increasing how much some participants pay (either for insurance or for medical care), or (3) reducing total program costs per beneficiary.

If costs cannot be kept down, then (4) additional revenues will have to be found. Despite concerns about unsustainable costs over the long term, there is pressure to (5) expand the program to cover prescription drugs and long term care.

The Concord Coalition will oppose any policy changes that increase the cost of future promised benefits without also identifying a credible way to finance those benefits. If the political will cannot be mustered to make the extraordinarily tough decisions to reduce taxpayer-borne Medicare costs in the future, then we favor adding the additional revenues needed to put the program on a long-term fiscally sustain-

able basis. (Discussion of what those revenue sources might be—consumption taxes, wealth taxes, higher progressive income taxes, mandatory savings accounts, energy taxes—is a lengthy topic for another day.)

Neither course will be easy. But if we as a nation want to provide our elderly citizens with a program as generous as today's Medicare, if not more generous, then we must be willing to foot the bill. And if, as a nation, we are unwilling to devote more than half our federal budget to the elderly, then we must be willing to trim back on Medicare and Social Security spending.

PREPARED STATEMENT OF UWE E. REINHARDT

My name is Uwe E. Reinhardt. I am professor of economics and public affairs in the Department of Economics and in the Woodrow Wilson School of Public and International Affairs of Princeton University, Princeton, New Jersey. I am honored, Mr. Chairman, by your invitation to appear before the Senate Finance Committee, and I hope that my remarks will provide added perspective on the issue of Medicare reform, even if my remarks may not always be uncontroversial before this Committee.

With your leave, Mr. Chairman, I would request that the following statement be made part of the official record of this hearing. In my verbal statement, I shall try to distill the written version statement into a few major points.

The central thrust of my statement is the following. While the current Medicare program certainly does have its shortcomings, many of these are actually of Congress' own making and could be remedied by giving the Health Care Financing Administration (HCFA) more administrative autonomy—and a larger administrative budget—to function as a more efficient health-insurance organization. This is not at all an argument against a major reform of the program—for example, a shift to the so-called "premium support" model recently proposed by some members of the National Bipartisan Commission on the Future of Medicare. My point is merely (1) that the traditional Medicare program remains highly popular with the American public, (2) that the traditional Medicare program is not in such dire straits as to warrant panic and (3) that the private health-insurance sector in the United States at the moment is beset with such uncertainty concerning its future development that little will be lost (and probably much gained) by Congress' taking its time to explore alternative options for the future of Medicare.

To shift Medicare hastily to current private-sector practices really would mean adapting Medicare to an evolving and meandering target whose ultimate destination is unclear even to the experts. For example, the idea of competitive bidding is central to the premium-support model. As members of this Committee surely know, however, the HCFA so far has been thwarted at every turn, by Congress and by the managed-care industry, in each and every attempt to launch a demonstration project on competitive bidding for coverage of Medicare beneficiaries. That sorry history alone makes the premium-support model appear problematic. Congress would do well in assisting the HCFA to get its competitive-bidding demonstrations launched soon.

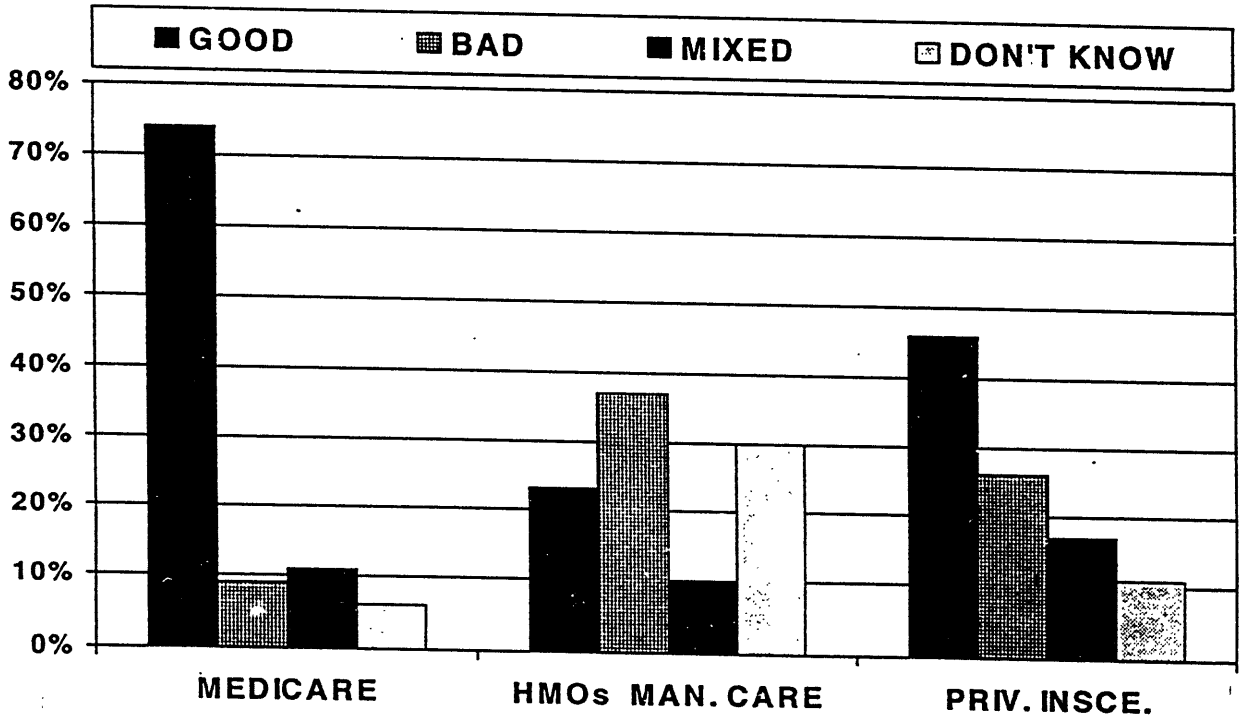
I. INTRODUCTION

It has become almost habitual among policy analysts and policy makers to adorn the federal Medicare program with derogatory adjectives such as "moribund," "obsolete," "inefficient" and "unsustainable." It is argued that the program has not kept pace with the pace of innovations in the private health-insurance market and that the private sector could administer it more efficiently—hence more cheaply—than can the public sector, thus delivering more "value" for the dollar.

This sorry description of the program stands in stark contrast to the image it has among the American people, both young and old. In national opinion surveys on consumer satisfaction, Medicare usually ranks very high or highest in consumer satisfaction. A recent national survey conducted by the Harvard School of Public Health and sponsored by the Kaiser Family Foundation indicated that in response to the question "What kind of job does each do serving health-care consumers?" Medicare received relatively more favorable responses than did private-sector insurance products, in the eyes of both people under age 65 and the elderly (see Figures 1 and 2). In the same survey, both young and old declared by overwhelming margins that "it is very important that Medicare is preserved for all people when they retire" (see Figure 3). Finally, in that same survey about two thirds of all respondents favored expansion of the Medicare benefit package to include prescription drugs and long-term care, even if that meant higher taxes and premiums. It is difficult to reconcile these responses with the image of a moribund program.

FIGURE 1

PERCENT OF RESPONDENTS WHO ANSWERED AS SPECIFIED IN THE QUESTION: "What kind of job does each do serving health-care consumers?" Respondents aged 65 and over



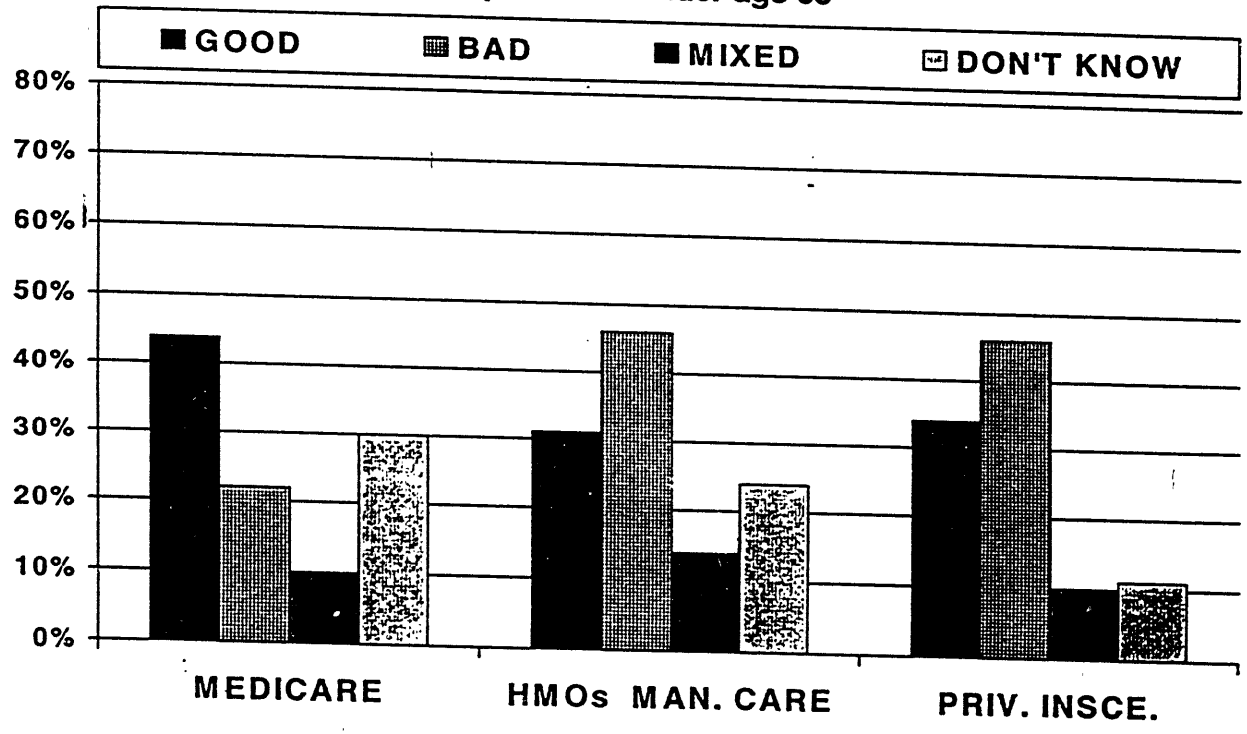
SOURCE: Kaiser Family Foundation/Harvard School of Public Health Survey, September, 1998.

FIGURE 2

PERCENT OF RESPONDENTS WHO ANSWERED AS SPECIFIED IN THE QUESTION:

"What kind of job does each do serving health-care consumers?"

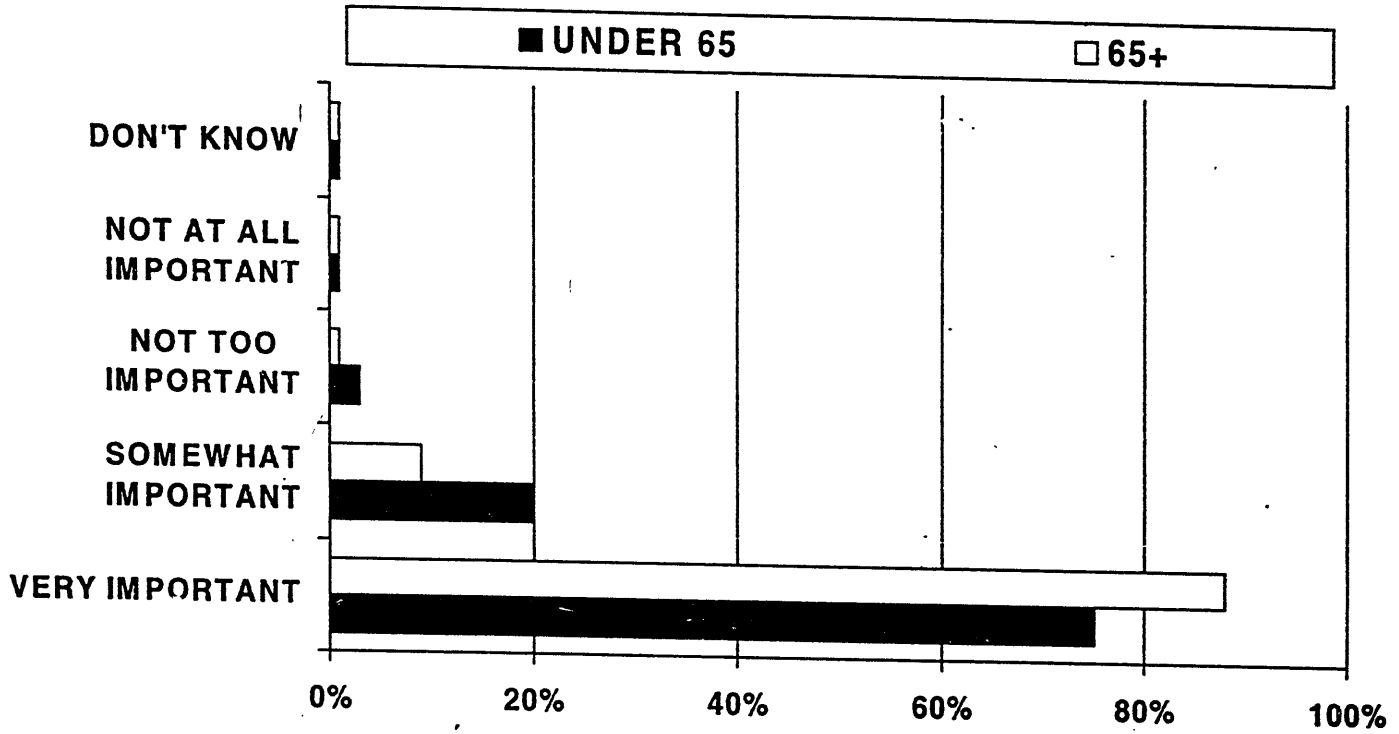
Respondents under age 65



SOURCE: Kaiser Family Foundation/Harvard School of Public Health Survey, September, 1998.

FIGURE 3

HOW IMPORTANT IS IT TO YOU THAT MEDICARE IS PRESERVED FOR ALL PEOPLE WHEN THEY RETIRE?



SOURCE: Kaiser Family Fdn/Harvard School of Publ. Health Natl. Survey Aug-Sep 98

In this necessarily brief statement, I shall offer commentary on two major items. First, I shall explore the sources of the high popularity that the Medicare program has enjoyed and continues to enjoy among the American people, in spite of the program's many vocal detractors. Second, I shall explore briefly the history and modus operandi of Medicare, to explain some of the program's perceived shortcomings, and also to lay blame for these shortcomings where, in my view, that blame ought primarily to be laid. I shall conclude with some thoughts on the merits of privatizing Medicare, and on the merits of a more conscious population policy designed to reduce the actuarial stress caused by the aging Baby Boom.

II. THE POPULARITY OF THE MEDICARE PROGRAM

The Medicare program was established in 1965 by a generation that had shared the harsh economic caprice of the Great Depression and the savage caprice of a world war in which rich and poor Americans fought and suffered together in complete social solidarity. One merely need read Stephen Ambrose's Citizen Soldiers to appreciate the enormous economic diversity represented in the typical platoon, navy vessel or air crew engaged in combat in World War II.

It is not surprising that this particular generation of Americans emerged from the horrowing experience of the Great Depression and World War II with two lasting imprints on their minds. First is the insight that many if not most of the good or bad fortune in an individual's life are a matter of pure chance—that good luck is just that, "luck" and not, as not seems widely supposed among the war-generation's children, "deserved" and not to be shared. Second, with the Great Depression and World War II came the realization that government is the ultimate source of protection from the many risks that individuals face and that, for one reason or another, the private sector cannot or will not assume.

To the generation of Americans who lived through the depression and the war, it must have appeared eminently sensible to enact a federal (i.e., national) health-insurance program based on the principle of social solidarity and to make that program part of the nation's social insurance program. Social insurance can be viewed as the natural response of modern societies to the private sector's inability to protect individual families from a number of major risks that, in principle, can be pooled over all members of society at a given point in time and among generations over time. Private-sector market failure in regard to risk pooling has been and continues to be the foundation for public social insurance programs worldwide.

Whatever the virtues of the private health-insurance sector may be, the fact is that this sector has never been able to offer Americans the permanent, life-cycle health insurance that citizens of other nations take for granted. If anyone would doubt that assertion, let him or her try to purchase permanent, life-cycle health insurance from the private sector today. They would not be served. In fact, Americans who are not covered by Medicare do not actually have what other nationals would call genuine-insurance. They have ephemeral insurance that is tied to a particular job and easily lost with that particular job. Alternatively, they may have Medicaid coverage that is tied to income status and is easily lost as well. As one clever wag has put it, as a rule Americans are not insured for the financial inroads of ill health; they are unsured.

Only Americans covered by Medicare have permanent, fully portable insurance that will protect them to their dying day and that they cannot lose. Therein, in my view, lies one of the major sources of this public program's great popularity among a citizenry that is not normally kindly disposed toward government.

The high value that citizens attach to permanent health insurance is ironically illuminated also by the peculiar role that the Veterans Administration's far-flung health-care delivery system plays in American life. Although the words "socialized medicine" customarily are intended as derogatory terms in our debate on health policy, even the most staunchly conservative members of Congress regularly go to the barricades to defend this purest form of socialized medicine on behalf of our veterans! Remarkably, most nations do not run separate, government-owned health-care facilities for their veterans. They enroll their veterans in the permanent, portable public or private health-insurance systems typical elsewhere in the industrialized world and, through these mainstream insurance programs, let their veterans share the health-care delivery system that is available to all other citizens. What, then, can explain the paradoxical fondness for socialized medicine even among American conservatives in regard to this nation's veterans? Evidently, it reflects the realization among these politicians and among the nation's veterans that private health insurance in the United States is just too brittle and ephemeral to serve as a reliable source of health insurance for our veterans, and that only a fallback pro-

gram run by the government ultimately can guarantee our veterans the financial- and health-care security that they crave and richly deserve.

The ability of government to offer citizens permanent, portable health insurance will remain one major comparative advantage of Medicare. Usually the value of this advantage—although evidently much appreciated by the citizenry—tends to be overlooked in assertions that private insurance is more "efficient" than government-provided insurance. In fact, as any properly trained economist knows, in comparing policy alternatives in terms of their relative economic efficiency, the word "efficient" is meaningless unless the policies being compared reach the very same ultimate objective. The goal of permanent, portable insurance protection surely must rank highly among those objectives. Any Medicare reform that erodes this permanent protection cannot claim to be more "efficient" than is the current Medicare program.

It can be surmised that any Medicare reform that fails to provide permanent and portable insurance coverage—if only as a fallback—will be doomed in the political arena. In place of public regulators, private health plans may possibly be advantageously employed as regulators of the cost and quality of health care. As recent history has demonstrated, however, the fiscal staying power of these private regulators is ephemeral at well. To be acceptable to the American public, any attempt to privatized control over the cost and quality of health care for the elderly therefore will have to be erected on a public fallback program that offers permanence and portability.

To test my hypothesis, Congress merely would have to propose that anyone who switches from the government-run Medicare program to a private insurance product may not rejoin the government-run Medicare program for, say, five or ten years. To avoid a perpetual game of adverse risk selection, that is, of course, precisely what Congress ought to mandate. It can be conjectured, however, that any such approach would doom privatization of Medicare in the political arena. When it comes to health insurance, Americans want the analogue of a faithful partner in marriage who permits multiple, temporary affairs on the side. Any privatization of Medicare will always be like that. Ironically, but not surprisingly, the only institution that the American people truly trust turns out to be the government that they are fond of decrying.

III. THE ORIGIN AND MODUS OPERANDI OF THE MEDICARE PROGRAM

Judging by the current debate surrounding the Medicare program, it seems to be taken as an axiom that Medicare has not been innovative. It is one of several reasons why there are calls for "privatizing" Medicare, by which presumably is meant that the tasks to controlling the cost of quality of the health-care given the elderly should be regulated by private rather than public health-care regulators.

To be sure, Medicare necessarily moves slowly in introducing any innovations. Unlike private health plans, Medicare must above all be fair, a requirement not usually expected of private markets. Furthermore, as will be argued below, Medicare has never been given by the Congress the required autonomy to function as a flexible, efficient health-insurance program. Finally, the administrative, budget accorded Medicare by the Executive and the Congress traditionally has been so small as virtually to guarantee major shortcomings in the program's operations.

Even within those constraints, however, Medicare and the federal government in general have actually been far more innovative in American health care than seems widely appreciated. Among the major innovations introduced by Medicare is the prospective-payment system for hospitals and for other health care facilities—innovations now copied around the world. Another major innovation has been the research and development effort leading to the introduction of the Resource-Based Relative Value Scale (RBRVS) for paying physicians. That innovation has been embraced with enthusiasm by the private health insurance industry of the United States, which had never been able to develop a defensible fee schedule for physicians and which now uses Medicare's RVRBS as a basis for negotiating fees with physicians. If Congress wished, it could make that relative value scale the basis of genuine price-competition among American physicians in general. The idea would be to mandate that every physician must use the RBRVS to set fees, but has the freedom to set and advertise his or her own monetary conversion factor. Only on that approach will price-competition among physicians ever become practical and meaningful.

Finally, the most frequently cited model for managed competition among private health plans turns out to be the Federal Employee Health Benefit (FEHB) program. If genuine managed competition in health insurance will ever come about the United States—as it has not so far in the private sector—then the federal government in general and the Medicare program in particular may well be the pioneers blazing the trail for the private sector to follow. Because so much of the research

for a proper information infrastructure for managed competition is a pure public good, economic theory suggested that the public sector should fund it. But by its very mandate, Medicare will also be forced to be one of the first to put such an infrastructure in place on a nationwide basis. Until now, only a few large companies have actually attempted to practice genuine managed competition in the private sector.

Yet, while the Medicare program has been and will continue to be a major innovator in the American health system, it must be acknowledged also that the program usually moves very slowly and cautiously, and that many of its regulations are vexingly cumbersome.

The conventional wisdom blames these shortcomings on the "bureaucrats" at the Health Care Financing Administration (HCFA) which administers the program. Some blame probably can be laid at the doorstep of this huge bureaucracy. No major private or public bureaucracy is perfect—neither, say, Aetna/US Healthcare, nor Medicare. The chief culprit behind Medicare's shortcomings, however, may not be the HCFA bureaucracy at all. For one, from its legislative birth in 1965, Medicare had been saddled by Congress with the requirement to mimic and adapt itself to the private sector. As I argue below, that has turned out to be a costly burden. Furthermore, if members of Congress wished to be perfectly candid with one another and with the American public, they would concede that, unlike boards of directors in the private sector, Congress has never been able to resist the temptation to micro-manage the program, and much of that micro-managing is imposed at the behest or particular interests in the private sector. Finally, as Bruce Vladeck [1] recently has pointed out in a seminal paper, Congress has long treated Medicare as much as an income-redistributive program shaped to look after the fiscal health of particular constituents as it has viewed Medicare as a health program focused on the physical health of America's elderly. Indeed, if the health of the elderly were Congress' chief concern, the program's benefit package would reflect far more faithfully than it now does the dictates of modern clinical medicine. Certainly it would not leave over 10 million American elderly without any coverage whatsoever for prescription drugs, for prescription drugs are an important part of a physician's clinical armamentarium.

Medicare as an adaptation to the private sector

When the Medicare and Medicaid programs were legislated in the mid 1960s, after decades of legislative struggle, these two programs were initially thought of as mere appendages to the general, private health system. As such, they were expected to adapt themselves to the standards (such as they then were) set by the private sector. To thoughtful persons it must have been clear from the outset, however, that the two programs would quickly take on a life of their own, mainly by virtue of Medicare's sheer size. For many medical interventions used mainly by elderly people—e.g., cataract surgery, hip replacements, heart surgery—Medicare quickly became the single most important buyer.

While prices and spending under Medicaid for the poor and disabled were controlled by varying mechanisms and to varying degrees of success by the states, the federal Medicare program experienced very rapid cost growth during its early decades. That cost growth, however, was not a completely unanticipated consequence. On the contrary, it was the price that Congress and the designers of the Medicare program had to pay to gain the acquiescence of the politically powerful providers of health care. From their perspective, the providers had reason to fear the monopsony (single-buyer) market power that usually is created with tax-financed, government-run health-insurance programs. To defang such a powerful buyer, Medicare was required to follow the open-ended financial contract that had become standard in the private health-insurance sector.

Virtually by design, the payment system Medicare was forced to put in place in 1965 was inherently inflationary. Every hospital in America was to be reimbursed by Medicare, retrospectively and individually, for the full cost that hospital reported to have incurred in the care of the Medicare beneficiaries. For investor-owned hospitals, this arrangement became a pure cost-plus pricing scheme, with a generous guaranteed profit margin under which such a hospital literally could not lose.

Everly physician, on the other hand, was to be paid his or her "usual, customary and reasonable" fee for each codified service on a list of some seven thousand distinct items. A particular physician's "usual" fee for a particular service was the median of the frequency distribution of the fees that this particular physicians had billed, in the previous year, for that particular service, It was one of two price ceil-

[1] Bruce C. Vladeck, "The Political economy of Pittsburgh," Health Affairs, vol. 18, No. 1, January/February, 1999; pp. 22–36.

ings that Medicare imposed on physicians in the following year, although the physician was free to charge more and thereby push up his or her "usual-fee" standard for the following year. A particular physician's "usual fee" for a particular service was judged "reasonable" if it did not exceed the 75th percentile of the frequency distribution of the fees for that particular service charged by all physicians in the physician's market areas. This unwieldy payment system, of course, forced every item on every bill submitted by every individual physician to a particular patient through two price-ceiling filters: first, the filter to determine whether the actual fee billed was equal to or less than that physician's "usual" fee and, second, the filter to determine whether that physician's "usual" (median) fee for that service was "reasonable" (did not exceed the 75th percentile of fees in the area during the previous year).

The entire system was administered through over 130 private insurance carriers whose work was coordinated by a rather small staff of federal Medicare bureaucrats. Not surprisingly, each carrier soon developed its own rules for claims processing, including their own definition of the codes by which medical procedures were described. When the Congressional Physician Payment Review Commission (PPRC) began its work in 1986, for example, if found it impossible to compare Medicare payments across regions, because the coding of services varied so much among carriers. A genteel hypothesis would ascribe this lack of comparability to an innocent lack of planning. One can think of alternative hypotheses.

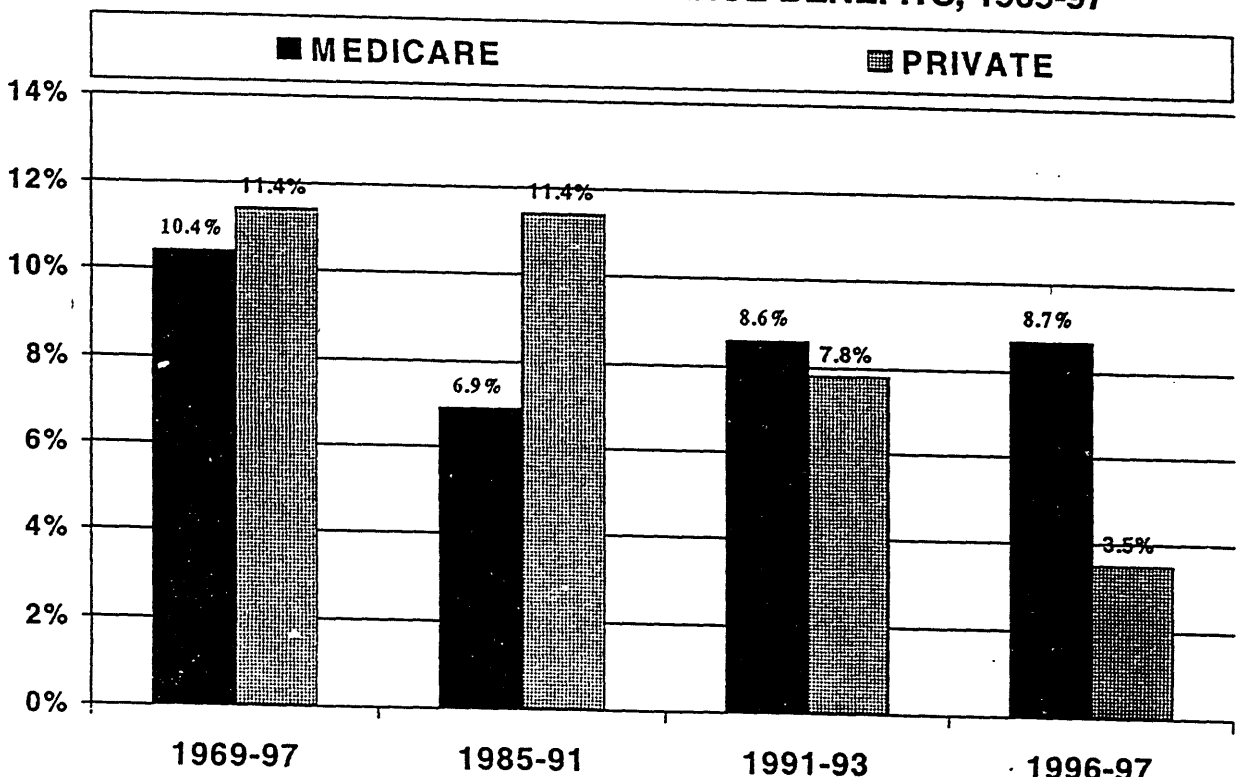
It would tax the imagination to think of a payment system that would be more unwieldy, more impenetrable to analysis and control, and more inherently inflationary than the system Congress imposed in 1965 upon the Medicare program. No one ought to have been surprised that the cost of such a system would soon be out of control But it was also not surprising that, even as early as 1970, Congress began a long drawn-out, valiant struggle to rein in this inflationary system. By the mid 1970s, the standard of "reasonableness" for physician fees was put under a ceiling that was determined by a national medical practice-cost index. At the same time, extensive research was funded by Medicare to shift the payment of hospitals from the uncontrollable, retrospective basis to a prospective one, and research was also begun to develop a common, national relative-value scale on which Medicare could base a common fees schedule for physicians.

By the mid 1980s the shift to prospective payment of hospitals was fully underway. It was completed by 1987. That highly innovative compensation method—a system of flat fees for each of some 500 diagnostically-related groups of cases (the DRGs)—has since been copied or adapted to local use elsewhere in the world—for example, in Germany, in France and in some countries in Asia. Furthermore, by early 1990s, Medicare had placed physicians on a uniform fee schedule that was based on carefully researched relative costs for a least the physician component of costs. As already noted, that fee schedule, too, now serves not only Medicare, but is also widely used by private insurance carriers in the United States in their negotiations with physicians.

Figures 4 and 5 illustrate the fruits of Medicare's cost-containment methods. These displays show that, during the period from 1980 to about 1992, real per-capita spending by Medicare actually increased much less rapidly than did spending per capita in the private sector. Indeed, Medicare's main problem in the 1980s was the rampant price inflation in health care that was tolerated by private insurance carriers. So effective had Medicare become in controlling its costs that private insurance carriers and business executives wailed loudly about a "cost shift" from Medicare into their budgets—that Medicare was not shouldering its "fair share" of hospital costs. Even as late as the mid 1990s, the fees paid physicians by Medicare were only about 65 percent of the average comparable fees paid physicians by private insurance carriers. Similarly, while Medicare tried to rein in the vast excess capacity of the hospital sector by paying hospitals less than the full cost of hospital care, that excess capacity was easily maintained with the aid of the enormous profit margins private insurance carriers were content to pay hospitals throughout the 1980s and, it would appear, to this day (see Figure 6).

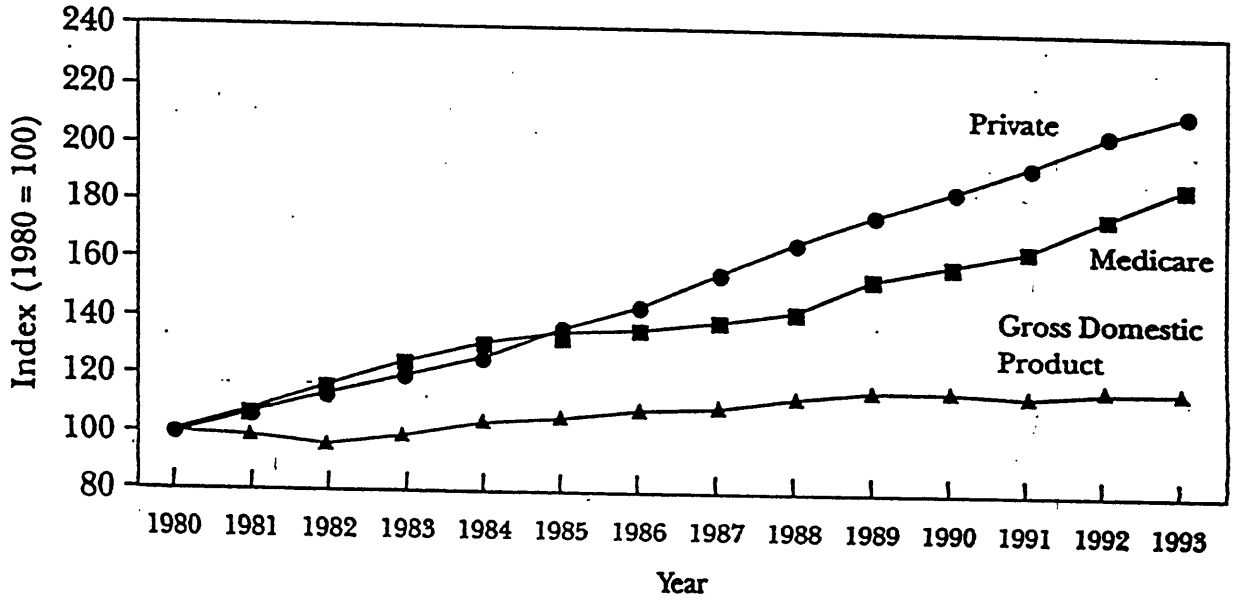
FIGURE 4

COMPARATIVE AVERAGE GROWTH IN PER ENROLLEE MEDICARE AND PRIVATE HEALTH INSURANCE BENEFITS, 1969-97



SOURCE: Levit et al., *Health Affairs*, November/December, 1998; Exhibit 5.

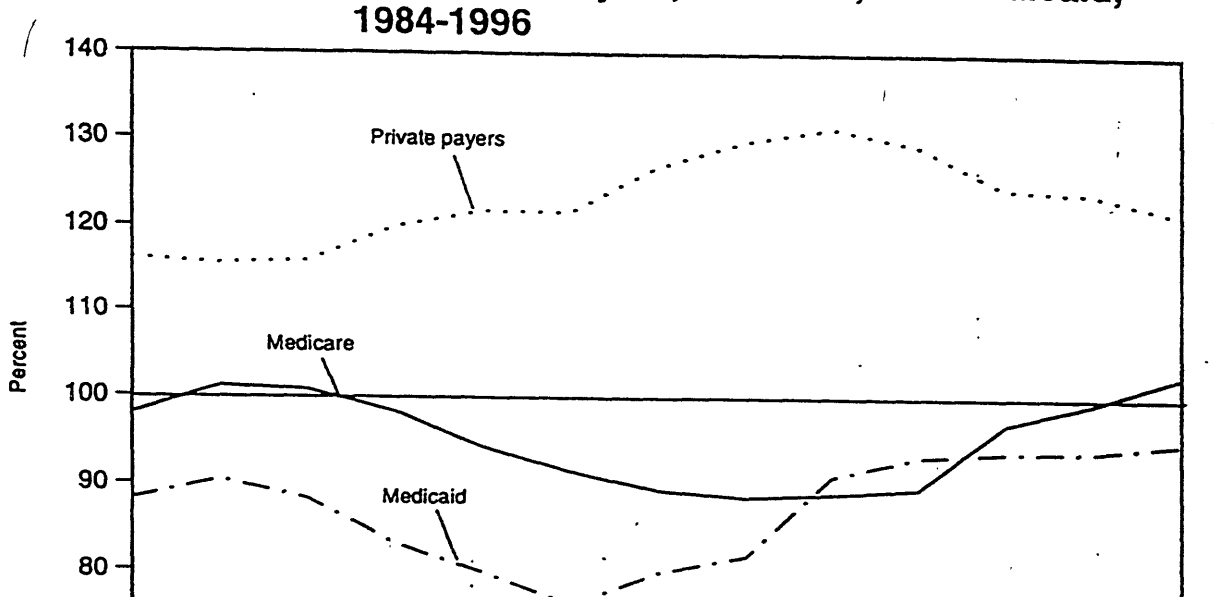
Figure 5 Trends in per Enrollee Expenditures for Medicare and Private Health Insurance and Gross Domestic Product per Capita, 1980–93



Source: Physician Payment Review Commission analysis of information compiled from the Health Care Financing Administraiton and the Congressional Budget Office.

Note: Values are adjusted for inflation and are expressed in 1980 dollars.

FIGURE 6 Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1984-1996



NOTE: Payment-to-cost ratios cannot be used to compare payment levels because the mix of services and cost per unit of service vary across payers. They do, however, indicate the relative degree to which payments from each payer cover the costs of treating its patients. Data are for community hospitals and reflect both inpatient and outpatient services. Imputed values were used for missing data (35 percent of observations). Most Medicare and Medicaid managed care patients are included in the private payers category.

SOURCE: Medicare Payment Advisory Commission analysis of data from the American Hospital Association Annual Survey of Hospitals.

It has been only since about 1993 that the private sector, by then truly desperate over the high double-digit increase in private health-insurance premiums, has set in earnest upon cost control. In that endeavor, private employers were greatly helped by the general economic recession of 1988–92 and the fear of job loss triggered by corporate reengineering and downsizing. That fear enabled private employers to shift their employees from their hitherto open-ended, free-choice indemnity insurance policies into health plans that limit the insured's choice of health-care provider at times of illness. Once employees were willing to acquiesce in that limitation, it was possible for health-insurance plans to contract selectively with doctors and hospitals. Selective contracting, in turn, meant effectively that a particular hospital or physician could literally be "fired" from a health plan, either because that provider did not grant the plan adequate discounts from regular fees, or because that provider's statistical practice profile was deemed too service-intensive and therefore too expensive. That shift of market power from the supply to the demand side, of course, can easily be diluted and reversed by the current trend among health plans to widen the network of providers with whom they contract and to offer enrollees so-called "point-of-service" riders that permit easy access to providers outside the health plan's contracted network.

It is the case that for several years after 1992 private health-insurers were able to control the annual increase in per-capital health spending much better than did Medicare. The turmoil surrounding the health-reform debate during 1992–94 and the political standoff between the Administration and the Congress since 1994 had left the Medicare program unattended, except through whatever regulatory cost-control measures Medicare was already authorized to pursue. Left adrift, the program fell behind the private sector in its ability to control the growth of its overall spending and will stay behind for a few years to come.

There is no reason to assume, however, that this state of inaction is permanent. Since passage of the Balance Budget Act of 1997 (BBA 97) the annual increases in Medicare spending per beneficiary have, once again, fallen much below the comparable annual increases in per-capita health insurance premium in the private sector. That trend is expected to persist until at least the year 2002, and possibly beyond.[2]

In short, the oft mouthed maxim that throughout the past decades government has been the chief culprit behind the rising cost of health care in the United States is not supported by the data, unless one wishes to argue that much money could have been saved simply by rationing the nation's poor and elderly out of health services altogether—by leaving them to their own fate and budgets. It is easier to make the case that, for all the many positive contributions private employers have made to American medicine and to the well-being of their employees, private employers actually have been the chief cost drivers in the American health system, at least until very recently.

Micro-management of Medicare by the Congress

In terms of management theory, one may view Medicare as a giant insurance company overseen by two boards of directors: the Senate Finance Committee and the House Ways and Means Committee, although some oversight is provided by yet other "boards" within the Congress. A sound management principle is that boards of directors should set strategic policy and then to ascertain that these general policies are properly followed, without micro-managing the day-to-day tactics of implementing the set strategy. Micro-managing an enterprise by members of the board is considered not only bad form, but downright inimical to the proper execution of policy.

In reviewing Medicare's managerial track record, Congress might do well to examine its own role as that enterprise's Board of Directors. How well has Congress' own comportment held up against the standards for boards followed in private-sector management. Could, say, Aetna/US Healthcare or Humana function as insurance companies if their boards intervened as heavily in the day-to-day management of these enterprises as Congress often does in the operations of Medicare?

To illustrate, the reimbursement methods followed by Medicare for particular providers of health care—e.g., for home- and skilled-nursing care—often seem dubious on their face. As a general principle, the providers of services to government should be paid and not reimbursed. There is a huge difference between these two words. A payment presumably ought to obey some standard of reasonableness set in a market, or be formally negotiated between payer and payee. A reimbursement, on the

[2] Sheila Smith, Mark Freeland et al., "The Next Ten Years of Health Spending: What Does the Future Hold?" Health Affairs, vol. 17, No. 5, September/October, 1998; pp. 128–40; esp. Exhibit 3, p. 131.

other hand, becomes the analogue of an open-ended expense account for a business traveler. In the hands of ordinary human beings, a reimbursement approach inevitably tempts payees into manipulation, just as business travelers are known to pad their expense accounts. To curb such practices, a reimbursement approach inevitably triggers detailed and cumbersome regulations on what may and may not be submitted for reimbursement. Medicare is now famous and often ridiculed for the over 50,000 odd pages of such regulations that govern the payments made by the program.

The question is whom one should blame for this clumsy approach to paying providers. The custom among executives of the private health sector is to blame the HCFA, as if it were a legislative body, a state within a state, governed by the American analogue of China's Red Guards, who are assumed to wake up every morning wondering whom next to torment in the defense of a dying ideology. Is that really fair imagery for the HCFA?

A fair observer notes that the HCFA merely implements and fine-tunes the compensation methods that have been concocted in the halls of Congress as part of a never-ending game between members of Congress and the legions of lobbyists who besiege the Congress and who busily help Congress write the laws that it passes. Indeed, if the private-sector health-care executives who chafe under the complexity of Medicare regulation truly wished to discover the culprits behind that complexity, and if they wanted to be brutally honest with themselves, they would look into the mirror, first, look at the Congress, next, and only then look at the government bureaucrats who administer the complicated laws and codicils hatched out by the former two.

One might call insistence that federal laws respect the idiosyncratic needs of so many diverse constituents "American particularism" or even "Le Vice Americain," for no other industrial democracy practices this particularism with quite our exuberance and with quite the costly consequences for the cost of American health care. Medicare's arcane reimbursement rules are a classic expression of American particularism, because they pay so much respect to entreaties by individuals and single institutions. Retrospective full-cost reimbursement, for example, is the ultimate form of that particularism, for it takes respect for local idiosyncrasies right down to the level of the individual institution's use of paper clips. While, in theory, there is something lovely about this enormous respect for individuals and single institutions, it does infuse our laws with an administrative complexity that borders on the criminal in this sense: it has the capacity of criminalizing the behavior of perfectly decent citizens who would never break laws that they actually can understand.

There can be no question that, over time, the administration of the Medicare program has been encumbered by layers upon layers of regulations that no ordinary human being can oversee anymore. In my view, however, it would be unseemly to blame these arcane rules on the hard-working HCFA bureaucrats who must convert the bewildering legislative effusions concocted in the Congress into operational rules that are fair to the millions of Americans who depend on Medicare for their health care, fair to the American taxpayer who foots the bill for these programs, and fair to the income-seeking private purveyors of health care who look upon the American taxpayer as their source of fiscal nourishment.

Any large health insurance program that compensates many diverse providers of health care on a fee-for-service basis invites fraud, waste and abuse. This is so for both privately and publicly administered programs. Indeed, to my knowledge there does not exist a body of empirical research indicating whether waste, fraud and abuse is relatively larger or smaller in Medicare than it is in the private sector. My best hunch is the two sectors are probably on par in this regard. The only difference might be that a private insurer can turn up the heat of investigation at will, while a government administered program may find its enforcement initiatives thwarted by legislature, at the behest of private interest groups.

For reasons already indicated, it is reasonable to suppose that even under a vigorous program of privatization, a large number of Medicare beneficiaries will, at any time, prefer to be in the traditional Medicare program. If Congress sought to maximize the value that taxpayers purchase for the elderly through that program, a good first step might be a searing self-examination of the micro-manage through which Congress now restricts the HCFA's ability to manage the program more flexibly and more innovatively. As other nations have demonstrated, even government-run fee-for-service programs can manage the procurement of health care better than the HCFA is now able to do.

Medicare's budget for administration

It is not as well known as it should be that Medicare spends less than 2 cents of every tax or premium dollar flowing into the Medicare program for the program's

administration, including the fees paid the private intermediaries who administer Medicare claims. After subtracting the cost of marketing and profits, no private insurance carrier would get away with spending such a small remainder on administration. By holding the program to such a tight administrative budget, both the Congress and the Executive literally guarantee major shortcomings in the program's execution. It is intriguing to speculate on the motives behind this inadequate allocation for administration. Can it really be believed by the Congress that this tight administrative budget will save the tax payer money overall? If not, what might motivate this short-sighted policy?

Recognizing the serious handicap Congress has placed upon Medicare with its insufficient budget allocations for administration, a fairly large group of policy analysts who are familiar with the program recently published an Open Letter to Congress and the Executive[3] drawing attention to the "mismatch between the HCFA's administrative capacity and its political mandate." As the statement continues: "HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse has been increasingly compromised by the failure to provide the agency with adequate administrative resources. * * * Congress and the administration must reexamine the organization, funding, management, and oversight of the Medicare program. Doing anything less is short-changing the public and leaving HCFA in a state of disrepair."

It must be hoped that, in its current review of options for Medicare reform, this important facet of the program will receive the attention it merits.

Medicare as a vehicle for income distribution

My fellow panelist, John Wennberg, M.D., has persistently brought to Congress' attention the large inter-rational variation in per-capita spending by Medicare. His research findings can be found in the Dartmouth Atlas of Health Care in the United States of which he is lead author. Only a small part of these variations can be explained by interregional variations in health status and practice costs. For the most part, their origin remains a mystery.

One should think that, when Congress mandates the American taxpayer to pay the providers $X per elderly in one part of the country and $2X per similar elderly in another part of the country, Congress would take upon itself the mandate to explain to the American taxpayer why this should be so. Remarkably, to my knowledge, Congress has not had hearings in which health-care providers from the high-cost regions would be forced to explain to their counterparts from the low-cost regions why providers in the high-cost regions need twice the allocation of tax money to look after elderly Americans than do providers in the low-cost regions.

As Bruce Vladeck,[4] the previous Administrator of the HCFA, observes in his recent "The Political Economy of Medicare," Medicare has become a major instrument of income redistribution. The politics of that income redistribution have long overshadowed the health-care imperatives that the Medicare program ostensibly is to address. From the viewpoint strictly of health-care and health-care economics, it makes little sense to tolerate these large variations in per-capita spending without a clear justification. From the perspective of the political economy of income redistribution, it may make perfect sense.

Vladeck sees current proposals to privatize Medicare through some system of tax-financed, defined contributions toward the purpose of private health-insurance coverage as an attempt (1) to limit the redistribution from the wealthy to the poor through the Medicare program and (2) to decouple Medicare policy from the politics of inter-regional income redistribution. He may well be right. I, for one, am not persuaded by the empirical record that, say, the premium support explored by the recent Bipartisan Commission on the Reform of Medicare would help to lower the overall health-spending per-capita on the elderly. The fact that healthcare providers have embraced the idea suggests quite the opposite. Rather, the proposed reform might be used to limit the tax-payer's exposure to health-spending on the elderly (and to shift more of that cost onto the shoulders of the elderly themselves) and, in the process, to deal directly with the regional variations in tax-financed Medicare spending. One can debate the pros and cons of that particular approach to policy making, but it certainly might be one way to address the variation of Medicare costs.

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[3] Crisis Facing HCFA & Millions of Americans," Health Affairs, vol. 18, No. 1, January/February, 1999; pp. 8–10.

[4] Bruce C. Vladeck, "The Political economy of Pittsburgh," Health Affairs, vol. 18, No. 1, January/February, 1999; pp. 22–36.

IV. CONCLUDING REMARKS

The purpose of this statement has been to explore an apparent paradox in American health care: the general feeling among policy analysts and policy makers that something is seriously wrong with the existing Medicare program, and the sustained popularity of that program among the American people.

It was argued that the great popularity of the program lies in its ability to offer the American people what they crave but what the private sector cannot ever offer them; truly reliable, permanent and fully portable health insurance. The great value that people assign to these attributes can "pay," in a sense, for many of the shortcomings now inputed to the program. Even so, there is every reason to reexamine these shortcomings from time to time and to correct what can be corrected without destroying the attributes of Medicare that the American people evidently value.

More choice for the elderly

In particular, the preceding discussion is not intended as an argument against reforming Medicare so that it can offer the elderly a wider choice of alternative private health-insurance products. Such changes may have merit, but their implications should be carefully and forthrightly explored.

For one, as already noted such a program could make it easier to reduce over time the indefensible geographic variations in health spending per elderly now forced upon the taxpayer. It could do so by making the defined premium-support contribution a national average adjusted only for defensible local variations in cost. That would make good sense from an economic viewpoint. Of course, as Vladeck points out, it may not make sense from a political perspective, which was long treated Medicare as a vehicle for income distribution and maintenance.

Second, because "choice" per se appears to play such a central role in American culture, any reform that offers more "choice" may be of value to the citizenry. To be sure, the new "choices" being talked about in connection with Medicare reform is not choice among the providers of care at time of illness. Medicare has traditionally afforded the elderly the widest choice possible among providers of health care. It would be hard to improve upon that record. Rather, the new "choices" being talked about are choices among insurance products, some of which might even limit their enrollees' choice of providers at the time of illness as a trade-off for other benefits. Such added choices might be appreciated, as long as the old, reliable government-run program remains within easy reach as a fail-safe insurance program. Like everywhere else in the world, in America, too, the tough tend to run to the government when the going gets tough.

Third, because private insurance carriers are not shackled with many of the administrative constraints that Congress imposes on publicly administered programs, the availability of more private insurance options might make the entire health-insurance program for the elderly more innovative, at least in theory. My sense is that, so far, this hypothesis remains just that: a mere hypothesis whose validity is yet to be demonstrated. But there is merit in testing that hypothesis with an empirical record, as long as we proceed cautiously.

At the same time, I would register some caveats on the current reform fever—especially on the mantra that Medicare is too archaic in structure and therefore should adopt the cutting-edge practices now apparently being invented in the private sector. Among these private-sector inventions are said to be (1) the coordination of care within an organization that can manage disease properly and (2) the ability and willingness among private health plans to be held fully accountable for the coordinated health care and the health status of entire populations.

First, for the most part these innovations have remained at the stage of mere blueprints. Aside from Kaiser, the long-established health maintenance organization, very few if any other private health plans have yet learned how to manage care in any meaningful sense of that term, and virtually none of them can be held accountable for the health status of their enrollees. Congress should remain properly skeptical about claims to the contrary and always demand hard evidence from any one who claims that the private sector has learned to deliver coordinated disease management and to practice accountability for its care.

Second, policy analysts are impressed by the chaos that currently reigns in American health care. It is everybody's guess, for example, who managed care so far has managed mainly to achieve some price discounts rather than to manage care properly, why health-insurance premiums in the private insurance sector are once again starting to rise at rates in excess of 7% per year and often at double-digit rates. Indeed, for members of Congress contemplating Medicare reform it should be a sobering thought that throughout the 1980s private health insurance premiums rose much more rapidly than did Medicare spending per enrollee and that, at this time,

that scenario finds itself repeated. As we speak, private sector premiums are once again rising faster than is Medicare spending per enrollee.

Third, at every health-care conference, futurists now profess great uncertainty over the direction that managed care is likely to take in the next decade. It is not clear who will manage care—doctors or insurance carriers; it is not clear who will bear the financial risk for an insured's illness—insurers or providers; and whether capitation of providers or fee-for-service compensation of providers will carry the day. Why should Congress hastily force Medicare to adapt itself to a private sector that is itself a chaotically moving target? Why not wait until the direction to be followed by the private sector is clearer? The Medicare program has shortcomings, to be sure, but many of these could be fixed for the duration, until the virtue of entrusting the program wholesale to the private sector is more evident—until the private sector has demonstrated that it can function responsibly as a reliable and steady partner in managing the health care of the elderly.

Finally, as already noted, I do not think that reforms such as the premium-support model would reduce total national health spending per elderly American relative to the total per-capita spending that would be recorded for the elderly under the traditional Medicare program. For one, it would be hard for the private insurance sector to match the very low administrative load factor of the Medicare program. Second, it would be hard for private insurers nationwide to achieve the large price-discounts that the Medicare program has been able to achieve, by virtue of its size. My best guess is that a "premium support" model probably would increase the total average per-capita health spending on the elderly relative to the current regime, although the proportion of that larger total spending that is paid through the public budget could, of course, be made to shrink at the discretion of Congress, within the constraints of electoral politics.

A national population policy

Among the many blessing bestowed on the United States in recent years is the breathing room that the economy has permitted for a thorough review of the program, an extensive national debate on the most desirable future path for the program and eventual reform of the program. It is also the case that, along with Canada and Australia, the United States is and will remain the youngest nation in the industrialized world. In fact, only in the year 2020 will the percentage of elderly in the American population reach the level that percentage has already attained in Europe today. For both Medicare and Social Security, demography will be economic destiny.

Virtually our entire debate on the reform of Social Security and Medicare revolves around the distribution of generalized claims to future GDP—in other words, about money. But monetary claims to real resources cannot provide succor to patients; that can come only from the nation's real resources—the human beings who produce health care and other components of GDP, and the non-human capital goods that support these human beings and make them productive. All the redistribution of monetary claims to real resources will do little for the elderly unless there is an ample supply of real resources actually to serve the elderly—e.g., to care for them in hospitals or nursing homes.

It is now projected that the number of Americans of working age per elderly Americans will decline from the current 3.9 or so to slightly over 2 by the year 2025. If that were really so, then human labor would be a very scarce input, indeed. The health-care sector—especially the long-term care sector—might find it very hard to compete for that scarce human labor in the open market. Money along simply cannot fix that problem.

This prospect raises the question why a deliberate population policy has never been an integral part of Social Security and Medicare reform. The so-called dependency ratio (young and old per worker) in the year 2025 need not be considered an exogenous factor over which a nation has no control at all. We might manipulate that ratio by encouraging greater fertility at home—for example, by making it less financially burdensome for families to have children—or encouraging more immigration from abroad. If we follow the latter strategy, it will not do to have welfare, health-care and educational policies that discriminate against the children of immigrants. They, like our own children, ought to be viewed as a precious national resource.

In principle, a deliberate population policy might be able to lift the ratio of workers to elderly by the year 2025 much above the currently projected 2.2 working adults per elderly, which would do much to reduce the actuarial stresses brought on by the retiring Baby Boomers. Perhaps, I hope, your Committee will find some time to explore that facet of the problem as well.

PREPARED STATEMENT OF HON. CHARLES H. ROBB

Mr. Chairman, thank you for calling this hearing to discuss the future of Medicare. This program has provided a health care safety net for seniors for over 30 years. The reliance and confidence that retirees have in the program is an indicator of Medicare's success. However, both the members of this committee and the American public recognize that the Medicare program is in need of reform to guarantee the stability of the program for future generations.

The challenges facing the Medicare program are extremely complex and will require difficult trade-offs. Modifications that enable seniors to access the benefits of modern health care are necessary. Equally critical are steps that will ensure the financial viability of the program as we approach the dramatic growth in the retiree population that will double the Medicare population over the next 30 years.

I have stood and continue to stand ready to make the hard choices necessary to provide balance between maintaining our commitment to seniors and other fiscal priorities. As we consider different proposals and various trade-offs, we must protect those most at risk; the sickest and frail, poor elderly and those rural seniors with limited health care access.

Within this context I have reviewed the report of the Bipartisan Commission on Medicare Reform and have been briefed by the Chair of the Commission. While I have some concerns about the Commission's proposal, it provides a starting point to our discussion of modernizing Medicare and reinforcing financial stability for the program.

I look forward to reviewing various options for Medicare restructuring. The input of health care experts at this series of hearings will be important in highlighting the potential benefits and costs associated with various Medicare reform options.

PREPARED STATEMENT OF WILLIAM L. ROPER, MD, MPH

INTRODUCTION

I am pleased to contribute to this important examination of Medicare's current and potential roles within the American health care system. I commend Chairman Roth and the other members of the US Senate Finance Committee for their leadership in this area. My goal today is to build on the information that will be presented by Drs. Pardes, Reinhardt, and Wennberg and offer insight about how Medicare has responded to the dramatic changes in medical practice and the health care marketplace during its 34-year history.

My experience as administrator of the Health Care Financing Administration and later as a senior manager of one of the nation's leading private health care organizations has shown me that Medicare can be a powerfully effective program for providing medical care to 38 million aged and disabled Americans. I have also learned that Medicare can be quite removed from the larger changes occurring within the health care environment. Consequently, Medicare continues to reflect the fragmented, open-ended fee-for-service medical care environment that existed in 1965.

I will suggest today that, for Medicare to remain a viable and effective program, it must be allowed to take full advantage of innovations occurring in medical care organization and delivery within the private sector. The movement toward organized and coordinated systems of care offer real advantages for aging and disabled populations that are living longer but facing more complex and chronic health care conditions. Medicare must join the private sector in its movement toward these coordinated, comprehensive, and accountable systems of care.

RESPONSIVENESS IN MEDICARE

You will hear today how the organization, delivery, and financing of medical care have changed dramatically over the years since Medicare's enactment. There have been important changes in Medicare's structure and operation over the past 15 years. The prospective payment system (PPS) for inpatient hospital services was implemented in 1983 in response to knowledge about the effects of payment policies on health care utilization and efficiency. HCFA instituted the resource-based relative value scale (RBRVS) for physician payment beginning in 1992 to reflect expanded knowledge about the production of physician services. These payment system changes were improvements, but they remain administered price systems that do not and cannot take advantage of the rapidly evolving market-based health care system.

Coverage for selected preventive health care services was implemented beginning in 1991, and expanded in 1997, reflecting mounting evidence about the effectiveness

of these services in improving health and reducing disease among the elderly. Dr. Wennberg's recent work, however, clearly shows that covering a service in a fee-for-service system is a long way from ensuring its provision.

In the years since I served as administrator of the Health Care Financing Administration, the number of Medicare beneficiaries has grown from 32 million in 1987 to 38 million today. Total Medicare expenditures have risen from $76 billion in 1987 to $215 billion over this same period, with the average expenditure per beneficiary rising from $3,146 to $5,012. The average hospital length of stay for Medicare beneficiaries has declined from 9.0 days in 1990 to 6.4 days in 1997. Meanwhile, Medicare spending for outpatient care has more than doubled from $6 billion in 1987 to $17 billion in 1996. These figures highlight the fact that Medicare has changed substantially in its operation and structure over time—largely in response to broader trends in demographics, technology, and clinical practice.

Despite these important changes, Medicare remains a program that is reflective of the open-ended fee-for-service medical care environment that existed in 1965. Beneficiaries access care from providers on an episodic, ad-hoc basis with very few safeguards in place to assure coordination of care and active management of diseases and health outcomes. No single care-giver is responsible and accountable for the health of the individual as a whole. Additionally, arcane benefit limitations persist in the program—such as lifetime limits on hospital and skilled nursing care, and a complete lack of coverage for services such as prescription drugs, dental care, and many preventive services.

Medicare is also limited in its ability to make rational and efficient decisions concerning coverage for new and innovative medical products and procedures. Under the current system, local carriers make coverage decisions regarding innovative products and procedures based on what is determined "reasonable and necessary." There is little additional guidance for decision-making beyond this broad scope. As a result, new life-saving and quality-enhancing technologies and procedures are made available in one locality but not another. This mechanism for covering new technologies and practices has substantial procedural flaws—it lacks flexibility, timeliness, and transparency to patients and providers.

These are clearly not the attributes of a modern-day health plan. As you know, most non-elderly Americans no longer receive health care through systems offering episodic, fee-for-service care. Rather, most Americans with private health insurance are served through organized medical care systems of some type. Despite the public's and the media's misgivings about managed health care, organized systems of care hold distinct advantages over the unmanaged fee-for-service approaches of the past. These organized systems offer an expanded ability to follow patients across a continuum of health care settings to ensure that the care received is appropriate, coordinated, and comprehensive. Organized systems of care are also much more responsive to consumer and purchaser demands than fragmented fee-for-service systems, as witnessed by the explosion of flexible and open-ended health plans being offered in the marketplace in response to consumer demands for greater choice of providers. These systems are also much more responsive to innovations in medical technology and practice.

Medicare, by contrast, is simply not designed to be a nimble and highly-responsive program. This rigidity is what prevents Medicare from responding to changes in medical practice and market structure.

THE RISKS OF NON-RESPONSIVENESS

Medicare's lack of responsiveness has ramifications across the entire health care system. By insulating health care providers from changes in medical practice and market structure, Medicare has the potential to stifle innovation and improvement in medical care. Medicare payments comprise substantial proportions of the annual revenue received by community hospitals and physicians. This monopsony power may dampen market-based imperatives for responding to trends in medical practice—such as the imperatives for adopting advanced medical technology and evidence-based clinical practice guidelines, implementing clinical quality improvement processes, and developing patient-centered strategies for disease prevention and management.

A key area of concern is Medicare's slow response to the movement toward organized medical care delivery—a trend that has developed rapidly in private health care markets. HCFA has experimented with organized delivery for two decades, but still Medicare remains largely a fee-for-service system. To date only about 17% of Medicare's 36 million beneficiaries are enrolled in health maintenance organizations (HMOs) and other forms of organized health care delivery.

Despite legislative changes and some administrative overhauls, Medicare and HCFA still are dominantly fee-for-service in their orientation and outlook. The rapid evolution in the rest of American health care threatens to leave them even further behind. A number of factors have prevented the movement toward organized care in Medicare. Medicare's administered pricing system for its managed care options has discouraged health plans from participating in many areas of the nation. Similarly, inadequate beneficiary information and cumbersome enrollment procedures have discouraged many Medicare beneficiaries from joining these plans where they exist. As I will mention shortly, the Medicare+Choice program enacted in 1997 under the Balanced Budget Act promises to address some of these issues, but serious barriers remain in the movement toward organized health care. These and other factors combine to ensure that Medicare's organized health care options do not exist on equal footing with the traditional fee-for-service program that serves most Medicare beneficiaries.

By failing to move toward organized medical care delivery, Medicare has retained the legacies of a mid-century fee-for-service system. These include:

- A lack of comprehensiveness in health care benefit design;
- Arcane limits on coverage;
- A slow and disjointed approval process for introducing new therapeutic products and procedures into clinical practice;
- Lack of coordination in health care delivery;
- Limited processes for measuring and improving quality of care;
- Limited processes for ensuring accountability; and
- Lack of incentives for improving efficiency, outcomes, and consumer satisfaction in health care.

The movement toward organized systems of care is an especially important issue for the elderly. More people are living longer lives, making Medicare's lifetime limits on coverage increasingly untenable. Today's elderly are also living with multiple chronic diseases requiring complex approaches to medical management. Many elderly struggle to keep up with multiple drug therapy protocols, and frequent visits to an array of health care professionals. The risk of error and omission on the part of the patient and the provider is high in these situations. The need for active care coordination and management in this population is critical, yet the traditional fee-for-service system is not organized to provide such comprehensive and integrated care.

The Medicare+Choice initiative is Medicare's latest movement toward organized medical care delivery, and Congress should be applauded for taking these important steps forward as part of the 1997 Balanced Budget Act. Notwithstanding the best efforts of those who shaped the Medicare+Choice program, there remain substantial barriers in the movement toward market-based organized medical care. The traditional fee-for-service Medicare program remains the dominant form of care because Medicare+Choice options are not given equal standing within the Medicare program. By retaining an administered-price system, Medicare+Choice precludes most of the competitive incentives for innovation and efficiency that exist in the private market. Additionally, beneficiaries still face too little information about the Medicare+Choice options and too many administrative hurdles to confidently enroll in these alternatives. As a result, the supply of and demand for organized medical care systems remain severely limited in the Medicare program.

The Breaux-Thomas proposal, which emerged from the work of the National Bipartisan Commission on the Future of Medicare, offers a promising improvement to Medicare+Choice. This proposal uses a defined premium support policy to change the existing administered-price system used by Medicare and Medicare+Choice. Under such a policy, organized delivery systems are able to offer competing price-benefit combinations to beneficiaries—rather than benefit packages that are severely limited by the administered-price system maintained by HCFA. By allowing flexibility in price and reasonable variation in benefit design, Medicare would be able to reflect some of the innovation and quality improvement that exists in the competitive private marketplace. Consequently, the supply of and demand for organized medical care in Medicare would be expected to rise steadily—directly benefiting beneficiaries.

STRATEGIES FOR IMPROVING MEDICARE

In considering strategies for improving Medicare and making the program more responsive, it is imperative to consider those program areas in which government involvement works best and those where it works less well. Government can be effective in ensuring consumer protection and in providing a safety-net for Medicare beneficiaries. It is important that the traditional fee-for-service system remain an

option for all Medicare beneficiaries—as a residual choice for those who, for whatever reason, choose not to use organized delivery systems. Public concerns about managed health care offer another reason for retaining the fee-for-service program as a residual choice.

Government is perhaps least effective in making decisions about medical practice and medical prices. Legislative and regulatory bodies cannot hope to keep pace with the continual innovations in practice and technology. Governmental programs that administer prices or regulate practice attempt to fix that which is inherently fluid—the processes of medical innovation and clinical practice improvement. In fixing these fluid processes, government risks impeding the advancement of medical science and practice.

For these reasons, I urge Congress to pursue policies that will responsibly reduce governmental roles in administering medical prices and setting standards of clinical practice within Medicare. These roles are more effectively carried out through market-based mechanisms subject to informed governmental oversight.

These ideas are certainly not new—indeed I myself articulated them more than twelve years ago in a Wall Street Journal article that will be included with my written testimony. These ideas are, however, quite difficult to implement within a program framework that has its origins in 1960s medical practice. Nevertheless, I believe that the premium support policy devised by the Bipartisan Commission offers a promising way to advance the movement toward organized medical care delivery in Medicare.

I want my 82 year-old father, and the millions of other Medicare beneficiaries, to have access to the latest and best in health care. This access should exist not only for innovations in technology, drugs, and treatments—but also for innovations in the organization and delivery of care.

Thank you again for the opportunity to contribute to this important effort. I commend the Chairman and members of the Committee for undertaking this difficult but critically important examination of Medicare. I will be happy to respond to your questions.

PREPARED STATEMENT OF MURRAY N. ROSS, PH.D.

Chairman Roth, Senator Moynihan, members of the Committee. I am Murray Ross, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I am pleased to participate in this hearing looking at Medicare's special payments and patient care costs. My testimony today is intended to provide you with background information about Medicare's policies and not to support or oppose any particular policy option under consideration.

For this hearing, the Committee asked MedPAC to describe Medicare payments to providers that are not directly linked to patient care services for beneficiaries. Policymakers' interest in this topic stems from questions about how provider activities supported by these special payments should be financed if the Medicare program were put on a more market-based footing. Where Medicare's special payments support activities that benefit society at large, they raise program spending and beneficiaries' premiums above what they would otherwise be. Beneficiaries might be unwilling to bear the costs of those activities through the premiums they paid to private health plans in a restructured program.

Classifying special payments

Several reasons make it difficult to describe Medicare payments not specifically linked to patient care. First, some payments that are commonly asserted to be for things other than patient care may in fact cover patient care costs. The payments Medicare makes to teaching hospitals for the direct costs of graduate medical education may fit in this category. Second, some payments that look like patient care—because they are made for specific units of service to Medicare beneficiaries—may cover costs other than patient care. Some portion of the indirect medical education adjustment that Medicare makes in setting payments to teaching hospitals for inpatient hospital stays fits in this category. Finally, in some situations Medicare may pay providers more than their average cost of providing care to Medicare beneficiaries. Medicare's payments to disproportionate share hospitals cover a portion of the cost of patient care for people other than Medicare beneficiaries. Special provisions for rural providers and payment floors in the Medicare+Choice program reflect the higher costs of producing services at low volume and the difficulties of operating health plans when both enrollment and provider supply are low. These policies are often seen as a way of maintaining beneficiaries' access to those providers and fostering the availability of choices.

My testimony today discusses these examples in more depth and points out the factors that policymakers need to consider as they weigh alternatives for reshaping the Medicare program.

Medicare's direct medical education payments to teaching hospitals

Medicare pays teaching hospitals an amount, separate from payments under the inpatient prospective payment system (PPS), for the direct costs of operating residency programs. These payments—known as graduate medical education (GME) payments—reflect salaries and benefits for residents and supervising physicians, office costs, and other overhead. The Congressional Budget Office (CBO) estimates that Medicare GME payments totaled $2.5 billion for fiscal year 1998, of which $2.2 billion was paid for residency training and $300 million was paid for nursing and allied health training.

When PPS was first enacted, Medicare paid its share of hospitals' full GME costs. Since the late 1980s, however, payments have been based on hospital-specific per-resident amounts, calculated using 1984 costs updated for inflation and based on Medicare's share of inpatient days, not its share of costs.[1] Several additional rules affect what is actually paid. First, residents in their initial residency period—up to five years—are counted in full toward payment, while those beyond the initial period are counted as half time. Second, the Balanced Budget Act (BBA) of 1997 capped the number of residents hospitals may include in their count at the 1996 level (although a 3-year rolling average of resident counts is now used to cushion the effect on hospitals that reduce the size of their residency programs). Finally, the per-resident amounts are set slightly higher for residents in primary care and related specialties.

Many observers view payments for the direct costs of graduate medical education as a subsidy to teaching hospitals—and ultimately residents—unrelated to the costs of care for Medicare beneficiaries. But economic theory suggests why this may not be so. In preparation for our forthcoming report on graduate medical education, MedPAC's Commissioners have considered whether hospitals' training costs are borne by residents in the form of lower salaries. If that is the case, the direct costs actually represent the costs of patient care rather than training costs. This conceptual approach, however, does not tell us whether the current level and distribution of GME payments is appropriate.

This idea stems from an accepted proposition in economics that in competitive labor markets, rational employers will be unwilling to pay for the costs of general training—training that makes workers more productive in all settings, not just that of a particular employer. This result occurs because employers cannot recoup the costs of such training through workers' higher future productivity; if they tried to do so, workers would move to other employers where their training was equally valuable. Workers who want general training must therefore pay for it by accepting lower wages; they are willing to do so because acquiring training allows them to earn higher wages in the long run.

If this general proposition holds in the context of teaching hospitals, then all of the direct costs of graduate medical education can be attributed to patient care. Although Medicare might appear to be paying for costs that are not directly related to patient care—salaries for supervising faculty, overhead, and the like—the payments it makes for the costs of residents' stipends are lower by that same amount.

In practice, the matter is considerably more complex, and reality does not always conform to economic theory. But as a general concept, this proposition implies that discussions about whether Medicare should pay for direct GME should not center on the issue of whether the program is subsidizing residents' educations. Rather, the focus should be on whether the additional costs of care from having residents reflect a difference in product for which society is willing to pay. (The next section discusses this point further.)

Medicare's indirect medical education payments to teaching hospitals

In addition to GME payments, Medicare adjusts teaching hospitals' operating payments to reflect their higher costs per discharge that cannot be directly attributed to teaching activities. These indirect medical education (IME) payments totaled $4.1 billion in fiscal year 1998, according to CBO.

The IME payment amount depends on hospitals' teaching intensity, as measured by the ratio of residents to beds. When PPS was enacted, the adjustment was set

[1] Medicare's share has been calculated as the fraction of total inpatient days accounted for by Medicare fee-for-service beneficiaries. Beginning in 1998, a percentage of inpatient days accounted for by Medicare+Choice enrollees has been included in the calculation. That percentage will increase gradually until all days are taken into account in 2002.

at 11.6 percent for each 10 percent increment of teaching intensity. This adjustment was double the estimated relationship between residents per bed and Medicare operating costs per discharge. Since then, the IME adjustment has been reduced several times, most recently by the BBA. The BBA reduced the adjustment from 7.7 percent in 1997 to 7.0 percent in fiscal year 1998, 6.5 percent in 1999, 6.0 percent in 2000, and 5.5 percent in 2001 and later years.[2] (For comparison, MedPAC's most recent estimate of the effect of a 10 percent rise in residents per bed on costs per discharge is 4.1 percent.)

The BBA also established a separate IME payment to teaching hospitals that treat Medicare beneficiaries who are enrolled in Medicare+Choice plans. That payment is being phased in over a 5-year period beginning in 1998.

Medicare's IME payments have been justified on the grounds that they compensate teaching hospitals for several factors that raise their costs but which cannot be separately identified:

- a more severe case mix that is not reflected in Medicare's DRG payments,
- special capabilities, such as the presence of trauma centers and burn units,
- unsponsored clinical research, and
- higher quality of care related to teaching hospitals developing—or being early adopters of—new diagnostic and therapeutic technologies.

In reviewing Medicare's payment policies, MedPAC believes that, other things being equal, Medicare's payments should reflect the costs an efficient provider would incur in providing patient care. By this standard, Medicare's IME payments clearly reflect patient care costs to the extent they correspond to a more severe case mix than is found in other hospitals. Where teaching hospitals' higher costs reflect a different product, or when payments finance social missions other than patient care, policymakers may ask whether those payments should be made by Medicare or some other way.

Medicare payment policies intended to maintain access and foster choice

A number of Medicare payment policies are intended to maintain access to care for Medicare beneficiaries and to foster choices among different providers and types of private health plans. These policies include disproportionate share (DSH) payments made to hospitals that treat large numbers of low-income patients, provisions for special payments to hospitals and other providers in rural areas, and the floor payments established in the BBA for Medicare+Choice plans.

These policies may be justified in different ways. DSH payments are intended to compensate hospitals that provide above-average amounts of care to low-income patients. If Medicare and other payers' payment rates covered only the costs of patient care for their own enrollees, hospitals would not be able to make up for the uncompensated costs of care furnished to low-income patients. Consequently, hospitals might seek to treat fewer low-income and uninsured patients. Special payments to rural providers and the floor payments to Medicare+Choice plans in some counties reflect a slightly different rationale. Because rural providers and plans must generally operate on a smaller scale, they cannot exploit economies of scale. Accordingly, their average costs will be higher. If Medicare paid only the costs of an efficient provider in average circumstances, its rates might not be sufficient for low-volume providers to continue in operation or to induce health plans to enroll beneficiaries in some areas.

Disproportionate share payments

The disproportionate share (DSH) adjustment was implemented in 1986, the third year after PPS began. An estimated $4.5 billion was spent on the DSH adjustment in fiscal year 1998. The BBA reduced DSH funding by 5 percent, in single percentage point increments implemented from 1998 through 2002.

DSH payments are distributed through a percentage add-on to Medicare's DRG payments for inpatient hospital stays. The add-on hospitals receive is determined by a complex formula and the share of their services provided to low-income patients. The low-income share is the sum of two ratios—patient days for Medicaid recipients as a share of total patient days and patients days for Medicare beneficiaries who are eligible for Supplemental Security Income as a percentage of total Medicare days.

The adjustment was originally justified on the assumption that because poor patients were more costly to treat, hospitals with substantial low-income patient loads

[2] In 1999, operating payments to a teaching hospital with a resident-to-bed ratio of 0.6 (typical of an academic medical center) are increased by about 33 percent. Payments to a teaching hospital with a resident-to-bed ratio of .083 (typical of teaching hospitals other than academic medical centers) are increased by about 5 percent.

would have higher Medicare costs per case than would otherwise similar institutions. That assumption has not borne out, however, and the DSH adjustment has increasingly been viewed as serving the broader purpose of protecting access to care for low-income Medicare and non-Medicare populations by assisting the hospitals they use. In both its March 1998 and March 1999 Report to the Congress, MedPAC has relied on this premise in recommending changes to the DSH adjustment. The Commission believes that DSH payments could be made more equitable by using a better measure of care to the poor and by using a distribution formula that more consistently links hospitals' DSH payments to their low-income share. Under MedPAC's proposal, the low-income share would be broadened to encompass all low-income groups by including uncompensated care and measures of care covered by local indigent care programs. The same distribution formula would be used for all hospitals, in contrast to the current 10 formulas that provide a wide range of payments for hospitals serving the same proportion of low-income patients.

Special payments to rural hospitals

Several provisions of Medicare payment policy increase operating payments for certain classes of rural hospitals above what they would otherwise receive under the PPS. These classes include sole community hospitals, small rural Medicare-dependent hospitals, reclassified hospitals, and rural referral centers. Some rural hospitals may benefit from more than one of these provisions.

Sole community hospitals. Sole community hospitals are geographically isolated providers representing the only readily available source of inpatient care in an area. These hospitals are paid the highest of three amounts: the PPS operating payments that would otherwise apply; a hospital-specific amount per discharge based on their operating costs in 1982, updated to the current year; or an amount per discharge based on their operating costs in 1987, updated to the current year. About 700 facilities are designated as sole community hospitals.

Small rural Medicare-dependent hospitals. These are rural hospitals with fewer than 100 beds and whose Medicare share of days or discharges exceeds 60 percent for the cost reporting period that began during fiscal year 1987. For discharges occurring in fiscal years 1998 through 2001, these hospitals receive PPS operating payments plus 50 percent of the difference between their updated hospital-specific base year amounts (1982 or 1987) and the PPS rate. About 370 hospitals meet the qualifying criteria.

Reclassified hospitals. Hospitals that meet certain criteria may be reclassified by the Medicare Geographic Classification Review Board to an area other than the one in which they are physically located. In most cases, hospitals are reclassified from a rural area to an urban area or from an other urban area to a large urban area. Reclassification may affect either the standardized payment amount (the basic payment rate under PPS) or the wage index (an adjustment made to the labor component of the standardized amount to reflect local labor market conditions). Even though the standardized payment amount does not vary between rural and other urban areas, hospitals reclassified for this purpose may benefit by qualifying for DSH payments (or for higher DSH payments) as urban hospitals. Rural hospitals reclassified for the purpose of the wage index receive a higher adjustment to the labor component of their standardized rate. In fiscal year 1998, 314 rural hospitals were reclassified for one or both of these reasons.

Rural referral centers (RRCs). Rural referral centers are rural hospitals that meet criteria regarding the number of beds, annual discharge volume, case-mix index, or proportion of care furnished to patients referred from outside their local area. The standards RRCs must meet for geographic reclassification are less stringent than for other hospitals, allowing many to qualify for a higher wage index and for DSH payments as urban hospitals. Each of these provisions raises PPS payment rates for RRCs relative to what they would otherwise receive.

Special payments to other rural providers

In addition to special payments to rural hospitals, Medicare payment policy includes provisions for special payments to other providers, including rural health clinics and physicians providing services in Health Professional Shortage Areas (HPSAs).

Rural health clinics. To promote access in rural areas with scarce medical services, P.L. 95–210, passed in 1977, authorized Medicare and Medicaid reimbursement to nonphysician practitioners providing primary-care services in rural health clinics. The clinics can be independent, or they can be part of a larger facility, such as a hospital. Medicare payments are based on an all-inclusive rate for covered services provided during each visit. These rates are based on costs up to prospectively set limits. Small rural hospitals with fewer than 50 beds are exempt from these limits.

According to a recent report from the General Accounting Office (GAO), the number of rural health clinics has grown by 30 percent per year since 1989. There were 3,000 clinics in 1996.

Physicians in Health Professional Shortage Areas. A HPSA is an area designated by the Secretary of Health and Human Services as having a shortage of primary-care providers. The Omnibus Budget Reconciliation Act of 1989 authorized a 10 percent bonus payment for services provided in HPSAs and reimbursed under Medicare's physician fee schedule. According to the GAO, about 46 percent of the $106 million in bonus payments made in 1996 were for services provided in rural areas.

Floor payments for Medicare+Choice plans

Until 1997, Medicare paid private health plans in any county 95 percent of the average per capita cost of care for fee-for-service beneficiaries in that county, adjusted for the demographic characteristics of Medicare beneficiaries in that county. The BBA broke the direct link between fee-for-service spending and payments to private health plans. Now, payments are the highest of a floor beneath which payments cannot fall, a 2 percent increase above the prior year's rate, or a blend of local and national payment rates (but only if a so-called budget neutrality condition is met).

In establishing payment floors, the BBA effectively raised monthly capitation rates in many counties above local fee-for-service costs of patient care. The objective of these provisions was to encourage private health plans to participate in areas (particularly rural areas) where they had not previously done so. In 2000, 944 counties—about one-third of the total—will have monthly capitation rates at the floor.

Medicare's special payments and market-based reform

How might the activities supported by Medicare's special payments for medical education, disproportionate share hospitals, rural providers, and health plans in floor counties fare in an environment that relied more heavily on market forces? A definitive answer cannot be provided for each case, but analysis suggests that if the Congress is interested in continuing support for the these activities, it may need to find new mechanisms for doing so.

In regard to graduate medical education and Medicare's special payments to teaching hospitals, the answer hinges on the extent to which beneficiaries observe and value the difference in the services these hospitals provide. Just as consumers are willing to pay higher prices for goods and services they perceive to be superior—from automobiles to college educations—we can reasonably suppose that some Medicare beneficiaries would choose plans that contracted with teaching hospitals. We observe this today among the nonaged population and among Medicare+Choice enrollees whose health plans contract with teaching hospitals. Whether beneficiaries' premiums would provide the same level of support currently provided through Medicare cannot be known. However, to the extent that part of Medicare's payments support social missions beyond patient care, one would expect a decline.

With respect to Medicare's payments to disproportionate share hospitals, it is likely that support would decline under a market-oriented program. In the past, hospitals were able to offset at least some of the costs of uncompensated care by charging more to insured patients. They have been less able to do so as the health care market has grown increasingly competitive, and private payers have resisted paying costs for people other than their own enrollees. Making Medicare more competitive would reinforce this trend. While the likely direction of the impact is clear, its magnitude is not. Health care markets are complex, and the ability of providers to pass on the costs of uncompensated care to payers varies from market to market.

The impact that moving to a more market-oriented program might have on support for providers in rural areas and health plans in floor counties is less clear and would depend in large measure on what the new program looked like. Discussions of market-oriented reform often assume that beneficiaries living in high-cost areas would receive a larger contribution toward their premium to reflect those costs. On the one hand, policymakers could provide greater support for beneficiaries living in areas where low volumes meant high average costs as they might do for beneficiaries living in areas where costs were high for other reasons (such as high labor costs). On the other hand, policymakers could choose not to recognize higher costs attributable to low volumes. In that case, market forces would encourage the expansion of geographic service areas if beneficiaries chose to incur greater travel costs in exchange for lower premiums that reflected greater volumes handled by providers.

PREPARED STATEMENT OF JOHN W. ROWE, M.D.

Thank you Chairman Roth, Senator Moynihan, and members of the Committee for inviting me to testify today on Medicare reform and the importance of the broader missions this Committee has traditionally called upon the Medicare program to accomplish. I am a geriatrician and serve as President of the Mount Sinai School of Medicine and am also President and Chief Executive Officer of the Mount Sinai-NYU Medical Center and Health System, one of the nation's largest academic health science centers. The system includes the Mount Sinai Hospital, the NYU Hospitals Center, the Hospital for Joint Diseases/Orthopedic Institute, and NYU Downtown Hospital. These hospitals serve an urban population that includes a substantial proportion of disadvantaged individuals who are Medicare beneficiaries. I am also a member of the Medicare Payment Advisory Commission, also known as MedPAC.

There is a certain symmetry to having been asked to appear before you today. Four years ago to the week—on May 16, 1995—just as you began the two-year debate on ways to ensure the fiscal solvency of the Medicare program, I testified before this Committee on the mission of the Medicare program. That two-year process culminated in the enactment of the Balanced Budget Act of 1997 (BBA), an act that was heralded as having made the most sweeping changes to the Medicare program since the program's creation in 1965. The hearing I testified at four years ago was on Medicare solvency. Medicare solvency is clearly something the BBA has achieved, with the Medicare actuaries having reported recently that the Part A Trust Fund will be solvent until 2015, a full 13 years longer than its projected solvency when we last met.

I would like to begin my testimony by repeating a section of my testimony from four years ago. At the time, I said the following: "We are entering a period of risk in Medicare that goes beyond fiscal solvency. The current preoccupation on reductions in expenditures has blurred our view of the broad mission of the program. Medicare is not just another insurance program, it has a broader mission, has made greater promises and commitments and serves a group of Americans who have substantially greater health care needs than their younger counterparts. Fiscal modifications must be undertaken in the context of a thorough understanding of the missions of the program to avoid adverse effects on those the program is designed to serve. We should, in brief, honor the first principle of medicine, *Primum Non-Nocere:* above all, do no harm."

For the most part, the provisions of the Balanced Budget Act reflect this principle. This Committee, the Congress as a whole, and the President should be commended for being guided by that principle when designing the myriad provisions contained in the BBA. As Senator Roth stated on the Senate floor on June 23, 1997, "We took a critical first step towards addressing the long-term solvency of the Medicare Program while at the same time making certain that the program meets the needs and expectations of its current beneficiaries. The changes we made in Medicare actually allow us to expand Medicare coverage for certain important preventive services including mammography, colorectal screening, bone mass measurement and diabetes self-management. We are able to offer this expanded coverage and protect and preserve Medicare by incorporating choice and competition into the current program, *and by slowing Medicare's rate of spending growth.* Our measures will save Medicare from bankruptcy for another 10 years, while still increasing Medicare spending per beneficiary from $5,450 this year to $6,950 in the year 2002." [Emphasis added.]

That statement by Senator Roth sums up the laudable intent of this Committee when the BBA was enacted, and, as I say, I believe that that intent has been largely fulfilled. In recent months, however, it has become clear that in a few critical areas there have been some unintended consequences of the BBA that need to be corrected. Just as the treatments prescribed by the best of doctors can have unintended adverse effects, so, too, can the best legislation. And, just as I was taught in medical school that it is best to stop the offending treatment sooner rather than later, I am here today to urge you to make some critical changes before irreparable harm is done to the nation's biomedical research, treatment, and education infrastructure, an infrastructure that is of critical importance to the nation's senior citizens.

As Senator Roth stated on the Senate floor nearly two years ago, your intent was to slow Medicare's rate of spending growth rather than to achieve absolute reductions in Medicare spending. Yet absolute reductions in Medicare spending have, indeed, been the result of the BBA. On May 4, 1999, Robert Pear of The New York Times reported in an article entitled With Budget Cutting, Medicare Spending Fell Unexpectedly, "New Government data show that Medicare spending actually declined in the first half of the current fiscal year. Congress and President Clinton clamped down on Medicare spending in the Balanced Budget Act of 1997, curbing

payments for many services. They expected to slow the growth of Medicare. But for the six months ended March 31, Medicare spending was in fact $2.6 billion less than the $106.5 billion spent in the similar period the previous year, according to data from the Treasury Department."

Two days later, The New York Times followed with two more articles entitled Teaching Hospitals Battle Medicare-Money Cuts, which focused on the difficulty academic medical centers in Boston are having coping with the BBA Medicare reductions, and another entitled New York Hospitals Braced for Cuts, which focused on teaching hospitals in the New York metropolitan area. These articles reflect a problem that we in the teaching hospital community had already identified, namely, that the Balanced Budget Act's reductions for teaching hospitals went too far. This is true when the BBA's Medicare reductions to teaching hospitals are measured both against the BBA's reductions for other types of hospitals but also against the standard set by Congress and the President for the BBA, which was to merely reduce the rate of growth in Medicare spending rather than cut it outright.

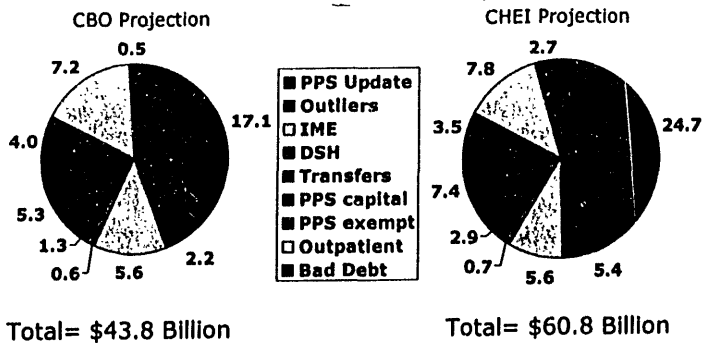
A recent study by the Center for Health Economics and Informatics (CHEI) at the Greater New York Hospital Association found several unexpected outcomes from the BBA with respect to the fiscal impact on inpatient and outpatient ("acute care") hospital services provided in the fee-for-service (FFS) program. These unexpected outcomes are described below. First, however, it is important to note that the CHEI's study methodology differed from the original Congressional Budget Office (CBO) estimates in two important ways:

1. CHEI's Medicare savings estimates were derived "bottom-up" from individual hospital cost report and patient data provided by the U.S. Health Care Financing Administration (HCFA), while CBO's estimates were derived "top-down" from aggregate projections. CHEI is currently reviewing its analysis with the CBO, the Office of Management and Budget (OMB), and MedPAC.

2. CHEI's fiscal impact model was static in that it changed Medicare payment policy provisions while holding all other variables constant. CBO's model was dynamic in that it also incorporated assumptions about trends in managed care enrollment, utilization in the fee-for-service program, and behavioral offsets.

CHEI's first unexpected finding was that the payment policy changes in the BBA would reduce baseline Medicare spending on acute care services by $61 billion from 1998 through 2002. This reduction is $17 billion higher than CBO's $44 billion estimate (see Figure 1). Part of the difference might be attributable to CBO's trend assumptions. However, to the extent that some of the discrepancy is due to CHEI's more accurate, bottom-up methodology, the finding of higher-than-expected Medicare savings from hospital-based acute care services would be in line with the recent data provided by the Treasury Department regarding total Medicare spending.

Figure 1.
Cumulative Medicare Revenue Loss for All Hospitals ($ in Billions)



CHEI's second finding was that the BBA slowed the growth in Medicare spending on acute care services through 2002 to a virtual halt of only 1% in nominal dollars. In so doing, it reduced the purchasing power of the Medicare payment rates by approximately 15%. More significantly, the 1% nominal growth for all hospitals represents an average of +2% for non-teaching hospitals, +1% for other teaching hospitals, and −1% for major teaching hospitals. Thus, the BBA actually cut Medicare payments to major teaching hospitals (see Figure 2). Furthermore, with no changes in either the volume or mix of services, or in hospital cost structure, the BBA would reduce the aggregate bottom-line margin of major teaching hospitals to a negative level, the only group of hospitals to be so affected (see Figure 3).

FIGURE 2.—2002 MEDICARE REVENUE LOSS COMPARED WITH BASELINE[a] AND BASE YEAR REVENUE[b]

Hospital type	N	% Change in nominal $ from baseline 2002 to post-BBA 2002	% Change in nominal $ to post-BBA 2002
All	5,648	−12.7	1.2
Major teaching	318	−14.0	−0.7
Other teaching	902	−12.5	1.3
Non-teaching	4,428	−12.2	2.0
Large urban	1,824	−13.1	0.2
Other urban	1,403	−12.2	1.7
Rural	2,421	−12.3	3.6
Voluntary	3,059	−12.8	1.1
Proprietary	1,186	−12.3	0.9
Government	1,403	−12.7	1.8

[a] The amount hospitals would have received in 2002 absent the BBA.
[b] The amount hospitals received in 1996.
Source: CHEI.

FIGURE 3.—CHANGE IN THE TOTAL MARGIN AS A RESULT OF THE BBA[a]

Hospital Type	Total Margin (in percent)	
	1996	2002
All	5.8	1.9
Major teaching	3.0	−0.9
Other teaching	6.9	2.9
Non-teaching	6.8	2.9
Large urban	5.1	1.0
Other urban	6.6	2.7
Rural	6.8	3.5
Voluntary	5.9	1.8
Proprietary	9.1	4.9
Government	3.1	0.1

[a] Assumes no changes in service mix or utilization, and no change in hospital cost structure.
Source: CHEI.

Among major teaching hospitals, academic medical centers are affected the worst. Within the Mount Sinai-NYU Medical Center and Health System, the Mount Sinai Hospital serves as a good example to illustrate the unexpected and unintended consequences of the BBA for major teaching hospitals in general and for academic medical centers in particular.

CHEI estimated Mount Sinai's cumulative loss during BBA implementation (1998–2002) at $177 million[1], or an average loss of $35 million per year. However, while $35 million is the average annual loss, the fully phased-in, year–2002 loss is $48 million, or 15.3% of the amount that Mount Sinai would have received absent the BBA for the same volume and mix of services. Furthermore, the 2002 Medicare revenue projection is $7.5 million less than what the hospital received in 1996, a

[1] The estimated cumulative Medicare acute care revenue loss for the entire Mount Sinai-NYU Medical Center and Health system in $323 million.

3% cut in nominal payments. All other things being equal, the BBA would force the hospital's bottom-line margin from a positive 3% to a negative 3%. Since the hospital cannot survive with chronic losses, to close our budget gap, we are cutting back important programs and services.

In diagnosing why major teaching hospitals and academic medical centers fare worse than other hospitals under the BBA, it is useful to examine the contribution of each of the individual provisions to the total loss (see Figure 4).

FIGURE 4.—RELATIVE IMPACT OF INDIVIDUAL BBA ACUTE CARE PROVISIONS ON MEDICARE REVENUE

BBA provisions	2002 loss as % of 2002 baseline category revenue			2002 Loss as % of 2002 baseline total revenue		
	All	Major teaching	Mount Sinai	All	Major teaching	Mount Sinai
PPS Update	−8.7%	−8.7%	−8.5%	−5.9%	−6.0%	−5.8%
Outliers	−15.2%	+1.6%	+7.7%	−1.0%	+0.1%	+0.2%
IME	−28.6%	−28.6%	−28.6%	−1.2%	−3.9%	−4.3%
DSH	−5.0%	−5.0%	−5.0%	−0.2%	−0.3%	−0.4%
Transfers	−23.0%	−25.4%	−27.4%	−0.6%	−0.5%	−0.2%
PPS capital	−16.9%	−16.9%	−17.3%	−1.2%	−1.1%	−1.0%
PPS-exempt	−8.5%	−10.1%	−19.1%	−0.7%	−0.5%	−1.5%
Outpatient–	10.4%	−12.9%	−30.5%	−1.5%	−1.5%	−2.2%
Bad debt	−45.0%	−45.0%	−45.0%	−0.5%	−0.4%	−0.2%
Weighted average or total	−12.7%	−14.0%	−15.3%	−12.7%	−14.0%	−15.3%

Source: CHEI.

In the first set of columns, the aggregate loss at the bottom of each column represents the weighted average of the individual line items, since the individual line items reflect the revenue loss in each category as a percent of the baseline revenue in each category. In contrast, in the second set of columns, the aggregate loss at the bottom of each column represents the sum of the individual line items, since the individual line items reflect the revenue loss in each category as a percent of the total baseline Medicare revenue.

Thus, in terms of the percentage loss within each category, the deepest cuts are:

1. The bad debt cut, a 45% reduction in reimbursement for unpaid deductibles and coinsurance;
2. The IME cut, a 29% reduction in the indirect medical education (IME) adjustment; and
3. The transfer cut, a redefinition of selected discharges to post-acute care a transfer cases.

In terms of their contribution to the overall loss, the worst cuts are:

1. The update cut, a five-year cumulative cut in the prospective payment system (PPS) operating inflation update from approximately 16% to approximately 6%;
2. The outpatient cut, a conversion from cost-based reimbursement to a PPS;
3. The IME cut; and
4. The cut in the inpatient capital PPS rate.

Cuts that make a significant contribution to the total loss for all hospitals are the update and capital cuts. Cuts that also make a significant contribution to the total loss for major teaching hospitals and academic medical centers are the IME cut and the outpatient cut. Finally, the PPS-exempt cuts and the DSH cut also disproportionately affect major teaching hospitals.

As already noted, the IME cut is a phased-in 29% reduction in the IME adjustment to the PPS rates. The IME adjustment pays for the higher costs observed in teaching hospitals resulting from the teaching mission. Such costs include: the higher acuity level of patients treated by teaching hospitals; the development and testing of new technologies and treatment protocols; the cost of maintaining expensive services such as emergency rooms, intensive care units, and psychiatric units; and additional time and testing provided by medical residents. The result of cutting this adjustment is a deterioration in the quality of both patient care services and physician training.

Also as already noted, the outpatient cut represents a conversion from cost-based reimbursement to a PPS. One reason why major teaching hospitals and academic medical centers bear a disproportionate impact is that the U.S. Health Care Financing Administration (HCFA) did not propose an IME and DSH adjustment to the new

ambulatory patient groups (similar to inpatient DRGs), even though its regression model suggested that such adjustments would be appropriate. In addition, major teaching hospitals tend to serve the highest share of patients with comorbidities and severe acuity. Finally, HCFA believes that the disproportionate impact on major teaching hospitals will be somewhat ameliorated once all hospitals learn to code their new outpatient bills correctly.

The PPS-exempt cut that threatens service delivery is a national, 75th percentile cap on cost-based payments per discharge (the "TEFRA caps") within three classes of services exempt from the PPS: psychiatric, rehabilitation, and long-term hospital services. These services were exempt from the PPS because their patients and treatment plans are so dissimilar that an average pricing scheme would be inappropriate. For example, burn treatment and medical rehabilitation are both classified in the rehabilitation category, but they are vastly different services. Because the variation in cost among services reflects service differences rather than inefficiency, the TEFRA caps are having the unintended effect of crippling important high-acuity services. Major teaching hospitals tend to provide the most intensive psychiatric and rehabilitation services, which is why they are disproportionately affected by the caps.

The DSH cut is a phased-in 5% reduction in the subsidy for hospitals that serve a highly disproportionate share of indigent patients. There is typically a high degree of overlap between these institutions and major teaching hospitals. For example, in New York State, the 76% of all hospital-based uncompensated care is provided by the 23% of hospitals that are major teaching hospitals.

As I stated earlier, one of the first things medical students learn is that if a treatment is having adverse unintended consequences, it is best to stop the offending treatment sooner rather than later. To that end, I would prescribe considering the following changes to the BBA in order to get the BBA back to its original goal of reduced cost growth. Since major teaching hospitals have an urgent need for relief, the changes listed below would provide the greatest assistance at the lowest cost, although more broad-based efforts could be considered with more resources:

- Halt the phased 29% reduction in IME payments, as proposed by Senator Moynihan; this would cost approximately $3 billion over five years, i.e., from FY 2000 through FY 2004.
- Repeal the phased 5% reduction in DSH payments; this would cost about $600 million over five years.
- Provide IME and DSH adjustments to the new outpatient PPS; this would be budget neutral, although it would reallocate roughly $100 million per year, or less than 1% of projected outpatient PPS spending. In addition, provide new funding for stop-loss payments until the problems with the new PPS are identified and corrected.
- Repeal the TEFRA cap provision; this would cost about $700 million over five years.
- Repeal the transfer provision; this would cost about $303 billion over five years.
- Provide for direct payment of Medicare DSH funds to DSH hospitals on behalf of Medicare managed care enrollees, also proposed by Senator Moynihan; this would be budget neutral.

This is not intended to be an exhaustive list of BBA changes, but I believe that these changes in particular would cure the disproportionate impact the BBA has had on our nation's teaching institutions. I would like to express my deepest gratitude to Senator Moynihan for already recognizing much of what I have said here today and for once again showing the leadership we have come to expect by preparing important legislation to remedy some of the severest consequences of the BBA on academic medical centers. Senator Moynihan, I salute you. We will miss you greatly when you retire in 2001.

You have also asked me here today to discuss Medicare's broader mission in the context of the major Medicare reform proposals that have been discussed to date, including the so-called "premium support" proposal.

First, I must reiterate that the first principle of Medicare reform must be Primum Non-Nocere : above all, do no harm. I believe that it is impossible to adhere to this principle until you know the impact of your most recent reforms. After all, the Balanced Budget Act of 1997 passed only 21 months ago. Many of its provisions have not yet phased-in. As I mentioned before, we have already seen adverse reactions to some of the provisions that have already taken effect. We cannot possibly know all of the effects, including complex interactive effects, of provisions that have not yet been implemented. Therefore, I prescribe extreme caution when proceeding with any new, untested reforms.

Second, I urge you to preserve the special character of the Medicare program and resist transforming it into "just another insurance program." The Medicare program

has always been committed not just to coverage but to access—an aspect of the mission of the Medicare program that is often neglected in the ongoing reform discourse. Payment to support the training of physicians, the maintenance of the biomedical research and treatment infrastructure necessary for National Institute of Health funding, reimbursement of capital expenditures, provision of support for hospitals that provide care to disproportionate numbers of indigent patients, and subsidies to rural hospitals that are "sole community providers" all guarantee access to care for your constituents who are Medicare beneficiaries.

In our inner cities as well as our rural areas we continue to have substantial pockets of underserved populations with very limited access to care. These populations are usually indigent. Few physicians practice medicine in offices based in poor communities in our major cities. For these populations, many of whom are elderly Medicare beneficiaries, the sole or dominant source of care is hospitals. Long ago, this Committee realized that without support for graduate medical education, without support for disproportionate share hospitals, without capital support, without subsidies to rural hospitals and "sole community providers," a large number of older Americans would be placed in the absurd position of being eligible for health care services under the Medicare program with no access to the health care services for which they are eligible.

Many policy makers have of late called for making the Medicare system more like private insurance and seek to largely turn the program over to private insurers and HMOs. Other members of this panel who are testifying today have recently published reports that show what happens to research and care for the indigent—two of the important public goods Medicare has traditionally sought to support through graduate medical education and DSH subsidies—in markets where managed care dominates. In both studies, the more managed care there is, the fewer the "public goods"—biomedical research, charity care—that are provided. These studies make clear that the private sector does not by itself finance public goods, does not voluntarily pay teaching hospitals higher rates, does not reimburse hospitals that care for indigent patients more to cover their extra costs, and does nothing to ensure that indigent patients have access. These are points Senator Moynihan has made repeatedly and eloquently over the years.

Some have said, "Only Medicare pays for these things," as if that statement is an indictment of the Medicare program. I believe, rather, that it is an indictment of the rest of the payer community, and, if Medicare stops paying for public goods, you will find senior citizens and other constituents losing access to teaching hospitals and hospitals in their urban and rural communities. You will then have both a public health problem—and, perhaps, a political problem—with which to contend.

At the very least, then, I urge you to recognize that there is a reason that Medicare is different. Medicare still supports public goods, albeit at a reduced level due to the BBA. The private sector does not and Medicaid often does not. Someone must, or these public goods will disappear. The BBA, along with the growth in managed care and cutbacks in Medicaid reimbursement, has the potential, in a relatively short period of time, to seriously damage the infrastructure of academic medicine and care for the poor. This infrastructure took decades to build; it will not be readily replaced.

Medicare payments to teaching hospitals and DSH hospitals, then, must continue to be made directly to teaching and DSH hospitals, even in situations where a Medicare beneficiary is covered by private insurance. With regard to graduate medical education payments, the ideal solution would be a mandatory graduate medical education all-payer trust fund, like the one proposed by Senator Moynihan. Unless and until Senator Moynihan's bill is enacted, however, Medicare must maintain its commitment to GME, and must maintain its commitment to DSH—in short, must maintain its commitment to access precisely because no one else will.

My final point on Medicare reform is to urge you to transform the Medicare program from a health insurance program into a health promotion program. Currently, Medicare's health promotion initiatives are limited to vaccination against influenza, hepatitis B, and pneumococcal infection. Other preventive services focus on early detection and include screening mammography, screening for colorectal cancer, Pap smears, and measurement of bone density. True reform would include comprehensive initiatives to promote health and prevent disease. Such an effort, launched in conjunction with a comprehensive review of the current benefits package, would improve Medicare's financial stability, since health care expenses are related to health status, and since reductions in risk factors are associated with reduced expenses. A broad Medicare-supported prevention program might include payment for exercise, nutrition, and smoking-cessation programs. I have attached to my testimony a recent editorial on this subject that appeared in the March 4, 1999 edition of the New England Journal of Medicine that contains more detailed recommendations.

Mr. Chairman, Senator Moynihan, I thank you once again for inviting me here today. I would be glad to answer any questions members of the Committee may have.

The New England Journal of Medicine

Editorial

Geriatrics, Prevention, and the Remodeling of Medicare

GERIATRIC medicine has focused primarily on the management of acute and chronic diseases in frail older persons, with much less emphasis on the promotion of health and the prevention of disease than there is in health care for children or middle-aged adults. A growing body of knowledge about disease prevention in later life, including important research by Inouye et al.[1] that is reported in this issue of the *Journal*, provides a valid basis for strengthening efforts in preventive geriatrics. Given its mission and responsibility, the Medicare program is well positioned to lead such an effort on a national level.

Inouye et al.[1] report a prospective, controlled trial of a multicomponent intervention to prevent delirium in elderly patients hospitalized in an academic medical center. Delirium is a morbid syndrome that develops in 20 to 30 percent of hospitalized elderly patients.[2] It is characterized by the abrupt onset, often at night (as in "sundowning"), of fluctuations in consciousness, inattention, and disorganized thinking. The pathophysiologic basis of delirium is unknown. Preexisting conditions that place patients at increased risk include cognitive impairment, severe acute illness (especially hip fracture or stroke), and visual or hearing impairment.[3,4]

Common factors precipitating delirium include psychotropic drugs, hyponatremia, extracellular volume depletion, adverse effects of general anesthesia, and adverse environmental conditions. Delirium is common, for example, in intensive care units (so-called ICU psychosis). Delirium complicates care and prolongs recovery, thus consuming additional resources. Often people assume incorrectly that delirium is transient, but many patients have cognitive and functional defects that persist for months.[5] Treatment focuses on the correction of precipitating factors, the removal of offending drugs, environmental controls to reduce disorientation, and drugs to control behavior.

In the study by Inouye et al.,[1] 426 elderly patients at risk for delirium who were admitted to a single medical ward received an intervention aimed at some of the major risk factors for delirium, including cognitive impairment, sleep deprivation, immobility, hearing and visual impairment, and volume depletion. Patients with profound dementia and those who were delirious on admission were excluded. The control patients were drawn from two "usual care" wards and were matched for age, sex, and base-line risk of delirium with the patients who received the intervention.

The intervention protocols were tailored to individual risk factors and included frequent reorientation and mentally stimulating activities for patients who were cognitively impaired, thrice-daily ambulation or other exercises (for those who were immobile), and visual aids or assistive hearing devices for those who needed them. The intervention reduced the incidence of delirium by 40 percent. Patients at intermediate risk for delirium, according to the number of risk factors, benefited more from the intervention than those at high risk. When delirium developed, it was as severe in the intervention group as in the control group, suggesting that the value of the intervention was in the prevention and not the treatment of delirium.

Surprisingly, the average length of the patients' hospital stay was not influenced by the intervention. Perhaps other clinical considerations outweighed the presence or absence of delirium in decisions about discharge from the hospital, or perhaps physicians assumed that recovery from delirium might be facilitated by discharge to the patient's home. However, the lack of an effect on the length of hospitalization should not be considered evidence of a lack of savings in cost. Studies of the cost effectiveness of this intervention are still needed, but it is probable that delirium is associated with delayed recovery from acute illness as well as an increased need for services and increased costs after discharge from the hospital.

This study is notable for its focus on prevention rather than treatment, which has been the target of most studies of delirium. This study also overcame some substantial logistic difficulties. One can only imagine the challenge of intensively studying more than 800 acutely ill hospitalized elderly people and performing more than 4800 detailed personal evaluations when the patients always seemed to be away from the ward for tests or being examined by students, residents, or consultants.

Preventive strategies in geriatrics are underdeveloped. Some important progress has been made, as in the prevention of stroke through treatment of isolated systolic hypertension (an important risk factor previously considered to be a harmless accompaniment of "normal" aging) and in the prevention of falls by means of physical training. However, great opportunities remain to prevent or delay geriatric disorders through modifications of lifestyle. For instance, the interrelated characteristics of obesity, a sedentary lifestyle, hyperglycemia, hyperinsulinemia, hyperlipidemia, and hypertension (syndrome X) carry significant risks for the development of coronary heart disease in older persons.[6] However, these risk factors respond to interventions that involve diet and exercise.[7]

Neglect of health promotion late in life seems based on two myths. The first myth is that the increased risk of disease in older persons reflects "normal" aging, which is seen as an inevitable, intrinsic

process that is largely genetically determined. The second myth is that the aged body has little plasticity and cannot respond to lifestyle changes. Both myths have been disproved.[8,9]

We now know that risk factors for coronary heart disease and stroke are neither immutable nor largely determined by genetic makeup. Substantial and growing evidence indicates that such established risk factors represent usual rather than "normal" aging and can be modified through lifestyle interventions, including diet and exercise.[8,9] A healthier lifestyle adopted late in life can increase active life expectancy, decrease disability,[10] and reduce health care costs.[11] Combining exercise and dietary interventions, such as the administration of folic acid and vitamin B_6 to reduce plasma homocysteine levels (hyperhomocysteinemia is an important risk factor for coronary heart disease), and smoking-cessation programs might further increase the benefit. Although many questions remain regarding the details of implementation, the time has come for greater emphasis on comprehensive behavioral and medical programs aimed at promoting health and preventing disease among older Americans.

In its new strategic plan, the Health Care Financing Administration (HCFA), which oversees the Medicare program, lists as the first of its goals "to protect and improve beneficiary health and satisfaction."[12] Despite this, Medicare is currently not a health program but rather a health care insurance program. Medicare's primary-prevention initiatives are limited to vaccination against influenza, hepatitis B, and pneumococcal infection. Other preventive services focus on early detection and include screening mammography, screening for colorectal cancer, Pap smears, and measurement of bone density. HCFA recognizes that even these minimal preventive measures are underused and is studying ways to enhance the effectiveness of prevention initiatives.

Current congressional efforts to "reform" Medicare focus primarily on ensuring its continued fiscal stability. The chief new health care service being considered is coverage for outpatient prescription drugs, a valuable benefit discussed in detail by Soumerai and Ross-Degnan in this issue of the *Journal*.[13] True reform would balance Medicare benefits by combining prudent purchase of health care services with robust, comprehensive initiatives to promote health and prevent disease. Such an effort, launched in conjunction with a comprehensive review of the current benefits package, would improve Medicare's financial stability, since health care expenses are related to health status, and since reductions in risk factors are associated with reduced expenses.

A broad Medicare-supported prevention program might include payment for exercise, nutrition, and smoking-cessation programs, perhaps offered in senior centers,[14] when these interventions are ordered by a physician for Medicare beneficiaries at documented high risk for disease. As a direct financial incentive, Medicare Part B premiums could be reduced for persons enrolled in health-promotion and disease-prevention programs and for those with low risk profiles, such as nonsmokers. Medicare might also establish requirements for preventive health services in its own managed-care programs. Evaluation of the feasibility and cost effectiveness of such efforts should be a high priority for Congress and HCFA, which must work closely with other federal agencies such as the Agency for Health Care Policy and Research and the National Institute on Aging and with professional organizations and foundations committed to improving the health status of older persons.

Although HCFA's current Healthy Aging Project is a first step in this direction, the initiative must be enhanced and its implementation made a central component of HCFA's strategic plan. Reorientation of the Medicare program toward the promotion of health and the prevention of disease would encourage healthier aging, would be true to Medicare's mission and goals, and could in the long run enhance Medicare's financial stability.

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PREPARED STATEMENT OF DIANE ROWLAND, SC.D.

Thank you Mr. Chairman and members of the committee for this opportunity to provide an overview of the role Medicare plays in meeting the health needs of our elderly and disabled populations. I am Diane Rowland, Executive Vice-President of the Henry J. Kaiser Family Foundation and Executive Director of Kaiser Commission on Medicaid and the Uninsured. I also serve as an Adjunct Associate Professor of Health Policy at the Johns Hopkins University School of Public Health.

Since its enactment in 1965, Medicare has made health care more available and affordable to millions of aged Americans, helping to close gaps in care between the poor and non-poor, whites and minorities, and urban and rural residents. Since 1972, it has extended similar assistance to the totally and permanently disabled population. Today 1 in 7 Americans receives their health care coverage from Medicare. My testimony today will focus on the population served by Medicare, the extent to which Medicare coverage is meeting their health care needs, and the challenges facing the program.

THE MEDICARE POPULATION

Medicare provides health insurance coverage to 34 million elderly and 5 million disabled beneficiaries. Because Medicare coverage is limited to those who are age 65 or older or disabled, the Medicare population is by design older and more disabled than the general population and thus at greater risk for chronic illness and disabling medical conditions.

Health needs increase with age. Over a quarter (28 percent) of those age 65 and above report their health as fair or poor compared to only 8 percent of those age 25 to 44 (Figure 1). Nearly a quarter (23 percent) of Medicare beneficiaries have cognitive impairments and one in five (20 percent) has functional impairments. Despite their greater health needs, the elderly have lower incomes with which to pay for their care. Median income rises through ages 45 to 54 and then begins to decline, leaving those age 65 and above with a median income of roughly $20,000 compared to over $50,000 for the 45 to 54 year old age group (Figure 2).

This combination of poor health and reduced incomes leaves Medicare's beneficiaries particularly vulnerable to health care costs that would be unaffordable without Medicare's assistance. Two out of three Medicare beneficiaries (63 percent) have either health problems or incomes that are below 200 percent of the federal poverty level (roughly $16,500 for an individual and $22,000 for a couple in 1999) (Figure 3). One in five Medicare beneficiaries has both fair or poor health and an income below 200 percent of poverty, leaving them to face health problems with few resources with which to pay for needed care.

While Medicare, coupled with Social Security, is credited with improving the financial security of elderly and disabled Americans, nearly half of all beneficiaries live on incomes below 200 percent of the poverty level (Figure 4). Fourteen percent of beneficiaries—5 million people—have incomes below the poverty level ($8,240 for an individual and $11,060 for a couple in 1999). Those who are under-65 and disabled and those age 85 and older represent a disproportionate share of low-income Medicare beneficiaries. Gender and race are also linked to low incomes among Medicare beneficiaries: women account for two-thirds (67 percent) of all beneficiaries with incomes below the poverty level, but only 56 percent of the total Medicare population; racial and ethnic minorities account for about 30 percent of those who are poor, but less than 15 percent of all people covered by the program.

The link between poverty and poor health among the elderly population has been well documented. Beneficiaries with incomes at or below the poverty level are significantly more likely to report health problems than beneficiaries with higher incomes. Nearly half of all beneficiaries living below the poverty level (44 percent) perceive their health status as fair or poor—more than double the rate of beneficiaries with incomes above twice the poverty level (Figure 5). Cognitive impairments are also more prevalent among the poor, nearly 40 percent have reported problems with mental functioning, a rate nearly 3-times that reported by those with incomes above 200 percent of poverty.

While Medicare is often thought of as a program for elderly people, disabled beneficiaries under age 65 represent 12 percent of the overall Medicare population (Figure 6). Under-65 disabled beneficiaries are significantly more likely than their older counterparts to have low incomes. Nearly one in three (30 percent) has an income below the federal poverty level. Poverty rates among the under-65 disabled are more than two and a half times those for the elderly. Disabled beneficiaries are also obviously a group with very significant health care needs as a result of their disability. A disproportionate share also have problems with mental functioning.

At the other end of Medicare's age spectrum are those age 85 and older—now 11 percent of the total Medicare population. The 85-plus segment of the Medicare population is more likely than younger seniors to be female, poor, in relatively poor health, and to have long-term care needs. Women account for 56 percent of all beneficiaries, but 70 percent of Medicare's oldest-old beneficiaries. These oldest beneficiaries are also more likely to have low incomes, with 59 percent living on incomes below 200 percent of poverty compared to 45 percent of the total Medicare population. Those age 85 and older are more likely than the general Medicare population to have functional limitations (45 percent vs. 28 percent) and to have problems with mental functioning (52 percent vs. 20 percent).

Thus, while the Medicare population is often described in homogenous terms, the health needs and ability to afford care differs markedly among the program's 39 million beneficiaries. Although most beneficiaries have good health, more than one in four is in fair or poor health, one in four has long-term care needs and about one in five has cognitive impairments. Nearly one-fifth (17 percent) are hospitalized each year and more than 75 percent use prescription drugs regularly. By definition, Medicare is the program providing health coverage to the old, the disabled, and the sick—a population with notably greater health needs than the non-elderly working population covered by private health insurance plans.

Reflecting the diverse and often expensive health needs of this population, Medicare spending varies by the health status of its beneficiaries. Medicare spends, on average, five times more for beneficiaries in poor health ($11,739) than for those in excellent health ($2,134) (Figure 7). Overall, ten percent of Medicare's beneficiaries account for 75 percent of Medicare's spending.

MEDICARE'S SCOPE OF COVERAGE

With the advent of Medicare, universal coverage was provided to virtually all elderly and later disabled Americans, keeping these vulnerable groups from the ranks of the uninsured. Medicare provides basic health insurance coverage for hospital, physician, and diagnostic services. Of the $217 billion in Medicare expenditures in 1997, hospital care accounted for 41 percent of spending, physician care for 15 percent, and managed care plan payment for another 15 percent. The remaining third of spending covered hospital outpatient, home health, skilled nursing facility, hospice, and other ambulatory care benefits.

Despite the significant protections offered by Medicare, Medicare does not provide fully comprehensive health insurance coverage. There are gaps in Medicare's benefit package, and relatively high deductibles and cost-sharing for most covered services. Medicare actually is less generous than coverage in health plans typically offered by large employers. Most notably, Medicare does not cover outpatient prescription drugs, nor does it cap the maximum amount that beneficiaries are required to pay for covered services (stop-loss protection). Long-term care services, most especially nursing home care and non-medical in-home assistance, are also not part of Medicare coverage.

SUPPLEMENTING MEDICARE COVERAGE

Many beneficiaries rely on supplementary insurance to help fill in Medicare's gaps and provide additional protection. In 1995, a quarter (26 percent) of all Medicare beneficiaries purchased private insurance, known as Medigap, to supplement Medicare, and others (34 percent) received supplemental coverage from a former employer or through a union as a retiree health benefit (Figure 8). One in seven Medicare beneficiaries (14 percent) relied on the Medicaid program for supplemental assistance in covering the Medicare premium and some cost-sharing requirements, and, for some, providing coverage for prescription drugs and other benefits.

Another 9 percent elected to enroll in Medicare HMOs that, unlike Medigap policies, generally have no additional premiums and offer benefits, such as outpatient prescription drugs, that are not covered under the traditional Medicare program. Managed care is attractive because of its potential to improve the delivery and coordination of services and reduce spending, but it is risky because people with chronic conditions may be underserved, not better served, in managed care.

However, a substantial share of the Medicare population (12 percent) lack supplemental coverage of any kind and depend solely on Medicare for assistance with their medical expenses. Those relying solely on Medicare are the most at risk for high out-of-pocket spending because they have no assistance for cost-sharing or uncovered services. Low-income beneficiaries are more likely to rely solely on Medicare than their higher income counterparts.

The nature and scope of health insurance coverage to supplement Medicare varies significantly by income. Among the poor, 16 percent relied solely on the traditional

Medicare program for their health insurance coverage in 1995. About half of Medicare's poor (49 percent) had Medicaid assistance, 6 percent were enrolled in a Medicare HMO, and 25 percent had private coverage. The likelihood of having a retiree health benefit to supplement Medicare increases significantly with income, from 8 percent of the poor to 26 percent of the near-poor and 52 percent of those with incomes above 200 percent of the poverty level. Conversely, Medicaid coverage is highest among the poor and diminishes as income increases, although it is notable that less than half of all poor Medicare beneficiaries receive Medicaid's financial protections.

The combination of supplementary insurance and Medicare provides varying levels of coverage within the Medicare population. Retiree health benefits as a supplement are generally the most comprehensive fill-ins and offer most enrollees some prescription drug coverage. Individually purchased Medigap policies, on the other hand, tend to have the most limited coverage despite their substantial premiums. The more affluent elderly are most likely to have the more comprehensive retiree benefits while he lower income beneficiaries obtain additional coverage by purchasing private Medigap plans. Increasingly, many beneficiaries are leaving traditional Medicare coverage and opting for enrollment in a managed care plan to gain supplementary benefits and expand their coverage for little or no premium increase.

MEDICAID'S ROLE FOR MEDICARE'S POOR

The poorest of Medicare's beneficiaries are eligible for assistance from Medicaid to provide expanded benefits and help pay for cost-sharing and Medicare premiums. Today, 6 million Medicare beneficiaries receive some assistance from Medicaid (Figure 9). The 5 million poorest beneficiaries, including those receiving cash assistance from welfare and those who have exhausted their personal resources paying for health care, receive the full range of Medicaid benefits including prescription drugs, long-term care, and payment of Medicare premiums and some cost-sharing. Others with somewhat higher incomes primarily receive assistance with their Medicare Part B premium and, in some cases, cost-sharing. They are referred to as Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB) and more recently, Qualifying Individuals (QI 1 and QI 2) (Figure 10).

The Medicare beneficiaries with full Medicaid benefits are those whose eligibility is based on receipt of cash assistance or impoverishment due to substantial and ongoing health needs, most often long-term care services in a nursing home. For them, the Medicaid wrap-around to Medicare benefits is the most comprehensive, covering not only premium and some cost-sharing requirements, but also prescription drugs, dental and vision care, and long-term care.

Of the 5 million people eligible for Medicare and Medicaid, a quarter are in nursing homes, nearly half are in fair or poor health, over a quarter have two or more limitations in activities of daily living, and over 40 percent have cognitive impairments (Figure 11). Because of their extensive health needs, dual eligibles account for a substantial share of spending in both programs ($106 billion in 1995). They represent 16 percent of Medicare beneficiaries and 30 percent of spending. For Medicaid, they account for 17 percent of beneficiaries and 35 percent of spending, largely due to their use of expensive long-term care services. It is often suggested that fully integrating Medicare and Medicaid benefits and capitating payments for this vulnerable population will save money, but evidence is limited.

For those with low-incomes who are not poor enough to qualify for full Medicaid benefits, Medicaid provides coverage of the Medicare Part B premium ($45.50 per month in 1999) for those with incomes below 120 percent of the federal poverty level and the premium plus some cost-sharing for those with incomes below the poverty level. However, many do not avail themselves of these protections either because they are unaware of the benefits or unwilling to apply through the state-based welfare system that administers Medicaid. Approximately 78 percent of those eligible for the QMB program participate, but many are automatically enrolled as part of receiving cash assistance. Only 16 percent of those potentially eligible for the SLMB program's coverage of the Medicare Part B premium take advantage of this assistance.

Given the limited scope of Medicare coverage and the greater health needs of the low-income population, it is particularly important that low-income beneficiaries receive help from Medicaid when available. Of the 20 million Medicare beneficiaries with incomes below 200 percent of poverty, Medicaid today only assists one in four (Figure 12). Improving the scope of protection for the low-income population is critical to achieving effective reform of Medicare while preserving and improving access to care. Today those who rely solely on Medicare without supplementary coverage from Medicaid or private insurance are more likely to not have a regular source of

care, to have delayed care due to cost, or to have not seen a physician in the course of a year (Figure 13). Clearly, having financial security and improved coverage helps to improve access to care for our most vulnerable citizens.

FINANCIAL BURDENS AND MEDICARE BENEFICIARIES

Out-of-pocket spending on acute medical services and insurance premiums for both Medicare and private supplemental policies are significant expenses in the budgets of elderly and disabled Medicare beneficiaries. Medicare is not a program in which enrollees have too little price sensitivity, for Medicare beneficiaries themselves pay a substantial share of their medical bills directly.

It is estimated that the average out-of-pocket spending for Medicare beneficiaries who are not in nursing homes was $2,149 in 1997 (Figure 14). Private insurance premiums, including HMO premiums, accounted for nearly one-third of spending on the Medicare Part B premium payments for another 20 percent. Prescription drugs accounted for 16 percent of spending.

However, the averages mask the vulnerability of particular groups. While the elderly on average pay a fifth of their income on out-of-pocket medical expenses, the poor and the sick bear the heaviest burden (Figure 15). The poor spend one-third (34%) of their income on health care as do those with a limitation in activities of daily living and those in fair or poor health spend over a quarter (27%) of their income on health care.

For the low-income population, having Medicaid coverage makes a substantial difference in out-of-pocket spending. Those with Medicaid spend only 8 percent while the poor without Medicaid coverage spend over half (54%) of their incomes on medical expenses in the traditional Medicare fee-for-service program and fare only slightly better when enrolled in a Medicare HMO (48% of income medical care) (Figure 16).

One of the most substantial expenses for most Medicare beneficiaries is the cost of prescription drugs, which are not included on an outpatient basis in the Medicare benefit package. As medical care has increasingly shifted from impatient hospital care to medical management at home, prescription drugs have become an essential part of most treatment plans. Three-quarters of all Medicare beneficiaries use prescription medications. Drugs, however, are often expensive, particularly new ones that offer help to those with arthritis, diabetes, ulcers, depression, heart conditions, and other illnesses.

Although Medicare does not cover outpatient prescription drugs, two-thirds of Medicare beneficiaries obtain some amount of coverage through their supplementary insurance coverage or from Medicaid. Drug coverage is most often provided through the retiree health benefits that tend to be provided to higher income beneficiaries. Over a third (35%) of Medicare beneficiaries, including many with private Medigap policies, have no coverage for prescription drugs (Figure 17).

The liability for paying for prescription drugs varies by the type of supplementary coverage and the generosity of the supplementary benefit in terms of deductibles, cost-sharing, and limits on covered drugs. Overall, Medicare beneficiaries directly pay for half of all prescription drug spending on their behalf (Figure 18). Those who rely solely on Medicare bear the full cost of any drugs and those with private Medigap policies pay directly for 80 percent of their drug bills depending on the type of policy they own. Employer-sponsored retiree plans and Medicare HMOs reduce out-of-pocket payments to about a third of beneficiaries' drug spending. Medicaid provides the best protection, but the low-income population with Medicaid coverage still pays for about one-fifth (21%) of their drug costs because not all individuals with Medicaid have coverage for prescription drugs.

Thus, while Medicare provides invaluable health insurance coverage to elderly and disabled Americans, it is not fully meeting the health care needs nor protecting against financial burdens for many of its beneficiaries. The economically better off, especially those with employer-sponsored retiree coverage, have the best protection and the lowest income get needed assistance for Medicaid. Yet, millions of low and modest income Medicare beneficiaries are in need of assistance with medical bills and especially prescription drug coverage to make the promise of Medicare a reality in their daily lives.

CONCLUSION

Medicare has served the nation's elderly and disabled well for more than 30 years. When Medicare was enacted, only half of the nation's elderly had health insurance protection. Today, virtually all elderly Americans and the severely disabled population have health coverage through Medicare. Much progress has been achieved

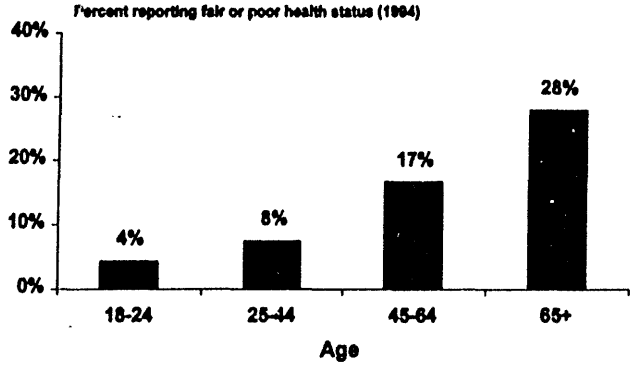
through Medicare in alleviating disparities in access to care and bringing life-saving medical advances to our elderly and disabled citizens.

In evaluating Medicare's role and assessing needed improvements to reform and modernize Medicare to meet the needs of the aging of the baby boom generation, care should be taken to preserve the best of Medicare while addressing its gaps and securing its financial viability. Medicare is a popular and well-liked program despite its less than comprehensive coverage. While some would move Medicare to be more like the private insurance options available to the working population, Medicare beneficiaries report higher levels of satisfaction with their coverage, medical care, and choice of doctors than those with private insurance (Figure 19). Medicare beneficiaries also report fewer access problems (Figure 20). Given that Medicare's population is older, sicker, and less affluent than the working population, it is notable that the people it serves hold the program in such high regard.

As changes in the program are considered, it is important to assure that the protections Medicare has brought to our elderly and disabled populations are strengthened, not weakened, in the future and especially that the needs of Medicare's most vulnerable—the low-income, the sick, and the frail are addressed. Efforts to reform the program should assure that future generations of elderly Americans have affordable health care when they need it.

Figure 1

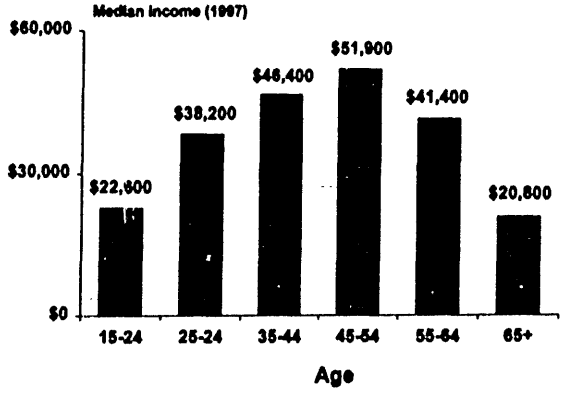
Health care needs increase with age



SOURCE: U.S. Dept of Health and Human Services, *Current Estimates from the National Health Interview Survey*, 1994. Series 10, No. 193, December 1995.

Figure 2

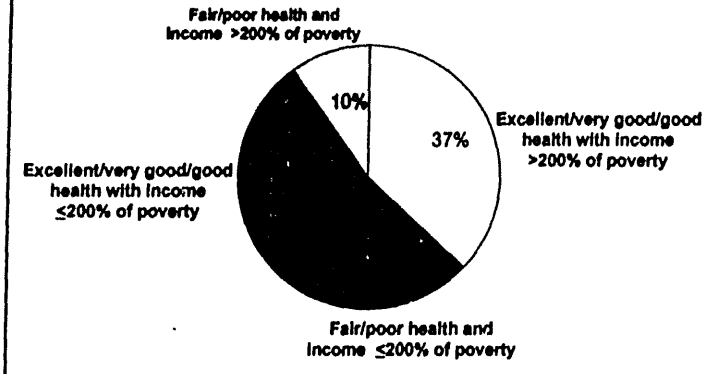
Median income declines with age



SOURCE: U.S. Census Bureau, Income 1997, [On-line]. Available: www.census.gov/hhes/income/income97/in97sum.html

Figure 3

Two-thirds of Medicare beneficiaries have health problems or live on low incomes

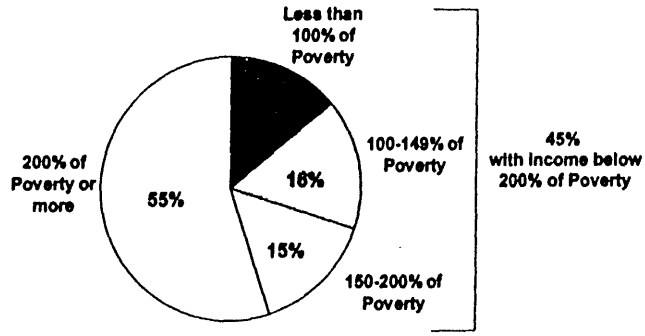


Total = 39 million Medicare beneficiaries

SOURCE: Urban Institute analysis of Medicare Current Beneficiary Survey, 1995.

Figure 4

Medicare Population by Poverty Level, 1996

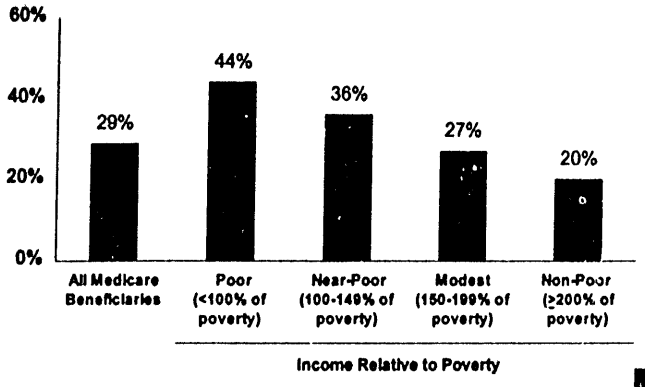


Medicare Beneficiaries = 35.6 Million

Note: 1996 federal poverty was $7,740 for individuals, $10,360 for couples
SOURCE: Urban Institute estimates based on the March 1997 Current Population Survey; non-institutionalized Medicare beneficiaries only

Figure 5

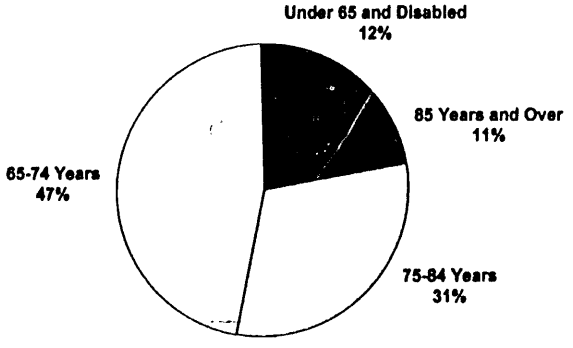
Percent of Medicare Beneficiaries Reporting Fair or Poor Health, by Poverty, 1995



SOURCE: Medicare Current Beneficiary Survey, 1995.

Figure 6

Medicare covers a broad age spectrum

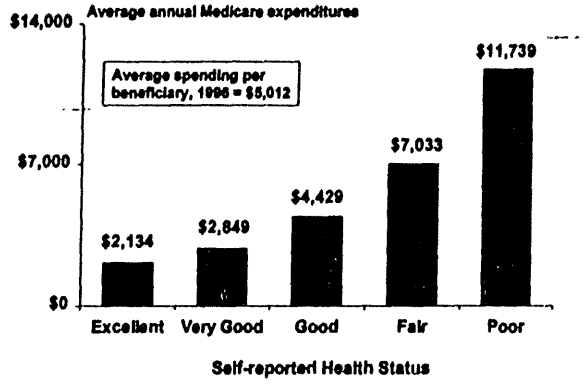


Total = 39 million Medicare beneficiaries, 1996

Note. Numbers do not add to 100% due to rounding
SOURCE Medicare Current Beneficiary Survey, 1996.

Figure 7

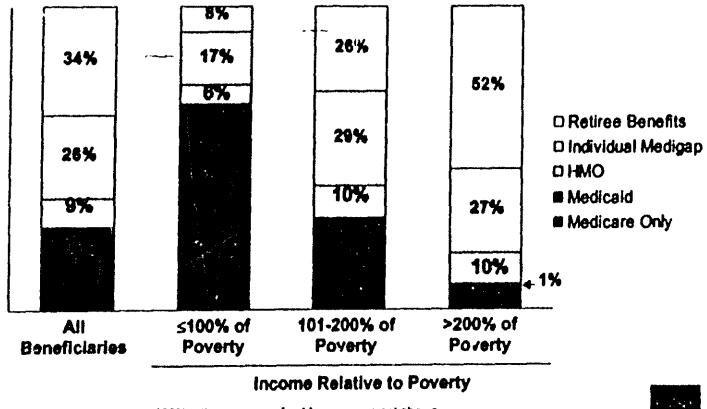
Medicare spends five times more for beneficiaries in poor health than for those in excellent health



SOURCE: Medicare Current Beneficiary Survey, 1996.

Figure 8

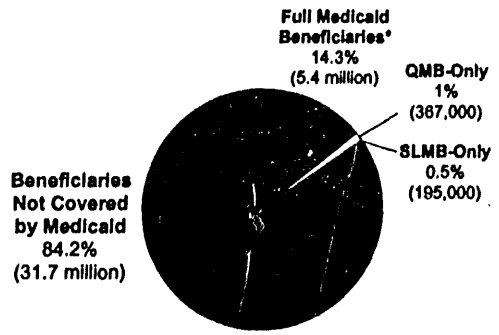
Health Insurance Coverage of Medicare Beneficiaries, 1995



Note: Columns do not sum to 100%; other sources of public coverage not shown.
Source: Urban Institute analysis of 1995 Medicare Current Beneficiary Survey, Cost and Use File.

Figure 9

Distribution of Medicare Beneficiaries, by Medicaid Eligibility, 1995



*Most full Medicaid beneficiaries are QMBs.
Note: Qualifying Individuals (QIs) are not included since the QI program was not yet enacted
SOURCE Alliance for Health Reform, 1997.

Figure 10

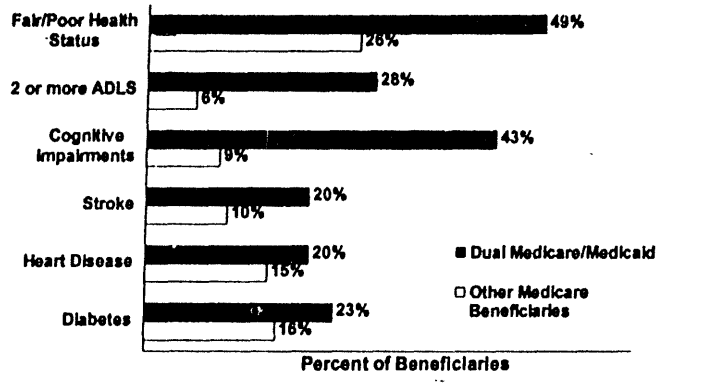
Medicaid's Protections

Program	Who's Eligible?	What Does Medicaid Pay?	Entitlement?
Full Medicaid Benefits	73% poverty* (SSI eligibility level)	Wrap around benefits; prescription drugs, long-term care, and Medicare Part B premium & cost-sharing	Yes
Qualified Medicare Beneficiary (QMB)	≤100% of poverty	Medicare Part B premium & cost-sharing**	Yes
Specified Low-Income Beneficiary (SLMB)	100-120% of poverty	Medicare Part B premium	Yes
Qualifying Individuals 1 (QI1)	At state option, up to 135% of poverty	Medicare Part B premium	No
Qualifying Individuals 2 (QI2)	At state option, up to 175% of poverty	A portion of the Medicare Part B premium	No

Note: Individuals must have limited assets (below $4,000 for an individual). The QI programs are block grants available on a first-come, first-served basis
* Some states (209b) are permitted to set lower levels, states have the option to go up to 100% of poverty
** States are not required to pay Medicare cost-sharing if Medicaid payments are lower

Figure 11

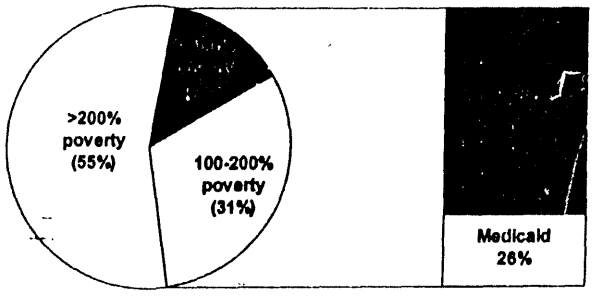
Health of Dual Medicare/Medicaid Beneficiaries Compared to Other Medicare Beneficiaries, 1992



Note: ADLS = Number of limitations in Activities of Daily Living
Data: Medicare Current Beneficiary Survey, 1992.
SOURCE: Health Care Financing Administration, 1997.

Figure 12

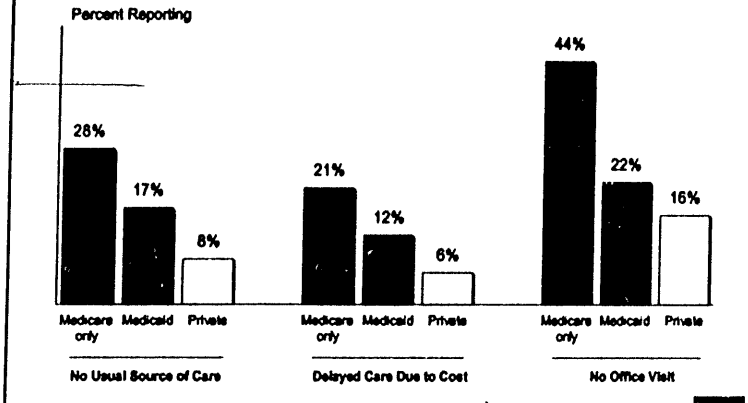
Most Medicare beneficiaries with low incomes do not have Medicaid to supplement Medicare



SOURCE: Medicare Current Beneficiary Survey, 1995.

Figure 13

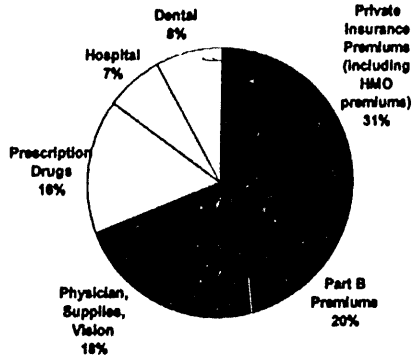
Access to Care for Medicare Beneficiaries, 1996



Note: Fee-for-service beneficiaries only.
Data: 1996 Medicare Current Beneficiary Survey.
SOURCE: Medicare Payment Advisory Commission, June 1998.

Figure 14

Sources of Out-of-Pocket Spending

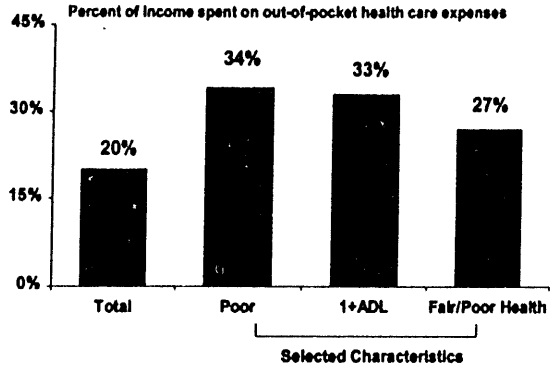


Average Out-of-Pocket Spending = $2,149

Note: Based on estimated 1997 average out-of-pocket health costs for non-institutional beneficiaries age 65 and older (excluding the costs of home health and nursing home services).
SOURCE: American Association of Retired Persons and The Lewin Group, "Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projection," December, 1997

Figure 15

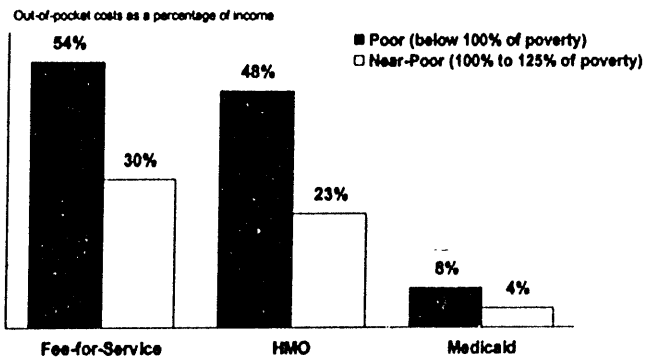
The elderly pay nearly a fifth of their income out-of-pocket for health care -- the most vulnerable pay a larger share



SOURCE: AARP, Public Policy Institute analysis, non-institutionalized beneficiaries age 65 and over in FFS Medicare using Medicare Benefits Simulation Model (1998 Projections)

Figure 16

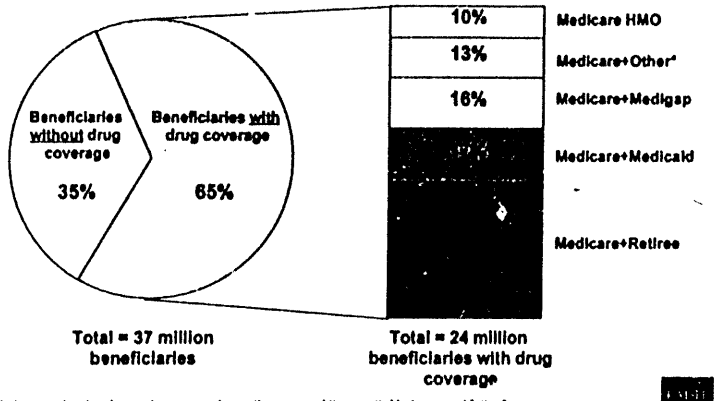
Average Annual Out-of-Pocket Costs for Low-Income Elderly Medicare Beneficiaries, 1997



Note: Non-institutionalized beneficiaries ages 65 and older
Data: 1993 Medicare Current Beneficiary Survey Cost and Use Files projected to 1997
SOURCE: American Association of Retired Persons and The Lewin Group, "Out-of-Pocket Health Spending by Poor and Near-Poor Elderly Medicare Beneficiaries," *Health Services Research* 34:1 (April 1999 Part II)

Figure 17

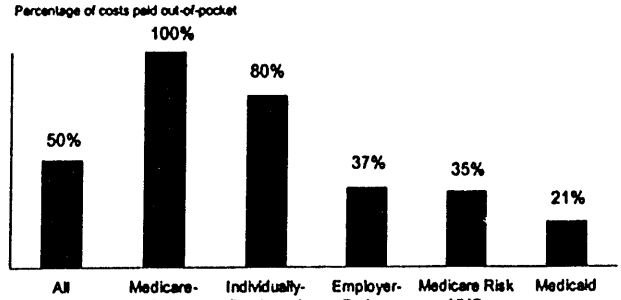
Prescription Drug Coverage among Medicare Beneficiaries, 1995



*Includes people who changed coverage during the year and those with Medicare and "other" coverage
SOURCE: Davis, Poisal, Chulis et al *Health Affairs*, 1999

Figure 18

Annual Out-of-Pocket Prescription Drug Expenditures for Medicare Beneficiaries, 1995

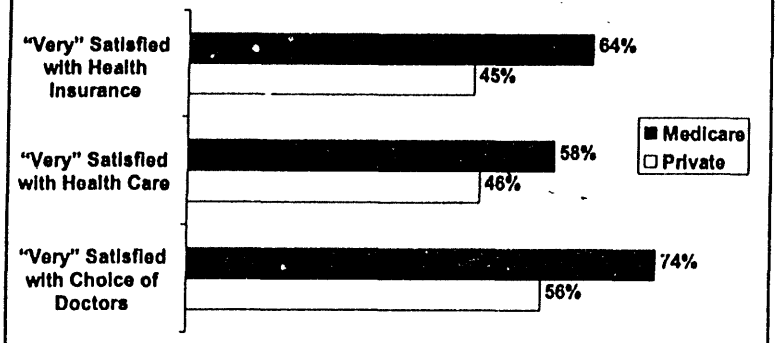


	All	Medicare-Only	Individually-Purchased Medigap	Employer-Retiree	Medicare Risk HMO	Medicaid
Out-of-Pocket Prescription Drug Expenditure	$300	$352	$440	$258	$160	$150

SOURCE: Davis, Poisal, and Chulis et al., 1999.

Figure 19

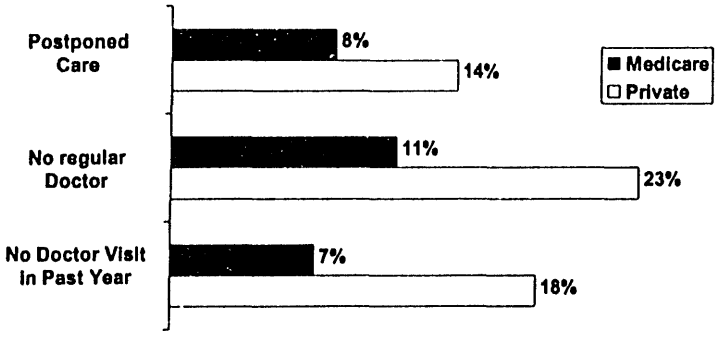
Medicare beneficiaries report higher levels of satisfaction than non-elderly adults with private insurance



SOURCE: Kaiser/Commonwealth 1997 National Survey of Health Insurance.

Figure 20

Medicare beneficiaries report fewer access problems than adults with private insurance



SOURCE: Kaiser/Commonwealth 1997 National Survey of Health Insurance.

Senate Finance Committee Hearing—Medicare Financing
May 5, 1999
Responses by Dr. Diane Rowland to Senator Grassley's Questions

Question #1

- **Aren't these numbers powerful arguments for increased income-relation of Medicare premiums? When low-income seniors are having such a struggle, can we afford to continue subsidizing high-income seniors by charging them the same premiums?**

Medicare provides nearly universal health insurance coverage of basic medical services to the nation's elderly and disabled, but gaps in the scope of Medicare benefits and financial obligations for coverage can often impose heavy financial burdens. The average senior pays about one-fifth of their income on out-of-pocket health care expenses. Low-income Medicare beneficiaries are particularly vulnerable because they are more likely to experience health problems that require medical services than those who are economically better off, but they are less able to afford needed medical care because of their lower incomes. Seniors who are poor spend over a third of their income on out-of-pocket health care expenses and those who lack assistance from Medicaid devote nearly half their income to pay for health care expenses. It is therefore important to improve assistance with financial obligations by guaranteeing certain financial protections to low-income beneficiaries and improving participation in programs such as QMB and SLMB. Expanding financial protections for the elderly and disabled poor would require additional revenues, as you observe in your question. Income-relating the Medicare Part B premium is one among many options that may help generate additional revenues to improve financial protections for Medicare's poor and near-poor beneficiaries and fund benefits for the growing Medicare population.

Question #2

- **Isn't it true for some benefits like drugs, beneficiaries are completely at the mercy of prices, while for other benefits like home health care, cost is no object? Doesn't this argue for major reform of the system of incentives in Medicare?**

There has been a long-standing interest in rationalizing cost-sharing incentives such as copayments and deductibles in the Medicare program in order to understand how such measures affect beneficiary behavior. Research suggests that imposing cost-sharing requirements deters some utilization of services, which would consequently save money for the Medicare program. However, one cannot be certain that cost-sharing deters only "unnecessary" utilization. Such requirements could also impose financial barriers for beneficiaries who truly need these services, but are compelled to forego care due to financial constraints. For example, imposing copayments for services such as home health care, could disproportionately affect poor and near-poor Medicare beneficiaries who are more likely than others to experience health problems that require medical attention, yet less likely to be able to afford needed medical care as a result of their low incomes. Since a substantial share of home health users have incomes below twice the poverty level, and low-income Medicare beneficiaries are disproportionately represented among high utilizers of home health services, these individuals would be most vulnerable to the financial burden that would result from implementation of a copayment. If beneficiaries forego necessary care, this could result in higher program costs for Medicare if these beneficiaries become sicker and eventually require more costly acute care services. Efforts to reform the system of cost-sharing requirements and incentives under Medicare should assess the extent to which financial requirements may deter needed care, giving careful attention to the impact that certain cost-sharing mechanisms might have on beneficiaries, especially those who are most vulnerable.

Senate Finance Committee Hearing—Medicare Financing
May 5, 1999
Responses by Dr. Diane Rowland to Senator Moynihan's Questions

Question # 1

- **Could you please elaborate on some of the risks associated with placing beneficiaries with chronic conditions in managed care.**

To date, little real experience and less evidence have been accumulated regarding managed care for persons with chronic conditions or limitations due to physical or mental impairments. However, one study conducted by John Ware and colleagues found that low-income individuals with chronic illnesses in managed care were more than twice as likely to experience a decline in health status as those receiving care through a fee for service.

One concern is whether the incentives in managed care will result in less than adequate care. Although relatively "unmanaged" care may create incentives to provide more care than is necessary, managed care, on a capitated basis, creates incentives to do less—limiting needed treatments, tests, or access to specialists. Lower service intensity may not pose a problem for most managed care enrollees, but for the chronically ill or disabled with greater need for services, it might be quite problematic. Where service is critical, these incentives may be so strong as to threaten the quality and outcomes of care.

There are also concerns that most managed care plans have little experience dealing with patients with chronic illnesses. The type of conditions, the complexity and the interaction between social and medical services for many individuals with chronic conditions suggests the need to organize and deliver care differently for different populations. It is not clear that most managed care systems have the information to identify populations with chronic conditions. Commercial managed care plans, organized to serve the under age 65 employed population and their families, may be poorly equipped for, and unwilling to invest in, managing the special needs of persons with chronic conditions. There is limited experience with Medicare and those enrolled are mostly younger and often healthier population. The Medicaid managed care enrollment process often does not have a system in place to identify persons with special health care needs.

Moreover, people with disabilities and chronic conditions frequently need both acute and long-term care, but almost nowhere do managed care plans deal with both. Capitation for acute and long-term care exists only on a very limited basis. Most Medicaid rnanaged care programs, for example, exclude long-term care. Experience with capitated managed care for both acute and long-term care services comes primarily from two federal demonstration programs: the Social Health Maintenance Organization (S/HMO) projects and the Program of All-Inclusive Care of the Elderly (PACE). Both programs have difficulty attracting enrollees and neither program has demonstrated that combining long-term care and acute care into a single program enhances efficiency or reduces costs.

Question # 2

- **Could you please comment on the unique needs of dual eligibles and what specific considerations must be taken into account when enrolling the chronically ill in managed care plans. Does Medicaid have any specific experience with dual eligibles or those beneficiaries with special needs in managed care plans?**

Dual eligibles are a vulnerable population with diverse and often costly health care needs. Relative to other Medicare beneficiaries they are disproportionately poor, non-white, and female. A substantial proportion are under-age 65 persons with disabilities, and many are over age 85. They are more likely than other Medicare beneficiaries to be living in nursing homes. About a third of all dual eligibles have ADL impairments and about a quarter live in institutions. Almost half of all dual eligibles report that they are in fair or poor health, and dual eligibles are substantially more likely than other Medicare beneficiaries to suffer cognitive impairments, including mental retardation, mental disorders or Alzheimer's disease.

On average, dual eligibles incur substantially higher health care costs than other Medicare beneficiaries. Medicare expenditures are about 70 percent higher for dual eligibles than for other Medicare beneficiaries. Medicaid spending for dual eligibles is similarly skewed, primarily because many dual eligible individuals use expensive long-term care services.

The characteristics of low-income elderly people and persons with disabilities raise a number of concerns regarding the role of managed care for this population. In principle, managed care organizations should be able to improve the coordination and quality of care for Medicare and Medicaid dually eligible beneficiaries. In practice, however, managed care has not had much experience with the low-income elderly and individuals with disabilities or their extensive care needs and no experience with managing long term care needs and costs. Evidence about the quality of care in managed care compared to fee-for-service is mixed, but much of the evidence to date suggests that enrollees with chronic conditions may be underserved, not better served, by managed care plans in Medicare. In general, states have moved more quickly toward enrollment of welfare families in Medicaid managed care, but some states have specific experience enrolling the frail elderly and younger persons with disabilities in managed care plans.

The Balanced Budget Act (BBA) of 1997 gives states new authority to mandate enrollment in managed care for most Medicaid beneficiaries without obtaining a federal waiver. This authority does not extend to Medicare beneficiaries. However, under the waiver authority of section 1115 and 1915(b), states may enroll Medicare beneficiaries (dual eligibles) in Medicaid managed care plans for their Medicaid benefits.

Overall, enrollment of dual eligibles in Medicaid managed care has been modest. Seventeen states required or allowed dual eligibles to enroll in Medicaid managed care in 1997. Of the seventeen state, nine used federal waivers to require mandatory enrollment of some or all dual eligibles in Medicaid managed care (Arizona, California, Kentucky, Minnesota, Nebraska, Oregon, Pennsylvania,

Tennessee, and Utah). Seven states excluded dual eligibles from their Medicaid managed care programs. Because enrollment of dual eligibles in Medicaid managed care is limited but growing, it will be increasingly important to monitor and assess the experiences of these individuals in order to determine if Medicaid managed care can be adapted effectively for low-income populations with special health needs.

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Committee: We are pleased to be here today as you discuss efforts to reform the Medicare program. In March 1999 testimony before this Committee, the Comptroller General noted an emerging consensus that substantive programmatic reforms are necessary to put the Medicare program on a sustainable footing for the future. Budget projections show health care consuming ever larger shares of the federal dollar, thus threatening to crowd out funding for other valued social and economic activity. In addition, deliberations by the National Bipartisan Commission on the Future of Medicare as well as recent testimony before this Committee reflect public concern about the adequacy of Medicare's benefit package and the potential for erosion in the face of future budgetary pressures.

Over the past several months, this Committee has held a series of hearings on Medicare reform issues to determine the nature and extent of modernization needed and invited us to discuss the array of reform options. To that end, my remarks today will focus on a conceptual framework for considering the various possible combinations of reform options and lessons about implementing reforms learned from recent Medicare experience.

In brief, options to reform Medicare have two major dimensions: (1) expansion of Medicare's benefit package and (2) cost containment through financing and other structural transformations. Two commonly discussed benefit expansions are the inclusion of a prescription drug benefit and coverage for extraordinary out-of-pocket costs, known as stop-loss, or catastrophic, coverage. The financing reforms are reflected in three models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after the Federal Employees Health Benefits Program (FEHBP). Each of these models is designed, to different degrees, to alter program incentives currently in place to make beneficiaries more cost conscious and providers more efficient.

As the various reform options come under scrutiny, the importance of design details should not be overlooked. Our work on efforts to implement reforms mandated in the Balanced Budget Act of 1997 (BBA) is instructive regarding reform specifics. The principal lessons drawn from recent experience include the following:

- The particulars of payment mechanisms largely determine the extent to which a reform option can eliminate excess government spending while protecting beneficiary access to care.
- Revisions to newly implemented policies should be based on a thorough assessment of their effects so that at, one extreme, they are not unduly affected by external pressures and premature conclusions or, at the other extreme, they remain static when change is clearly warranted.
- For choice-based models to function as intended, consumer information that is sufficiently comparable to create competition based on cost and quality is essential.

BACKGROUND

The future of an unreformed Medicare program includes a likely scenario in which an increasing population of seniors and technology advancements consume ever-growing shares of the nation's health care resources and federal budget. A growing consensus, which includes the trustees of the Medicare Hospital Insurance Trust Fund, notes that BBA took strong steps toward addressing this problem, but additional reforms are needed.

Medicare spending pressures impel need for major reform

Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom generation. For example, today's elderly make up about 13 percent of the total population; by 2030, this group will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of Medicare beneficiaries. Thus, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Compounding the cost pressures of serving a larger and needier Medicare population are the costs associated with the scientific breakthroughs for treating medical conditions and functional limitations. Technological and treatment advances have resulted in more services being provided to more beneficiaries. These services can restore health, reduce pain, increase functioning, and extend lives. At the same time, certain high-tech services may be of limited clinical value or fail to meaningfully improve the quality or length of life. Nevertheless, technological advances fuel the public's expectations that more health care is better.

The actual costs of health care consumption are not always fully transparent to consumers. Third-party payers generally insulate patients and providers from cost-

of-care decisions. In traditional Medicare, for example, beneficiaries are required to contribute 20 percent of the payment for physician visits and other services and a significant deductible for inpatient hospital care. These cost-sharing requirements are designed to give beneficiaries direct financial incentives to curb inappropriate care or services of marginal value. Yet the impact of the cost-sharing provisions is muted because about 87 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs.

While demographics and technology drive up health care utilization, pressure is mounting to update Medicare's outdated benefit design. At present, Medicare leaves beneficiaries without coverage for important services and at risk for large out-of-pocket costs due to coverage limitations. In 1965, when the program was first created, outpatient prescription drugs were not nearly as important a component of health care as they are now. Used appropriately, pharmaceuticals can cure diseases, improve quality of life, and sometimes substitute for more expensive services. Further, the Medicare benefit does not provide truly catastrophic coverage for those requiring lengthy hospitalizations. Nor are there any limits to the copayments required of beneficiaries needing extensive care from physicians and other providers. While Medicare coverage limits do not affect many beneficiaries, the limits can prove devastating for the few who exhaust the benefit without any supplemental coverage. Most private insurance options and Medicaid programs provide prescription drug and catastrophic coverage. Many individuals seek to similarly modernize Medicare's benefits. The cost implications, however, could be enormous. Their consideration needs to take account of the future unsustainability of the current program and its financing gap which already greatly exceeds that of Social Security.

BBA took bold steps toward modernizing Medicare

Enacted in 1997, BBA set in motion significant changes toward modernizing Medicare. The act's combination of constraints on provider fees, increases in beneficiary payments, and structural reforms is expected to lower program spending by $386 billion over the next 10 years. Because certain key provisions have only recently or have not yet been phased in, the full effects on providers, beneficiaries, and taxpayers wrought by BBA will not be known for some time.

Of particular significance was BBA's creation of the Medicare+Choice program, which furthered the use of a choice-based model of providing Medicare benefits. Medicare+Choice expanded Medicare's managed care options to include, in addition to health maintenance organizations (HMO), health plans such as preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. As part of this expanded consumer choice program, BBA provisions placed a dramatic new emphasis on the development and dissemination of comparative plan information to consumers to foster quality-based plan competition. Other BBA provisions were designed to pay health plans more appropriately than Medicare had done under the previous HMO payment formula.

BBA also made historic changes to traditional Medicare. It is gradually eliminating, for the most part, cost-based reimbursement methods and replacing them with prospective payment systems (PPS). The intent is to foster the more efficient use of services and lower growth rates in spending for these providers, replicating the experience for acute care hospitals following the implementation of Medicare's PPS for hospitals, which began in the mid-1980s. BBA mandated phasing in PPSs for skilled nursing facilities (SNF), home health agencies (HHA), hospital outpatient services, and certain hospitals not already reimbursed under such arrangements.

DIMENSIONS OF REFORM INCLUDE BENEFIT EXPANSIONS AND FINANCING CHANGES

Concerns continue to be voiced about the obvious gaps in protections for Medicare beneficiaries, which contrast with what is available for most individuals with private employer-based coverage. At the same time, competing concerns remain about the need to dramatically check Medicare's cost growth, even without adding new benefits. In response, a range of proposals has been made, each seeking to update Medicare's benefit package, restructure the program to constrain cost escalation, or both (see fig. 1).

Figure 1: Major dimensions of Medicare reform

Updated Benefit Package Options:
- Coverage for outpatient prescription drugs
- Limit on beneficiary liability

Financing and Organizational Change Options:
- Fee-for-service modernization
- Medicare+Choice modernization
- FEHBP-type premium support

Benefit expansion reforms

Medicare's basic benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although commercial policies have evolved since then, Medicare's package—for the most part—has not.[1] For example, unlike many current commercial policies, Medicare does not cover routine physical examinations or outpatient prescription drugs or cap beneficiaries' annual out-of-pocket spending. Some beneficiaries can augment their coverage by participating in the Medicaid program (if they are eligible), obtaining a supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. However, these options are not available or affordable for all beneficiaries. Furthermore, to the extent that Medicaid and supplemental policies provide first-dollar coverage of services, the beneficiary population's sensitivity to service costs is dulled, contributing to some continued excess utilization. Consequently, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms.

Two benefit reforms under discussion by policymakers are the inclusion of prescription drugs and stop-loss coverage that caps beneficiary out-of-pocket spending. Each involves a myriad of options, and assessing the merit of these reforms would depend on the specifics that may be included. For instance, a Medicare prescription drug benefit could be designed to provide coverage for all beneficiaries, coverage only for beneficiaries with extraordinary drug expenses, coverage only for low-income beneficiaries, or coverage for selected drugs, e.g. those deemed to be cost beneficial. Such coverage decisions would hinge on understanding how a new pharmaceutical benefit would shift to Medicare portions of the out-of-pocket costs borne by beneficiaries as well as those costs paid by Medicaid, Medigap, or employer plans covering prescription drugs for retirees. How would these new program costs be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments? Would subsidies be provided to help low-income, non-Medicaid eligible beneficiaries with these costs? The administration of the benefit raises other questions, such as, who would set and enforce drug coverage standards among the private health plans participating in Medicare? And, for traditional Medicare, how would reimbursable prices be set? Price-setting options include using a formula based on market prices, negotiating directly with manufacturers, or contracting with a pharmaceutical benefit management company. A catastrophic, or stop-loss, coverage benefit would similarly entail its own set of design permutations, variables, and related consequences.

Financing and other structural reforms

Many Medicare reforms are designed to slow spending growth to keep the program viable for the nation's growing aged population. Although the various proposals differ from one another in concept, they all include mechanisms to make beneficiaries more cost conscious and incorporate provider incentives to improve the efficiency of health care delivery. The various financing and structural reforms are organized around three general models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after FEHBP (see fig. 2).

Figure 2: Medicare reform: Options for financing and structural change

	Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
Pending:	• Prospective payment systems (HHAs, hospital outpatient departments, and others)	• Health-based risk adjustment of rates • Annual enrollment and lock-in • Competitive pricing demonstration	
Potential:			

[1] Some Medicare benefits have changed. For example. BBA added or expanded coverage for screening mammograms, prostate cancer screening tests, bone mass measurements, and several screening or preventive services.

Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
• Selective purchasing • Negotiated pricing • Case management for complex and chronic conditions • Utilization management • Medigap and beneficiary cost-sharing reforms	• Plan savings shared with program	• Premium based on offered or negotiated price. • Beneficiary contribution based on plan cost. • Traditional Medicare incorporated: Enhanced flexibility; Self-financed.

Fee-for-service modernization

BBA improved the efficiency of Medicare's traditional fee-for-service program by substituting a variety of PPSs and other fee changes for the cost-based reimbursement methods and outdated fees that existed. Nevertheless, Medicare is still not an efficient purchaser. Adjusting its systems of administered prices and fees up or down to ensure beneficiary access or to capture potential savings as the market changes poses an overwhelming, if not impossible, challenge. Medicare largely remains a passive bill payer, exercising no meaningful control over the volume of services used. Proposals to modernize fee-for-service Medicare aim at providing flexibility to take advantage of market prices and introducing some management of service utilization.

Preferred provider arrangements, whereby insurers select certain providers because of their willingness to accept lower fees and their efficient style of practice, have become commonplace in the commercial insurance market. By accepting negotiated or competitively bid fees that fall below the usual levels, selected providers and the beneficiaries using their services would be afforded certain advantages. The selected providers with lower fees may experience increased demand, while beneficiaries using their services could be subject to lower cost sharing. Comparable arrangements have been proposed for fee-for-service Medicare. Testing of this concept has been under way in the Health Care Financing Administration's (HCFA) Centers of Excellence demonstrations where hospitals and physicians agree to provide certain procedures for negotiated all-inclusive fees. BBA also allowed for testing of competitive bidding for medical equipment and supplies with high bidders being excluded from serving Medicare beneficiaries.

About 87 percent of beneficiaries in traditional Medicare face little cost sharing in the form of deductibles or copayments for services by virtue of their eligibility for Medicaid or their enrollment in a supplementary insurance plan. While increases in cost sharing have been common in private insurance to make beneficiaries sensitive to the value and cost of services, it has been a cost-containment tool largely unavailable to Medicare. Protecting low-income beneficiaries from financial barriers to care remains a critical concern. However, changes in allowable supplementary coverage could restructure cost sharing to heighten beneficiary sensitivity to the cost of services while removing catastrophic costs for those who have extreme medical needs.

Private indemnity insurers have moved to incorporate certain utilization management techniques into their policies, such as prior authorization of some expensive services and case management for persons with serious chronic conditions. Though such techniques are increasingly common among private insurers, their impact and effectiveness on the unique population Medicare covers is unknown.

Medicare+Choice modernization

Medicare+Choice signaled a new phase in efforts to transform Medicare. Built on the program that allowed beneficiaries to enroll in participating managed care plans, Medicare+Choice expands options available to beneficiaries and substantially changes plan payment methods. By raising payments in certain areas and allowing additional types of entities to contract with Medicare, Medicare+Choice is intended to boost plan participation and beneficiary enrollment. Payment changes are designed to adjust the per capita rates to more accurately reflect expected resource use of enrollees and slow the growth of spending over time.

Among other payment changes, BBA required HCFA to implement by January 1, 2000, a methodology to adjust plan payments to reflect the health status of plan members. Favorable selection—that is, the tendency for healthier beneficiaries to enroll in managed care plans—has resulted in payments that are higher than warranted. The new risk adjustment method developed for Medicare will more closely align payments to the expected health care costs of plans' enrollees. This will help produce the savings originally envisioned when managed care enrollment options

were offered to Medicare beneficiaries and will foster competition among plans on the basis of benefits and quality rather than enrollment strategies.

The design of the Medicare+Choice program does not, however, allow taxpayers to benefit from the competition that currently occurs among health plans. If a plan can provide the Medicare package of benefits for less than the Medicare payment, it must cover additional benefits, reduce fees, or both.[2] Plans that offer enriched benefit packages—such as, including coverage for outpatient prescription drugs or routine physical examinations—may attract beneficiaries and gain market share. Medicare, however, pays the predetermined price even in fiercely competitive markets.

The Medicare+Choice program could be modified, through new legislation, to require that taxpayers and beneficiaries both benefit from health plan competition. The Congress could require that when payments exceed a plan's cost of services (including normal profit), part of the savings be returned to the program and the rest be used to fund additional benefits. Another alternative would be to set plan payments through competitive bidding. In fact, BBA mandates a competitive pricing demonstration. However, setting the parameters of a competitive pricing system is a formidable task. Furthermore, this payment setting approach may be best suited to urban areas with high concentrations of managed care members.

FEHBP-type premium support

Although modernizing traditional Medicare and Medicare+Choice could improve control of program spending, several incentives would remain unaltered. For example, beneficiaries would remain partially insulated from the cost consequences of their choices. They would not benefit directly from selecting plans capable of delivering Medicare-covered benefits less expensively since the premiums they pay may well remain constant. Program payments to plans would continue to be established administratively. The Bipartisan Commission and others have accordingly discussed the adoption of an FEHBP-type of premium support for Medicare. Such a reform would raise the sensitivity of both beneficiaries and providers to the costs of services.

The two defining elements of an FEHBP-type of premium support are (1) the establishment of premium levels for plans through negotiations between the program and plans and (2) the linking of beneficiaries' contributions to the premiums of the plans they join. This system makes transparent to beneficiaries which plans operate less expensively and can therefore charge lower premiums. In principle, it encourages competition because plans that can deliver services more efficiently can lower premiums and attract more enrollees. In practice, some caveats remain. Differences in premiums can reflect more than variation in efficiency. Plans may achieve savings through narrower provider networks that, while capable of providing Medicare-covered benefits, could cause beneficiaries to experience inconveniences and delays in accessing services. Providing beneficiaries adequate comparative information on plans' expected performance becomes even more critical.

Since most beneficiaries participate—and are expected to continue to participate—in traditional fee-for-service Medicare, its incorporation into the FEHBP-type system is seen as important. Under current arrangements, the only premium for participating in the traditional program is the fixed monthly amount that beneficiaries voluntarily pay to receive coverage for part B (physician, outpatient, and other services and supplies) or to be eligible to enroll in a Medicare+Choice plan. Because the premium amount represents a fraction of the program's cost and is deducted from beneficiaries' monthly Social Security payments, participants are less aware of the cost of the traditional Medicare program. The Bipartisan Commission discussed incorporating traditional Medicare as another plan under an FEHBP-type premium support system. Traditional Medicare would propose and negotiate premiums like any other plan and be expected to be self-financing and self-sustaining. Recognizing the challenge the latter requirement creates, the commission would also provide traditional Medicare more flexibility to manage costs using tools similar to proposals for fee-for-service modernization.

Incorporating traditional Medicare as another plan puts all plans on equal footing and maximizes beneficiary awareness of costs. However, the sheer size of the traditional program creates questions. How much flexibility can be granted to traditional Medicare given its market power? What will it mean for a public plan to be self-sustaining and self-financing? Can it generate and retain reserves as a protection

[2] Alternatively, plans can contribute to a stabilization fund that would allow them to provide additional benefits or lower fees in future years. Before BBA, health plans also had the option of accepting a lower capitation payment. In practice, plans preferred to add benefits to attract beneficiaries.

against future losses? How will losses be managed? Today's hearing is precipitated in part by the fact that the self-sustaining Hospital Insurance Trust Fund is projected to become insolvent. That prospect is intolerable. Similarly, insolvency of traditional Medicare, which may continue to enroll the majority of beneficiaries and may be the only plan serving many areas of the country, is not acceptable. The dilemma of how to guarantee traditional Medicare's solvency in the context of an FEHBP-type premium support system needs to be addressed.

An FEHBP-type premium support system increases the importance of effective program management and design. In particular, the ability to risk adjust premiums to reflect the variation in health status of beneficiaries joining different plans becomes paramount. Participating plans that attract a disproportionate number of more seriously ill and costly beneficiaries would be at a competitive disadvantage if their premium revenues are not adjusted adequately. In turn, enrollees in those plans may find services compromised by the plans' financial situation. Inadequate risk adjustment may be a particular problem for the traditional Medicare plan, which may function as a refuge for many chronically ill persons who find selecting among plans challenging and opt for something familiar.

RECENT MEDICARE REFORM EXPERIENCE ILLUSTRATES THE NEED FOR CAREFUL ATTENTION TO REFORM SPECIFICS

Our analyses of efforts to design and implement BBA reforms suggest several lessons as reform options come under closer scrutiny. Highlights from our recent studies on new payment methodologies, provider behavior in evolving markets, and Medicare+Choice information initiatives are instructive.

Engineering payment mechanisms to achieve desired outcomes

The particulars of payment method reforms can affect whether reforms promote or deter unnecessary spending, ensure or impede access to appropriate health care, and facilitate or frustrate implementation efforts. Experience implementing BBA provisions mandating prospective payment systems and new payment rules for capitated managed care plans illustrates that design details matter.

Our review of the recently implemented PPS for SNF care is a case in point.[3] Under PPS, SNFs receive a payment for each day of care provided to a Medicare beneficiary. Since not all patients require the same amount of care, this amount—called a per diem rate—is "case-mix" adjusted to take into account the nature of each patient's condition and expected care needs. In general, a PPS gives SNFs an incentive to provide daily services efficiently and judiciously because SNFs with costs higher than the adjusted per diem rate are at risk for the difference between their costs and the payments. The case-mix adjuster incorporated into the new PPS, however, allows a SNF to increase its payments by manipulating the services provided and thus bypass the need to become more efficient. Furthermore, whether a SNF patient is deemed eligible for Medicare coverage and how much will be paid are based on a facility's assessment of its patients. HCFA's ability to monitor these assessments, however, is limited. If SNFs manipulate service use to raise payments or make inappropriate patient assessments, expected savings from PPS could be threatened. Monitoring these assessments and determinations will be key to realizing the expected savings from PPS.

The Medicare+Choice payment rules established by BBA—in essence, reforming Medicare's previous HMO payment rules—similarly illustrates the need for effective design and adequate oversight. Currently, health plans that participate in Medicare+Choice receive a predetermined amount, known as a capitation payment, for each beneficiary they enroll. Because health plans are not paid for each service they provide, they have no incentive to oversupply services. In fact, the incentive is reversed; health plans may—at least in the short run—earn greater profits if they inappropriately withhold services or avoid enrolling beneficiaries who have above-average health care needs.

To reduce the undesired incentives of capitation, BBA mandated the implementation of a new Medicare risk adjustment methodology based on individuals' health status. The new risk adjuster is intended to reduce overall excess payments and improve the fairness of payments to individual health plans.[4] Although this new methodology has its own shortcomings, it represents an important improvement, particularly given health plans' limited ability to supply comprehensive health data on their members. HCFA anticipates that health plans soon will be able to supply more

[3] BBA phased in PPS for SNF care beginning on July 1, 1998.

[4] Medicare Managed Care: Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T–HEHS–99–72, Feb 25, 1999).

comprehensive data so that the agency can implement a more refined risk adjustment methodology in 2004.

Adequately adjusting payments—either prospective rates in fee-for-service Medicare or capitation amounts under managed care—becomes more important as Medicare improves its cost-containment efforts. Previously, there was little need to account for variations in patient needs when payment methods reimbursed the total cost of providing Medicare services or when rates were overly generous. Absent these wide margins for error and an increased emphasis on efficiency, case-mix adjustment and risk adjustment become increasingly important. When adjustment methods are inadequate, providers may be motivated to increase revenues by skimping on essential services, selecting healthier beneficiaries to serve, or both. Such behavior would thwart the twin goals of controlling spending while providing beneficiaries access to benefits.

Understanding provider behavior in evolving markets

Medicare experience also illustrates that an incomplete assessment of a new policy's effects can lead to potentially premature calls for action. Recently, the introduction of certain BBA reforms caused the affected provider communities to assert that immediate remedies were needed. Last fall, nearly 100 managed care plans decided to terminate their Medicare contracts or reduce the geographic areas they served—actions they attributed to payment changes mandated by BBA.[5] As a result, approximately 407,000 beneficiaries (7 percent of the managed care population) had to choose a new managed care plan or switch to fee-for-service.

Determining the extent to which BBA inappropriately precipitated the withdrawals is difficult, however. Managed care plans' participation decisions appear to be associated with a variety of factors. Indeed, our recent review suggested that a portion of the plan withdrawals occurred because plans decided they could not effectively compete in certain areas. Moreover, 40 managed care plans have recently applied (and some of these applications have already been approved) to serve Medicare beneficiaries. Medicare is not unique in experiencing changes in plan participation. In each of the past several years, FEHBP has seen new health plans participate while others have dropped out. This year, approximately 90,000 FEHBP beneficiaries had to switch plans because their original plan withdrew from the program.

As another example, between October 1, 1997, and January 1, 1999, over 1,400 HHAs closed. Providers have attributed these changes to BBA payment and other reforms. After several years of large increases in home health expenditures, BBA mandated stricter limits on HHA payments, making it difficult for some agencies with expensive treatment patterns or those located in areas with many other HHAs to maintain current practices. Our recent analysis of HHA closures indicated that almost half of the closures occurred in just four states—three of which had previously experienced agency growth well above the national average. This pattern suggests that the closures could be a result of market corrections for recent overexpansion as much as a response to Medicare's efforts to control its spending on this benefit. Further, we found little evidence of beneficiary access problems due to closures, thus raising questions about industry calls for relaxing payment limits to help HHAs remain open.

It is clear, however, that payment and other reforms—even when correcting a poor policy of the past—have the potential to be disruptive for both beneficiaries and providers. Avoiding sudden, dramatic changes may be the key to minimizing disruptions and ensuring any reform's success. HCFA has wisely taken this approach, for example, in its decision to phase in the new managed care risk adjustment methodology over a period of several years. Nonetheless, it is not possible, or even desirable, to eliminate completely the natural disruptions that result from voluntary plan and provider participation decisions. The impact of these disruptions on beneficiaries needs to be ameliorated. Reforms that are accompanied by such safeguards are likely to receive greater public support.

Shaping consumer involvement in choice-based models

Enabling beneficiaries to make better, more efficient health care choices underlies the majority of the reform options. Such improved decisionmaking hinges on beneficiaries having the necessary information to accurately assess their choices. BBA took significant steps to foster the success of the new choice-based managed care option by mandating improvements in Medicare's consumer information. The mandated initiatives were designed to help beneficiaries decide whether to choose traditional Medicare or an available Medicare+Choice plan. Prior to BBA's enactment,

[5] Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals: Plan Interest Continues (GAO/HEHS–99–91, Apr. 27, 1999).

comparative information about health plan options was not systematically available to Medicare beneficiaries, as we reported in 1996.[6] Now, post-BBA, Medicare has a toll-free information telephone number, a web site, and plans to include some limited comparative information in its mass mailing of handbooks.

Despite these gains, substantial improvements are needed to enable Medicare seniors to become discriminating consumers. Recent analysis indicates that many beneficiaries poorly understand traditional Medicare and comprehend less about their managed care options. At present, Medicare beneficiaries must continue to rely largely on plan-supplied information, which currently lacks adequate standardization and reliability. In our recent study of plans' marketing and contract approval materials, we found information that was inaccurate, incomplete, or otherwise misleading, reflecting weak federal oversight of industry marketing efforts.[7] Information on the relative performance of health plans is also lacking, but the field of performance measurement is in its infancy, as experts struggle to reach consensus on which health outcome measures would be meaningful to consumers in general and Medicare beneficiaries in particular.

CONSIDERATIONS IN WEIGHING FUTURE OPTIONS

In his March 10 testimony to this Committee, the Comptroller General enunciated several criteria for assessing the merits of reform proposals that bear summarizing here: (1) affordability: reforms should address the current program's incentives inhibiting effective cost containment; (2) equity: reforms should not impose a disproportionate burden on particular groups of beneficiaries or providers; (3) adequacy: reforms should account for the need to foster cost-effective and clinically meaningful innovations, furthering Medicare's tradition of technology development; (4) feasibility: reforms must provide for such administrative essentials as implementation and monitoring; and (5) acceptance: to make program costs more transparent to the public, reforms must provide for sufficiently educating the beneficiary and provider communities to the realities of trade-offs required when significant policy changes occur. Most importantly, reforms need to address the sustainability of the program and ensure it does not consume an unreasonable share of our productive resources and does not encroach on other public programs or private sector activities. An incremental approach to changes of the magnitude likely required would enhance both their feasibility and acceptance.

The lessons learned in implementing BBA reforms touch on aspects of these five criteria. For example, payment mechanisms designed to achieve frugal program spending must avoid fostering perverse incentives for providers to skimp on services as a way to maximize revenue. In addition, interest group pressure to swiftly undo newly implemented reforms should not overwhelm policy decisions, as misdiagnosed problems can lead to misguided solutions. Finally, consumer information can create stronger, quality-based competition when the information made available is sufficiently standardized and complete to make cost, benefit, and performance comparisons easy.

To apply these lessons in a fashion so that reforms meet the five criteria for success, implementation of reforms must be done with effectiveness, flexibility, and steadfastness. Effectiveness must include the collection of necessary data to assess impact—separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed when particular interests pit the primacy of their needs against the more global interest of preserving Medicare.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee might have.

PREPARED STATEMENT OF RAY SCHEPPACH

Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today on behalf of the nation's Governors.

One of the most critical responsibilities we have is to protect and improve the health of our nation's citizens. To this end, the Medicare program has been tremendously successful. Seniors are more likely to have health insurance coverage than any other group, and, together with Social Security, Medicare has drastically re-

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[6] Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS–97–23, Oct. 22, 1996).

[7] Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS–99–92, Apr. 12, 1999).

duced the number of seniors living in poverty. In addition, Medicare has given American families the assurance that they will not have to bear by themselves the burden of illness of their elderly or disabled parents or other family members.

Despite Medicare's success, the program faces enormous challenges. The trust fund is scheduled to become insolvent within the next decade, and without changes, the status quo is not providing low-income seniors with the comprehensive health care they can and should receive. In recognition of these problems, the Bipartisan Commission on the Future of Medicare was created to find consensus on solutions. While many of the Commission's proposals are not fully formed, and NGA does not have an official position on them, there are certain basic considerations that must be included in any discussion of Medicare reform.

The primary concern for states in the Medicare reform debate is the issue of dual eligibility—the six million individuals eligible for both Medicare and Medicaid. I will discuss the characteristics of dual eligibles in more detail later in this testimony. The current system contains no coordination between the two programs. We believe better coordination could improve health care alternatives for seniors without adding federal and state costs. We must do better for the sake of seniors, and as states, we know how to do better. Congress must give states the tools with which to integrate funding streams, coordinate care, and improve health outcomes for seniors.

Our proposals to achieve this coordination are detailed below and specific language is included with my testimony. These programmatic changes will give states the ability to make meaningful changes in the Medicare and Medicaid programs that will not only improve health care for beneficiaries but actually save money at the state and federal levels.

Since 1988, the federal government has increasingly passed on to the states the responsibility to cover the cost-sharing responsibilities of many low-income Medicare beneficiaries (e.g., the Qualified Medicare Beneficiary Program, the Specified Low-Income Medicare Beneficiary Program, and the new groups of beneficiaries created by the BBA, the Qualifying Individuals). The nation's Governors want to ensure that elderly beneficiaries receive the best possible care, and are committed to providing the highest quality of services to seniors who are eligible for Medicaid benefits. But for the QMBs and SLMBs and other groups, Congress should recognize that the strength and responsibility of the Medicaid program is in providing high quality services, not in cutting checks. The governors would therefore recommend that the patchwork of eligibility categories that provide only cost-sharing assistance be streamlined, simplified, and fully federalized.

Beyond these specific changes, Governors ask that you remember the interrelation of the two programs and consider the potential implications for Medicaid before proposing changes to Medicare. There are several legislative proposals that have emerged from the Medicare Commission's work that contain serious potential cost-shifts to states, and the creation of new unfunded mandates. If any reform proposal is to succeed, it is vital that states be an equal partner with Congress and the Administration in development and implementation.

Integrating acute and long-term care

The lack of coordination between the Medicare and Medicaid programs contributes to the fragmentation of acute and long-term care. Currently, it is impossible for Medicaid to participate in acute care decisions when Medicare is the primary payer. Medicare's current managed care program is incapable of addressing these issues, because participating managed care organizations neither are responsible for providing long-term care services, nor are accountable for the cost of such services.

As a result of the lack of clinical care coordination, primary care physicians or specialists frequently are unaware when their patients are admitted to nursing facilities, and home care case managers often are not informed when their clients are hospitalized. This fragmentation of care and lack of accountability for outcomes contribute to higher rates of preventable nursing facility and hospital admissions. Ultimately, poor clinical outcomes and service decisions that are reimbursement-driven lead to higher expenditures for both Medicare and Medicaid.

There must be more effective coordination of acute and long-term care services to better serve beneficiaries and eliminate unnecessary declines in functional status. Two general strategies exist for coordinating care more effectively. The first relies mostly on case management of individuals with acute and long-term care needs. The second, more comprehensive approach is to fully integrate acute and long-term care.

Using case management models and integrated care plans

States and the federal government have begun to assess the efficacy of case management and integrated care programs for seniors. However, there are significant statutory and administrative obstacles to conducting effective coordinated care dem-

onstrations. Among the major administrative obstacles is a federal waiver review process that can take several years to complete.

These federal barriers must be addressed so that interested states can make such demonstration programs broadly available to low-income beneficiaries. The authority to test new approaches could be clarified through explicit legislative authorization or the creation of substantial Medicare waiver authority similar to the waiver options that exist in Medicaid. A simple change to enable the development of such integrated care programs would be the explicit recognition that budget neutrality should be measured across all federal benefit programs, not just the Medicaid program. Integration and coordination can realize savings for Medicare, Supplemental Security Income, Social Security Disability Insurance, and other programs, and states should be allowed to factor in those savings.

In addition, stronger partnerships between the Health Care Financing Administration (HCFA) and states are needed to strengthen the coordination of Medicare and Medicaid. Cooperation between states and HCFA to develop demonstration programs that integrate benefit packages and funding streams would be cost-effective and produce better health outcomes.

Included with my testimony today is some draft language prepared by the National Association of State Medicaid Directors. This language sets forth several options that would remove these federal barriers and allow states to pursue demonstration programs to improve seniors' health care by coordinating and integrating Medicare and Medicaid.

Integrated Medicare and Medicaid programs are the best way to improve health outcomes for consumers and control spending. The benefits of integrated programs include:

- a comprehensive service package that recognizes the interaction of acute and chronic needs;
- greater flexibility for providers and consumers to design a care plan that meets the individual's needs and is unencumbered by fee-for-service reimbursement restrictions;
- an emphasis on prevention and coordination of care across providers and settings, including the coordination of medical services and social support services; and
- the opportunity to hold a single entity accountable for quality of care and health outcomes.

The option to enroll in an integrated plan should be among the Medicare options available to beneficiaries—which currently include traditional fee-for-service plans, Medicare+Choice plans, and medical savings accounts. In particular, federal policies should allow seniors to use their Medicare benefit to enroll in an integrated program administered by a state-federal partnership. States should have the flexibility to determine whether Medicare's contribution would be paid directly to the integrated plan or collected by the state to make a single combined Medicare-Medicaid payment to the integrated plan.

States are strongly positioned to take the lead in administering and managing integrated programs through state-federal partnerships. One reason for states' readiness is that many publicly funded health programs are operated at the state level. A second reason is that states already have expertise in managing health plans to improve quality and health outcomes while controlling costs. In addition, states have shown that they can target long-term care services appropriately while maintaining informal care support networks in the home or community.

Current proposals to reform the Medicare program

The Medicare Commission should be commended for its hard work on a vastly complex and important issue. There are no easy solutions to the Medicare reform problem; not only is the trust fund predicted to become insolvent within ten years, but even if the program is maintained at current levels, it does not do nearly enough to promote better health outcomes for the frail elderly.

NGA has not yet developed a position on any of the various legislative proposals to improve, expand, further the solvency of, or otherwise reform Medicare. However, I would like to offer the state perspective on some of the ideas that have been advanced. My comments should not be interpreted as support or opposition, merely a reflection on the proposals that are the most visible to date.

Age eligibility proposal

The proposal to increase the age of eligibility from sixty-five to sixty-seven might seem to make sense because it would mirror the gradual change in eligibility for Social Security. This proposal might save money for the trust fund in the short run. However, in the long run, it could have disastrous implications for beneficiaries and

for states, which will be left holding the bill. The creation of a two-year window in which seniors will have no access to Medicare will force states to be the only source of health care for dual eligibles, in contrast to the wrap-around coverage that they currently are provided.

Cost sharing proposal for home health services

The proposal to increase cost-sharing for home health services has been promoted as a way to contain the rapid increases in expenditures for this service under Medicare. It is unfortunate that these increases are viewed as a negative at the same time that state Medicaid programs have been actively looking to increase expenditures in this area as a way to prevent and substitute for more costly institutional care. Many of the price controls and coverage limitations in BBA were predicated on the concern over the growth in home health care, and states are spending millions trying to compensate for these Medicare changes. This proposal would have a direct impact on state Medicaid programs because states are responsible for all cost-sharing expenses for the 5.4 million dual eligibles.

The proposal to increase cost sharing for home health services would also have an indirect impact on states. Drastic increases in out-of-pocket expenditures can have two unintended consequences. One is that seniors will continue their current utilization patterns and incur enough costs to effectively spend down to Medicaid eligibility. The other is that the coinsurance will have a dampening effect, causing seniors to go without services. Although this may reduce Medicare home health costs in the short run, it will result in an increase in preventable hospitalizations, paid for by Medicare, and nursing home admissions, paid for by Medicaid.

There are also serious financial implications for both programs in light of an upcoming Supreme Court decision (L.C. and E.W. vs. Olmstead). This case could potentially require massive deinstitutionalization and community placements for frail seniors and adults with disabilities, placing massive strains on state and federal budgets. Adding to this burden by requiring additional state spending on cost-sharing would be devastating.

Successful Medicare reform must provide seniors with more options, not fewer. Restricting benefits, placing fiscal barriers in front of beneficiaries, and forcing seniors to rely on the failing fee-for-service system are all proposals that limit access to health care and should be rejected out of hand.

Premium support proposals

The cornerstone of the reform proposal generated by the Medicare Commission is what is called the "premium support model." This model would essentially convert Medicare into a voucher program relying on market factors and individual responsibility to hold down costs. Although Governors do have faith in the health care market and the ability of properly educated consumers to make sensible decisions, they do have serious concerns about some of the unintended consequences of this proposal.

Keep in mind that dual eligibles have practically no experience in the managed care market and, furthermore, have absolutely no fiscal incentive to economize. The 5.4 million dual eligibles currently have no out-of-pocket expenditures and no reason to be fiscally prudent, because Medicaid provides for all of their needs.

It remains unclear what the Medicaid cost-sharing obligation would be for dual eligibles who select a plan for which the beneficiary's premium exceeds the federal voucher amount. Dual eligibles are not only the poorest of the Medicare beneficiaries, but they have the highest medical needs. Therefore, this demographic group is simultaneously the most expensive to care for and the least able to finance that care without Medicaid's support. Unless this proposal includes risk-adjusters to account for functional status and institutional placement, it could have monumental fiscal implications for the Medicaid program.

Prescription drug coverage

The Medicare program does not have a comprehensive outpatient drug benefit. For the 5.4 million dual eligibles, Medicaid provides coverage for all of their pharmaceutical needs. Other seniors receive drug coverage through Medicare+Choice plans, Medigap, or through costly out-of-pocket expenditures.

Any consideration of adding a prescription drug benefit to the Medicare program must recognize that state budgets have shouldered these costs for years, and that these costs should be borne by the Medicare program. For example, proposals to have states continue to pay for prescription drugs for seniors through the QMB and SLMB programs are essentially unfunded mandates, driving up state costs for what should be a federal benefit.

If Medicare is to add a drug benefit, it should be administered through the Medicare program, not merely delegated to the states to administer on behalf of the fed-

eral government. States have gained valuable lessons in providing drug benefits for Medicaid beneficiaries, and should share best practices with HCFA in setting formularies, negotiating rates, and contracting with pharmacy benefits managers.

States are particularly concerned about the above mentioned proposals due to the following concerns.

Medicare and Medicaid program dynamics

The Medicare program was originally intended to provide health insurance coverage for the medical needs of older Americans. However, there have always been significant gaps in this coverage. The most important gaps are for preventive care, prescription drugs, and long-term care. Moreover, there are significant beneficiary cost sharing responsibilities under the program. As a result, Medicare covers, on average, only about half of beneficiaries' health care costs.

The gaps in Medicare coverage are widening. Advances in medical care that have expanded the availability and use of outpatient treatment and home health care have increased beneficiaries' out-of-pocket costs for Part B premiums, copayments, and prescription drugs. Medical advances have increased life expectancy so that an increasing number of chronically ill seniors need long-term care and support for basic activities of daily living, such as eating, bathing, and dressing. These factors contribute to, and are compounded by, the challenges facing Medicare that threaten its long-term financial viability.

Although the Balanced Budget Act of 1997 (BBA) ensured the short-term solvency of the Medicare Part A trust fund, the trust fund is projected to go bankrupt in the next decade without further reform. In addition, BBA provisions designed to address fraud and abuse are exacerbating the financial crunch for some seniors. For example, changes in Medicare's home health payment methodology have led to service reductions that are forcing many beneficiaries to seek private, state, and Medicaid-funded alternatives to supplement or replace their Medicare home health services. Although some seniors can afford to absorb increases in their out-of-pocket costs, the majority cannot; 40 percent of Medicare seniors have annual incomes of less than $15,000 and 70 percent have annual incomes of less than $25,000.

For low-income Medicare beneficiaries, Medicaid fills the gaps in Medicare coverage by providing assistance for Medicare premiums and cost-sharing expenses, and by covering the costs of outpatient prescription drugs and long-term care. Medicaid serves not only low-income Medicare beneficiaries, but also higher income Medicare beneficiaries as well, who turn to Medicaid after exhausting their own resources to pay for their care.

Moreover, because Medicaid's role in providing coverage for these individuals is supplementary to Medicare, states are in an untenable position. States share the responsibility for providing coverage but lack any way to affect the policies that govern Medicare or to manage the up-front primary and acute care treatment decisions that drive beneficiaries' use of long-term care services and Medicaid spending.

Characteristics of dually eligible beneficiaries

Although states play a key role in funding the services provided to many low-income seniors, the most evident connection between Medicare and states is for individuals eligible for both Medicare and Medicaid coverage. According to the HCFA, 15 percent of Medicare beneficiaries also are eligible for Medicaid. These dually-eligible beneficiaries, however, account for 30 percent of all Medicare spending, or about $62 billion in fiscal 1997.

Dually eligible beneficiaries also are an expensive population for Medicaid programs. Although they account for only 16 percent of Medicaid recipients, dual eligibles account for 35 percent of Medicaid expenditures, or about $58 billion in fiscal 1997.

Dually eligible beneficiaries are a particularly vulnerable and high-cost group. Compared with other Medicare beneficiaries, dual eligibles are more likely to suffer from chronic illness and require significant long-term care and social support services. They also are more likely to live alone or in a nursing facility and are less likely to have a living spouse. Of course, dually eligible beneficiaries are much poorer, on average, than other Medicare beneficiaries. 80 percent of dual eligibles have annual incomes of less than $10,000.

Dually eligible beneficiaries also are different from other Medicare beneficiaries in another, very important way: they do not have the same financial incentive to choose among fee-for-service and managed care options, based on differences in price and benefits, because Medicaid programs cover their out-of-pocket costs and provide comprehensive coverage. National data show that dual eligibles are 75 percent less likely than other Medicare beneficiaries to enroll in managed care plans.

The majority of the 6 million dually eligible beneficiaries, about 5.4 million, receive full Medicaid coverage. Medicaid provides coverage for their Medicare premium and cost-sharing expenses and for services not covered by Medicare, including long-term care and outpatient prescription drugs.

The remaining 600,000 beneficiaries are not eligible for full Medicaid coverage but do receive Medicaid assistance for Medicare premiums and/or cost-sharing expenses. They include individuals with incomes up to 120 percent of the federal poverty level (i.e. "qualified Medicare beneficiaries" and "specified low-income Medicare beneficiaries") and, at least through 2002, individuals with incomes between 120 percent and 175 percent of the poverty level ("qualified individuals").

Not included in these population figures are low-income Medicare beneficiaries who are eligible for Medicaid coverage but who decide to forgo such assistance or who are not aware that assistance is available. States have been criticized for failing to enroll 100 percent of eligible seniors in these programs. Although states take their responsibilities seriously and are working with HCFA to identify effective outreach methods, in many cases, the cost of outreach exceeds the value of the benefit to the individual. It simply is not worth the effort for many seniors to apply for federal assistance to receive $1.07 per month.

Allowing the Social Security Administration or some other federal agency to provide assistance to these beneficiaries would streamline a cumbersome system and ensure greater program participation. This common-sense solution would help reverse the trend of creating a patchwork of optional and mandatory eligibility categories that is confusing to both caseworkers and beneficiaries. It would also recognize that the strength of the Medicaid program is in providing vital health care services to low-income beneficiaries, not in cutting checks for a few dollars each month.

Conclusion

The nation's Governors support Medicare reform to ensure the long-term solvency of the program, and improve its quality for all beneficiaries. As reform measures are considered, however, they must be assessed for the human impact on dual eligibles and the fiscal impact on Medicaid and other state-funded programs. Medicare reform must not create unfunded state mandates or otherwise shift costs to states. Such reform must also account for the fact that dual eligibles, which account for 30 percent of program expenditures, have no incentive to select a health plan based on price because Medicaid pays for their out-of-pocket costs. In addition, Medicare reform should support state flexibility to develop mechanisms to contain the growth in Medicaid spending. Finally, Medicare reform should support state-federal partnerships to coordinate and integrate Medicare and Medicaid to ensure greater accountability for health outcomes.

I thank you again for the opportunity to participate in this hearing. I look forward to answering your questions.

Technical Revisions to the Social Security Act to Streamline Programs for Dually Eligible Beneficiaries

Background

Several states are developing better ways to serve dually eligible beneficiaries, those eligible for both Medicaid and Medicare. Because Medicare and Medicaid are separate programs administered by HCFA and the states, respectively, program rules are often inconsistent and create perverse incentives to use expensive institutional care, and to shift costs from one program to the other. Statutory authority for programs that coordinate or integrate Medicare and Medicaid is unclear at best, and provides significant barriers to innovation at worst. In attempting to negotiate waivers, states and HCFA have been frustrated by the lack of clear authority in this area. These proposed revisions to the Social Security Act provide clear, flexible and complementary authority in both the Medicare and Medicaid titles of the Act, providing a flexible approach that can accommodate the numerous program models currently under discussion across the states.

Summary of Revisions

1. Sections 1 and 2 amend the Medicare+Choice statute and general provisions of the Medicare statute, respectively, to create explicit new Medicare waiver authority for voluntary programs that coordinate or integrate Medicare and Medicaid services. The language goes beyond existing authority (§222) by explicitly including many programmatic elements in the waiver authority.

2. Sections 1 and 2 provide two options for consideration regarding budget neutrality. Option 1 requires that Medicare costs, considered alone, must be no greater than they would be for similar people served in traditional fee-for-service settings. Option 2 departs from the current practice of treating Medicare and Medicaid separately. Instead, total Medicare and Medicaid costs would be taken into consideration, and projects would be cost neutral as long as Medicare and Medicaid payments combined did not exceed combined costs in traditional fee-for-service.

3. Section 3 amends §1915(a) of the Medicaid statute to streamline the contracting process for programs serving either dually eligible beneficiaries or Medicaid-only beneficiaries by incorporating certain features of 1915(c) waiver programs under 1915(a). Specifically:

- Paragraph (A) incorporates the eligibility provisions currently used in home- and community-based waiver programs, allowing states to use those eligibility provisions without the significant complication of combining a (c) waiver; and
- Paragraph (B) incorporates spousal impoverishment provisions currently used in home- and community-based waiver programs.

3. Section 3, Paragraph C gives states explicit authority to seek Medicare waivers in conjunction with 1915(a) programs. Whether to pursue Medicare waivers is a state option. States are not precluded from operating Medicaid-only programs under this section.

4. At Section 3, Paragraph D, two options are offered for consideration regarding budget neutrality. Option 1 requires that Medicaid costs, considered alone, must be no greater than they would be for similar people served in traditional fee-for-service settings. Option 2 adds a second cost neutrality definition for programs that combine Medicare and Medicaid. For those programs, total Medicare and Medicaid costs would be taken into consideration, and projects would be cost neutral as long as Medicare and Medicaid payment combined did not exceed combined costs in traditional fee-for-service.

Draft Legislation Follows:

An Act Making Technical Revisions to the Social Security Act to Streamline Programs for Dually Eligible Beneficiaries

Section 1. Amend Title XVIII, §1859(d) as follows:

Sec. 1859(d). COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.--Nothing in this part shall be construed as preventing a State from coordinating benefits under a Medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan. The Secretary may waive requirements of this title to permit states to enhance the coordination and integration of services and administration provided under this part with services provided under title XIX. The Secretary shall issue an approval, denial or request for additional information within 90 days of receiving a waiver request under this section. Coordination and integration of services and administration may include, but is not limited to: a unified enrollment process; a unified quality improvement program; a streamlined grievance and appeals process; streamlined reporting requirements; and alternative Medicare payment methodologies, including modified risk adjusters and risk sharing approaches; provided that--

(1) waiver services developed under this section are offered as a voluntary option to beneficiaries; and

[SUBSECTION 2, OPTION 1]:
(2) waiver services are cost effective to Medicare. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare program than providing Medicare services on a fee-for-service basis to an actuarially equivalent population group.

[SUBSECTION 2, OPTION 2]:
(2) waiver services are cost effective. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare and Medicaid programs combined than the combined costs of providing Medicare and Medicaid services on a fee-for-service basis to an actuarially equivalent population group.

Section 2. Create a new §1897 as follows:

Sec. 1897. DEMONSTRATIONS TO COORDINATE AND INTEGRATE SERVICES AND ADMINISTRATION.-- The Secretary may waive requirements of this title to permit states to enhance the coordination and integration of services and administration provided under this title with services provided under title XIX. The Secretary shall issue an approval, denial or request for additional information within 90 days of receiving a waiver request under this section. Coordination and integration of services and administration may include, but is not limited to: a unified enrollment process; a unified quality improvement program, a streamlined grievance and appeals process; streamlined reporting requirements; and alternative Medicare payment methodologies, including modified risk adjusters and risk sharing approaches; provided that--

(1) waiver services developed under this section are offered as a voluntary option to beneficiaries; and

[SUBSECTION 2, OPTION 1]:
(2) waiver services are cost effective to Medicare. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare program than providing Medicare services on a fee-for-service basis to an actuarially equivalent population group.

[SUBSECTION 2, OPTION 2]:
(2) waiver services are cost effective. For purposes of this section, "cost effective" means that services offered under a waiver will cost no more to the Medicare and Medicaid programs combined than the combined costs of providing Medicare and Medicaid services on a fee-for-service basis to an actuarially equivalent population group.

Section 3. Amend §1915(a) to add sub-§3 as follows:

SEC. 1915. [42 U.S.C. 1396n] (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)--
(1) [no change to current law]; or
(2) [no change to current law] ; or
(3) has entered into a contract with an organization to provide care and services, which may include care and services beyond those offered in the State plan, to individuals

eligible for medical assistance who have elected to obtain care and services from the organization and are at least 65 years of age or have a disability or chronic illness, including individuals who are also eligible for medicare benefits under title XVIII.

(A) For purposes of payments to States for medical assistance under this title, individuals who are eligible to receive care and services under this subsection and who meet the income and resource eligibility requirements of individuals who are eligible for medical assistance under section 1902(a)(10)(A)(ii)(VI) shall be treated as individuals described in such section 1902(a)(10)(A)(ii)(VI) during the period of their enrollment in a program established under this subsection.

(B) Section 1924 applies to individuals receiving care or services under this subsection. For purposes of applying section 1924, "institutionalized spouse" means--

(i) an individual who is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(ii) is married to a spouse who is not in a medical institution or nursing facility.

(C) States may seek waivers under Title XVIII, sections 1859(d) and 1897 to integrate services provided under this subsection with services provided under Title XVIII.

PARAGRAPH D, OPTION 1

(D) Under a risk contract executed under this subsection, aggregate medical assistance payments to the organization, for a defined scope of services to be furnished to beneficiaries, may not exceed the medical assistance costs of providing those same services on a fee-for-service basis, to an actuarially equivalent population.

PARAGRAPH D, OPTION 2

(D) Services provided under this subsection must be cost effective, as defined in subparagraph (i) or (ii), as applicable.

(i) For purposes of programs implemented under this subsection with no corresponding waivers under Title XVIII, aggregate medical assistance payments to the organization, for a defined scope of services to be furnished to beneficiaries, may not exceed the medical assistance costs of providing those same services on a fee-for-service basis, to an actuarially equivalent population.

(ii) For programs implemented under this subsection in combination with waivers under Title XVIII, section 1859(d) or 1897, services offered will cost no more to the Medicare and medical assistance programs combined than the combined costs of providing Medicare and medical assistance services on a fee-for-service basis to an actuarially equivalent population group.

PREPARED STATEMENT OF DEBORAH STEELMAN, ESQ.

Medicare is the single most important contribution to seniors' health care ever enacted. Because of Medicare, every senior has basic health insurance. The prospect of reforming Medicare, with its necessary goals of improving the benefits and stabilizing the financing, is a task taken on in the shadow of the greatness of its original architects. The only true homage that can be paid them is to ensure the program continues to meet the needs of beneficiaries and taxpayers as it once did, so long ago. The Breaux-Thomas proposal lives up to this standard because it addresses Medicare not as merely a set of political opportunities or a bundle of impossible choices, but as the public good Medicare is and must continue to be.

Health care has changed dramatically since Medicare was created. In 1965, long hospital stays and confinements in nursing homes were common. People were either treated in a doctor's office or in the hospital. Today, thanks to medical research, hundreds of breakthrough medicines are available allowing people to live longer and healthier lives, especially seniors. Advances in medical treatments means that more people can be treated at home or in outpatient settings, and with a combination of services like home care, therapy, and drugs.

Yet, as this committee is well aware, Medicare's benefit package has not kept pace with modern medicine or the quality of coverage available to the average citizen today. For example, coverage for outpatient prescription drugs and a cap on out-of-pocket expenses have been standard features for many years in private health plans, including those sponsored by the federal government as an employer.

To compensate for the anachronistic nature of Medicare's benefit package, the private sector has responded by creating a supplemental insurance market. Over 12 million seniors obtain "wrap-around" coverage through retiree benefit programs, and another 10 million purchase individual insurance products commonly referred to as Medigap.

The federal government's most recent attempt to significantly modify Medicare's benefit package, the Medicare Catastrophic Coverage Act, was repealed ten years ago. Its repeal was due largely to the opposition from seniors who had paid for retiree benefits in their working years and found themselves faced with significant premium liabilities under the new law. Since then, the federal focus has been on incremental improvements to Medicare's benefit package, improving the options for comprehensive coverage through the Medicare+Choice program, and ensuring a comprehensive set of benefits to the poorest seniors through Medicaid.

In the decade since the repeal of the Medicare Catastrophic Coverage Act, many state governments have created special state assistance programs just for pharmaceutical therapy. Currently 13 states offer 14 such programs, covering 930,000 seniors. Income eligibility varies from state to state, ranging from about $9,000 in Maryland to about $23,000 in Pennsylvania and New York for individuals.

Nevertheless, too many elderly Americans can't get the medicines they need because they cannot afford the private sector coverage that is available, but their resources are too great to qualify for Medicaid or their own state's assistance program. Up to 6 million of these beneficiaries would have drug coverage paid for under the Breaux-Thomas plan.

The inadequate coverage of the Medicare program forces beneficiaries to piece together coverage from multiple sources. Bob Reischauer, former CBO director and current senior fellow at the Brookings Institution, refers to this piecemeal system of acquiring coverage as the "hybrid system." This system is inherently inefficient.

This inefficiency is more serious than may be apparent upon initial review. The Health Care Financing Administration is often credited with disbursing 98 cents on the dollar in benefits. This two-percent administrative cost would be a great source of pride were it not so "penny wise and pound foolish." This year, for example, the agency received significant kudos for reducing waste to a mere $12.6 billion. Perhaps losing $12 billion out of $200 billion is, as the saying goes, "good enough for government work." I don't think so. This only proves how low our standards are for a program in which the highest standards should be demanded. For example, twelve billion dollars a year would be enough to fund a modest prescription drug benefit.

How did Medicare get to the point where $12 billion in unaccountable expenditures is considered an improvement? The program's complexity, internal inconsistencies, and multilayered governance structure provide some clues.

Last year the Mayo Clinic estimated that Medicare contained over 132,000 pages of regulation, manual instruction, fraud and abuse guidelines and other federal directives. How much time and talent is consumed by an organization as respected and as well run as the Mayo Clinic to comply with this blizzard of paperwork? How do many smaller hospitals and physicians offices keep up? And how much true

criminal fraud is invited by a system where the clever can so easily manipulate complexity for their own personal gain?

Taxpayers are not the only ones who pay for the inefficiency of the hybrid system. Beneficiaries pay. The most common complaints from seniors are due to the lack of appropriate coordination of benefits between the federal and private sector components of seniors' three-part benefit package; Part A, Part B, and their supplemental coverage. While one carrier decides it is another carrier's responsibility to pay and that carrier decides it is the other carrier's responsibility to pay, seniors are left with confusion and unpaid bills. Or bills get paid twice and a senior calls their doctor's office or the hotline, reporting it, only to be told the amount is too small to worry about.

Any reform of Medicare that does not take into account the entirety of this "hybrid" system will doom seniors and taxpayers to the higher costs of such inefficiency.

Stan Hinton, a retiree who writes of the practical side of retirement for the Washington Post wrote a common sense list of Medicare improvements he and his wife wanted. He wrote, "We want to feel that if we get ill we can depend on Medicare's contractors to handle our claims quickly, efficiently and without a lot of confusion over what Medicare will pay for. * * * We want to stop getting those mysterious 'Explanation of Benefits' notices that don't really explain anything. We want to get a letter from Medicare once a year telling us which contractors are handling our doctors' and hospital claims, where their offices are located and their phone numbers. * * * We want Medicare, once it reviews and pays one of our claims, to send it electronically to our medigap policy company. That would help end some of the payment delays." The list continued.

One of the best ways to reduce the confusion is to allow all seniors the option of a single comprehensive benefit plan. This is also the best way to provide seniors the kind of benefits that have become so commonplace for workers all across America. Surely it cannot be too difficult for the Congress and the President to agree that all seniors should have the same kind of health plan choices that they have themselves.

From all sides of the political and academic spectrum, there is agreement on the need for a new model. Before the Medicare Commission, witnesses from Heritage Foundation, the Urban Institute, and a variety of universities urged the adoption of some system based on better pricing and better choices. Bob Reischauer testified that "[He did] not think there is any way to address these deficiencies within the current system and so the question is whether there is some different structure that might address these deficiencies."

This was the conclusion of at least 12 of the 17 members of the National Bipartisan Commission on the Future of Medicare. While only ten of us voted for the Commission's final product, it was not due to lack of consensus on this point. As Laura Tyson and Stuart Altman said in the Washington Post on March 29, "We have long supported the idea of market competition to encourage efficiency in health care, so we are sympathetic to the premium support approach."

The Breaux-Thomas proposal supported by a bipartisan majority—10 of 17 of the Commission members. It adapts the principles embodied in the Federal Employee Health Benefits Program (FEHBP) to the special needs of seniors and disabled beneficiaries, and to the political, policy, and budgetary challenges that accompany any serious attempt to modify the Medicare program.

The FEHBP, a form of premium support, has served millions of employees and retirees for over 30 years. Employees in every region of the country have numerous choices of comprehensive benefit packages, and benefits are routinely updated to reflect continuing advances in medical technology and improvements in quality of care. Plans have an incentive to offer the most attractive options for beneficiaries at a reasonable cost. Beneficiaries routinely pay about 25% of the premium and their employer, the federal government, pays the rest. Perhaps because beneficiaries have a stable partner in paying their premiums, many federal employees and retirees have chosen fee-for-service plans. Seventy percent of enrollees are in BlueCross/BlueShield or other fee-for-service plans. The remaining thirty percent are in HMOs.[1]

The question for the Commission was how to preserve the best of Medicare while incorporating the best of FEHBP?

Guarantee Benefits. Federal employee benefits are delivered year in and year out without arbitrary budgeting by Congress or micromanagement by government.

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[1] Merlis, Mark (February 1999), "Medicare Restructuring: The FEHBP Model," (report commissioned by the Henry J. Kaiser Family Foundation).

The first priority of Medicare reform must be to increase the confidence level beneficiaries have in the benefits of the program. This is true not only for today's seniors, but also for those who retire over the coming decades. The biggest fear younger generations have for Social Security is that it will not "be there" when they retire. The biggest fear younger generations have with Medicare is the illusion its benefit package is becoming.

The notion that the Medicare entitlement is secure today is just plain wrong. In fact, as AARP's political ads have pointed out for much of the last two decades, the largest threat to the security of Medicare's entitlement is the relentless and relatively arbitrary budgeting reductions routinely taken by Congress and the Administration. Just this year, we see the Administration underspending the original Congressional estimates for this fiscal year by $20 billion; that is almost 10% of the total program spending. HCFA cannot say why this is happening, and has yet to say how many beneficiaries are being harmed.

Medicare's price controls squeeze benefits. How secure does a stroke victim feel when he or she hits the $1,500 therapy cap and still can't talk? How does a Medicare+Choice enrollee feel when they see their benefits diminish or their health plan leave a market because payment is too low? How secure does a beneficiary feel when Medicare will not allow coverage for multiple procedures performed in the same day? How secure does a transplant patient feel when Medicare's coverage for their immunosuppressant drugs runs out?

These are things no federal employee has to worry about. And yet, the FEHBP has a slower growth rate than Medicare over the same time period, by over a full percentage point.

This seems a good lesson to draw upon in terms of making Medicare's benefits more secure, while at the same time making the program more efficient and cost less.

If our priority is to make benefits predictable and stable from year to year, yet flexible enough to improve over time, prices must vary. In the current Medicare+Choice program the government administers prices; no wonder benefits vary. This system of price distortion is inefficient and ineffective.

As Professors Feldman and Dowd testified before the Medicare Commission, "HCFA [the Health Care Financing Administration, the agency which runs Medicare] never learns the true cost of providing health care in an efficient system." Under the Breaux-Thomas plan, in contrast, plans would determine the premiums and plan designs under oversight of The Medicare Board. This encourages plans to offer the most attractive benefit packages at the most affordable rates.

Guarantee Level of Premium Sharing: Today seniors pay about 33 percent of their total medical care costs, even though they pay only about 12 percent of their Medicare costs[2] which is deducted from their Social Security checks as the Part B premium, currently $45.50 per month. The Breaux-Thomas proposal maintains this same share of beneficiary-to-taxpayer premium sharing.

Like the FEHBP, the federal government would guarantee a certain percent of the total plan premium, allowing beneficiaries to pay a lower premium if they choose a less costly plan and pay more if they choose a high option, or more costly plan. As in FEHBP, the premiums for all health plans would be set by the plans in the marketplace. Experience suggests that running the Medicare program this way would save between 1 and 1.5 percentage points per year.

Beneficiaries are good shoppers, much better than those in Congress and the bureaucracy at HCFA. As Len Nichols of the Urban Institute said at one of the Commission's early hearings, "it is very difficult to get 10,000 prices right in each of 3,000 counties." Government's role is much better suited to consumer protection than price regulation.

The Breaux-Thomas proposal focuses the power of government on what it has shown it can do well in FEHBP: overseeing plans, and not micromanaging prices. Seniors should be able to rely on a guaranteed level of benefits and payments, making their benefits secure and their premium obligations predictable and controllable.

Provide Full Choice of Plans and Comprehensive Benefit Packages. In assessing the differing needs of Medicare beneficiaries and employees enrolled in FEHBP plans, one of the biggest differences we had to address was the supplemental insurance many seniors already have. Federal employees get all their insurance from one source; Medicare beneficiaries do not.

We resolved this difference by requiring all plan sponsors, whether the federal government or private plans, to offer both a standard option plan and a high option plan.

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[2] Upon full implementation of the Balanced Act of 1997, in 2002.

The standard option would cover the same services as provided through Medicare today, allowing seniors to keep their supplemental insurance if they chose. Seniors must have the option of keeping what they have not only in terms of the existing Medicare program, but also the existing supplemental coverage, whether that coverage is employer-sponsored, individually purchased, or available through Medicaid or other state assistance.

We also required all plan sponsors to offer a high option plan that would add coverage for outpatient prescription drugs and a cap on out-of-pocket expenses to the current Medicare benefits. This would allow all seniors no matter where they live, to comparison shop and to apply any or all of the resources they may have available to the purchase of a single, comprehensive health plan of their choice. Amazingly, this simple form of health insurance, the comprehensive health plan, has never been an option in Medicare.

Clearly, a high option comprehensive plan will be much less expensive than purchasing the equivalent coverage through the multi-part "hybrid" system of supplemental+A+B+out-of-pocket. In testimony to the Medicare Commission Reischauer stated, "We provide Medicare, or health benefits to the elderly right now in an inefficient way. And * * * they are paying a lot out-of-pocket. By restructuring the program and consolidating the insurance into one insurance rather than into multiple insurances, you can provide at least those same benefits at less cost." This is the reason I believe the top priority for any reform must be to provide a predictable, reliable, comprehensive benefit package for seniors, no matter where they live or their level of income.

Create Room for Innovation. How would beneficiaries gain if the Medicare "reform" locks the new benefit designs in the same concrete sinking the Medicare benefit package today? Health plans must have a certain flexibility to offer new benefits and services that reflect medical advances and quality improvements giving seniors access to the latest medical treatments.

Again, adopting a FEHBP approach makes senses. The federal program allows plans to talk with enrollees and to do the market research to determine what plan design and innovation in coverage is desired. The Office of Personnel Management oversees the process to ensure against excessive premium increases, unfair competition or intentionally risk averse plan designs, allowing benefit offerings that do not exceed a 10% increase in the actuarial value of the standard package

Guarantee Access to High Option Plans Regardless of Ability to Pay. Other differences between federal enrollees and Medicare beneficiaries include the disparity in income levels and health status.

To enable comprehensive coverage through high option plans, the federal government should cover the entire cost of premiums (but not all deductibles and copays) for seniors whose annual incomes are less than $10,500.

To guarantee access to health plans for people with serious illness and to ensure against intentional risk selection, Medicare health plans must receive payments that differ according to the health care needs of the patient. I believe a system that required health plan participation in reinsurance, or one that isolates the costs of high cost care, would be more effective than a characterization of individuals health status or statistical compilation of plan usage.

Stabilize Medicare Financing. By introducing competition and choice into the Medicare program, we can slow the rate at which the program's costs rise and preserve it for generations to come.

Competition between plans encourages them to offer quality services at an affordable price. And by linking the government's contribution to the average cost plan, the proposal encourages beneficiaries to select more efficient plans, further keeping down costs.

According to the Congressional Budget Office, the Health Care Financing Administration and independent sources, the competition and choice inherent in Breaux-Thomas can keep costs down and stem the long-term growth rate of the Medicare program. Estimates indicate Medicare's growth rate would decrease from between one and one and one-half percentage points per year.

But even the Breaux-Thomas proponents recognize the difficulty of predicting health care costs over the long term, whether in public or private health spending, regardless of what program is in place. No one can predict with certainty how much this reform, or any other, would reduce Medicare's spending.

At the Commission's first meeting, Alan Greenspan cited the impact of technology as just one of the more unpredictable obstacles to long term estimates, saying that he "* * * could allude to all sorts of forecasts over the most recent generations—one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity." That is just one reason why "long-term solvency" is not the primary reason to enact reform today. There are far more important reasons to

enact reform than the "exercises in comparative fantasy," as Bruce Vladeck describes all long-term estimates.

Beneficiaries' health and health care are the primary reasons to reform Medicare and to do it now.

New drugs are at the heart of our hope for long and healthy lives. It is unthinkable that there is no comprehensive and predictable way for all seniors to have drug coverage today. Yet we cannot avoid the possibility that including prescription drugs in the benefit package will bring with it costs that would absorb any savings our reform might achieve as well as add additional, and likely, intolerable taxpayer burdens to future generations.

Along with every other parent of children under the age of 30, I care very much about my children and their fate of becoming the taxpayers supporting millions of baby boomer retirees. My children will be 26 the year I retire. They will be in a first or second job; they will be trying to buy their own health care, a first home, paying the costs of raising children. They will not have had a lifetime to build up assets. And there will be fewer of them in relation to us retirees. Their burden will already be great. So I want to reduce the tax burden for them; I want to do all I can to make the shared responsibilities of future taxpayers and future beneficiaries fair.

In the Commission the question became how much of the new drug coverage available through the high option plan should be financed by the taxpayer, and how much should be financed by the beneficiary? I believe it should be financed by beneficiaries, as supplemental coverage for pharmaceuticals is today. I believe my generation is going to have to pay more than 12% of Medicare costs. But asking my generation to pay more than today's beneficiaries should be accompanied by the promise that our coverage will be comprehensive and our premiums will be affordable.

The Breaux-Thomas proposal offers a fair deal for three reasons. First, it requires health plans to offer comprehensive coverage, including outpatient prescription drugs, and allows retirees to choose their own plan based on price and quality. Drug coverage in such integrated plans should cost no more than $700–900 per year. That is significantly less than the annual median cost of $2,400 for Medigap plan "J," which includes limited drug coverage. Second, the Breaux-Thomas proposal pays the full cost of a comprehensive health plan for all beneficiaries of low and modest means who cannot afford their share of the premium. Third, The Breaux-Thomas proposal guarantees today's Medicare benefits at today's taxpayer-beneficiary share of the premium, with the promise of improved efficiency to lower the beneficiaries' premium and the taxpayers' obligation.

The proposal provides financing for these guarantees through the same combination of sources as exists today: payroll taxes, beneficiary premiums, and general revenues. Over the next 10, 20, 30 years, our economy will change, technology may explode or implode health care costs, and our tax code will change. What combination of these resources will be fair in the future? Should another be considered?

To ensure this debate is more open than the one occurring today—creating Part A "solvency" through general fund transfers of one kind or another—the Breaux-Thomas proposal would create a new concept of solvency. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test is one based on the amount of general revenues required to make up the difference.

In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, I believe the Trustees should be required to notify the Congress that the Medicare program is in danger of becoming insolvent. Congress would be required to legislate alternative funding or to increase the level of general revenues dedicated to the program. This new measure of Medicare solvency would clearly illuminate the ratio of relative financing burdens on general revenues, the Hospital Insurance payroll tax, and the premiums beneficiaries pay, and would require a public dialogue to determine the fairest financing burden between beneficiaries and younger taxpayers.

The Time Is Now. We have reached a point where we must bring Medicare into the 21st century, giving our nation's elderly the same access to high quality care as the rest of us, while slowing the program's growth rate. Both the Chief Actuary of HCFA and the Director of the CBO, who is with us today, have testified to this committee that change to Medicare must occur sooner, rather than later. This time is now.

Mr. Chairman, I believe that by the time I retire we will have a system that looks much like the Breaux-Thomas plan. It combines the best of the marketplace and government—innovative and efficient health care and a guaranteed benefits for seniors, and equitable financing obligations for beneficiaries and younger taxpayers,

which ensures quality care at a reasonable price. Medicare is a critical social contract we made with our elderly citizens long ago and we must honor this important pledge, preserving Medicare for today's seniors, for my generation, and for my children's generation.

Seniors will never be totally secure about their Medicare program until two things happen:

- The Medicare program is taken out of the arbitrary, budget-driven and, bureaucratic process and governed by an independent board;
- The program is administered like the Federal Employees Health Benefit Program that gives beneficiaries more choices and the same level of benefits enjoyed by every Member of Congress.

Limitations of Medicare Coverage

Part A

Coverage:
- hospital services
- skilled nursing facilities
- hospice care

Financing:
- payroll taxes on all earned income

Part B

Coverage:
- physicians
- medical supplies
- home health

Financing:
- 75% general revenue
- 25% beneficiary premiums

Gaps

- No Prescription Drug Coverage
- No Stop-Loss Protection
- No Coordination of Care

Seniors will never be totally secure about their Medicare program until two things happen:

- The Medicare program is taken out of the arbitrary, budget-driven and, bureaucratic process and governed by an independent board;
- The program is administered like the Federal Employees Health Benefit Program that gives beneficiaries more choices and the same level of benefits enjoyed by every Member of Congress.

The Hybrid System: How Seniors Fill The Gaps

Medicare Part A

+

Medicare Part B

+

Supplemental Coverage

- **Medigap**
- **Employer**
- **Medicaid**
- **Individual out-of-pocket**

11% of FFS beneficiaries do NOT have any supplemental

PREPARED STATEMENT OF HON. BILL THOMAS

Mr. Chairman, Senator Moynihan and Members of the Finance Committee, thank you for inviting me to testify about the Breaux-Thomas Medicare proposal. This proposal was supported by 10 of the 17 Members of the Medicare Commission. I note that this 60 percent margin would meet the high threshold to pass in this chamber. I was pleased that 4 of the 5 Senators on the Commission voted for the proposal and 3 of those 4 are on your Committee. Clearly, you have a bipartisan foundation upon which to move forward.

HOW PREMIUM SUPPORT WORKS: MYTHS AND REALITY

Premium Support, the core-concept in the Breaux-Thomas proposal was not dreamed up at a think tank. Rather, it is based on the largest pool of insured individuals next to Medicare itself: 9 million federal employees and their families including Members of Congress. Premium Support will modernize Medicare by integrating innovations of the marketplace while preserving the entitlement and safety net.

Under premium support, qualified private plans and the government-run fee-for-service plan would submit bids based on the actual costs of providing health care to Medicare beneficiaries. The government contribution would be 88% of the weighted national average of these negotiated bids. This guaranteed government contribution is equal to the current government-beneficiary ratio, since the beneficiary Part B premium of 25% amounts to 12% of total Medicare costs.

Beneficiaries would then choose whatever health plan best suits their needs. If they chose an average plan, they would pay 12% of the premium. They could choose a more munificent plan if they wanted to add their own dollars, or choose a more efficient plan and reduce or even eliminate their premiums.

Medicare will now have the ability to harness the market power to control costs through competition. The Congressional Budget Office commented that the Breaux-Thomas plan "would foster greater competition among plans and greater choice for beneficiaries" and that "increased competition will reduce costs."

Recently, there has been much castigating of Premium Support and use of pejorative terms to describe the proposal. I would like to set the record straight:

Premium Support is not a defined contribution. A defined contribution is based on an arbitrary number and index that may or may not provide the sufficient funds to meet beneficiaries' needs. In contrast, Premium Support guarantees the current benefit package. Secondly, under Premium Support, when health care costs rise, the government contribution rises commensurably.

Premium support is not a voucher. A voucher implies handing seniors some money and asking them to go off in the cruel world to see if they can find someone to sell them insurance. In contrast, the Breaux-Thomas proposal establishes a "Medicare Board" which would negotiate with health plans and prevent plans from cherry picking only the healthy individuals and turning away unhealthy individuals. The Board would also provide beneficiaries unbiased information about their plan choices. This has the benefit of getting HCFA out of the inherent conflict-of-interest of regulating its competition.

Premium support does not force seniors into managed care. To the contrary, under the Breaux-Thomas bill, seniors can choose to remain in the government-run FFS plan, and they will have more options for open-network private plans because the new payment structure will permit these plans to compete.

ADVANTAGES OF PREMIUM SUPPORT

More Choices for Beneficiaries: Some allege that premium support may not work because 7 out of 10 counties do not have Medicare+Choice plans and that a number of plans have recently pulled out of the Medicare market. I think these problems are the very reason we must move to a premium support system. Currently, we pay plans based on the arbitrary, county-wide administered prices determined by government policy. Then we wonder why many private plans, acting in the real world, find payments in many areas insufficient. Our attempts to address this issue in the BBA through "blended rates" and payment floors can only help at the margins.

In contrast under FEHBP, every enrollee in every state of the country has a choice of at least 10 different plans. While Medicare has many states with no plan choices, enrollees in FEHBP in West Virginia have 23, South Dakota: 17 and Nebraska: 19. This is because the plans are paid on the rates that they bid. Under premium support, plans will bid for the real costs of health care. This will expand choices for seniors, particularly in rural areas.

Quicker Beneficiary Access to Innovation: I was proud to work with my Democratic Colleague, Ben Cardin, to assemble a package of preventive benefits, which became the core of the Medicare changes in the 1997 Balanced Budget Act. This package included important new benefits such as mammographies, diabetes self-management, colorectal screenings and others. While this was a great improvement to Medicare, most private plans had already adopted these benefits more than a decade earlier. This illustrates that Medicare's current statutory and regulatory structure simply cannot keep pace with the changes in the marketplace. As long as Congress must be relied on to legislate and micro-manage the program, Medicare will always be behind the curve and seniors will have to wait for new benefits and innovative health delivery systems. My first attraction to premium support was the long-overdue flexibility and responsiveness it will provide so that the program becomes more self-correcting.

Produces Significant Savings Through Greater Efficiency: Shortly after the HI trust fund is scheduled to go broke, 77 million baby boomers begin to retire and the number of workers to beneficiary will drop from a ratio of about 4:1 today to about 2:1 in 2030. At the same time, health care costs are anticipated to grow at a far higher rate than the economy. This leaves Congress with an enormous challenge and three fundamental choices: cut benefits, raise taxes or make the program more efficient. Obviously, the most preferable course is increasing efficiencies.

Premium support makes the program more efficient by giving seniors incentives to make more rational choices and plans more incentive to provide high quality care at the greatest economy. Data from the FEHBP show that enrollees chose less expensive plans every year, even when the average premiums decreased. The Medicare Commission estimated that the Breaux-Thomas plan will slow the Medicare growth rate 1 to 1.5% a year. Any manager of a mutual fund will tell you that 1.5% compounded over time produces enormous results. We expect this savings to amount to $800 billion a year by 2030. The sooner we can begin to moderate these growth rates, the better off we will be as savings compound over time.

Reduced Costs for Beneficiaries: Under Premium Support, seniors will have incentives to choose more efficient plans because they can share in the savings. This is unlike the current Medicare+Choice program, in which seniors can never reduce their premiums by choosing less expensive plans. In fact, our proposal allows seniors to choose zero premium plans. By reducing the growth rate, the Commission estimated that beneficiary premiums would be 17–24% lower than under current law.

MAKING PRESCRIPTION DRUGS ACCESSIBLE AND MORE AFFORDABLE

One key feature of premium support is integrating prescription drugs in Medicare in a responsible way. Over the past 5 years, the FDA has approved more than 200 new innovative pharmaceuticals, half of which are targeted to seniors. But 35% of seniors currently lack prescription drug coverage. Our goals were to (1) target assistance to those who need it most—low income beneficiaries; (2) permit seniors to insure against the risk of high pharmaceutical expenditures and benefit from the market discounting common in the employer market; and (3) design a program that would permit employers a greater ability to integrate their retiree coverage with Medicare.

Comprehensive Coverage for Low-Income: The neediest beneficiaries, those with incomes up to $10,500, will get comprehensive prescription drug coverage. This is a significant commitment to improving the safety net, costing $30 billion over 10 years for the prescription drug coverage and an additional $31 billion for the expected increased participation in the low income programs that cover premiums and cost-sharing.

Restructured market for all seniors: The 35% of seniors that lack drug coverage and millions of others that have inadequate coverage through Medigap, are now faced with high retail prices for drugs and no way to insure against the risk of high pharmaceutical expenditures. This is a particular problem when many seniors take 10 or more prescriptions a year. The Breaux-Thomas plan restructures the market to address these problems. All plans, including the government-run FFS plan, must offer a high-option plan, which includes prescription drug coverage and stop loss protection. Secondly, all Medigap plans must include prescription drug coverage as a core benefit, and one Medigap plan must be a prescription drug only plan. These plans will now be in a position to negotiate discounts on seniors' behalf and permit seniors to insure against large pharmaceutical expenditures.

Encouraging Employer Participation: Finally, employers who are finding it increasingly difficult to maintain open-ended retiree plans, can easily add their dollars to these integrated high-option plans for their retirees. Thus, we can maintain and

even increase employer participation for retirees. Many other Medicare prescription drug proposals displace employer-sponsored coverage, rather than integrating it.

CONCLUSION

In short, Premium Support brings Medicare into the 21st century as a stronger, improved health program for today's and tomorrow's retirees. I look forward to working with you and Democrats and Republicans in the House in improving this proposal and modernizing the Medicare program. Thank you.

Congress of the United States

Washington, DC 20515

May 21, 1999

The Honorable Dennis Hastert, Speaker of the House
The Honorable Dick Gephardt, Minority Leader
Washington, DC

Dear Mr. Speaker and Mr. Minority Leader:

You may believe that the window of opportunity for Medicare reform has closed on the 106th Congress, but we would not agree. We believe that the American people expect this Congress to step up to the challenges facing our aging society.

The American people do not need bankruptcy signs waived in front of them in order to support the common sense type of reform embodied in the premium support concept developed by the majority of the members of the National Bipartisan Commission on the Future of Medicare. Experts from both sides of the aisle agree that this concept has the potential to reduce the financial burden on future generations while eliminating the one true deficiency of today's Medicare program -- the lack of coverage for outpatient prescription drugs.

The proposal embodied by the Breaux-Thomas report is not perfect. We believe it should also include support for drug coverage and that the support should go beyond the 135 percent above poverty threshold established by the authors. Some of us also have serious reservations about raising the eligibility age for Medicare. Nevertheless, we believe the concept they developed is the basis for a responsible plan of Medicare reform that is politically supportable by both parties and a broad spectrum of the American public.

We would urge that these positive changes be incorporated into a legislative package that would allow us to support and work for real Medicare reform in this Congress.

Sincerely,

Cal Dooley

Charlie Stenholm

Adam Smith

P.3/3

Karen McCarthy	Tom Kind
Bud Cramer	

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

May 21, 1999

The Honorable Nancy Ann DeParle
Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

We have reviewed your agency's recent draft of the proposed *Medicare and You* handbook for the year 2000. As currently drafted, we find the handbook to be legally insufficient, delusive, wasteful and confusing. It ignores the statutory requirements spelled out for the publication as part of Medicare+Choice ("M+C") program. As disturbing, rather than "promoting informed choice" as envisioned by the Medicare+Choice law, it seems designed to frustrate a beneficiary's ability to evaluate the comparative benefits of different health plan options available to them through Medicare.

The specific problems described below underlie, in part, my sentiments:

VIOLATIONS OF THE STATUTE

As part of its broader effort to ensure that seniors could comparatively evaluate all of their options under the Medicare program, Congress mandated that the Health Care Financing Administration ("HCFA") specifically include in the material mailed to each beneficiary prior to the new open enrollment period *more than a dozen specific facts about each specific Medicare+Choice plan* available in the beneficiary's area. In spite of this mandate, the draft handbook contains absolutely no detailed benefit information about any specific plan. It doesn't even contain basic elements such as how much a given plan costs, or what, if any, additional benefits it covers. In fact, nowhere does it contain a decent summary of the benefits *a typical* Medicare+Choice plan offers.

Instead, the handbook contains only aggregated, cryptic, poorly organized, and relatively meaningless information organized by Medicare+Choice *contractor*. Even then, comparative information is limited to the name of the contractor, the total number of plans they offer in each state, the *range* of premiums they charge for these plans, the number of plans they offer that cover prescription drugs (not which ones), and a phone number.

This format makes it impossible to learn even the most basic plan information. The reader

cannot tell if a specific plan is available to them, what the premium is for a given plan, what the applicable co-payments or deductibles are, or what, if any, extra benefits are covered. This is not what the statute requires, and clearly not what Congress envisioned when it enacted the mailing requirement.

CONTENT BIASED AGAINST MEDICARE+CHOICE

In some ways we find it even more troubling that the content of the handbook seems designed to frustrate the very purpose for which it was clearly created -- to help educate seniors and enable them to make informed choices under the new Medicare+Choice program. Sadly, the draft contains no significant discussion of the options available because of Medicare+Choice until page 17 (after an extensive description of the traditional Medicare program, and its benefits and a description of the low-income assistance programs).

Where the handbook does discuss the M+C program, it fails to make clear even the most basic distinctions and relationships between "The Original Medicare Plan" and Medicare+Choice plans. For example, nowhere is it clearly stated that all Medicare+Choice plans must cover all of the benefits covered in both Medicare Parts A and B.

WOEFULLY INADEQUATE QUALITY AND PERFORMANCE INFORMATION

The paucity of comparative quality data that is included in the draft is poorly presented and "oversold." More importantly, it fails to adequately include and present comparisons to the traditional Medicare plan.

Only one quality indicator comparing Medicare+Choice plans to traditional Medicare is included. It reports plan mammography rates. Even then, the traditional Medicare program data is not presented in the bar graphs comparing individual M+C plans, but is compared to aggregate M+C data for each state. It is as if HCFA does not want the traditional program to be judged on its own relative merits.

The only additional comparative "quality" measure for Medicare+Choice plans is derived from the results of an enrollee survey, and reflects the perceived communication skills of a plan's participating doctors. Representing this information as a major quality indicator is dubious at best. Yet, the draft devotes 7 full pages to reporting this one fact -- via a nearly indecipherable multi-variable bar graph. By comparison, the Office of Personnel Management's ("OPM") standard beneficiary booklet for the Federal Employee Health Benefit Plan presents on one page the results of 11 different consumer satisfaction measures. I ask you -- can't HCFA do a better job of giving seniors some truly valuable information?

OVERALL CONTENT CONFUSING AND WASTEFUL

Finally, the overall structure and layout of the booklet is long, duplicative and poorly organized. As a result, it only further frustrates the purpose for which it was mandated and is a poor reflection on the program. A few examples:

- It devotes nearly a dozen pages to describing in detail the benefits structure of the traditional fee-for-service program -- before adequately explaining the general advantages and disadvantages of fee-for-service Medicare as compared to Medicare+Choice.

- The vast majority of the text contains general explanatory text -- much of which is redundant and not clearly written. Only 11 pages are devoted to providing comparative information. And then a grand total of 7 facts per *contractor* are provided – this includes the contractor's name and phone number. By comparison, the most recent OPM booklet devotes 41 of 55 pages to comparative, plan specific information. It provides roughly 35 facts concerning every plan in the country (approximately 300 plans).

- One final example of wasted space is the listing of phone numbers one can call to get additional information. In addition to numerous references to phone numbers spread throughout the text, a full 7 pages are devoted to nothing but describing government phone numbers where seniors can get more information – yet, approximately 75% of this material refers seniors to the same 1-800-MEDICARE number. This could easily be condensed into two pages at most and either save money or free up space for more detailed, comparative plan information that seniors could actually use.

At a time when many seniors are struggling to determine how to pay for medical needs such as prescription drugs, the government does not serve them well by providing only incomplete and misleading information about their options under the Medicare+Choice program.

Given the potential of the Medicare+Choice program to help millions of seniors and disabled citizens, I ask that you take the necessary steps to ensure that these inadequacies are addressed before authorizing the expenditure of any printing funds for this project.

Sincerely,

Bill Thomas

Bill Thomas
Chairman

cc: The Honorable Donna Shalala

PREPARED STATEMENT KENNETH E. THORPE, PH.D.

Chairman Roth, Senator Moynihan, members of the Committee. I am Ken Thorpe, Professor of Health Policy at Tulane University. I am pleased to be invited to share my views on the future options for restructuring the Medicare program. My observations draw, in part, on recent work we have completed evaluating the performance of the Federal Employees Health Benefit (FEHB) program.

My testimony will highlight three key areas:

1. What is the real extent of the problem facing Medicare? As I will discuss, how we measure the fiscal pressures facing the Medicare problem is critical for crafting policy options.
2. What will it take to "solve" the financial problems facing Medicare?
3. What reforms in the program are desirable to achieve these results?

I focus on three areas of potential reform for the Medicare program.

- Move toward the use of competitive bidding for establishing payments to Medicare+Choice plans. At the same time, include a limited outpatient prescription drug benefit as part of the standard benefit package.
- Modernize Medicare's fee-for-service program. This would include adopting a single deductible, a cap on out-of-pocket spending, and the phase-in of an outpatient prescription drug benefit over the next ten years.
- Restructure how Medicare (and Medicaid) finance and deliver long-term care services.

As is discussed below, the costs associated with the long (10-year) phase-in of an outpatient prescription drug benefit could be accommodated by reducing the expected growth in Medicare beyond 2002 by 0.5 percentage points. This rate of growth would still exceed the growth in Medicare spending created through the BBA.

I first turn to a brief discussion of the medium term financial issues facing the Medicare program, and then turn to a discussion of the reform options.

II. MEDICARE'S FINANCIAL PROBLEM

Two measures are traditionally used to monitor the financial shape of the Medicare program. The first, a more narrow view, examines the financial status of two component trust funds, the Hospital Insurance (HI) fund and the Supplementary Medical Insurance (SMI) fund. The Balanced Budget Act of 1997 (P.L. 105–33) reduced the growth in HI outlays to 4 percent (2.9 percent per beneficiary) between 1998 and 2002. Between 2002 and 2009 HI spending is expected to rise by 6 percent per year (4.3 percent per beneficiary). The substantially slower rate of HI growth, bolstered by a strong economy has pushed the date of exhaustion for the fund to 2015.

Focusing solely on the HI fund may be misleading. For instance, the HI fund could be solvent in perpetuity by simply shifting spending to Part B of the program, and funding it through premium contributions and general revenues. This exercise, of course, merely alters the mix of funding without addressing the broader issues of overall program growth.

A broader measure of the financial state of Medicare would measure the program's impact on the federal budget deficit. Rising federal debt traced to rising Medicare spending could crowd-out private sector investment, and potentially reduce the overall growth in the economy. Moreover, rising spending would, other things the same, leave less room in the budget for expanding other sources of spending, or lowering taxes.

A. What will it take to solve Medicare's financial problem?

Using the unified budget as a framework for evaluating the fiscal and economic impact of the Medicare program provides a slightly different set of results compared to the HI focus (see Tables 1 and 2).

TABLE 1.—CHANGES IN MEDICARE SPENDING, PRIVATE HEALTH INSURANCE AND THE FEDERAL BUDGET DEFICIT 1999–2009

Year	Medicare per beneficiary	Medicare % GDP*	Private insurance per capita (percent)	Baseline deficit (billions and % GDP)			
				On-budget		Off-budget	
				$	% GDP	$	% GDP
1999	0	2.2	6.9	−19	−0.2	127	1.2
2000	6.2	2.3	6.9	−7	−0.1	138	1.4
2001	6.4	2.3	7.1	6	0.1	145	1.6

TABLE 1.—CHANGES IN MEDICARE SPENDING, PRIVATE HEALTH INSURANCE AND THE FEDERAL BUDGET DEFICIT 1999–2009—Continued

Year	Medicare per beneficiary	Medicare % GDP*	Private insurance per capita (percent)	Baseline deficit (billions and % GDP)			
				On-budget		Off-budget	
				$	% GDP	$	% GDP
2002	1.4	2.3	7.4	55	0.6	153	2.1
2003	7.7	2.4	7.1	48	0.5	161	2.0
2004	5.6	2.5	7.3	63	0.6	171	2.2
2005	8.3	2.6	7.4	72	0.6	183	2.3
2006	2.3	2.6	7.4	113	1.0	193	2.6
2007	8.1	2.7	7.5	130	1.0	204	2.7
2008	6.0	2.8	7.4	143	1.1	212	2.7
2009	5.6	2.9	7.3	164	1.2	217	2.8
1999–02	4.7	.....	7.1	.....	.....	.....	.....
1999–09	5.7	.....	7.3	.....	.....	.....	.....

*Net of Premiums.

Source: CBO for Medicare projections and HCFA for private health insurance.

Table 1 presents baseline projections for Medicare the federal budget deficit over the next ten years. For comparison purposes, I have also included the projected growth in private health insurance spending developed by the Health Care Financing Administration during this time period. Three key points are presented in the Table:

- Medicare spending per beneficiary is expected to rise nearly 1.5 percentage points lower than the growth in private health insurance spending over the next ten years. Medicare is projected to rise by 5.7 percent per beneficiary compared to 7.3 percent for the private sector (the CBO projections are slightly higher than those noted above developed by HCFA).
- Despite the low projected growth in Medicare, it will increase by 0.7 percent of GDP, from 2.2% in 1999 to 2.9% by 2009. It will also rise as a percent of federal spending (largely due to reductions in interest payments) from 12.9 percent to 18.9 percent.
- Yet, the federal budget deficit, however measured, will increase by approximately 1.5 percentage points as a share of GDP. Thus, the growth in Medicare will, under current law, be facilitated through the expected $146 Billion reduction in interest payments during this ten year time period.

The results using the unified budget as a framework for evaluating the "fiscal crisis" facing the program provides a somewhat different perspective than the more narrow view of the status of the HI trust fund.

What if we extended the projected growth in Medicare per beneficiary expected between 1999 and 2009 through 2020. This would allow for the bulk of the demographic changes in the program. We use the CBO base projections for other elements of federal spending and revenues for reference. These results are displayed in Table 2, and show the following:

- Absent changes in other elements of federal spending or revenues, the growth in Medicare spending can largely be "accommodated" in the budget through savings in interest payments.
- However, by 2020, the federal budget would again face a deficit, even with the projected growth in Medicare rising 5.7 percent per beneficiary—the level currently projected over the next ten years. A balanced budget would require slower growth in Medicare, additional premiums from beneficiaries, slower growth in other federal spending or higher revenues.
- The budget would, however, remain balanced if the growth in spending per beneficiary were similar those in the BBA—4 percent per beneficiary (not shown).

TABLE 2.—PROJECTED FEDERAL REVENUES AND SPENDING, 2000–2020 AS A PERCENT OF GROSS DOMESTIC PRODUCT

	Year (in percent)—		
	2000	2010	2020
Receipts	21	20	20

TABLE 2.—PROJECTED FEDERAL REVENUES AND SPENDING, 2000–2020 AS A PERCENT OF GROSS DOMESTIC PRODUCT—Continued

	Year (in percent)—		
	2000	2010	2020
Expenditures	20	19	21
Consumption	5	4	4
Social Security	4	5	6
Medicare	3	3	4
Medicaid	1	2	2
Other	5	4	4
Interest	2	1	1
Deficit (-) or Surplus	1	1	−1

Source: Non-Medicare projections based on long-term budget projections from the Congressional Budget Office (1998).

II. POLICY OPTIONS FOR REFORMING THE MEDICARE PROGRAM

Federal policy concerning the Medicare program has repeatedly displayed its ability to slow the growth in Medicare spending at key points in the program's history. While the growth in private health insurance, largely due to the shift into managed care, was slower than Medicare spending between 1994 and 1999, Medicare spending will grow substantially slower than the private sector in 1999. Moreover, the projections from Table 1 indicate that Medicare is expected to grow slower than private health insurance over the next decade. This trend largely replicates the experience with Medicare and private insurance over the past twenty years—some years Medicare grows slower, others private insurance. With this in mind, two issues come to the forefront:

1. What structure and process should be used to keep the growth in Medicare similar to those projected, and similar to those in the private sector? How much should we rely on regulation, and how much on competition?

2. What specific changes should be made in the structure of the Medicare program to modernize it, and improve on the current set of services it currently offers?

A. Policy options for Medicare

1. Continue the implementation of the BBA proposals

The low rates of projected growth in the Medicare program assumes that the Department of Health and Human Services develops and implements several key changes in how the program pays for post-acute care benefits, and for hospital outpatient care. These new payment systems target the fastest growing portions of the Medicare program—the provision of post-acute care benefits. The successful implementation of these new program will have an important impact on the ability to control costs in future years.

2. Use competitive bidding to pay Medicare+Choice plans

The low rates of growth in Medicare are generated from the existing tools used to control fee-for-service (and by extension managed care) and several new prospective payment programs for post-acute care and hospital outpatient care. It is essential to assure the timely implementation of these new programs. In addition, several changes in how Medicare pays managed care plans could, and should be explored.

The Congress and Medicare should continue its push to move toward competitive prices in determining payments to Medicare+Choice plans. Competitive bidding offers several advantages to the current regulatory approach.

1. Premiums would be established at the plan service area instead of county by country. The plan service area better represents the network of physicians and hospitals in the managed care plan. Moreover, the broader market area will prevent plans from selecting which counties in their plan service areas to offer or not offer their services. The current county-based approach to plan payments invites such selection.

2. It would assure that the growth in premiums is linked to overall trends in the managed care market for the under-65 population.

3. Competitive bidding could result in slower growth in premiums compared to the overall average trend in private insurance noted earlier in my remarks. Whether competitive bidding would reduce further the expected growth in Medicare over the next decade is debatable, however. If we use the premium support model developed

by the National Bipartisan Commission on the Future of Medicare, our analysis of the FEHB suggests that premiums in health plans above the "average" bid would grow much slower than other health plans. Table 3 presents the results of our analysis of the FEHB during the 1990s.

TABLE 3.—AVERAGE ANNUAL GROWTH IN HEALTH INSURANCE PREMIUMS, ABOVE AND BELOW THE MAXIMUM FIXED DOLLAR FEHB CONTRIBUTION, 1991–1999

Year	Percent increase in premiums for plans above "target"	Average percent increase in premiums
1992	6.3	9.5
1993	3.9	8.1
1994	0	5.5
1995	−7.4	−2.7
1996	−5.7	−1.4
1997	−1.9	1.6
1998	1.4	6
1999	2	9.6

Target is defined as the maximum federal dollar contribution divided by 0.75.

One approach for speeding up the transition to competitive bidding in the managed care marketplace is to continue to push for the implementation of the Competitive Pricing Advisory Committee's recommendations (CPAC). The BBA directed the Department of Health and Human Services to design and implement four competitive pricing demonstrations based on the CPAC recommendations. The CPAC has made some important design decisions that could serve as the basis of a new Medicare+Choice payment system. These include:

- The standard benefit package should be enhanced beyond the Medicare package, and include a national minimum standard drug package (with a $500 cap and cost sharing).
- The use of a formal bidding process for setting payments to plans.
- Include all Medicare+Choice plans (except MSAs) in the program.

The CPAC recommendations represent an important blueprint for transitioning Medicare to a competitively bid Medicare+Choice program.

3. Modernize traditional Medicare

The traditional Medicare plan is modeled after plans developed over thirty years ago. Its cost sharing structure is antiquated, and the plan does not include an out of pocket cap. When compared to private health plans in today's market, the Medicare benefit structure is less generous than 90 percent of all private health insurance plans. Several steps could be pursued, at low or virtually no cost. Many of these provisions have already been recommended by the Bipartisan Commission on Medicare.

- Combine the part A and B deductibles (now set at $768 per benefit period and $100 for part B) into a single deductible—say $400 or so.
- Provide a full year of hospital coverage.
- Provide an out-of-pocket cap (say at $5000 or so).

Medicare also needs to add coverage for outpatient prescription drug coverage. However, even a modest drug benefit would cost $10 to $20 Billion per year. To accommodate these higher costs, traditional Medicare could implement a modest drug benefit, phased-in over a five to ten year period. The phase-in would start with the lowest-income beneficiaries, and eventually would be available to all Medicare beneficiaries. Costs of the program could be financed through slower growth in Medicare beyond 2002.

One positive aspect of these changes is the reduction in demand for and need of Medigap coverage.

4. Merge Parts A and B into a single program

While the Medicare program makes a clear distinction between the financing of HI and Part B services, it is less useful for public policies affecting the use of services. Episodes of care extend across both trust funds. Moreover, the growth in managed care in the program also makes the distinction between HI and Part B less important than the policy choices affecting the fee-for-service and Medicare+Choice program. The separate HI trust fund also diverts attention away from the key financial measures of the Medicare program—its impact on the budget and the budget

deficit. The funding sources for the program would continue to rely on a combination of payroll taxes, general revenues and premiums from beneficiaries.

5. Restructure long-term care

Though substantial attention has been paid to restructuring how Medicare pays Medicare+Choice plans and benefits under its fee-for-service program, restructuring long term care is perhaps the most important challenge facing the Medicare program. The number of persons requiring assistance due to physical, cognitive or other disabilities is expected to rise from 7 million today to over 15 million by the year 2030. Our current patchwork of programs funded through Medicare and Medicaid are not well positioned to meet the demographic challenges that await us.

One approach would establish a federal long-term care benefit, funded by Medicare and Medicaid. This would allow a national definition of eligibility, based on income and disability, replacing today's patchwork system. Several existing models, such as the Program of All-inclusive Care for the Elderly (PACE) could serve as a starting point.

Many of the changes noted above, particularly the phased-in drug benefit and the slight enhancements of the traditional Medicare benefit package could be financed through slower growth in spending beyond 2002. For instance, reducing the growth in Medicare spending per beneficiary from 5.7 percent to 5.2 percent after 2002 would finance the costs of the phased-in drug benefit. Even with this reduction, this rate of growth would still be higher (by a 0.5 percentage points) than the growth in spending developing from the BBA.

I thank you for the opportunity to share my thoughts, and would be happy to address any questions the Committee may have.

PREPARED STATEMENT OF BRUCE C. VLADECK

Mr. Chairman, Senator Moynihan, members of the Committee, I am Bruce C. Vladeck, Senior Vice President for Policy of Mount Sinai NYU Health and Professor of Health Policy and Geriatrics and Director of the Institute for Medicare Practice at the Mount Sinai School of Medicine. It is a privilege to have the opportunity to appear before you once again, although I hasten to emphasize that, not only am I here as an individual private citizen, but the views I will express are entirely my own, and not necessarily those of Mount Sinai NYU Health or the Mount Sinai School of Medicine. Indeed, it was a refreshing experience for me to be able to prepare my testimony for today without having to get anyone to clear it.

I'm especially pleased to be here today because it's just two years ago that I had the opportunity to work with many of you on the formulation of the Medicare and Medicaid provisions of the Balanced Budget Act of 1997. With each passing month, we are learning more and more about the effects of that legislation, which contained the most far-reaching changes to Medicare since the program's initial enactment in 1965. We should be very proud of what we accomplished, working together, but we need also to be clear-minded about the lessons to be drawn from the BBA and its effects. I would like to make some observations about that subject, followed by some comments about private health insurance which connect directly to the issue of proposals for adopting a so-called "premium support" approach to Medicare. It's certainly neither my desire nor my intention to use this opportunity of appearing before you to rehash the arguments we had during the proceedings of the National Bipartisan Commission on the Future of Medicare, but in the context of a broader discussion of Medicare reform it's necessary to set the record straight on a few critical points. Finally, I will conclude with a few more general observations on Medicare's place in the broader health system in this country.

To begin with the BBA, we should start by recognizing that, to the extent there ever was a real short-term problem in Medicare financing, it is now over. The most recent projection by the Medicare Trustees that the Hospital Insurance Trust Fund should remain solvent through 2015 represents the most optimistic forecast for the Fund in a generation. The HI Trust Fund, as you all know, is now taking in far more in receipts than it's paying out in benefits, and will do so for eight more years to come. And these results have been produced despite the fact that many large and important provisions of the BBA which have not yet been implemented will produce still further savings in the years ahead.

Second, we were able to achieve the enormous savings the BBA has produced almost entirely through the use of "traditional" measures, of the kind that have been used in the Medicare program for 25 years, without increasing financial risks to beneficiaries—and indeed, while fully paying for some significant new benefits. I'm not going to get into a long semantic argument about what constitutes "reform" and

what doesn't, but we have some proven approaches that have been working for years and appear to have more significant impacts now than they've had in the past, and whether that's "reform" or not it seems to do the trick. I would also remind all of you that most of these changes—I won't call them "reforms"—expire in 2002, and while it would probably not be prudent to assume that we could just extend them blindly, it's also hard to believe that similar mechanisms for reducing expenditures would never again be available in the future. We can go back to this well in the future, as we've done in the past.

Third, as with any legislation as complex and far-reaching as the Balanced Budget Act, experience is increasingly revealing technical changes or corrections that need to be made. I'm certainly not talking about wholesale undoing of the major savings provisions—to add substantial amounts of new money to provider payment would be to snatch defeat from the jaws of victory—but such technical changes as adjusting the date by which Medicare+Choice plans are required to file their ACRs; incorporating labor-market adjustments into the caps on TEFRA payments; removing the dollar cap on independently-supplied therapy services; incorporating a teaching adjustment in the prospective payment system for hospital outpatient services; and insuring that Disproportionate Share hospitals receive the full adjustments provided by the payment formula. I also believe that a significantly revised baseline should require reevaluation of empirical estimates for the Indirect Medical Education adjustment and the Sustainable Growth Rate for the Physician Fee Schedule.

But on a more global basis, we need to recognize how much the policies of the Balanced Budget Act have contributed not only to the long-term financial well-being of Medicare, but to that of the Federal budget as a whole, and give serious thought to the appropriateness of reinvesting some of the resulting surplus into the Medicare program itself—not, again, by undoing the savings, but by sharing them with the program's beneficiaries. While the impact of Medicare on health care providers, the federal budget, and all taxpayers must not be overlooked for one minute, we do need to remind ourselves that Medicare exists in the first place to serve its beneficiaries, and that many of those beneficiaries are experiencing very real hardships, in the midst of this remarkable economic boom, directly because of the program's limitations. Because of the savings we have achieved in Medicare itself, we should now have the wherewithal to begin paying for a decent prescription drug benefit at least comparable to that available to almost every other American with health insurance, especially since Medicare beneficiaries need such a benefit more than any other group in the population.

Finally, on the subject of the Balanced Budget Act, it is necessary to acknowledge how badly all of us underestimated its likely effects, and to derive some appropriate humility from that experience. I would remind the members of this Committee that, not only did CBO and OMB underestimate the Medicare savings in the BBA by many of tens of billions of dollars, but they also both predicted that as of today the federal government would still be operating at a deficit, and that the federal budget would not be balanced on a full-year basis until 2002. I remind you of this not to criticize the forecasters at CBO or OMB—who rank just behind HCFA's actuaries as the best in the world—but to raise the following question: If, for whatever reasons, we are having so much difficulty predicting macroeconomic trends from one quarter to the next, how can it be at all rational to undertake major changes in critical public programs that are essential to the lives of almost all Americans on the basis of twenty or thirty-year projections that are largely shaped by macroeconomic assumptions? Or to say it more succinctly, if in August, 1997, we guessed wrong about the state of the economy in 1998, how much confidence can we have in predictions for 2030?

THE PRIVATE HEALTH INSURANCE EXPERIENCE

Although you wouldn't know it from listening to the deliberations of the Bipartisan Commission or reading the literature on "premium support," private health insurance plans have been participating in Medicare for more than thirty years, and we have a considerable body of empirical evidence on that experience. The overwhelming proportion of beneficiaries enrolled in such plans appear to have been highly satisfied with them—but that's hardly surprising, since almost all beneficiaries in such circumstances have had the choice of enrolling or disenrolling at will, so that presumably those who didn't want to be in the plans either never enrolled in the first place or quit; in any event, the high level of overall satisfaction beneficiaries have expressed with private plans is not notably different from that they've expressed with "traditional" Medicare. Medicare beneficiaries' satisfaction with private managed care plans is also much higher than that reported for pri-

vately-insured enrollees, which should remind us once again how important uncoerced choice is to consumer satisfaction.

As best we can tell, the overall quality performance of private plans participating in Medicare has equaled or slightly exceeded that of the fee-for-service program, but there is considerable variation across plans, and within plans over time. In general, private managed care plans have outperformed fee-for-service Medicare in providing preventive services and access to office-based primary care, but have probably underprovided services for the chronically ill. Since to date most Medicare enrollees in private plans have been relatively healthy—or at least healthier, on the average, than fee-for-service enrollees—it's not unfair to suggest that the fewer services one needs, the more likely one is to be satisfied with a private plan.

Most importantly, for the purposes at hand, the evidence is overwhelming that, to date, participation of private health plans in the Medicare program has not saved the program a nickel. Indeed, prior to the changes enacted in the Balanced Budget Act, the evidence was entirely clear that, on average, it cost Medicare 5 to 7% more when an enrollee left fee-for-service to join an HMO. Even with the payment changes already made under the BBA, that's why timely implementation of even relatively crude forms of risk adjustment in Medicare+Choice payments is so essential.

The economic performance of private plans in Medicare should not be at all surprising when one considers that private health insurance costs in the private market, presumably unaffected by Medicare's particular payment practices, have increased, during the life of the Medicare program, at an average rate of one percent per year faster than Medicare costs. Much of the debate over Medicare reform in the last several years has clearly been distorted by the experience of 1992–1997, when private health insurance costs grew at historically atypical low rates, and Medicare costs grew much faster (although the increase in Medicare costs in that period was largely driven by payments for post-acute services, which private insurers purchase much less of than Medicare does). But since the BBA that situation has reversed. The most recent news reports include a prediction from Hewitt Associates that private premiums are expected to increase by about 7% this year—as compared to about half that rate for Medicare—while CalPERS has announced that it expects its premiums to increase almost 10% next year, on top of an increase of more than 7% this year. One thing I can predict with confidence is that it won't be long until this Committee begins to hear again—as we did in the 1980s—complaints from providers about "cost shifting" from Medicare to private payers, since Medicare is paying so much less.

I can also predict that you will hear testimony tomorrow—as you have already over the past year—from private plans to the effect that, unless you increase the amount of money Medicare is planning to pay them, they will reduce or cease altogether their participation in the Medicare program. The comings and goings of particular suppliers are, of course, one of the characteristics of real competitive markets (and of the Federal Employees Health Benefits Plan, from which almost 20% of participating plans dropped out in the last year), but I just want to suggest that anyone who both gives credence to those complaints and still defends the notion that greater private plan participation will save Medicare money is simultaneously believing two contradictory arguments.

In the face of all this evidence, I am personally left somewhat puzzled about where all the enthusiasm for promoting Medicare reform through a "premium support" approach is coming from. I have three hypotheses. The first concerns my colleagues in the academic and policy analysis communities, who seem always to prefer theoretical elegance to empirical reality. The operative rule seems to be: when the theory and the facts conflict, deny, distort, or explain away the facts. Thus, there's no question that, in theory, creation of a competitive market in health insurance should reduce the rate of increase in health insurance costs. The facts that no such market has ever existed, that it is probably impossible to create one, and that the sources of market failure in health insurance are well-defined, well-recognized, and probably inescapable, tend to get ignored. For those of you who haven't caught on yet, "premium support" is just the newest, Medicare-specific version of so-called "managed competition" which many of you found so far-fetched and disconnected from reality when it was the core of the Clinton Administration's health plan.

My second hypothesis emerges from a recognition that many of those who are now promoting a "premium support" approach to Medicare reform are the same folks who voted in 1995 to convert Medicare from a defined benefit to a defined contribution program, although they all strenuously deny that "premium support" is a defined contribution—and in fact it technically isn't, at least in its current garb. But it would have the same effect on beneficiaries: putting them at financial risk for cost increases in excess of some easily-manipulated formula, and at clinical risk by leav-

ing the determination of how they are to receive the benefits to which they are entitled to profit-maximizing private firms that simply can not be held to the same level of accountability as a public agency. More concretely, I still can't understand how a premium support plan would save the Medicare program any money other than by transferring costs to beneficiaries, which is of course exactly what's wrong with a defined contribution approach.

My final hypothesis for why anyone would encourage "premium support" arises from the generally laudable instinct of people, especially in this city, who feel a need to respond to a crisis—real or perceived—by doing something, even if that something is unlikely to make things better. To the extent that Medicare really did face a financial crisis in the near-term future, premium support would constitute something to do, even if it wouldn't work, that would provide its proponents a defense against any accusations of complacence, or indifference. In that regard, whether or not premium support would actually ever do anyone any good becomes largely irrelevant.

THE REAL HEALTH-CARE CRISIS

That leads me, Mr. Chairman, to the final set of observations I would like to make this morning, which are drawn not from my experience in this city but rather from what I am seeing and working with back in my home town since I returned to the private sector. We are extremely concerned about the impact of the Balanced Budget Act on health care in New York and other major cities, but it's important that you understand where that concern is coming from. For Medicare is the one island of stability and reliability in a health care system that is otherwise unraveling before our eyes. In New York City at the moment, in the midst of extraordinary prosperity brought about by the boom in the securities and communications industries that are centered here, fully one in four non-elderly residents has no health insurance at all. That number includes several hundred thousand who are legally entitled to Medicaid but who, because of the administrative and organizational effects of welfare reform, are not enrolled. The shrinking private health insurance market is now entirely dominated by managed care plans which, we must acknowledge, are tough bargainers on payment rates, but at the moment we are more concerned with legislative and legal efforts to insure that those plans pay their bills at all. One's ability to negotiate a favorable rate with a private insurer doesn't do much good if that insurer defaults, goes out of business, or simply loses its claims in an inadequate computer system—all phenomena with which we have been grappling in the very recent past. As the number of uninsured people continues to increase, subsidies for uncompensated care continue to diminish.

Every community is different, but New York City is not unique on any of these dimensions. If it were not for Medicare, in its existing configuration, the health care delivery system would collapse altogether.

From this point of view, Medicare is thus the only major component of our health care financing system that isn't broken. Given the extraordinary efforts of this Committee and others, less than two years ago, to change Medicare, and given all the other problems in the health care system that fall within the jurisdiction of this Committee, I would therefore respectfully suggest that we turn our energy and attention to those places where the problems are most acute. Let's focus on fixing what is broken in the health care system, not on tinkering with what works.

Again, I appreciate the opportunity to appear before you, and I'd be happy to try to answer any questions you might have.

PREPARED STATEMENT OF JOHN E. WENNBERG, M.D., M.P.H.

My name is John Wennberg, and I am a member of the faculty of Medicine at Dartmouth College. I have been asked to comment on how Medicare varies from one part of the country to another, and what are the implications for Medicare reform. Over the past few years, my colleagues and I have studied geographic variations in the health care services provided to Medicare enrollees throughout the United States. The findings, in the form of the Dartmouth Atlas of Health Care series, has been published by the American Hospital Association. I have included a synopsis of our principal findings: Exhibits One through Four. Let me briefly summarize them.

It is by now well known that, on a per-enrollee basis, spending varies substantially among regions in the United States, even after adjustment for differences in illness and price. For example, in 1995, Medicare spending for fee-for-service medicine was about 2.1 times greater for residents of the Miami region than for enrollees living in Minneapolis. To understand the implications of this variation for the Medi-

care program, we need to know what additional Medicare spending buys and whether more is better.

The most recent edition of the Dartmouth Atlas examines whether areas that spend more also offer better quality. By quality, I mean the appropriate use of effective services, the avoidance of services with dubious or no value, and broad-based agreement across regions about appropriate care. The results challenge the view that regions with higher levels of per capita spending provide higher quality care. Indeed, the opposite may be the case.

THE UNDERUSE OF EFFECTIVE CARE (EXHIBIT ONE)

There is massive underuse of services which have been proven effective in preventing illness and even death. Most of these services cost very little, and it is a tragedy that in so many cases they go undone. The numbers of mammograms provided to Medicare women age 65 to 69 is less than half the rate recommended by the U.S. Preventive Services Task Force. There are similar patterns of underuse of immunizations, screening for colon cancer, eye exams for diabetics and the use of life-saving drugs for patients who have had heart attacks.

The irony is that more resources doesn't mean better performance: there is no correlation between the use of these services and the local supplies of primary care doctors, medical specialists, access to care, or measures of continuity of care. Nor does more Medicare spending cure underservice. The problem is the organization—or disorganization—of medical practice.

THE QUALITY OF CARE IN THE LAST SIX MONTHS OF LIFE (EXHIBIT TWO)

Although there is substantial underuse of services that prevent serious illness and death, the acute and chronically ill receive significant over-intensity of care in many regions of the United States. The intensity of care received depends on where the patient happens to live, not on the patient's preferences or the power of care to extend life. This is dramatically illustrated in the remarkable variation in the American experience of death. For example, the likelihood of being admitted to an ICU in the last six months of life ranged from less than 15% in regions like Sun City, Arizona, to more than 45% in areas like Los Angeles. The average number of visits to physicians during this period of life ranged from about 10 in Salt Lake City to 43 in Ridgewood, New Jersey. Medicare spending in the last six months of life varies markedly, and is highly correlated with the overall pattern of Medicare spending. Spending, in turn, is correlated with local supply of resources.

But more Medicare spending does not translate into longer, or better, life. Communities that use more resources, such as intensive care admissions or physician visits, do not appear to have improved life expectancy as a result. In terms of return of its investment in Medicare spending, the nation is, at best, on the flat of the cost-benefit curve. Indeed, when the quality of life is factored in, some would conclude that we have a substantially negative return on money spent.

SURGERY, MEDICAL SCIENCE AND PATIENT PREFERENCES (EXHIBIT THREE)

Surgery rates for most procedures vary extensively from regions to region. Part of the problem is poor clinical science: failure to evaluate the outcomes of care means substantial disagreement and controversies exist concerning what actually works. The debates about the value of autologous bone marrow transplants for breast cancer and radical surgery for prostate cancer are examples.

But the more fundamental problem behind the variations in surgery is the question of what patients want. For example, a previous edition of the Dartmouth Atlas showed that the use of lumpectomy for breast cancer ranged from less than 2% to 48% of all women having breast cancer surgery. The likelihood of undergoing surgery for cancer of the prostate varied more than ten-fold among hospital regions. In both of these examples, the choice of treatment should depend on the needs and preferences of the individual patient. Under the current strategy for allocating surgery, which depends largely on the physician's opinion, such preferences are all too often ignored.

What is the real demand for many common surgical procedures? If patients were informed about the risks and benefits of available treatments and were actively involved in the decision making process, surgical rates would be based on patient choice among the appropriate options rather than the preferences of individual physicians or the recommendation of panels of experts geared toward the "average" patient.

If we were to implement shared decision making nationally, I expect that the amount of surgery and the cost of surgery would decline. Several studies have found that the level of demand for surgery that results from shared decision making is

different—and sometimes substantially less than—the level of demand in circumstances where patients are not involved. Exhibit Three includes evidence that for some procedures, the amount of surgery that informed patients want is lower than that the prevailing rates in almost every region of the country.

MEDICARE EQUITY

The variations in spending also pose a problem in geographic equity. Why should residents living in low cost regions subsidize, through their premiums and payroll taxes, the care of those in high cost regions? In fee-for-service medicine, these transfer payments from low cost to high cost regions have been more or less invisible. However, if the Medicare benefit structure is changed from a defined benefit to a defined contribution plan, the continued willingness of government to spend more on residents living in high cost regions will become highly visible because health plans operating in such regions can offer more benefits, for example, a generous pharmacy benefit.

MEDICARE REFORM AND THE QUALITY OF CARE (EXHIBIT FOUR)

I believe this Committee's deliberation over the future of Medicare should include a thorough debate over the equity, effectiveness and efficiency of the current Medicare program and how to improve it. The quality of care is not greater in regions with greater Medicare per capita spending. Promoting the appropriate use of effective services; reducing the use of medical interventions of dubious or no value; and assuring that the use of discretionary services is based on the patient's own wants and values would reduce geographic variations, improve the quality of care and save enough money to maintain the solvency of the Trust Fund. Indeed, if vigorously pursued, measures to improve the quality of care might also provide the extra funding Medicare needs to pay for a supplemental drug benefit.

SUMMING UP

- First, more spending does not guarantee better-quality health care.
- Second, more money is being spent in the Medicare program than is supported by scientific evidence.
- Third, more spending in a region does not improve the Medicare population's life expectancy.
- Fourth, at least for some conditions, more elective surgery is performed than informed patients want.
- Fifth, promoting the appropriate use of effective services; reducing the use of medical interventions of dubious or no value; and assuring that the use of discretionary services is based on the patient's own wants and values would improve health care quality, save enough money to maintain the solvency of the Trust Fund, and, perhaps, provide the extra funding for Medicare to pay for a supplemental drug benefit.

United States Senate Committee on Finance
Hearing on Medicare:

Its Context and Evolution

Wednesday, April 28, 1999

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Wennberg Exhibits for 4/28/99 Testimony

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LIST OF EXHIBITS. (All are excerpts from the Dartmouth Atlas Series)

Exhibit 1 – Underuse of Effective Medical Care

Exhibit 2 – The Quality of Care in the Last Six Months of Life

Exhibit 3 – Practice Variations and the Quality of Surgical Care for Common Conditions

Exhibit 4 – Summing Up: Inefficiency in the Allocation of Medicare Spending

Exhibit 1

Underuse of Effective Medical Care

Underuse represents a failure to provide diagnostic tests, preventive services and treatments that are proven effective in improving health status. The 1999 edition of the Atlas and related studies confirm several of the findings of underuse cited in the Roundtable's report. Among hospital referral regions, there are striking variations in Medicare enrollees' use of:

- Immunizations of demonstrated efficacy in preventing pneumonia (Chapter Four);
- Tests and drugs widely believed to reduce complications in patients with diabetes (Chapter Four);
- Treatments proven effective in lowering mortality rates of patients with heart attacks (below).

For services such as these, there can be little debate over the question, Which rate is right? The interventions are known to be effective, and the benefits far exceed associated risks. Moreover, Medicare enrollees want these benefits. The right rate — the "best practices" benchmark — is the rate when all eligible patients are provided with appropriate care. In actual practice, there is evidence of extensive waste of the opportunity to prevent serious illness (Figures 7.1 and 7.2).

Why is there underuse of services that work — and that patients want — in a nation so amply endowed with medical resources? Underuse cannot be explained by an inadequate supply of either primary care physicians or specialists, because underservice is prevalent in hospital referral regions with both high and low supplies of all these resources. Nor is underuse related to access to physicians or the continuity of ambulatory care (Chapter Four). If undersupply is not the cause of underuse, then spending more is not the cure for the problem (Figure 7.4). There is little consistency in the quality of performance; regions that approach the standard for "best practice" for one preventive service commonly do notably poorly in other measures. Performance seems to vary in an idiosyncratic way, reflecting local physicians' opinions and practice styles (Figure 4.9). The extent of underuse, and the haphazard nature of compliance with recommended guidelines, indicate there is substantial opportunity to improve the quality of care by improving the process by which preventive and therapeutic services are delivered.

Exhibit 1

Screening for Breast Cancer

The United States Preventive Services Task Force recommends routine mammographic screening every one or two years for women age 50 to 69. Clinical trials provide convincing evidence of the effectiveness of this screening in reducing mortality from breast cancer. The Task Force found that there was not enough evidence to recommend universal screening for women over age 69, but opined that healthy women age 70 and over might benefit from routine mammography.

The frequency of mammography among female Medicare enrollees between 65 and 69 fell considerably short of the Task Force's recommendation in 1995-96. The two year rate of mammography in the United States was 28.3%, and varied by a factor of more than four, from less than 12.5% to over 50%.

There were interesting regional patterns of variation: women in the Northeast, Florida and Michigan were much more likely to receive mammography than women elsewhere. In every hospital referral region in Michigan, the mammography rate was substantially higher than the national average. Rates were higher than 40% in ten hospital referral regions, six of them in Michigan, including Traverse City (50.1%); Petoskey (45.2%); and Flint (43.1%). The higher than average rates of mammographic screening in all Michigan hospital referral regions might be the result of local outreach efforts spearheaded by the Centers for Disease Control's National Breast and Cervical Cancer Early Detection Program, in which a principal aim was to increase the use of mammography among the elderly.

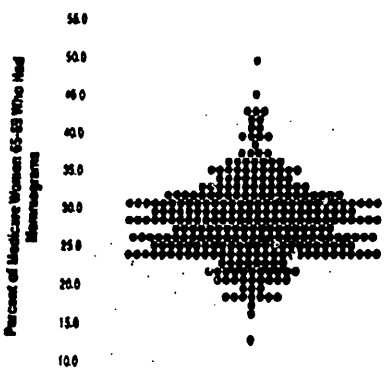
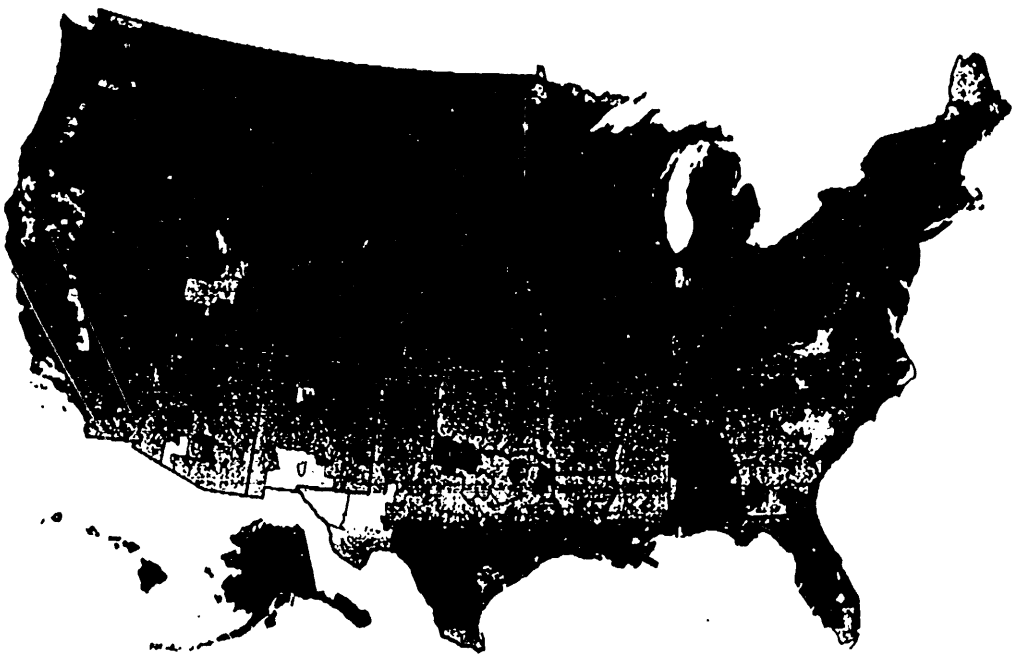


Figure 4.2. Percent of Medicare Women Age 65-69 Who Had Mammograms at Least Once in a Two-Year Period (1996-96)

The target screening rate of the U.S. Preventive Services Task Force is one mammogram every one to two years for women between 65 and 69. Actual rates of screening ranged from less than 15% to 50%. Each point represents one of the 306 hospital referral regions in the United States.

Exhibit 1



Map 4.2. Percent of Medicare Women Who Had Mammograms (1995-96)
Rates of mammography were high among female Medicare enrollees in Michigan, in the Northeast, and in Alabama and Florida. Rates of mammography among eligible women were lower in parts of the Southeast and in several areas in the Southwest.

Percent of Medicare Women Age 65-69 Who Had Mammograms
by Hospital Referral Region (1995-96)

- 40 or More (10)
- 30 to < 40 (99)
- 20 to < 30 (184)
- 10 to < 20 (13)
- Less than 10 (0)
- Not Populated

Annual Eye Examinations for Diabetics

In people with both insulin-dependent and non-insulin-dependent diabetes, randomized trials have confirmed that yearly retinal exams and treatment of eye disease reduce the risk of blindness. The Diabetes Quality Improvement Project recommends annual eye exams. In 1995-96, all hospital referral regions fell well short of the guideline recommendation for annual eye examinations for Medicare enrollees who were diabetics. Compliance with the guideline varied by a factor of more than 2.5, from 25.1% to 66.1%.

Among the hospital referral regions with higher than average rates of annual eye examinations for diabetic Medicare enrollees were Fort Lauderdale, Florida (66.1%); Worcester, Massachusetts (62.1%); Ormond Beach, Florida (60.2%); Hudson, Florida (59.9%); and Sarasota, Florida (59.6%).

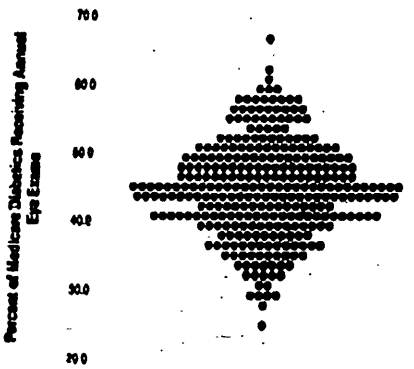
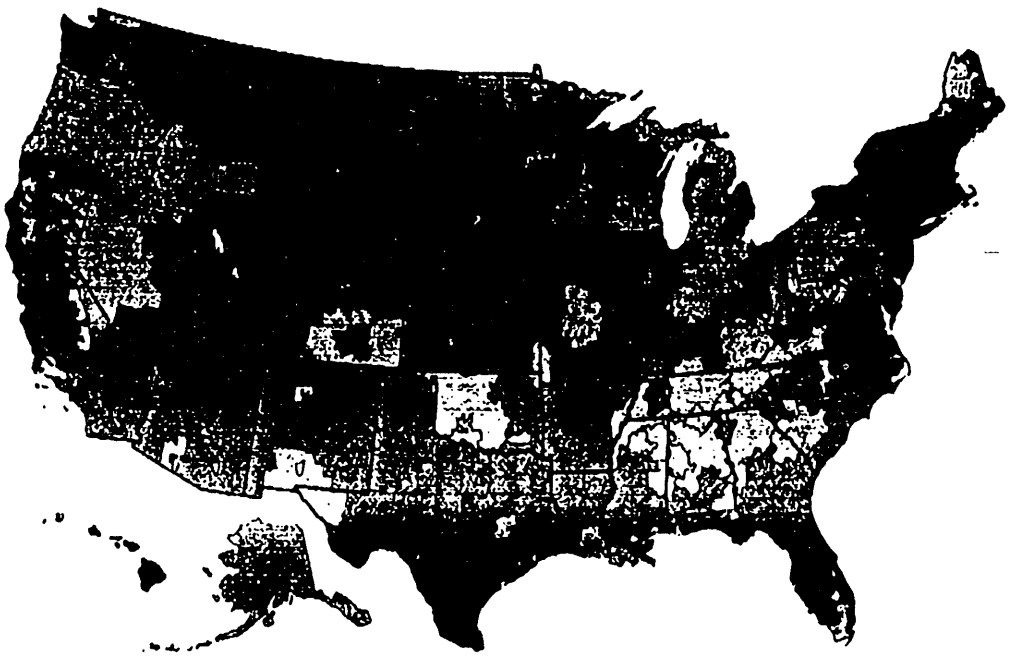


Figure 4.4. Percent of Diabetic Medicare Enrollees Receiving Annual Eye Examinations (1995-96)

The Diabetes Quality Improvement Project recommends annual eye exams for all diabetics. Actual rates of compliance with the guideline ranged from 25% to 66%. Each point represents one of the 306 hospital referral regions in the United States.

Among the hospital referral regions with lower than average rates of annual eye exams for diabetic Medicare enrollees were Terre Haute, Indiana (25.1%); Johnson City, Tennessee (27.5%); Portland, Oregon (28.5%); Bloomington, Illinois (28.5%); and Petoskey, Michigan (28.9%).

Exhibit 1



Map 4.4. Percent of Diabetic Medicare Enrollees Receiving Annual Eye Examinations (1995-98)

Compliance with the guideline for annual eye examinations was less than 60% in all but three hospital referral regions. Compliance was lowest in the East South Central states, parts of the Midwest and Texas, and in Oregon and Western Nevada.

Percent of Diabetic Medicare Enrollees Receiving Annual Eye Examinations
by Hospital Referral Region (1995-96)

- 80 or More (0)
- 60 to < 80 (3)
- 40 to < 60 (232)
- 20 to < 40 (71)
- Less than 20 (0)
- Not Populated

San Francisco | Chicago | New York | Washington-Baltimore | Detroit

Exhibit 1

Capacity of the Health Care System and Use of Screening and Preventive Services

What is the relationship between the capacity of the health care system to provide preventive services and the outcomes of care, measured by the use of services of known effectiveness? What is the relationship between measures of access, continuity of care, and outcomes?

The supply of primary care physicians in 1996 varied from fewer than 34 physicians per 100,000 residents of the McAllen, Texas hospital referral region, to more than 105 per 100,000 residents of White Plains, New York. But the supply of generalist physicians was essentially uncorrelated with the frequency of use for any of the screening and preventive services recommended by the United States Preventive Services Task Force and the Diabetes Quality Improvement Project (Table 4.2). In simple correlation analysis, there was virtually no association between the level of the generalist physician workforce and use of mammography (R^2 = .06); pneumococcal vaccination against pneumococcal pneumonia (R^2 = .00); or eye examinations for diabetics (R^2 = .05); and little relationship with screening for colorectal cancer (R^2 = .13).

The supply of specialist physicians in 1996 ranged from 53 per 100,000 residents of the McAllen, Texas hospital referral region, to 227 per 100,000 residents of White Plains, New York. As with generalist physicians, the supply of specialists was generally uncorrelated with the frequency of use of preventive services recommended by the United States Preventive Services Task Force and the Diabetes Quality Improvement Project. There was virtually no association between the level of the specialist physician workforce and use of mammography (R^2 = .03), pneumococcal vaccinations (R^2 = .00), or eye examinations for diabetics (R^2 = .08); and only a modest relationship between the supply of specialists and rates of colorectal screening (R^2 = .19).

Access to care, as measured by the percent of Medicare enrollees living in a region who had one or more visits to a doctor in calendar year 1995, was only weakly related to use of mammograms (R^2 = .18) and pneumococcal vaccinations (R^2 = .14), and had very little correlation with the frequency of eye examinations among diabetics (R^2 = .03).

An index of the continuity of ambulatory care measures the proportion of patients who see a single physician for the majority of their ambulatory care visits. Continuity of care, measured by the percent of patients in a region who receive at least 50% of their ambulatory care visits from one physician, also bore little relationship to the rates of use of preventive services. There was an inverse relationship between continuity of care and use of mammography, screening for colorectal cancer, and blood lipids testing for diabetics.

Immunization for Pneumococcal Pneumonia (1995-96)	0.00	0.00*	0.14	0.00
Screening for Breast Cancer (Age 65-69) (1995-96)	0.08	0.03	0.18	0.07*
Screening for Colorectal Cancer (1995-96)	0.13	0.19	0.08	0.20*
Eye Examination (Diabetics) (1995-96)	0.05	0.08	0.03	0.13*
HgbA1c Testing (Diabetics) (1995-96)	0.03	0.04	0.01*	0.05*
Blood Lipids Testing (Diabetics) (1995-96)	0.05	0.21	0.02	0.30*

*indicates inverse association (negative correlation coefficient)

Table 4.2. The Relationships Between the Supply of Generalist and Specialist Physicians, Access to Care, and Continuity of Care and the Frequency of Use of Recommended Preventive Services (R^2 Values) (1995-96)

There was little relationship between the supply of specialist and generalist physicians and access to care, continuity of care, and the use of preventive services. The strongest positive correlation was between the supply of specialist physicians and the rate of blood lipids testing (R^2 = .21); no correlation at all was found between the supply of physicians (generalists or specialists) and the rate of compliance with guidelines for pneumococcal pneumonia vaccination (R^2 = .00). There was a moderately strong inverse correlation between measures of continuity of care and the rate at which diabetics received recommended blood lipids testing (R^2 = .30).

More Medicare Spending Does Not Cure Underservice

The Dartmouth Atlas series has focused on the wide geographic variations in both underservice and variations in overall Medicare resources and utilization. But do areas that have larger per capita expenditures also provide better quality care? This is obviously a complicated and multidimensional question, and we cannot entirely resolve it. However, we can ask whether there is a relationship between areas with higher per capita Medicare expenditures and the rates at which enrollees receive appropriate and recommended screening tests. Figure 7.4 shows per capita Medicare spending by hospital referral regions, adjusted for age, sex, race, regional price levels, and illness burden (on the horizontal axis). The vertical axis is an index of underservice: the average proportion, by hospital referral region, of Medicare enrollees who (1) received immunizations for pneumococcal pneumonia; (2) had at least one mammogram (women age 65-69); (3) were screened for colorectal cancer; and (4)the proportion of diabetics receiving annual eye examinations; (5) the proportion of diabetics receiving glucose (Hgba1c) screening; and (6) the proportion of diabetics receiving LDL blood lipids testing. A score of 100 would mean that each eligible person had received the appropriate screen or tests; a score of zero would mean that no eligible person received the recommended preventive care. A higher index is indicative of better compliance with the guidelines for preventive and screening services.

Figure 7.4 demonstrates that there was no correlation between overall Medicare spending in hospital referral regions and the index of the quality of preventive services (R^2 = .01). It appears that, even in areas that spent up to $3,000 per capita more than other regions, the quality of preventive care was no better (and very slightly worse) than in regions with lower per capita lower spending.

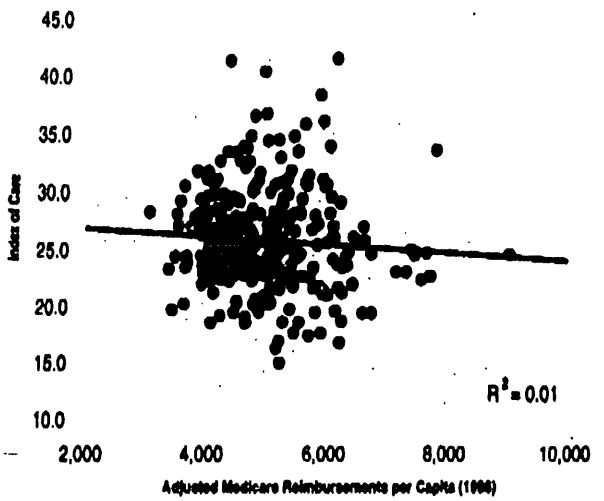


Figure 7.4. The Association Between Age, Sex, Race, Price and Illness Adjusted Medicare Spending (1996) and the Quality of Preventive Care (1995-96)

The vertical axis gives the values for the quality of care index (see text); the horizontal axis gives the fully adjusted Medicare per capita spending. There was little association between spending level and the quality of preventive care ($R^2 = .01$).

Exhibit 2

The Quality of Care in the Last Six Months of Life

The quality of medical intervention is often more a matter of the quality of caring than the quality of curing, and never more so than when life nears its end. Yet medicine's focus is disproportionately on curing, or at least on the ability to keep patients alive with life-support systems and other medical interventions. This ability to intervene at the end of life has raised a host of medical and ethical issues for patients, physicians, and policy makers.

The Dartmouth Atlas demonstrates that, to the extent that end of life issues are addressed in practice, they are resolved in ways that depend on where the patient happens to live, not on the patient's preferences or the power of care to extend life. The American experience of death varied remarkably from one community to another in 1995-96:

- The chance that the decedent was an inpatient in an acute care hospital at the time of death varied by a factor of 2.8, from less than 20% to almost 50%.

- The chance of being admitted to an intensive care unit at the time of death varied by a factor of 4.6, from 6.3% to almost 30% of all deaths.

- Time spent in intensive care varied substantially. In some regions, more than 20% of patients spent a week or more in intensive care units during their last six months of life; in other regions, less than 4% did.

The intensity of care in the last six months of life also varied remarkably in 1995-96:

- The number of visits to physicians varied by a factor of 5.6, from an average of less than nine to almost 50.

- The number of physicians involved in patients' care varied substantially. In some regions more than 30% of patients saw ten or more physicians during their last six months of life; in other regions fewer than 3% were treated by that many different physicians.

Exhibit 2

■ Price adjusted reimbursements by the Medicare program for inpatient care during the last six months of life varied by a factor of three, from about $6,200 to almost $18,000 per decedent.

Like other medical decisions, end of life decisions about the use of resources are influenced by the available supply of acute care hospital resources and by individual physicians' practice styles. But is more better? The intensity of care in the last six months of life is an indicator of the propensity to use life saving technology. The question of whether more medical intervention is better must be framed in terms of the potential gain in life expectancy for populations living in regions with greater intensity of intervention. Research conducted in conjunction with the Atlas project provided evidence that populations living in regions with lower intensity of care in the last six months of life did not have higher mortality rates

More than 80% of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness, but those wishes are often overridden by other factors. If more intense intervention does not improve life expectancy, and if most patients prefer less care when more intensive care is likely to be futile, the fundamental question is whether the quality of care in regions with fewer resources and more conservative practice styles is better than in regions where more aggressive treatment is the norm.

The Likelihood of Being Admitted to an Intensive Care Unit During the Last Six Months of Life

The chances that the last six months of a Medicare enrollee's life included at least one stay in an intensive care unit varied by a factor of more than three. In one region, less than 15% of Medicare enrollees who died were admitted one or more times to intensive care units (including coronary intensive care) during their last six months of life; in other regions almost one-half of enrollees were admitted to intensive care at least once during their last six months of life.

In 18 hospital referral regions, the likelihood of one or more admissions to intensive care during the last six months of life was greater than 40%, including Miami (49.3%); Munster, Indiana (48.7%); Los Angeles (45.8%); St. Petersburg, Florida (44.2%); Beaumont, Texas (43.9%); and Newark, New Jersey (43.9%).

In ten hospital referral regions, the likelihood of admission to intensive care during the last six months of life was less than 20%, including Sun City, Arizona (14.2%); Bloomington, Illinois (15.2%); Bend, Oregon (16.6%); Wausau, Wisconsin (16.9%); Mason City, Iowa (16.9%); and Grand Junction, Colorado (17.4%).

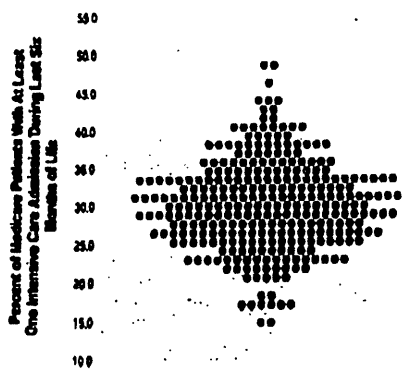
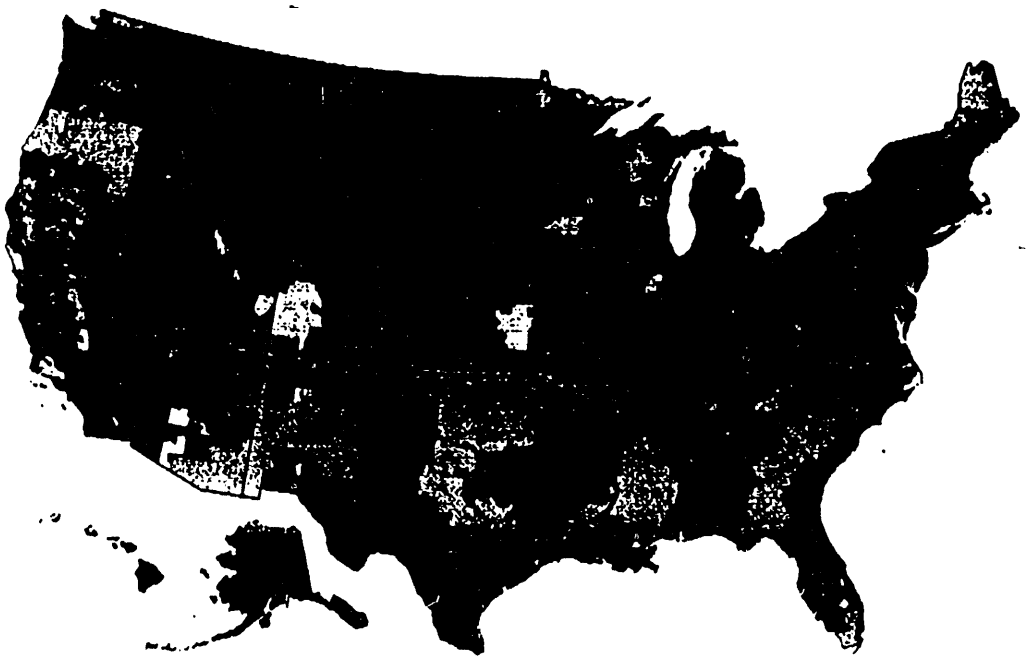


Figure 6.3. Percent of Medicare Enrollees Admitted to Intensive Care During the Last Six Months of Life (1995-96)

The percent of all Medicare decedents who were admitted to intensive care units at least once during their final six months, after adjusting for differences in age, sex, and race, ranged from less than 15% to almost 50%. Each point represents one of the 306 hospital referral regions in the United States.

Exhibit 2



Map 6.2. Percent of Medicare Enrollees Admitted to Intensive Care During the Last Six Months of Life (1995-96)

The likelihood of at least one admission to intensive care during the last six months of life was generally higher in the Eastern and Southern United States than in the Western and Northwestern states.

Percent of Medicare Enrollees Admitted to Intensive Care During the Last Six Months of Life

by Hospital Referral Region (1995-96)

- 40 or More (18)
- 30 to < 40 (137)
- 20 to < 30 (141)
- 10 to < 20 (10)
- Less than 10 (0)
- Not Populated

San Francisco | Chicago | New York | Washington-Baltimore | Detroit

Physician Visits During the Last Six Months of Life

Although people in the last six months of their lives are generally quite sick, the intensity of physician care that Medicare enrollees in their last six months of life were likely to receive, as measured by the average number of visits to physicians, varied from fewer than nine visits per decedent to almost 50. The national average was 24.4. About 90% of physician visits in the last six months of life were with either primary care physicians or medical specialists; surgeons were visited much less frequently.

The average number of physician visits during the last six months of life was almost double the national average among residents of the Miami hospital referral region (47.9). Rates of visits were also high in the New York-Northern New Jersey metropolitan area, including Newark, New Jersey (45.5); Ridgewood, New Jersey (43.0); New Brunswick, New Jersey (42.4); Paterson, New Jersey (42.2); East Long Island, New York (40.0); and Manhattan (39.4).

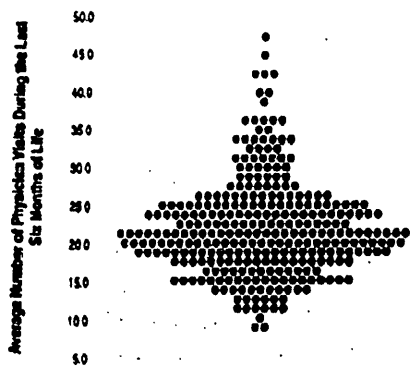
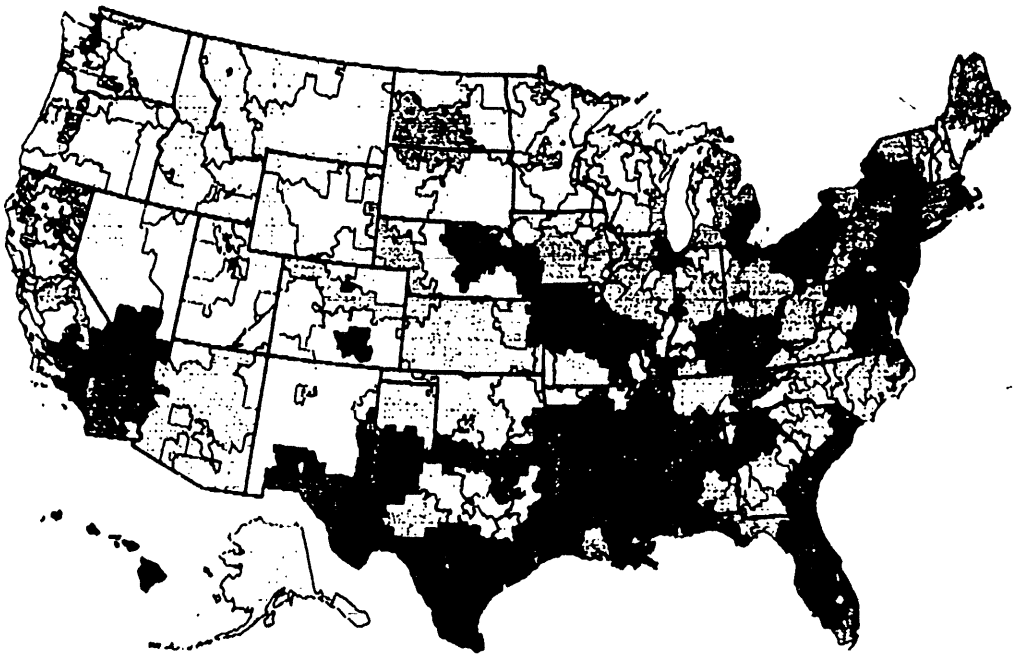


Figure 6.6. Average Number of Physician Visits per Decedent During the Last Six Months of Life (1995-96)

The number of physician visits during the last six months of life varied by a factor of about five, from fewer than 10 to almost 50, after adjustment for differences in population age, sex, and race. Each point represents one of the 306 hospital referral regions in the United States.

Dying residents of other hospital referral regions were much less likely to make multiple visits to doctors during the last six months of life. Hospital referral regions where rates of visits were low included Grand Junction, Colorado (8.5); Ogden, Utah (8.6); Salt Lake City (10.9); Mason City, Iowa (11.0); and Salem, Oregon (11.0).

Exhibit 2



Map 6.5. Physician Visits During the Last Six Months of Life (1995-96)
Rates of physician visits during the last six months of life were higher than the national average in the Eastern United States, and lower in the West and Northwest. Rates were at least 30% higher than the national average in 27 hospital referral regions, most of which were in Florida, New York, New Jersey, Texas and California.

Ratio of Rates of Physician Visits During the Last Six Months of Life to the U.S. Average
by Hospital Referral Region (1995-96)

- 1.30 to 1.97 (27)
- 1.10 to < 1.30 (27)
- 0.90 to < 1.10 (85)
- 0.75 to < 0.90 (91)
- 0.34 to < 0.75 (76)
- Not Populated

San Francisco | Chicago | New York | Washington-Baltimore | Detroit

Exhibit 2

How Effective Is Medicare Spending in the Last Six Months of Life?

There were wide differences in the treatment provided to people who spent their last six months of life during 1995-96. Did the greater intensity provided in some hospital referral regions actually save lives, or increase the survival of the elderly sick? At the very heart of the question is the economics of the end of life, and the question, What are we getting for our investment in the very aggressive care provided to some members of the Medicare population?

Answering this question is complex, since sicker people might be expected to account for more health care spending, and also are more likely to die. But the treatment of people in their last six months of life is an excellent marker for the treatment being given to everyone in the Medicare population who is seriously ill. For example, there was a strong relationship between the intensity of inpatient health care spending in the last six months of life and average per capita Medicare reimbursements for all enrollees (Figure 6.13).

Despite the fact that this indicator of intensity of care is highly correlated with overall per capita spending among the Medicare population, it is not closely associated with standard measures of health status, such as population-based rates of acute myocardial infarction, stroke, and hip fracture. In other words, how people are treated in the last six months of their lives is a good indicator of the overall intensity of medical intervention in the population, but it does not reflect the underlying level of illness or sickness.

In turn, the intensity of care, while raising spending, does not appear to have had an impact on the overall mortality level of the community. Regions providing more intensive levels of medical interventions to the elderly sick yielded no discernible improvement in life expectancy, suggesting that the United States might be on the "flat of the curve" in terms of the relationship between spending (inputs) and survival (outputs).

Simply measuring mortality does not capture the entire spectrum of possible benefits of end of life spending. The quality of health care includes more than the ability to prevent or postpone death; it also includes the capacity to improve the quality of life. While the extra resources devoted to health care intensity in some regions might provide comfort, if not life extension, to the population of people who are near death, it is unclear by what measure or mechanism more intensive acute care per capita resulted in improved quality of care at the end of life.

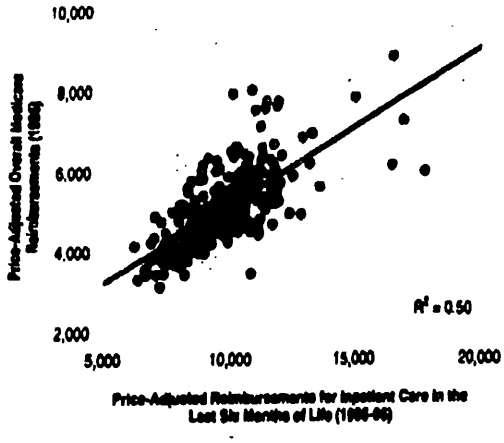


Figure 6.13. The Association Between Inpatient Medicare Spending in the Last Six Months of Life and Overall Per Capita Spending in the General Medicare Population (1995-96)
The intensity of care in the last six months of life, measured by Medicare Part A spending, is closely correlated with overall Medicare per capita spending (Part A and B) for the entire Medicare population.

Exhibit 2

Capacity, Patient Preferences and the Likelihood of a Hospitalized Death

Quality medical care includes respect for the patients' preferences about the end of life. There is growing concern in the United States about the quality of how we die. In two Gallup polls, one in 1992 and a second in 1996, nine out of ten Americans said they would prefer to be cared for at home if they were terminally ill. Of course, answers to this hypothetical question might not correspond to the preferences of those actually facing death. Another study, called SUPPORT (Study to Understand Preferences for Prognoses and Outcomes of Treatments) examined preferences about the place of death among patients who were facing death — those with very serious, life-threatening illnesses. The vast majority — 82% — reported that if a doctor told them they had "very little time to live," they would prefer death at home, rather than in a hospital. In most cases, however, those who die do not know with certainty that they will die within a certain time frame. Different people might place different degrees of importance on the (perhaps small) chance of surviving, versus the discomforts and risks of high-technology interventions. Some people die in intensive care units not because they prefer them to other settings, but because they were willing to take the risk of intense intervention in exchange for the chance of recovery.

The degree of regional variation in how many people die in hospitals, and how many have been admitted to intensive care units at least once during the last six months of their lives, however, is surprising, given the almost universal expression of a desire for death to happen elsewhere, and otherwise. Can this be explained by patient preferences — are people in some areas are more willing to take the risks associated with intensive medical interventions than similar people living elsewhere? Probably not. The SUPPORT study is unique among studies of terminal care and advance directives because it sought to "re-engineer" the clinical setting in order to respect and incorporate into the care plan the individual patient's own preferences at the time of death. The core of the intervention was specially trained and philosophically committed nurses who "spent all of their time counseling patients and families, convening meetings with physicians and others, eliciting preferences, making plans for future contingencies and ensuring that the best possible information about prognosis and preferences was available to the care team."

Exhibit 2

The intervention failed. The majority of patients who had expressed their preference for dying at home were actually in the hospital at the time of death, despite the best efforts of the SUPPORT group to redirect the clinical pathway.

Why did this happen? Probably the best explanation is that the local supply of hospital resources, and local physicians' practice styles, are far more dominant determinants of how care is given at the end of life than either patient preferences or the best clinical strategies to avoid unwelcome interventions. The SUPPORT study took place at five different hospitals in five different hospital referral regions. The percent of study patients who died in hospitals ranged from a low of 29% to a high of 66%. The variations were not explained by sociodemographic characteristics, clinical profiles, or patients' preferences.

Among the Medicare population, there was a strong, and apparently prevailing, association between acute care hospital capacity and the likelihood of a hospitalized death. Indeed, the supply of acute care hospital beds per 1,000 residents explained 71% of the variance among sites in place of death, and patient days per 1,000 Medicare enrollees explained 88% of the variance among sites in place of death. As with medical care and surgical interventions, in death geography is destiny. The place of death and the intensity of interventions provided depend much more on the region's patterns of use of acute care hospital resources than on what dying patients say that they want.

Population-based studies strongly suggest that greater intensity of medical care does not yield benefits, either in terms of longevity or in terms of providing patients with the kinds of deaths that they want. Clearly, below some critical level, less care is harmful because treatable illnesses go untreated or are under-treated; and we might be unable to identify such groups in population-based studies. Nevertheless, the evidence presented in this chapter characterizes a system in which large amounts of money are spent on medical intervention that provides no benefit, whether that benefit is measured in longevity or in honoring patients' preferences.

Exhibit 3

Practice Variations and the Quality of Surgical Care for Common Conditions

Quality in health care means doing the right things right. Traditional efforts to improve the quality of surgical care have concentrated on improving surgical performance — *doing things right*. Performance quality in surgery is usually measured in terms of mortality or complication rates, and problems are indicated by variations in outcome rates. Efforts to improve quality usually focus on improving processes of care, from how skillfully the operation is performed to how well patients are cared for after surgery.

Although performance quality is important, so too is the quality of clinical decision making — *doing the right thing*. To measure this aspect of quality, it is necessary to ask whether the initial decision to proceed with surgery was correct. Measuring decision quality is much more difficult than tracking mortality or complication rates. However, as with performance quality, variation is an important indicator of problems in the quality of decision making. From a population perspective, variation in surgical decision making becomes apparent from the large regional variations in the rates at which populations undergo specific surgical procedures. Population-based rates of many common procedures vary by as much as a factor of ten (sometimes even more) — that is, residents of some parts of the country are as much as ten times more likely to receive particular surgical procedures than people with the same disease profiles who live elsewhere.

This chapter explores how both these components of quality — decision making and performance — are reflected in the patterns of surgical care across the United States. The chapter first describes the current degree of regional variation of ten common surgical procedures, identifying the procedures in which there is the greatest opportunity for improving decision making. The chapter then profiles two procedures, surgery for stroke prevention (carotid endarterectomy) and invasive treatment of coronary artery disease, to describe the factors that determine quality in surgical decision making and the quality of the surgery being performed — the outcomes of surgery.

Exhibit 3

Variations in the Surgical Treatment of Common Diseases

Ten surgical procedures — repair of hip fracture, colectomy for colorectal cancer, cholecystectomy, angioplasty, coronary artery bypass surgery, hip replacement, lower extremity bypass surgery, carotid endarterectomy, back surgery, and radical prostatectomy — represented approximately 42% of Medicare inpatient surgery and accounted for 44% of reimbursements for surgical care in 1995-96.

The ten procedures had very different variation profiles. For example, rates of colectomy for colorectal cancer varied by only a factor of two, from 1.5 per 1,000 Medicare enrollees in the Harlingen, Texas hospital referral region to 3.2 per 1,000 Medicare residents of the Sioux City, Iowa hospital referral region. There were only ten hospital referral regions with rates of colectomy for colorectal cancer less than 25% lower than the national average, and only one with a rate more than 30% higher than the national average.

There was far more variation in rates of most other common surgical procedures. Rates of radical prostatectomy for prostate cancer varied by a factor of more than nine, from 0.5 per 1,000 Medicare enrollees in the Binghamton, New York hospital referral region to 4.7 in the Baton Rouge, Louisiana hospital referral region. There were 67 hospital referral regions which had rates of prostatectomy more than 25% lower than the national average, and 62 hospital referral regions where male Medicare residents underwent prostatectomy at rates more than 30% higher than the national average. According to the systematic component of variation, rates of radical prostatectomy were more than 12 times more variable than rates of colectomy for colon cancer (Table 5.1). Rates of lower extremity bypass surgery for Medicare enrollees with inadequate circulation to their legs, carotid endarterectomy for stroke prevention, and back surgery were also highly variable among hospital referral regions.

Exhibit 3

Why Procedures Vary to Different Degrees

Although regional variation in health care is ubiquitous, not all surgical procedures vary to the same degree. Procedures which are not very variable are generally applied to clinical conditions for which treatment is constrained to a single clinical approach. For example, there is wide consensus that surgery is the primary treatment for both hip fracture and colorectal cancer. The geographic variation in the use of surgery for these two conditions is largely due to variations in illness rates — for example, colorectal cancer is slightly more common among residents of the Mountain states and parts of the Southeast than among residents of other parts of the country (Chapter Three).

The amount of regional variation for most procedures, however, is too large to attribute to chance or variation in illness rates; the rates of surgery described in Table 5.1 and Figure 5.1 have been adjusted for regional differences in illness rates, but still vary substantially. Variations in the rates of the use of these procedures reflect variations in practice style and in how physicians diagnose and treat common clinical conditions.

Table 5.1. Quantitative Measures of Variability of Ten Common Surgical Procedures by Hospital Referral Region (1995-96)

	Hip Fracture Repair	Colectomy for Colorectal Cancer	Discectomy	Coronary Artery Bypass Surgery	Hip Replacement	Back Surgery	Carotid Endarterectomy	Percutaneous Transluminal Coronary Angioplasty	Lower Extremity Bypass	Radical Prostatectomy
Systematic Component of Variation										
Systematic Component of Variation (SCV)	10.3	15.7	26.5	36.0	61.8	66.0	66.8	102.0	104.8	130.3
Ratio to SCV of surgical repair of hip fracture	1.0	1.5	2.6	3.7	6.0	6.6	9.3	9.9	10.2	12.7
Random Variation										
Extremal Ratio (highest to lowest region)	2.0	2.2	2.7	3.7	4.5	5.7	7.7	8.0	8.0	9.4
Interquartile Ratio (75th to 25th percentile region)	1.2	1.2	1.3	1.3	1.4	1.5	1.5	1.5	1.5	1.6
Number of Regions with High and Low Rates										
Rates more than 25% below the national average	1	10	10	19	40	41	54	61	60	67
Rates 30% or more above the national average	0	1	19	21	46	63	53	54	29	62

Exhibit 3

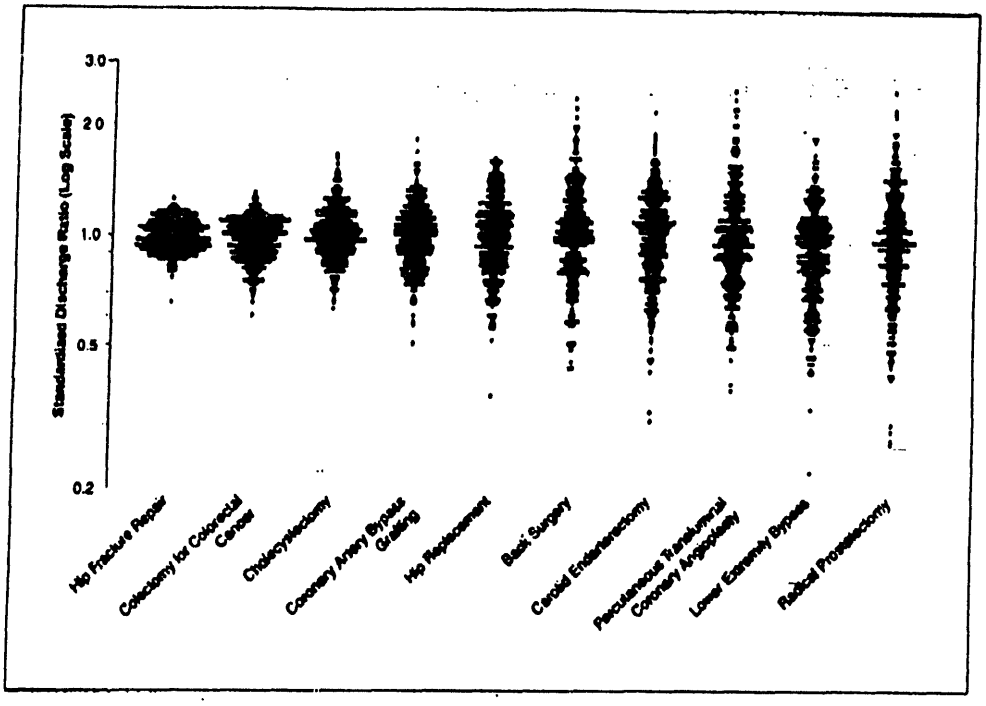


Figure 5.1. Profiles of Surgical Variation for Ten Common Surgical Procedures (1986-88)

■ **Variation in diagnostic intensity.** Surgery rates might vary because physicians in different regions vary in how aggressively they look for surgically treatable disease. For example, because early-stage prostate cancer frequently has no symptoms, the diagnosis is increasingly being made through a screening test for prostate-specific antigen. There is a great deal of regional variation in the frequency of use of this controversial screening test; as a result, there is also variation in the rate at which men are diagnosed (screening more men means that more men are diagnosed with early-stage disease) and variation in how often men undergo surgery (where more men are diagnosed with early-stage disease, more undergo surgical treatment for the condition).

■ **Problems with medical science.** For some procedures, regional variation in the use of surgery is due to gaps in medical science and professional uncertainty about the implications of alternative treatments. For example, variation in rates of radical prostatectomy might be partly attributable to the lack of controlled clinical trials comparing the risks and benefits of surgery, radiation therapy, and watchful waiting. For other procedures, even the best clinical trials are often not sufficient to eliminate variation in procedure rates: physicians vary in how they interpret and apply findings from the carefully controlled settings of clinical trials to decision making for individual patients in other settings.

■ **Failure to incorporate patient preferences into treatment decisions.** Although medical science is necessary for quantifying risks and benefits, some of the trade-offs involved in surgical decisions can only be assessed by patients. For example, the major risks of radical prostatectomy are urinary incontinence and impotence. Only patients themselves can weigh the importance of these side effects against the potential benefits of surgically removing the prostate cancer. Table 5.2 lists the treatment options available to patients and the clinical trade-offs patients face in terms of the risks and benefits for the ten conditions for which the procedures in Figure 5.1 are commonly performed.

Exhibit 3

Table 5.2. Trade-Offs, Risks and Benefits of Treatment Options for Selected Conditions

Clinical condition	Treatment Options	Trade-Offs Among Alternatives
Hip fracture	Surgical repair	No alternatives
Colorectal cancer	Colectomy	No alternatives
Chronic cholecystitis (intermittent abdominal pain from gallstones)	Watchful waiting	Avoids surgery, but carries a risk of a later serious attack (acute cholecystitis) and the need for urgent, open surgery
	Cholecystectomy (usually laparoscopic rather than open surgery)	Very effective, but there are small risks of serious complications
Chronic stable angina (chest pain or other symptoms from coronary artery disease)	Medical treatment	Avoids the downsides of interventions, but is less effective at improving symptoms and some patients have shorter survival
	Angioplasty	Lower procedure risks than surgery, but symptom relief is not as long lasting
	Bypass surgery	Effective and durable in relieving symptoms, but there are significant risks of mortality and disability, including stroke
Hip osteoarthritis	Medical treatment	Low risk, but not very effective in relieving symptoms
	Hip replacement	Very effective, but there are modest risks of mortality and complications, as well as a long recovery period
Claudication (exertional leg pain from peripheral vascular disease)	Medical treatment, exercise	Low risk, but only modestly effective
	Angioplasty	Effective at improving symptoms, but there are risks of complications and subsequent interventions are often necessary
	Bypass surgery	Very effective and durable, but there are significant risks of complications and death
Carotid stenosis (stroke risk from narrowing of carotid artery)	Aspirin	Lower short-term risks, but higher risks of stroke over the long term
	Carotid endarterectomy	Reduces overall stroke risks, but there are significant risks of mortality and of perioperative stroke
Herniated disc or Spinal Stenosis (causing back pain or other symptoms)	Medical treatment, chiropractic, other	Symptoms often resolve without surgery, but might not
	Back surgery	Frequently relieves symptoms, but has complication risks and is not always effective
Early-stage prostate cancer	Watchful waiting	Many prostate cancers never progress to affect quality of life or survival, but some do
	Radiation (conventional or implant seeds)	Shrinks or eliminates cancer in the prostate, but there are risks of side effects
	Radical prostatectomy	Removes prostate cancer entirely, but there are substantial risks of incontinence and impotence

Exhibit 3

Discretionary Surgery and the Question of Which Rate Is Right

Sparing patients from surgery that experts believe is actually harmful obviously improves the quality of care; and on purely ethical grounds, such care should not even be offered. However, the overuse of harmful care or care that patients do not want does not explain geographic variations, and the elimination of overuse would not be sufficient to define what care patients actually want.

Increasingly, outcomes researchers are documenting the importance of patients' preferences in deciding which treatment best meets the individual patient's needs and wishes. A treatment is discretionary precisely because medical practice offers patients at least one other option. A woman with breast cancer, for example, has a choice between breast sparing surgery and mastectomy. Extensive clinical trials have shown that improvement in survival (the main goal of either treatment) is about the same for both options. However, other outcomes of the two interventions are not the same, and the choice between them involves trade-offs. The patient who undergoes lumpectomy will need radiation therapy, and faces a risk of local recurrence of her breast cancer. The patient who undergoes mastectomy avoids radiation and local recurrence, but must deal with the loss of her breast. Individual women differ substantially in how they evaluate the risks and benefits of these two treatment options. Breast sparing surgery is appropriate for some patients, and mastectomy is the right choice for others. Since the trade-offs must be made according to the preferences and values of individuals, the decision rightfully belongs to the patient — and not to panels of experts, managed care companies, surgeons, or patient advocates. The definition of unnecessary care must be expanded to include care that does not reflect what individual patients actually want.

Benign prostatic hyperplasia is a common disease in men over the age of 50, and there is considerable debate about how — and whether — the condition should be treated. Traditionally, men with benign prostatic hyperplasia have relied on their physicians to decide on the course of treatment for them, assuming that "the doctor knows best." Outcomes research has clarified the theoretical reasons for treatment, which is primarily to improve the quality of life by reducing the inten-

Exhibit 3

sity of symptoms. For most men, surgery does not increase the length of life and, in fact, might shorten life expectancy slightly because of the risk of operative mortality. The importance — the necessity — of the patient's active involvement in the choice of treatment is illuminated by these outcomes studies, because they have shown that the most important consideration for the patient is the tradeoff between risks and outcomes. Surgery is superior in improving urinary tract symptoms; foregoing surgery is superior to surgery in avoiding surgical complications, including impotence, incontinence, and retrograde ejaculation. Individual patients differ substantially in how they assess their own situations, including their feelings about sexual activity. There is nothing in a given patient's physical examination, clinical history, or laboratory test results that would allow a physician to prescribe the treatment that a patient who was informed and involved in the decision making process would prefer. The patient must be actively involved in the decision process.

An observational study of treatment choice for benign prostatic hyperplasia conducted in two health maintenance organizations showed that in a program of shared decision making, treatment choice was determined by the individual patient's own assessment of two subjective factors: how much his symptoms bothered him (not the severity of symptoms, but the extent to which symptoms at any level of severity were considered bothersome) and his concern about side effects, particularly the impact of surgery on sexuality.

Exhibit 3

Shared Decision Making and the Right Rate for Discretionary Surgery

If patients were informed about the risks and benefits of available treatments, and were actively involved in the decision making process, surgical rates would be based on patient choice among the "appropriate" options, rather than the preferences of individual physicians or the recommendations of panels of experts. The rates of surgery that would result from the incorporation of informed patients' choices into the decision making process would then be available as measures of how much surgery is necessary according to patients. We would also know whether the amount that informed patients want is less or more than the amount now being prescribed by physicians and experts.

Several studies have found that the level of demand for surgery that results from shared decision making is different and sometimes substantially less than in circumstances in which patients are not involved in decisions about surgical options. When informed about the risks and benefits of the alternative treatments, and invited to make decisions according to their own preferences, patients with benign prostatic hyperplasia and coronary artery disease demanded more conservative treatments and less surgery than was being performed before shared decision making was implemented (Figure 7.5).

Rates of prostate surgery in the two health maintenance organizations were already substantially lower than the national average when the study began. Among men who participated in the study, rates dropped even lower — more than 40% below the health maintenance organization's baseline. There was no reduction in demand among men in the control groups. (A subsequent randomized clinical trial showed a similar result, but the trial was underpowered and the result was not statistically significant.)

Current rates of other kinds of surgery might, by the same token, be lower than the rates that would be demanded by patients who were informed and actively engaged in decision making. The point is that learning which rate is right (and how much underuse or overuse of surgery there is in the United States) depends on improving the

quality of clinical decision making. The extreme variations in the rates of most surgical treatments (Chapter Five) is evidence of the extent of the decision quality aspect of the problem of overuse, underuse, and misuse of care.

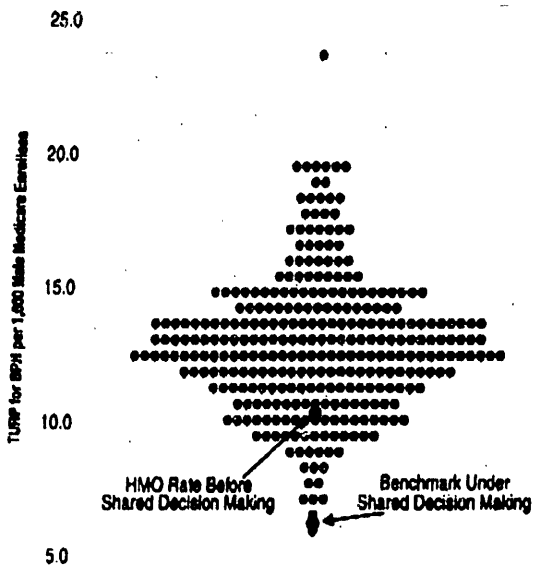


Figure 7.5. Distribution of Transurethral Prostatectomies for Benign Prostatic Hyperplasia Among Hospital Referral Regions (1992-93) Compared to Shared Decision Making Benchmark in Two Staff Model HMOs

The rate of surgery fell about 40% after implementation of shared decision making, although the rate prior to the intervention was lower than the national average. Rates in the control region did not change.

Exhibit 3

The Shared Decision Making Benchmark: Patient Demand for Surgery for Benign Prostatic Hyperplasia

The experience of the health maintenance organization in implementing shared decision making provides a benchmark for addressing the question, Which rate is right? In 1992-93, the last years of the shared decision making observational study, the rates of surgery for benign prostatic hyperplasia among men participating in shared decision making were comparable to the rates in the hospital referral regions with the lowest rates in the United States (Figure 7.5). If the preferences about surgical treatment of the men who participated in the shared decision making study reflect the preferences of most men, then the amount of surgery for benign prostate disease being performed in the United States in those years substantially exceeded the amount that informed men would actually have wanted. In 1992-93, 309,000 operations for benign prostatic hyperplasia were performed among men enrolled in fee-for-service Medicare. The health maintenance organization benchmark predicts that patient demand was less than half the amount supplied — that about 160,000 more procedures were performed on Medicare men than would have been wanted, had shared decision making been the standard of care in those years.

The quality problem of surgery that patients don't really want has another dimension: the misapplication of resources. For example, in 1992-93, Medicare reimbursements for hospital care alone related to surgery for benign prostatic hyperplasia exceeded $1.08 billion. The level of spending predicted by the health maintenance organization benchmark — the amount of surgery patients actually wanted — was $511 million, less than half that amount. More than 1.6 million days of hospitalization were allocated to the care of patients having surgery for benign prostatic hyperplasia; had the health maintenance organization benchmark prevailed throughout the United States, such patients would have used almost 800,000 fewer hospital days.

The health maintenance organization benchmark can be used to estimate the extent of excess use of surgery for benign prostatic hyperplasia by hospital referral regions (Figure 7.6).

Exhibit 3

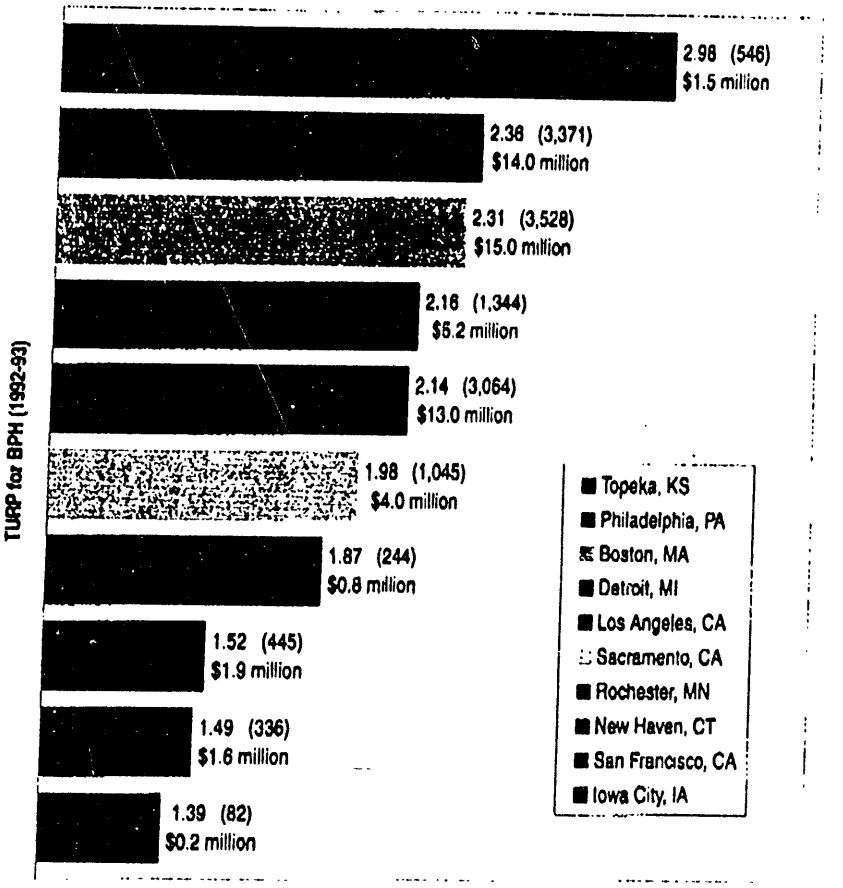


Figure 7.6. Predicted Overuse of Surgery for Benign Prostatic Hyperplasia in Selected Hospital Referral Regions According to a Shared Decision Making Benchmark (1992-93)

The figure gives the ratio of the rate of surgery in the selected hospital referral regions to the rate in two health maintenance organizations after the implementation of shared decision making. It also indicates the numbers of surgical procedures (in parentheses) and the reimbursements for hospitalization in excess of that predicted by the health maintenance organization benchmark. For example, in the Boston hospital referral region, the rate of prostate surgery in 1992-93 exceeded the benchmark rate by a factor of 2.3. If the rate of surgery had been the same as in the benchmark health maintenance organization, 3,371 fewer procedures would have been performed and Medicare reimbursements for inpatient care would have been $15.0 million less.

Exhibit 4

Summing Up: Inefficiency in the Allocation of Medicare Spending

Per capita Medicare spending varies substantially among the nation's hospital referral regions, even after adjustments for differences in regional prices and illness rates, but there is little evidence that greater spending brings better health. In the example of the underuse of services known to be effective (Figure 7.4), more spending does not result in less underservice. In other words, the "cure" for underservice, as demonstrated by the best practice health maintenance organization benchmark, appears to be better management of resources, not more spending. In the case of spending for discretionary surgery, more does not appear to be better: in the case of surgery for benign prostate disease, the amount provided by fee-for-service Medicare exceeds the amount demanded by informed patients (Figure 7.5). In the case of use of hospitals for medical conditions and for treatment of the seriously ill, greater use and greater spending does not appear to improve life expectancy. While populations living in regions with greater supplies of physicians have more visits per capita and greater spending per capita for physician services, more physicians do not assure less underservice (Chapter Four) or the participation of patients in shared decision making.

Improving Quality and Achieving Efficiency

The evidence in this edition of the Dartmouth Atlas confirms the conclusion of the National Roundtable that "serious and widespread quality problems exist throughout American medicine." Some of these problems can be addressed by improving the management of care. This is particularly the case for errors of omission, such as the failure to provide effective care that patients want, including immunizations, mammograms, eye care for diabetics and the timely use of effective drugs for patients who have had heart attacks. But many quality problems require a different focus. Those that derive from poor science require improvement in the quality of clinical science. Those that emerge from inefficiency in medical spending and resource use require improvement in the quality of resource allocation.

The Quality of Clinical Science

The evaluative sciences need to be applied in a systematic way to medical innovation, whether it arises from biomedical research or from the efforts of practicing physicians to adopt existing technologies to new purposes. We must assure that medical theory is tested in an orderly way in order to make accurate prognoses and to improve the process of care.

The Quality of Clinical Decision Making

Quality problems that emerge from failure to base the choice of discretionary care on the preferences of the patient require improvement in the quality of clinical decision making. The subtle, often unrecognized influences that physicians have on choices among available treatments is the major cause of variations in the rates of surgery and of many other common interventions. Discretionary interventions involve trade-offs that only patients can make, and to make good decisions patients must have access to up to date, evidence-based assessments of the outcomes that matter to them. Moreover, patients must be encouraged to choose according to their own preferences, particularly in situations where individuals have very different attitudes and preferences.

The Quality of Resource Allocation Decisions

For decades, the health care debate has taken place against the background assumption that more is better; but from the perspective of patients and the welfare of populations, the Atlas provides ample evidence that this assumption is not necessarily true.

The Economics of Quality

Improving the quality of clinical science, decision making, and resource allocation is linked to the problem of growth in Medicare spending. A recent study by the Congressional Budget Office projects a rapid increase in the proportion of the gross domestic product invested in medical care, if Medicare's current defined benefit (fee-for-service) program is left unchanged. An increase of this magnitude in total costs of care is widely regarded as politically unsustainable. One proposal for reducing this increase is to move the age of eligibility for the Medicare program to 67 by 2025 and to 70 by 2032. A second proposal is to change the benefit package from the present fee-for-service plan to a defined contribution plan. Under this option, spending per capita would increase 4% per year after the baseline year, 2000.

The Congressional Budget Office has examined the effect of these options on projected increases in the proportion of the gross domestic product allocated to Medicare. Delaying retirement helps a little, reducing spending by 11% in years 2030 and beyond. But the best strategy for reducing the rate of growth is the defined contribution approach, which results in a 38% reduction in the projected increase in proportion of gross domestic product.

The projections are based on average per capita spending — which assumes that average spending is somehow the efficient amount to spend. But the national average has no inherent validity; it is simply the weighted average of all hospital referral regions (Figure 7.7). In 1995, price adjusted Medicare spending for residents of the Miami hospital referral region was $7,955 per enrollee, a rate which if nationalized would be equivalent to about 4.2% of gross domestic product. Spending in the Minneapolis hospital referral region for the fee-for-service defined benefit plan was $3,528, or about 1.9%.

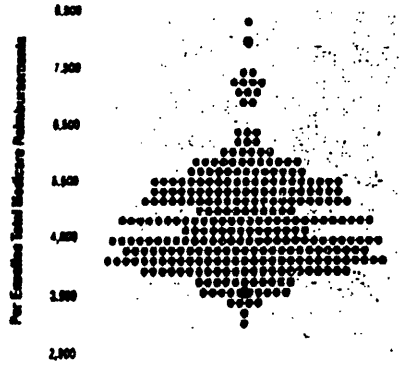


Figure 7.7. Total Medicare Spending per Enrollee (1995)
Per enrollee spending varied from less than $3,000 to more than $8,000. Levels of the Minneapolis and Miami hospital referral regions are indicated in red. Other hospital referral

Spending projections are clearly sensitive to the health care market used as a benchmark. When Minneapolis, rather than the national average, is used as a benchmark, projections of the percent of gross domestic product allocated to the defined benefit fee-for-service program are very different. Indeed, if all regions in the United States were to spend at the level of Minneapolis, spending would be lower than the Congressional Budget Office's projection for the defined contribution plan until late in the 2020s (Figure 7.8).

It is important to link the problem of Medicare spending with the issues of improving the quality of care. Much of medical care is not governed by well-articulated medical theory, much less by empirical evidence about the outcomes of care. Although our medical culture is dominated by the assumption that more is better, greater total per capita spending does not buy better outcomes. There is no apparent advantage in terms of life expectancy of spending more on acute hospital care or intensive care, and no relationship between spending and the quality of ambulatory and preventive care.

The implications for the quality debate seem straightforward. We must pay attention to the quality of medical science, making sure that common treatments that now escape systematic evaluation are brought under protocol. Likewise, the quality of clinical decision making should focus on the empowerment of patients to participate in the choice of their own treatments. Finally, we must review the quality of resource allocation decisions.

Exhibit 4

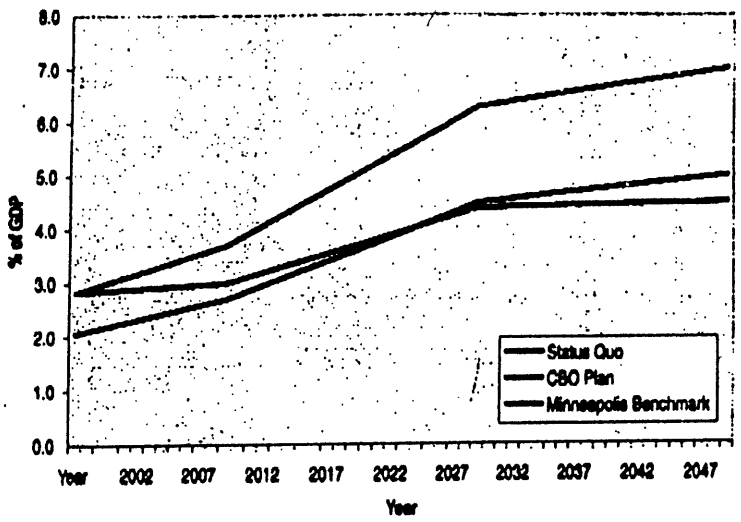


Figure 7.8. Projections of Spending Using Congressional Budget Office Projections for Defined Contribution Plan Spending, and Projections Based on Current per Enrollee Spending in the Minneapolis Hospital Referral Region (1996-2080)

Exhibit 4

Chapter Seven Table

The data in the table provide benchmarks for each hospital referral region. The benchmarks are used to answer the question: If all regions with higher rates were brought down to the rate of the benchmark region, and all regions with rates below the benchmark remained the same, how many excess admissions to ICUs, hospitalizations, specialist visits, etc. would there have been in the United States during the designated year(s)? For example, if in 1996 the suppply of generalists in all regions with more generalists per 100,000 residents than were allocated to the Birmingham, Alabama hospital referral region had been reduced to the level of the Birmingham benchmark, the calculated surplus number of generalists in the United States would be 28,816.

This approach to benchmarking was used in developing the maps and tables in this chapter. The benchmark question can, of course, be framed differently. One strategy poses the obverse question: if all regions with lower rates were brought up to the benchmark (and those with higher rates were left the same), how many additional visits or physicians or admissions would be required? And the benchmark question can also be framed in a another way: If all regions with higher rates were brought down to the benchmark, and those with lower rates were brought up to the benchmark, how many physicians, admissions, or visits would there be in excess (or deficit) of the current supply or rate?

The Dartmouth Atlas Data Viewer makes it possible to calculate, using any of the above strategies, the surpluses or deficits in the resources and utilization of any hospital referral region, including such measures as hospital beds, employees, physicians, surgical procedures, admissions to hospitals and to intensive care units, and the use of preventive and ambulatory care.

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

Mr. Chairman and members of the committee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am a John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences running HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or MedPAC.

THE NEED FOR REFORM

Medicare's popularity as a social program notwithstanding, the program is in major need of reform. Although Medicare solved the primary problem it was designed to address, ensuring that seniors had access to health care, there are a variety of problems with Medicare as it is currently constructed.

Much of the motivation for Medicare reform has been financial. Medicare, as it is currently structured, is partially dependent on a Part A trust fund that is scheduled to be depleted of funds just as the pressure of the baby boomers retirement starts to be felt. Although the April 1999 report of the Social Security Trustees moved the date of depletion from 2010 to 2015, the new estimate is extremely fragile. The additional five years of Part A solvency are based on razor-thin surpluses over several years that could easily disappear if Part A expenditures increase slightly faster than anticipated or wage tax revenue grows slightly slower than anticipated. In addition, the pressure on general revenues from Part B growth will continue although this is less observable since Part B is not funded by a stand-alone trust fund.

However, the motivation for Medicare reform is and should be more than financial. Traditional Medicare is modeled after the indemnity insurance plans that dominated the way health care was organized and delivered in the 1960's. The benefit package also reflects the 1960's, not covering outpatient pharmaceuticals or protection against very large medical bills.

Because of the limited nature of the benefit package and, at least until recently, the restricted nature of plan choices allowed under Medicare, almost all seniors supplement traditional Medicare. The use of this two-tiered insurance strategy has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with annual premiums varying between $1000 and $3000 or more. The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in the greater use of Medicare-covered services and thus increased Medicare costs.

In addition to concerns about the incentives associated with Medicare, there are also issues of equity. The amount Medicare spends on seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health status among seniors. Since seniors and others pay into the program on the basis of income or wages and pay the same premium for Part B services, this results in substantial cross-subsidies from people living in low cost states and states with conservative practice styles to people living in higher cost states and states with aggressive practice styles.

THE DIRECTION OF REFORM

As I have testified previously before this Committee, I believe a program modeled after the Federal Employees Health Benefits Program or what is now generically referred to as a premium-support program would provide a better structure for Medicare. I believe such a program could produce a more financially stable and viable program, and would provide better incentives for seniors to choose efficient plans and/or providers and better financial incentives for physicians and other health care providers to produce high-quality, low-cost care. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that suited their needs.

I am well aware that not all members of the Committee share this view about the desirability of a premium support program. However, many of the most vexing issues that need to be resolved for a premium support program must also be resolved for the current Medicare program. This will remain true as long as the Medicare program includes a traditional fee-for-service benefit and a variety of Medicare replacement programs. These include such issues as risk adjustment, providing un-

derstandable and user-friendly information to seniors, assuring that quality care is being delivered and providing safeguards for frail and vulnerable populations.

GETTING FROM "HERE" TO "THERE"

Because Medicare is a program that finances health care for our senior citizens, the desirability of phasing-in necessary changes and reforms seems obvious. To the extent that some changes in the structure or organization of a reformed Medicare program require substantially different roles for government or substantially different roles for the administrative institutions supporting the program, it is important that we begin now what could be a decade-long series of changes. The more we may wish to experiment with various strategies for reform or the administrative structures supporting reform, the more urgent it is that we begin now.

Concerns have been raised about instituting significant changes in a program involving the elderly. Some have raised concerns that many of today's seniors have had little experience with health plans other than fee-for-service indemnity plans, that many seniors have modest incomes and that some have little education. These are valid concerns. Whatever changes are made to the Medicare program will probably need to be modified for at least some subsets of the existing seniors. Some groups of seniors may be need to be excluded from any change.

Concerns about the difficulties of changing programs involving seniors make it all the more important that we set the stage now for where we want to go with a reformed Medicare program. This will allow a more gradual transition to a Medicare program appropriate for the baby-boomers and the 21st Century.

It is also important to understand that the people who will be reaching age 65 over the next decade as well as the baby-boomers have had very different experiences relative to today's seniors. Most of them have had health plans involving some forms of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems, and if we start soon, with different expectations.

THE ADMINISTRATIVE STRUCTURE SUPPORTING A REFORMED MEDICARE

At least two major administrative issues need to be addressed. The first involves using a Medicare Board as the major administrative structure supporting a premium support type of program. The second involves the potential role of the Health Care Financing Administration in running a modernized fee-for-service Medicare program.

I support the notion of a separate Medicare Board that would oversee and negotiate with the private plans and the traditional Medicare program. The most important functions of such a Medicare Board would be to review and approve benefit packages, to negotiate premiums, make payment modifications (such as risk adjustment), direct open enrollment periods and to provide information about plan choices.

While I think it is appropriate and proper that the individuals who have been involved in administering the Medicare+Choice program at HCFA be moved to the Board, it would be better to have a Board that is separate from HCFA and with leadership from outside of HCFA. It would be desirable to include people with experience administering the FEHB program, the CalPERS program and some of the more comparable programs from the private sector.

The reason I think a separate Medicare Board is desirable is that the mind-set of HCFA is focused on running a publicly administered, price-setting, fee-for-service system. The functions and roles for government in running and monitoring a premium support system are so fundamentally different from the experiences and mind-set of HCFA personnel that it would detract from rather than enhance the successful operations of a premium-support program.

The more difficult issue is whether HCFA or any governmental entity could administer a modernized fee-for-service system that competes effectively with privately administered plans. At a recent retreat on Medicare reform put together for this Committee, Lynn Etheridge outlined a series of changes that would be needed to modernize the traditional Medicare program. These included the use of selective contracting, centers of excellence, disease management programs, best practice programs, variations in benefit structures and other changes that are commonplace in the better-run private sector plans.

The question in my mind is whether the Congress will allow HCFA the flexibility that would be needed to run such a program and whether the Congress and the Administration will provide HCFA with the resources needed to carry out such a task. History is not encouraging on either of these issues.

If HCFA or any other governmental agency is to run a modernized fee-for-service program, Congress will need to change its relationship with HCFA and retreat from its very micro-prescriptive directives. This would require both changes in statute and changes in attitude. It would also require changes in attitude and behavior by the employees of HCFA. Demonstration and/or adoption of promising ideas from the private sector have been painfully slow to be undertaken by HCFA. Some of this slowness may be caused by political difficulties associated with these strategies, such as the selective exclusion of providers, or by a lack of appropriate funding. But too often it appears to be the results of bureaucratic inaction and indecision.

An alternative to a publicly-administered, modernized fee-for-service Medicare program is the use of competitively-procured, private fee-for-service plans. These plans could be bid out on a risk basis at a national, regional or state level with plans using administered pricing if they chose to do so.

The attraction of the privately administered fee-for-service plans is that they can introduce changes in local markets that HCFA may not be able to do. But for many people, this is also the fundamental drawback of the privately administered plans. The public oversight and control of a publicly administered plan provides a sense of protection that will be difficult to ignore and at least to me, the political objections likely to result from eliminating a publicly administered traditional Medicare program, seem overwhelming.

This means that if there is to be a publicly-administered, modernized fee-for-service component to a premium support program, which I think is both desirable and politically necessary, Congress will need to change its relationship with HCFA and grant it more flexibility than it has done in the past. In return, HCFA will need to be more responsive, more pragmatic and more creative in its behavior.

Let me summarize my points as follows:

There is a continuing need to reform Medicare

1. Solvency and financial pressures continue as important issues.
2. The current benefit structure is inadequate and unfair.

A premium support model is a reform vehicle to address these issues

1. Many of the most vexing issues of premium support are also present with the current combination of fee-for-service Medicare and Medicare replacement plans.

Medicare reform will require a series of changes

1. Reform should start now; building the infrastructure will take time.
2. Future seniors will be different from today's seniors in terms of work experiences, health plan experiences, income and education.

Premium support model requires a different institutional structure

1. A Medicare Board, separate from HCFA, to oversee and negotiate with plans.
2. A Modernized FFS Medicare requires a different mind-set from HCFA and a more flexible relationship with the Congress.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF ACTUARIES

[SUBMITTED BY DWIGHT K. BARTLETT III, SENIOR HEALTH FELLOW]

Dear Senator Roth:

The American Academy of Actuaries commends you and your committee for addressing the long-term solvency of the Medicare program. Although the Academy is a nonpartisan professional organization that does not support or oppose specific legislative proposals, actuaries recognize that solutions for Medicare's financial problems will be less painful if adopted sooner rather than later, allowing for the grading of necessary charges over time. Therefore, the Academy urges Congress to take swift action to ensure the long-term stability of Medicare.

Some policy makers, including Sen. John Breaux and Rep. Bill Thomas, who served as the Co-Chairmen of the National Bipartisan Commission on the Future of Medicare, have expressed support for restructuring Medicare into a system of premium supports, along the lines of the Federal Employees Health Benefits Program (FEHBP). The FEHBP is a successful program that allows federal workers and retirees to choose from among a range of private health plan options whose premiums and benefits are set by the government. Although in some respects the FEHBP's experience may be useful in considering Medicare reforms, the FEHBP does not represent a completely analogous model for Medicare.

As you and your committee examine this proposal, you may wish to consider the following points:

(1) Medicare's insured population—elderly and often in poor health—is quite different from the FEHBP's insured population, which is younger, more likely to be in the active work force, and thus generally healthier on average. Policy makers should use extreme care in drawing conclusions about the effects on aggregate plan costs of shifting Medicare to a system similar to the FEHBP.

(2) Recent studies of Medigap experience show that giving participants a choice of health benefit plans increases costs for two reasons:

2 (a) Individuals with costly health conditions tend to select plans with more generous benefits, even if their own premium contributions increase. This phenomenon is known as antiselection.

(b) Participants with more generous supplemental benefits, such as coverage of prescription drugs, tend to use health care services more than if they did not have the supplemental benefits. This phenomenon is called induced utilization.

Thus, all else being equal, expansion of choice would probably increase the total cost of Medicare to government and to plan participants. There are, however, techniques which may be employed to offset these effects. These techniques include reducing the range of choices in benefit structures through the adoption of standardized benefit provisions. In addition, risk adjusting participant contributions for each plan would help. Using risk adjustment means that the contribution schedule would reflect the differing characteristics among plans, particularly the average condition of health of the participants as well as differing geographical and demographic characteristics. Furthermore, increased competition among plans may lead to increased efficiencies reflected in lower scheduled contributions for a given level of benefits.

(3) Tying premium costs directly to income may aggravate some of the effects of antiselection. Studies suggest that lower income individuals tend to be in poorer health on average than higher income individuals. Greater premium subsidies might allow them to elect plans with more generous benefits than otherwise, depending on how the subsidies are structured.

(4) It is currently proposed to delay Medicare's full eligibility age for coverage to match Social Security's eligibility age for full benefits. Increasing eligibility age will produce much smaller savings for Medicare than for Social Security. This is because a Social Security beneficiary's monthly cash benefit generally remains unchanged as the beneficiary ages except for annual cost of living increases based on the consumer price index. Medicare's experience is quite different. Medicare's costs increase as beneficiaries age and suffer from declining health with greater need for health care.

The Academy looks forward to working with your committee as you continue your consideration of Medicare reform. In particular, we are eager to offer more specific comments on premium support proposals as details are fleshed out. Some details could result in savings adequate to offset or avoid the effects normally resulting from giving health plan participants a range of choices among health plans. If you have any questions, please feel free to contact me.

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The 88,000 members of the American Academy of Family Physicians would like to provide the following recommendations for improving the nation's graduate medical education (GME) financing system. We are pleased that the Senate Finance Committee is reviewing the current GME system as it seeks ways to strengthen and improve the nation's Medicare program.

The Academy has had a long-standing interest in graduate medical education because of our commitment to a rational physician workforce policy that both discourages an oversupply of physicians, and encourages increased training of those physician specialties in short supply. Our organization has produced and updated regularly a number of policies on physician workforce issues, as well as specific GME recommendations. Recently, the Academy undertook a year long process to revise our physician workforce recommendations with the goal of supporting efforts to ensure that all Americans have access to primary care services, that the needs of underserved rural and urban populations are met, and that evolving managed care delivery systems have an adequate supply of an appropriate mix of primary care physicians.

In addition, the Academy has long been concerned that graduate medical education in the US is currently financed by the Medicare program without sufficient incentives to reduce the oversupply of physicians or ensure appropriate distribution of physicians by geographic location and specialty. Although there are several harmful consequences as the result of this disconnect between Medicare policy and physician workforce needs, one of our primary concerns is the imbalance between primary care and subspecialist physicians in this country.

We are pleased to present to you our recommendations for reforming the current GME system, our suggestions for a major restructuring of graduate medical education generally, as well as specific corrective action that is required to correct changes made to the GME system by the Balanced Budget Act of 1997. First, however, let us provide background on the current shortage of primary care physicians to provide an initial framework for our recommendations.

BACKGROUND: NEED FOR ADDITIONAL PRIMARY CARE PHYSICIANS

Analysis indicates that any attempts to control costs and maintain quality in the American health care system will be frustrated by a structural problem in our country: the shortage of primary care physicians. While in most countries at least 50 percent of physicians are generalists (family physicians, general internists and general pediatricians), the US physician workforce is made up of 70 percent subspecialists and 30 percent primary care physicians. Family physicians make up only 13 percent of the total.

Most experts believe that a physician workforce of at least 50 percent generalists and 50 percent subspecialists would best meet America's health care needs. The Physician Payment Review Commission, Council on Graduate Medical Education, The Pew Health Professions Commission, Institute of Medicine, American Medical Association and the Association of American Medical Colleges all advocate increasing the supply of primary care physicians. A March, 1996, study by the Institute of Medicine also encourages support for training of a primary care workforce.

At one time, the physician workforce in the US was comprised of 50 percent primary care physicians, but after World War II, the nation's primary care workforce declined from a majority of the workforce to approximately one-third today. During the 1990's, the number of medical students electing primary care residencies, and participating in family practice residencies, has been increasing. However, the trend

of increases appears to be slowing, and the percentage is still only about one-third of graduating medical students. Much more progress is needed to begin affecting the national shortage.

The demand for family physicians in the market is greater than our nation's training capacity. Medical education, which is relatively insensitive to market forces due to the current GME system, is moving too slowly to meet the workforce needs of the nation. Medicare payment policies have contributed significantly to the over-specialization of physicians. These policies have historically promoted training in the inpatient specialties rather than in family practice and other primary care specialties. While the recent Balanced Budget Act of 1997 changed current Medicare policies to allow funding for some residents training in ambulatory settings, the law has also had a number of unintended harmful effects on family medicine training programs.

RECOMMENDATIONS FOR REFORM OF THE CURRENT GME SYSTEM

Preferential Funding for Physician Specialties in Short Supply

The Academy believes that any efforts to reform the current GME system must be undertaken with an eye toward meeting specific, national policy goals. Specifically, we believe that federal funding for graduate medical education should reflect physician workforce policy, with preferential funding for the training of primary care physicians coupled with less funding for the training of subspecialist physicians in surplus.

In addition, other proactive changes to the GME system should be based on preferential support for training physicians who are committed to locate in and/or serve rural and inner-city populations, and physicians from under-represented minorities. The Council on Graduate Medical Education has also made these recommendations.

Limiting the Number of Physicians

The Academy supports limiting the number of physicians in training in the United States. Specifically, we believe that support for training physicians should be limited to first year residency positions, equal to 110 percent of the graduates in 1993 of MD and DO schools. This cap on physicians would limit the number of first year residency positions in the US to about 19,600; the figure is currently 24,000. The Council on Graduate Medical Education has also made this recommendation.

Based on our analysis, Academy policy on reducing and limiting the number of physicians in training is still relevant despite the hospital-specific limits on the growth of Medicare-supported residency programs and residents in the Balanced Budget Act of 1997. The Academy believes that the provisions in the Act are far weaker than in our proposal. Specifically, the Act's provisions do not guarantee a reduction in the number of residents being trained. Moreover, there is no workforce policy to ensure that the residents in training are in the most needed specialties, nor that they will practice in the areas of greatest need.

In addition, the Academy believes 10 percent of the first year residency positions in the US should be available annually for International Medical Graduates (IMGs), with open competition by all eligible physicians for the first year residency positions. To ensure that IMGs have the opportunity to train in the US, we believe that a specific number of training positions should be available annually for exchange visitors whose costs are paid by their host country, and who return to practice in their home country upon graduation.

All-Payer System for GME Costs

The Academy has historically supported an "all-payer" system to finance the direct and indirect costs of graduate medical education, a view that is also held by the Council on Graduate Medical Education, the former Physician Payment Review Commission, American Medical Association, and the Pew Health Professions Commission, among others. We believe that all payers of health care services should contribute to the costs of medical education.

Academy support for an all-payer system stems from our belief that graduate medical education is a public good for our society and should be supported through a broad funding mechanism. In fact, the original purpose of the GME system was to ensure an appropriate number of physicians to serve our nation's communities. The Medicare program currently shoulders the burden for GME costs of training the majority of our nation's doctors. However, equity, as well as the current, precarious position of the Medicare budget dictate that serious consideration be given to removing GME funding, in part or in whole, from the program.

We also share the concerns of 26 US Senators who "oppose efforts to subject GME programs to an annual appropriations process," in an August 9, 1998 letter to the

National Bipartisan Commission on the Future of Medicare. The Academy believes that a stable source of funding for graduate medical education is required, which is not guaranteed in the appropriations process.

Direct Payments to Legal Entities Providing Training

Based on our analysis, the Academy believes that federal support for graduate medical education should be in the form of capitation payments to the entity legally responsible for the training program. Under this proposal, the directors of the programs would gain the authority to determine where training should occur, and training in community settings, for example, would be simpler to arrange. In addition, we support providing full capitation payments to support the training of residents for the minimum number of months necessary to meet the training requirements of one certifying board. The three primary care specialties require a three-year training period, while subspecialty residency programs require additional years.

RESTRUCTURING GRADUATE MEDICAL EDUCATION

Since the Finance Committee may also develop recommendations for restructuring the entire system, following are our proposals in that regard.

As noted above, the Academy believes that GME should be funded from both public and private sources, and that the overall numbers and types of physicians trained should be structured to meet national needs. As a result, we recommend that a national physician workforce policy, including but not limited to allocation of the total GME financing support pool, and the weighting of per-resident capitation payments, should be developed by a public-private commission. Further, the recommendations of this commission should be accepted or rejected, without modification, by the US Congress.

The commission should be charged with the responsibility for long-range planning to ensure that sufficient physicians in the appropriate specialties are available to meet the nation's health care needs, as well as the needs of each region, state and underserved area in the country. The commission members should be skilled health professionals, including primary care physicians, and its deliberations should be public.

CHANGES NEEDED AS A RESULT OF THE BALANCED BUDGET ACT OF 1997

In general, the Balanced Budget Act of 1997 contains several graduate medical education policies advocated by the Academy for years. As noted above, the Academy supports a limit on the number of medical residents, and we also support GME payments for training in non-hospital sites and the carve-out of payments to teaching hospitals from the average adjusted per capita cost. However, we have supported these policies in conjunction with specific protections for needed primary care programs. Such protections are absent from the law and regulations. In fact, the only section of the Act that includes an acknowledgment of the importance of primary care training programs is the demonstration project, which allows incentive payments for voluntary reduction in residents. Unfortunately, the Act has had serious consequences for family medicine programs.

Some of the harmful effects of the Act are demonstrated in the following results of a survey of family medicine training programs, which was conducted by the Organizations of Academic Family Medicine.

- 56 percent of family medicine programs responding that were in the process of developing new rural training sites have indicated they will either not implement those plans, or are unsure of their sponsoring institutions' continued support.
- 21 percent of family medicine programs responding report planning to decrease residency slots in the immediate future.
- The majority of those family medicine programs that are planning to decrease residency slots are the sole residency program in a teaching hospital. (This means these family practice programs have no alternative way of achieving growth such as decreasing other specialty slots within the 1996 cap on positions.)
- Due to significant training out of the hospital, most family medicine residency respondents did not have their full residency positions captured in the 1996 cost reports upon which the reimbursement is based, causing a loss of Medicare revenue compared to most other specialties that train almost exclusively in the hospital.

Following are the specific problems with the Balanced Budget Act of 1997 and the Academy's recommendations for solving them. All of the relief the Academy seeks

can be achieved in the provisions of the Graduate Medical Education Technical Amendments Act of 1998 (S 541/HR 1222).

Supporting Residency Training in Ambulatory Sites

The bill would treat all hospitals sponsoring residency programs fairly—not just those that were training residents in the hospital in 1996—by including those residents who were training in the community in the cap. As you know, the BBA capped the number of residency slots in an institution, a number that determines the amount of indirect graduate medical education funding (IME) the institution receives. Without "resetting" the caps, the residency programs that were training residents in the community in 1996 will have their Medicare IME cap lowered and receive less funding in subsequent years. Ironically, while one intent of the Act was to encourage ambulatory training by providing IME support after 1998, the Act inadvertently did not account for those residents who were already training outside of the institution at the time, such as family medicine residents. The Academy supports Medicare funding for all residents training outside of the hospital.

Providing Limited Growth to Single Residency Program Hospitals

The bill would allow hospitals that sponsor only one residency program to increase their resident count by one per year, up to a maximum of three, to meet community needs for primary care physicians. Under the BBA, a hospital with several residency programs can move positions from less popular subspecialty programs to high-demand primary care programs, such as family medicine, to meet the residency caps. By contrast, a hospital with only one program does not have this option. Approximately 300 hospitals sponsor only one residency program; 191 are in family medicine.

Supporting Residency Programs Under Development

The bill would allow a few, new, family medicine residency programs that have long been under development to be established by extending the cut-off date for new residencies. Specifically, any residency programs that were approved after January 1, 1995, and before September 30, 1999, could be set up. The BBA set August 5, 1997, as the cut-off date for new residencies, which had a disproportionate, negative effect on family medicine residency programs because of the growth in these training programs.

Meeting the Needs of Rural Communities

The bill would permit the establishment of new, rural training programs by allowing urban residency programs sponsoring these programs to receive an exception to the caps (for the rural programs only.) The BBA capped all residency programs, but strongly supported the establishment of rural programs. This provision clarifies the intent of the Act by supporting the growth of rural programs.

CONCLUSION

The American Academy of Family Physicians appreciates the opportunity to inform your deliberations on the graduate medical education system. We ask you to address the current imbalance between primary care physicians and subspecialists, and support a rational, national physician workforce plan. Thank you for the opportunity to provide these comments.

STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS/AMERICAN SOCIETY OF INTERNAL MEDICINE

[SUBMITTED BY WHITNEY ADDINGTON, MD, FACP, PRESIDENT]

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing over 120,000 internists (doctors for adults) appreciates this opportunity to submit this written testimony concerning Medicare reform and graduate medical education (GME). Among our members are tens of thousands of teaching physicians, residents, and administrators at teaching hospitals, clinics and other training sites providing graduate medical education throughout the nation. We are alarmed by recent proposals to remove GME-related payments from the Medicare program and make them subject to the annual appropriations process. We are concerned that such action would jeopardize the adequacy and the stability of funding for graduate medical education (GME).

Graduate medical education is a public good—a combination of special activities that benefit all of society, not just those who directly purchase or receive it. The public benefits from having well-educated, highly-trained physicians who meet high

standards of clinical competence. Physicians-in-training obtain hands-on experience in providing direct patient care, while patients are assured that care is provided under the direction and supervision of teaching physicians and high standards of quality are maintained. Further, society benefits from having institutions that foster medical innovation and research and that facilitate the development, testing, refinement, dissemination, and integration of scientific and technological advances. Teaching facilities also often provide continuing medical education for practicing physicians, enabling them to maintain and expand their medical knowledge and clinical skills, thereby enhancing the quality of care in the community. Like other public goods, graduate medical education requires public support and might not survive if funding depended solely on market forces.

The framers of Medicare recognized that all of society, including Medicare beneficiaries, benefit from having well-trained physicians and high quality teaching hospitals and clinics. The Medicare framers further recognized that the Medicare program, as well as other health care payers, should provide financial support to assure the continued high quality of the institutions and programs that provide the environment of education, training, and research needed to prepare our future physician workforce. The Medicare program has long recognized that payments for patient care services provided to Medicare beneficiaries by physicians-in-training must reflect the direct costs of GME (DME) and that additional payments are required to compensate hospitals that provide a disproportionate share of care for low-income, indigent, and otherwise medically under-served patients (DSH).

ACP-ASIM SEEKS STABLE AND PREDICTABLE FUNDING FOR GME, AND THEREFORE, OPPOSES PROPOSALS AT THIS TIME TO REMOVE FUNDING FOR THE DIRECT COST OF GME FROM THE MEDICARE TRUST FUND

The College believes that shifting federal GME funding from Medicare to the annual appropriations budget would jeopardize the adequacy and the stability of federal funding for graduate medical education. Medicare is now the largest single source of funding for graduate medical education. It provides a stable source of funding for the culmination of an educational process that involves four years of college, four years of medical school and three to seven years of residency and fellowship training. Irreparable harm to the educational process could result from replacing this stable source of funding for residency education and training with a process that would be subject to political pressures and the vagaries of the appropriations process. Major changes in Medicare funding for GME have already been authorized by the Balanced Budget Act of 1997 (BBA). These budgetary reductions are being phased-in over a four-year period, but their full impact is yet to be determined.

Currently, legislation, such as that proposed by Senator Moynihan (S. 210) and Rep. Cardin (H.R. 1224) is being considered to increase GME funding participation by other payers. We support these proposals, but until an all-payer funding system is implemented, it would be extremely dangerous to further destabilize Medicare funding for GME by making it subject to the budget appropriations process.

1. GME is an important source of funding for teaching institutions. It enables them to compete in a very tough healthcare market. Without it, they could not support the costs of training in primary care, which is very costly.
2. With the amount appropriated for GME varying, the hospitals' income would fluctuate unpredictably from year to year, making it much more difficult to plan and to invest in improvements that would be good for patients and for clinical research.
3. Aside from unpredictability, placing GME in the appropriations process would make it more vulnerable to further short-term budget cuts.

GME FUNDING SHOULD FOLLOW THE RESIDENT AND INCLUDE TRAINING IN AMBULATORY SITES

Graduate medical educational training programs must be responsive to changes in the organization and delivery of health care services. As patient care is increasingly provided in outpatient settings; it is extremely important that physicians receive training experiences at outpatient sites such as clinics, HMOs, and physician offices. Yet, until recently Medicare funding for GME had been limited solely to training programs of teaching hospitals. Although the medical profession and federal policy sought to encourage ambulatory training for physicians, Medicare GME reimbursement was provided only to the teaching hospitals that sponsored and incurred the costs of such approved programs. ACP-ASIM has strongly supported community-based teaching and has advocated that funding should follow the resident to include ambulatory training sites. Under the Balance Budget Act of 1997, non-hospital sites are now eligible to receive DME payments from Medicare based on

their counts of residents in approved training programs. We strongly favor these provisions and are alarmed by recent remarks before the Medicare Physician Advisory Commission that questioned the importance of physicians receiving training at ambulatory sites.

ACP-ASIM SUPPORTS AN ALL PAYER SYSTEM FOR FUNDING GME

We firmly believe that the ultimate solution for achieving adequate and stable funding for GME will be to develop a health care system in which all payers contribute their fair share of the educational and training costs. We strongly commend this solution to the Committee's attention. ACP-ASIM supports the establishment of a separate new trust fund (or funds) for medical education to which all health care payers would contribute. All health care payers, not just Medicare, depend on high-quality medical graduates, medical research, and technical advances from teaching facilities. All payers also derive value from this system and should share in the requisite investment in medical education. All members of society should be concerned that the nation's system of graduate medical education is preserved, that the high standards of quality required for patient care services provided by resident physicians are maintained, and that opportunities for entry to the medical profession are available to the most qualified candidates.

Establishing separate medical education trust funds to which all-payers would be required to contribute their fair share would help preserve our system of medical education and could lessen Medicare's share of the burden. Unless there is continued, broad-based funding to support GME, access to the medical profession will increasingly be available only to families of the very affluent and the fortunate few who are able to obtain private financing. Efforts to maintain opportunities for students from low and middle-income families and to increase ethnic and racial diversity will be thwarted. Further, without adequate financial support, teaching facilities will be unable to continue to perform their missions and new physicians will be forced by financial necessity into fields with the greatest income potential rather than those specialties and areas where there are shortages.

Teaching programs often serve as providers of health care for inner-city populations that otherwise are under-served. They provide substantial amounts of uncompensated care for poor and indigent patients. However, GME is the lynch pin for these inner-city "safety net" hospitals, and they cannot survive if their educational programs are not adequately funded. Because of the complexities of funding GME and the substantial impact that any major restructuring of financing would have, we advise that adequate provision be established for an orderly transition to an all-payer system for funding GME. We urge that Medicare continue to provide stable funding as any new broader base of financing is developed and implemented.

STATEMENT OF THE MEDICAL EDUCATION COUNCIL

[SUBMITTED BY GAR ELISON]

Within the last few months, there has been a general outcry from the health care community as the impact of the Balance Budget Act (BBA) has been realized. Mounting evidence from across the country indicates that the longterm financial stability of teaching hospitals is seriously threatened. The perilous effects of the BBA, as well as price competitive market forces, are severely impacting teaching hospitals. Teaching hospitals in cities such as Boston, San Francisco, and Philadelphia have been highlighted in the national news as they are experiencing losses of between $50 and $100 million due to the BBA. Like these teaching hospitals, Utah's teaching hospitals are also severely impacted, but unlike these hospitals, Utah hospitals do not have the reserves to sustain large losses for long.

CONDITIONS IN UTAH

The University of Utah Health Sciences Center, Intermountain Health Care (IHC), and St. Mark's Family Practice program are responsible for training health professionals for the State of Utah and for the region. The University of Utah Health Sciences Center is a public institution while IHC and the St. Mark's Family Practice program are nonprofit organizations. While the University of Utah receives some state support for its teaching programs, it is minimal. The school of medicine receives only eight percent of its budget from the state to support student education, while none of the sponsoring institutions of residency programs receive any direct funding for their residents. Thus, while these organizations are responsible for health professional education and accountable to both the state and to various ac-

crediting agencies for its programs, the institutions have control of few resources to accomplish their mission.

In addition to limited state resources, revenue streams that have historically supported graduate medical education (GME) at the University of Utah and at other sponsoring institutions are quickly drying up. Utah's health care market is one of most highly organized in the country, with a 60-70 percent penetration of managed care. Because many managed care plans do not carve out medical education funds, a critical GME funding base has been eroded. Additionally, since Utah's medical education programs are under-funded, the costs of education have been managed through cost shifting. However, with an increasingly competitive health care market, past methods of cost shifting to pay for training are no longer acceptable. And finally, because of the competitive nature of the market, for-profit health care institutions in Utah are choosing not to carry the burden of education. Recently, Columbia HCA decided to close its residency program at St. Mark's Hospital in Salt Lake City. The competitive market has made it increasingly difficult for teaching hospitals to compete with non-teaching hospitals for contracts and at the same time fulfill their academic mission and remain financially viable.

Not only are Utah's residency programs challenged by diminishing revenue streams, they are also vulnerable because many programs are at minimum levels for accreditation. As a result, most residencies cannot lose one slot without compromising the entire program. If Utah loses residency programs, the losses will be particularly significant because they will escalate a physician shortage.

Historically, Utah has been prudent in developing its training programs. Unlike many states, Utah has not grown its residency programs beyond what is needed. Although many areas in the country are experiencing a surplus in physicians, Utah is still a net importer of physicians. Today Utah trains only 579 residents. Nearly half of the residents are trained at the University of Utah Medical Center while the other half are trained in hospitals that are operated by IHC, Paracelsus, St. Mark's Family Practice Program, and the VA. With Utah's population growth and the number of physicians who will leave practice due to retirement or to pursue other professional opportunities, it is anticipated that Utah will experience a physician shortage of over 200 physicians by the year 2002. Because Utah is a regional health care service provider, the shortage will be felt not only by Utahns but also by residents in Idaho, Montana, Wyoming, and Nevada.

IMPACT OF THE BALANCED BUDGET ACT

Like many other states, the financial impact of the BBA in Utah will be severe. The reduction in indirect medical education (IME) payments will cost Utah $40 million by 2002. The loss of $40 million is intensified by the penetration of managed care in Utah's market, the competitive nature of the market, and the limited institutional reserves available to cover the costs of education. Additionally, Utah has not received its fair share of federal funding. Utah's training programs have consistently received a lower rate of reimbursement than a number of programs in the United States.

One way to gage whether or not reimbursement rates are equitable is to consider per resident payment amounts. In Utah the hospital specific DME amounts range from $40,000-$60,000 per resident, whereas nationally the variance is from $10,000-$240,000. It appears that the reimbursement rate in Utah is from one-half to one-third the amount paid to a number of other programs in the country. This payment inequity places smaller programs, like those in Utah, at greater risk from disturbances in the traditional funding streams. A number of programs do not have a financial safety net to weather funding variations imposed by the BBA.

Not only will the BBA impact Utah financially, the cap placed on full-time residency slots and the inability to transfer programs from one institution to another will seriously challenge the viability of some programs. Limiting the number of full-time residents that hospitals can count for GME payments to 1996 levels impacts Utah negatively for two reasons: (1) Utah's population is growing at a rate of 50,000 people a year. In order to ensure that the physician to population ratio remains adequate, it may be necessary to expand some residency programs, particularly primary care programs. However due to the cap imposed by the BBA, Utah would be severely constrained in its ability to add residency slots to existing programs. (2) Nearly all of Utah's residency programs are at minimum levels for accreditation. As mentioned previously, if one residency slot were lost in the Family Practice program at St. Mark's, the entire program would be shut down. Thus, Utah would lose not just one Family Practice slot but twelve. In this way, Utah's training programs are particularly vulnerable.

This vulnerability is compounded by another component of the BBA. The BBA disallows the transfer of programs from one institution to another. In September 1998, Utah felt the impact of this provision. Columbia HCA decided to close twenty-six residency programs across the country. One of those programs was at St. Mark's hospital in Salt Lake City, Utah. A critical situation ensued. Utah can not afford to lose twelve Family Practice residents without severely crippling its ability to meet the health care needs of the population. Although other systems were willing transfer the program to their facilities, the BBA prohibited such a transfer. The program has been temporarily preserved through the establishment of a foundation. However, it is not financially stable. Without the ability to transfer residency programs, it is possible that Utah will ultimately lose the Family Practice program at St. Mark's.

RECOMMENDATIONS

Because of the adverse effect the BBA will have on Utah's training programs and by extension, the quality of Utah's health care, Utah recommends the following:

- Return IME and DSH payments to their pre-BBA levels. Sponsors of GME need stable funding to plan and fulfill the ethical and moral obligations they have made to physicians currently-intraining.
- Reconfigure the basis for allocating federal GME dollars to correct current inequities and establish a uniform base per resident for primary care and specialty programs. Under the current mechanism inefficient programs are rewarded while efficient programs are penalized.
- Separate the cost of care from the cost of education and make both efficient.
- Allow states flexibility in shifting training programs from one sponsoring institution to another. This is a budget neutral adjustment that will preserve training programs that are vulnerable and allow teaching institutions to train the appropriate mix of health care professionals.
- Create a national GME Trust Fund.

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RANKING MEMBER

May 26, 1999

The Honorable William Roth, Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Roth:

I am disappointed at not being provided the opportunity to present live testimony at the Senate Committee hearings on **Changes to the Medicare System.** This is most unfortunate considering that as the sole non-voting representative in Congress of the nearly four million U.S. citizens in Puerto Rico, we lack the presence in the U.S. Senate that would ensure that our issues are taken fully into account.

My testimony raises significant concerns with respect to the differences in implementation of the Medicare program between the 50 states and Puerto Rico that results in discrimination against U.S. citizens who are subject to the same rate of contributions through payroll deductions.

I urge your attention to this important issue and appreciate the opportunity to discuss with you an appropriate strategy for a legislative initiative to correct these inequities in our nation.

I look forward to hearing from you at your earliest convenience.

Sincerely,

Carlos Romero-Barceló

Enclosures

STATEMENT OF HON. CARLOS ROMERO-BARCELÓ

Mr. Chairman and members of the Senate Finance Committee, I am pleased to have this opportunity to present testimony on behalf of the U.S. citizens of Puerto Rico on Changes to the Medicare System. The committee has focused national attention on one of the most important issues to all Americans, but in particular to older Americans. I wish to commend each of you for your fine work and the courage that you have demonstrated through the many challenges in finding appropriate solutions to the problems that plague Medicare.

I appreciate the opportunity to address some of the most critical concerns with respect to Medicare policies as they apply to the U.S. citizens that reside in Puerto Rico. There are substantial differences on how Medicare is applied to the Americans in the territories that result in unequal and inequitable treatment. This discrimination runs counter to all of our nation's most fundamental and valued tenets of equality, not to speak of established laws.

With respect to Medicare, the situation is unacceptable not only for our Medicare beneficiaries, but also for all those persons who qualify but are in fact excluded from coverage because they cannot afford to pay the Medicare premiums or the deductible, that is paid by Medicaid in the 50 states but which is not extended to Puerto Rico or the other territories. This discrimination is unacceptable also to the health care providers who are reimbursed at much lower rates than their corresponding providers in the 50 states.

It is my hope that as you discuss changes to the Medicare system and consider alternative proposals, the following issues can be evaluated and resolved in order to eliminate the discrimination that now exists against U.S. citizens by the mere fact that they reside in Puerto Rico.

MEDICARE BUY-IN PROGRAM

Federal law mandates that State Medicaid programs pay Medicare costs for certain elderly and disabled persons with low incomes and very limited assets. There are several programs that help individuals pay their Medicare expenses, including: the Qualified Medicare Beneficiary (QMB) program; the Specified Low-Income Beneficiary (SLMB) program; and the Qualifying Individual (QI) program. While all states are required to offer this benefit, participation in the territories is optional and Puerto Rico and American Samoa do not participate.

While I cannot speak for American Samoa, the reason for Puerto Rico's lack of participation is that we do not receive adequate funding for Medicaid to provide appropriate coverage for Medicare expenses, deductibles and premiums. You are aware of my quest for equality for the American citizens in the island territory and I believe that this is one of the most egregious examples of separate and unequal treatment for the Americans in Puerto Rico as compared to their fellow citizens in the other 50 states despite the fact that we pay the same premiums and are subject to the same payroll deductions.

In what is one of the greatest injustices against U.S. citizens anywhere, Puerto Rico only receives a block grant that is capped at $171.5 for FY 1999 for Medicaid, about one-tenth (10%) of what we would receive if we were treated as a state. Obviously, this sum is woefully inadequate to provide a safety net for the neediest older Americans in Puerto Rico, equal to that of their fellow needy older Americans in the 50 states.

In addition, since Puerto Rican-Americans are also excluded from the Supplemental Security Insurance program, commonly known as SSI, the income protection is not available to elderly and disabled Americans who are among the neediest of the needy in our society.

REIMBURSEMENT FOR HEALTH CARE PROVIDERS

Despite the fact that costs are comparable to the costs for providing hospital and health care services in any one of the 50 states, the reimbursement rate for health care providers is calculated at a much lower rate. This problem continues to increase as the Health Care Financing Administration implements the lower payment schedule enacted within the provisions of the Balanced Budget Act of 1997. I am particularly concerned about the impact of this policy on services, and their availability, to Medicare beneficiaries.

ENROLLMENT IN MEDICARE PART B BENEFITS

The automatic enrollment available for all beneficiaries in the United States is not available to the residents in Puerto Rico. As required by Federal statute enacted in 1973 that applies solely to Puerto Rico, when an eligible beneficiary enrolls in Medicare, they must enroll in person and travel to the local Social Security Office to authorize the deduction of the monthly payment from their Social Security check ($45.50 currently). This is not the case in the 50 states, where only those eligible individuals who opt-out of Medicare coverage must personally visit the Social Security office to sign the refusal waiver. I am convinced that this policy makes it harder for individuals to enroll in Medicare and actually discourages individuals from participating in this critically important program to which they have contributed through payroll deductions.

This policy has yet another and even more negative impact that, in effect, detrimentally penalizes some of the lowest income Medicare beneficiaries in the entire nation. For reasons that can only be ascribed to the requirement to enroll in person, Puerto Rico leads in the number of late payment Medicare enrollees. According to the most recent statistics, of all Part B enrollees 30,202 Medicare enrollees in Puerto Rico pay penalties for late enrollment in the program. This group represents over 8% of all enrollees and represents the largest number of late penalty payers in the entire nation. The second highest number of late penalties is reported in the U.S. Virgin Islands and the District of Columbia (3.4%), while only 10 states are next and average late penalties for only 1.1-1.7% of their Medicare enrollees.

The Social Security Administration estimates that approximately 2,000 Medicare beneficiaries monthly visit the local SSA offices to enroll, imposing a burden and causing further delays in servicing other pressing issues even though SSA is reimbursed under an agreement with HCFA.

In addition, Puerto Rico has the lowest rate of Part B enrollees in Medicare in the entire United States when compared with Part A eligible individuals. The most recent data collected by the Social Security Administration indicates that as of December 1998, there were 528,867 individuals in Puerto Rico who were eligible for the automatic enrollment and premium-free Hospital Insurance (HI/Part A coverage). Of that total, 369,758 were also enrolled in the Supplementary Medicare Insurance (SMI/Part B). These numbers indicate that only about 70% of the enrollees in the HI (Part A) program in Puerto Rico are also enrolled in the SMI (Part B) program. I suspect that the reasons for lower participation and that a significant number of eligible individuals did not enroll in Part B is due to several reasons including the required trip to the SSA field office, the substantial cost ($45.50) of the premium to be deducted from the social security benefit payment, the high incidence of penalties or a combination of these reasons. How many of these individuals would be able to benefit from QMB, SLMB or QI is yet to be determined.

I urge the members of the Senate Finance Committee to correct this gross inequity that penalizes in every possible way those who are most in need. Such discrimination must not be allowed to continue in our nation. This is an issue of economic justice, since Puerto Rican-Americans are subject to the same rate of contributions through payroll deductions, but do not enjoy the same benefits as all other Medicare beneficiaries in the nation.

It is not in our nation's best interest to continue to maintain unequal and separate policies that discriminate against the very people that government programs attempt to protect. I would like to urge each of you to present viable proposals during this session to correct such discrimination to our neediest Americans.

I am urging your assistance and support in this quest to achieve equality in Medicare for the American citizens in Puerto Rico. I would appreciate the opportunity to meet with each of you to discuss a legislative strategy to correct these inequities in our nation.