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Introduction

Thank you Chairman Grassley, Senator Baucus and other distinguished members of the Committee for the opportunity to testify before you today. I am Lois Quam, the Chief Executive Officer of Ovations, UnitedHealth Group's business that focuses on meeting the health care needs of the over-50 population. I am pleased to speak on our experiences with providing health care services in a competitive market.

Ovations, and the other companies of UnitedHealth Group, have extensive experience providing health care services to the federal government, state governments and private payers in many types of competitive environments. As the largest health and well-being company in the United States, UnitedHealth Group's operating businesses provide a diverse and comprehensive array of services to over 48 million Americans. We provide services to approximately 300 large employers, over half of the nation's 100 largest companies, and serve over one million beneficiaries of Medicaid and other government-sponsored health care programs in 14 states.

UnitedHealth Group has a long-standing commitment to serving senior Americans. Our participation in the Medicare program is fundamental to our core mission – to support individuals, families, and communities to improve their health and well-being at all stages of life. We aim to facilitate broad and direct access to affordable, high quality health care.

My business, Ovations, is the largest provider of health care services to seniors in America. We offer a unique perspective on Medicare because we are a major provider of services through the traditional fee for service program, health plans, and demonstrations for the frailest Medicare beneficiaries. Our commitment is therefore to Medicare and its beneficiaries – rather than a specific Medicare product offering.

Ovations is dedicated to helping Americans in the second half of life address needs for preventive and acute health care services, deal with chronic conditions and respond to unique senior issues relating to overall well-being. On behalf of AARP, we operate the only national Medigap offering today. We deliver supplemental health insurance products and services to 3.7 million AARP members living in all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. Through this program, we provide prescription drug coverage to the majority of all Medicare beneficiaries who receive drug coverage through Medigap plans. The prescription drug card we offer, also working with AARP, is the nation's largest, providing beneficiaries who remain in traditional Medicare with some of the best drug discounts available. Over two million working aged and retirees receive Medigap health coverage through our employer-sponsored programs. Through Evercare, our business that serves the unique needs of frail elderly and chronically ill patients, we provide specialized care services to nearly 25,000 frail elderly individuals and 36,000 elderly and disabled Medicaid beneficiaries on behalf of the federal government and the states of Texas, Minnesota, Arizona, and Florida. Additionally, more than 200,000 Medicare beneficiaries are enrolled in one of our Medicare+Choice plans and nearly 4,000 are enrolled in one of our Preferred Provider Organization (PPO) demonstration plans.

In 2003, we have reaffirmed our commitment to Medicare through continued expansion of Evercare, participation in the PPO demonstration, continued enhancement of AARP offerings in all 50 states, and by making every effort to remain in counties that are not marked by high reimbursement. In fact, we just received approval from CMS to introduce a PPO product in Council Bluffs, Iowa, and Omaha, Nebraska. We support Medicare offerings in metropolitan, urban and rural areas and have developed culturally sensitive programs such as multi-lingual customer service and programs focused on social well-being.

Designing a Better Medicare

We believe a better Medicare would be a less expensive Medicare. It would be less expensive because it would deliver services in a more cost effective way, allowing for an expansion of benefits, not because it would cut payment levels or reduce benefits. It would be more cost effective because it would vastly improve care to people with chronic conditions and would provide greater emphasis on keeping healthy beneficiaries healthy longer.

Addressing the needs of chronically-ill beneficiaries is imperative to the success of Medicare modernization. The opportunity to improve the lives of chronically-ill beneficiaries and conserve Medicare resources is enormous. Research has widely documented the costs, lack of coordination, and poor health outcomes associated with chronic illness.

- Medicare spends two out of every three dollars on people with five or more chronic illnesses.
- A beneficiary with five chronic conditions has Medicare costs of about $13,700 per year, compared to $980 for a beneficiary with one chronic condition.
- Medicare beneficiaries with multiple chronic conditions experience unnecessary or avoidable hospitalizations for illnesses that could have received effective outpatient treatment.
- Per 1,000 beneficiaries, these hospitalizations increase from seven for people with one chronic condition to 95 for beneficiaries with five chronic conditions, and to 261 for people with 10 or more chronic conditions.
- There is clear evidence of adverse outcomes from hospitalizations exposing seniors to risk factors for which they do not need to be exposed. In 1999, the Institute of Medicine released a report that contends that two million medical errors occur in hospitals every year.

Research also has documented the effectiveness of various clinical and social interventions designed to treat the highest users of Medicare services. One study showed that nurse-directed education programs and follow-up interventions for patients hospitalized with congestive heart failure have reduced subsequent hospitalizations by over one-half and overall health care costs by nearly $500 per patient. In addition, the evaluation of the PACE program for frail elderly beneficiaries eligible for both Medicare and Medicaid shows that PACE program participants have fewer hospitalizations and nursing home days, short-run improvements in quality of life, satisfaction with care and functional status. A study of our own Evercare program, which provides coordinated medical care through primary care teams for institutionalized Medicare beneficiaries, shows a 50 percent decrease in hospitalizations and improved family satisfaction.

These types of results could be achieved across the Medicare program. However, the government has not made major changes to Medicare to address these issues.

How Can Competition Lead to a Better Medicare?

Many have contended that competition would reduce Medicare costs and improve care. Competition does not automatically achieve desired goals. Our experience has shown us that three principles are vital to competition that works:

1. The competitive process focuses on results for consumers
2. It promotes improvements in services
3. It aligns the interests of the parties

Results for Consumers

Competition will only succeed if it is focused on delivering results to consumers. To do this, two conditions must be met. First, the unique needs of the different groups of Medicare beneficiaries need to be understood and reflected in the Medicare program. Second, consumers should have the opportunity to choose based on their own preferences rather than having the choice be made at the agency level.

The first condition is imperative to achieving a better, less expensive Medicare program. In many ways, Medicare has operated in a uniform way, a one size fits all approach. Competition can help Medicare provide options that are linked to the diverse needs of beneficiaries – in particular those who have chronic illnesses.

The first condition is especially important when designing competitive offerings for Medicare, because competitive designs have normally been modeled on the employer market. Medicare beneficiaries are very different from the employees of large companies. They represent vastly different age groups and therefore very different clinical needs. The average age of enrollees in employer-sponsored health plans is 37 – half the median age of Medicare beneficiaries. Moreover, Medicare beneficiaries have multiple chronic illnesses and comorbidities that are not addressed by the single-focus disease management programs used by employers. Unlike the employer population, many Medicare beneficiaries cannot manage their own care due to dementia or other functional limitations.

Currently, 50 percent of Medicare resources are consumed by five percent of Medicare beneficiaries. Reducing the impact of chronic illness requires a different approach than those currently provided through the Medicare program. Changing the way the chronically ill and frail elderly are served by the Medicare system not only will result in better quality of care for these beneficiaries, it also provides the best opportunity for controlling costs associated with this special population. For example, Evercare efforts have resulted in a 50 percent reduction in hospitalizations, a 97 percent satisfaction rating among families and a 20 percent reduction in the number of medications consumed by enrollees.

Creating specialized approaches for treating the chronically ill also will provide a more stable environment for general health plan competition. It will allow for competition over cost and quality, not over risk selection. Without addressing the issue of the highest users of Medicare services first, no amount of competition will be effective in producing significant savings or improving outcomes in the Medicare system.

Providing flexibility to establish programs that meet the varying needs of the various Medicare populations would provide dramatic results in improving the competitive environment. A consumer-results focused approach would increase choices and allow beneficiaries to select the plan that best meets their needs. It should include programs that effectively deal with the health care needs of the highest users of Medicare services, plans that focus on keeping healthy beneficiaries healthy, and strategies designed to meet the unique aspects of our diverse culture.

Allowing consumers, rather than the contracting agency, to select from competing options is vital to successful competition. The agency should establish a framework and then allow for a variety of Medicare options to be offered within that framework. This model most effectively responds to the diverse needs of beneficiaries, beneficiary expectations, and offers the opportunity to develop best practices.

Our experience has shown us that competition that focuses on "competitive bidding" tends to be process oriented, rather than results focused. Often, it serves to reduce competition and limit consumer choice. It tends to reflect the preferences of the contracting organization, which often are not aligned with those of consumers. Competition that places great emphasis on low cost most likely would result in a more restrictive health care option, not unlike a staff-model HMO with limited networks, rigid medical management practices (denial of care) and fewer beneficiary options. In our estimation, competitive bidding that relies on low bids or a "winner takes all" approach provides high risk for both beneficiaries and the government.

Consumers look to Medicare for a degree of security and stability. This model does not provide it. A consumer driven model that provides various options from which beneficiaries may choose is more like the model used by large employers and even the federal government. We think Medicare beneficiaries and their families are in the best position to decide which plan is best for them.

Improvements in services

In addition to focusing on results for consumers, effective models of competition are designed in a manner that fosters improvements in services. A better Medicare encourages improvements in services. Historically, innovations in Medicare too often have faced barriers because they are different from the status quo.

An effective competition model is one that encourages new and innovative ideas and includes streamlined, efficient review processes that allow the government and beneficiaries to quickly benefit from innovation and advances in technology. A structure that strives for a fair and reasonable balance between the need for regulatory oversight and the promotion of quality health care, rather than a monolithic one, would facilitate innovation and broader participation. Finally, an effective model of competition would foster the development of population-specific approaches.

We participate in many effective competitive programs. Those that work best have built in ways to improve services during the contract term. As a result, they have mechanisms to allow dialogue, which can lead to a modification of terms and required conditions during the contract term. These competitive models assiduously avoid contractor micro-management or over-specification of process. Instead, they rely on clearly articulated objectives and performance standards that are related to those objectives.

Aligned Interests

Through our experiences, we have learned that the most effective contract relationships are those in which our incentives are closely aligned with the goals of our customer. The best contracts include clearly articulated performance standards and appropriate incentives for results tied directly to functions over which the contractor exerts control. We're proud to say that we have a good track record of meeting or exceeding performance standards.

Effective contracts also include reimbursement levels that are reasonable and provide plans the opportunity to gain if they meet or exceed expected results for beneficiaries. Additionally, contracts based on aligned interests seek ways of linking the financing structure and the delivery system. They seek to achieve a true partnership between both entities in order to provide the most effective services possible.

TRICARE as a Model for Medicare

UnitedHealth Group spent considerable time and resources preparing a bid in response to the recent Department of Defense solicitation for the next generation of TRICARE contracts. We want to emphasize that we appreciate the leadership at the Department of Defense and support its efforts to improve the TRICARE program. However, after much consideration, we decided not to submit a bid. At the Committee's request, we are providing our reasons for not participating.

There were many things we liked about the TRICARE solicitation, and we think it should provide significant improvements in the program. However, from our point of view, the solicitation was not structured in a manner that supported our three principles of effective competition.

The TRICARE contracts are competitively bid under a "winner takes all" approach in each of the three TRICARE regions. This approach has led to a TRICARE format that is strongly rooted in the existing contractor practices and the historic practices of the TRICARE contract management staff. Therefore, while the Request for Proposals (RFP), and the DOD leadership, has been articulate about the desire to achieve results for beneficiaries, the actual RFP favored these historic, institutional practices.

For example, one of the objectives of the TRICARE solicitation was the achievement of the highest levels of beneficiary satisfaction. However, rather than looking to commercial contractors to offer best business practices, the solicitation established complex reporting requirements, burdensome referral processes, and other costly administrative items. The RFP requirements appeared to be historical and process oriented rather than focused on producing the best results for TRICARE beneficiaries. They did not seem to support the Department's clearly articulated objectives and evaluation criteria.

Achieving "best value" health care is a principal objective of the DOD solicitation. However, the solicitation requirements limit contractors' ability to achieve this objective. For example, contractors are at risk for target health care costs, yet they have no control over many key decisions and factors that could impact TRICARE costs. These factors include benefit changes, implementation of best practices across the direct care system, major policy changes and structural changes to the MHS. Under this arrangement, the contractors assume tremendous risk while DOD maintains control of circumstances necessary for cost control and penalty avoidance. This approach creates a gross misalignment of interests and negative practices, such as change orders. As a result, the costs of the TRICARE program have been high and less stable.

In the end, we decided that the structure of the solicitation limited our ability to deliver results to beneficiaries and improve services. Moreover, from our point of view, the contract specifications and requirements did not align with the achievement of the Department's objectives. We concluded that the TRICARE solicitation contained barriers to entry for new competitors, and that only incumbent companies would be likely to participate given highly specificied process requirements in the RFP and the ambiguity about provider financial risks.

Why TRICARE is an Ineffective Model for Medicare

Based on our experience with TRICARE, we do not believe it a good model for Medicare. The Military Health System is very different than Medicare. As a result of its dual mission and direct care system, it requires a tailored approach designed to optimize its unique structure. Under TRICARE, the military's direct care system delivers the bulk of services to DOD beneficiaries. TRICARE has been effective in producing savings for DOD largely through improving the efficiencies of its direct care system and steering more care into military treatment facilities. Medicare has no direct care system. Therefore, while a TRICARE-like model may be effective for the Department of Defense and the unique mission of the Military Health System, it probably would not produce comparable savings for Medicare.

Also, the TRICARE population is very different from the Medicare population. TRICARE covers active-duty military members (average age is about 25 years), their families, retirees and their families. While over-65 retirees are covered by TRICARE, they actually are covered under a separate program – TRICARE for Life – that serves as a comprehensive Medicare supplemental program. In fact, under the new TRICARE contracts, TRICARE for Life is being addressed under a separate contract, not under the managed care contracts that provide comprehensive health care services on a regional basis.

Finally, while DOD believes that a "winner takes all" approach works the TRICARE program, it probably would be more challenging to manage under Medicare. The TRICARE program serves just over six million beneficiaries; Medicare serves 40 million today and that number is expected to climb dramatically in the coming years. Even if the country were divided into several regions like the TRICARE program, it's hard to imagine how a healthy mix of health care organizations would be able to compete to serve so many beneficiaries under a TRICARE "winner takes all" model.

Conclusion

In closing, Medicare would experience better results at lower costs under a model which embraced these principles – a competitive process that focuses on results for consumers, promotes innovation and aligns the interest of the parties. Congress can advance this model by establishing a consumer-driven competitive process that creates programs tailored to meet the varying needs of Medicare beneficiaries, particularly the five percent that consumes 50 percent of Medicare resources; promoting innovation; and ensuring that Medicare contractor interests are aligned with the government's objectives for Medicare. Simply introducing competition to the program will not affect meaningful change.

Results for Consumers

If Congress decides to establish a more competitive environment for Medicare, we strongly recommend that it be based on consumer-driven competition rather than process-driven competition. More importantly, it should focus on delivering results for consumers by providing programs tailored to meet the varying needs of the diverse Medicare population. Specifically, Medicare needs to change the way it delivers health care services to beneficiaries with chronic illnesses and should include preventive coverage to keep healthy beneficiaries healthy longer. Introducing competition will not produce meaningful savings without addressing this issue first.

Including special programs for the chronically ill and frail elderly population would benefit Medicare beneficiaries by providing better quality and outcomes, as well as increased patient satisfaction. The government would benefit from lowered hospitalizations and other health care costs, as well as demonstrated effectiveness. These tailored approaches should be provided through both Medicare fee-for-service and Medicare health plans, building upon the traditional Medicare program and while expanding health plan options for the chronically ill.

Efforts to modernize and improve Medicare should include specialized health plan options for the chronically-ill. The government would contract with organizations that met specific clinical, financial, and quality requirements. Organizations would guarantee the government savings relative to the current costs of treating beneficiaries with chronic illness. Organizations would also be required to achieve agreed-upon clinical outcomes that measure health and functional status. Enrollment in these plan options would be voluntary, and beneficiaries who choose to enroll would keep their current primary care physicians.

Modernization efforts also should include a new fee-for-service chronic illness coordination benefit for Medicare beneficiaries with four or five chronic conditions. The program could be modeled on the Medicaid primary care management benefit. Medicare would reimburse certain qualified providers for complex clinical care management and coordination. A physician or other practitioner would be responsible for coordinating the care by all practitioners, and facilitate non-Medicare covered supportive services in exchange for an additional fee. Care coordinators would monitor all aspects of a beneficiary's care and maintain a comprehensive medical record. Medicare would establish fees for these services and would set requirements for improvements in outcomes, including the frequency of avoidable hospitalizations, and other accepted measures of quality.

In addition, Medicare improvements should include options to allow care management organizations to provide care coordination services for fee-for-service beneficiaries. Beneficiaries would voluntarily enroll in the program and receive care coordination services including a nurse line, a comprehensive health assessment, and ongoing education and communication. Care management organizations would receive a fee from the government for providing these services, and in exchange guarantee a level of medical cost savings relative to fee-for-service Medicare. The fees would be contingent on an organization's ability to meet cost savings and other quality targets.

Many have suggested that Medicare would benefit from a PPO option that would improve beneficiary access to care, even in rural parts of the country, and help to provide efficiencies in the system. In reality, traditional Medicare is a lot like a PPO already – there are "network" (Medicare) providers who agree to accept Medicare rates in return for prompt payment of properly submitted claims. The primary PPO element missing today is care management. Adding care management services to traditional Medicare would in effect, create the desired PPO structure.

Innovation

Critical to the success of consumer-focused competition is the flexibility to innovate and design options tailored to meet the varying needs of the diverse Medicare population. In order to ensure an environment that is conducive to robust competition, the competitive model selected needs to minimize administrative and regulatory requirements to streamline the process for introducing innovation and emerging technologies. Additionally, the competitive environment should create a level-playing field for all competitors to ensure the best services and outcomes for both beneficiaries and the government.

Aligned Interests

Finally, we recommend that efforts to improve Medicare be focused on alignment of the interests of the federal government, companies and beneficiaries to produce stable and innovative options for Medicare. Congress and the Administration should decide the desired outcomes of any changes to the current system and provide effective rewards and incentives for performance in whatever structure is created to achieve those goals. In designing a competitive approach to Medicare, Congress and the Administration should focus on specific objectives – operating more efficiently, refining the system to meet today's health care needs, effectively incorporate emerging technologies, providing better outcomes for beneficiaries, promoting healthy aging, and increasing access to care. Then, design a competitive structure that supports achieving those outcomes.

Closing

At UnitedHealth Group, we have extensive experience in the competitive environment and compete in a number of ways and based on a number of factors. Therefore, we cannot provide you with a single "best approach" for competition; each situation is somewhat unique. However, based on our experience, we do think that a consumer-driven approach unencumbered by regulation, such as a modified Federal Employees Health Benefits Program, offers the best competitive solution for Medicare.

In closing, we believe a better Medicare would include a prescription drug benefit and deliver most cost-effective health care services. We see opportunities for improving the current Medicare system to provide better results for both beneficiaries and the federal government. We think efforts to do so will be most effective if they build upon the choices currently available to beneficiaries and draw upon the strengths of both the public sector and the private sector. Creating a structure designed to meet emerging health care needs by changing the way care is delivered to the highest users of Medicare services, coupled with contracts that focus on results for beneficiaries and allow for innovation, will provide enormous benefits to the Medicare program. Not only would these structural changes improve outcomes and increase efficiencies, they also will increase beneficiary satisfaction and provide them with greater choice.

We have heard numerous references in discussions on modernizing Medicare that emphasize the concept "do no harm." We agree that it is very important to do no harm, but believe that simply focusing on that concept is not enough. Efforts to modernize Medicare should result in a better Medicare – for beneficiaries, taxpayers and the federal government. Competition alone will not provide that. A better Medicare, we believe, is a more efficient Medicare that uses prevention to keep the healthy fit and specialized programs to improve the quality of life and effectiveness of health care services provided to the chronically ill. Medicare improvements could change Medicare from a uniform system, where one size fits all, to a responsive program with options tailored to distinct groups of beneficiaries.

We appreciate the committee's leadership on this important matter and thank you for the opportunity to share our thoughts. I would be happy to answer any questions you might have for me.