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MEDICARE: PERSPECTIVES ON THE PAST AND IMPLICATIONS FOR THE FUTURE

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MEDICARE: PERSPECTIVES ON THE PAST AND IMPLICATIONS FOR THE FUTURE

TUESDAY, FEBRUARY 28, 1995

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

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Simpson, Pressler, D'Amato, Moynihan, Baucus, Rockefeller, Conrad, Graham, and Moseley-Braun.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Committee will come to order please. Now I will tell you what we are going to do, and Dr. Vladeck has kindly accommodated us. We may have an objection to the Committee meeting. There is a Senate rule that, if anybody objects, you cannot meet more than two hours after the Senate has convened. It started at 9:00 o'clock and, in fact, I think there is going to be an objection. So we cannot go past 11:00 a.m.

So Dr. Vladeck will make his opening statement. Then I am going to ask the other two witnesses to make their statements because Dr. Davis is from out of town. And I want everybody to get on before we possibly get shut down against our will.

So, Dr. Vladeck, we will start with you right now.

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

Dr. VLADECK. Thank you very much, Mr. Chairman. As you know, I have submitted a written statement for the record, and I will also try to condense my oral testimony as much as I can. But we have some beautiful charts that I would like to take a couple of minutes to share with you.

Let me very briefly say how pleased I am to be here today, to have the opportunity to discuss the Medicare program, and its extraordinary success in providing health care to the elderly, as well as the challenges it faces in controlling expenditures without jeopardizing the services it offers to its beneficiaries.

Medicare has fulfilled its promise of providing access to basic health care for elderly and disabled Americans. As it enters its 30th year, however, we face a world quite different from that in

which the program began. We will face continuing challenges in assuring access to care, assuring the quality of that care, responding appropriately to technological advances in medicine, and in helping to reform the health care delivery system.

It is important to remind us that, before Medicare was created in 1965, over half the elderly population had no health insurance at all. Now over 95 percent of the elderly are insured. In addition, in 1972, as you know, Mr. Chairman, Congress expanded Medicare to include disabled individuals and those afflicted with end-stage renal disease. Today these individuals have basic health insurance, and no longer need to fear massive bills or having to do without basic care they need.

While sustained by our program, many of our beneficiaries could be described as vulnerable. And let me just very quickly review some of these charts, if I may.

A relatively few beneficiaries can be considered financially well off. And the better off beneficiaries use fewer services, either because they are still covered by employers past the age of 65, or because of the general principle that the wealthier older people tend to have a lower burden of illness.

As you can see from Chart No. 1,* approximately 83 percent of Medicare program expenditures are on behalf of those with individual or household incomes of less than $25,000 per year. That, obviously, follows from the fact which both of you gentlemen know well, that almost 60 percent of senior citizens rely on Social Security for 50 percent or more of their income.

The third chart, I think, is particularly relevant to looking at the future of the program because it shows that currently 20 percent of Medicare beneficiaries are over the age of 85, and most of those over 85 are women who live alone.

For persons with disabilities or end-stage renal disease, these are by far the two fastest growing groups in the Medicare population. And providing coverage for them is considerably more expensive than for other groups in the population.

In the last several years, in part because of these demographic changes, there have been substantial shifts in where Medicare dollars go. This may be a little difficult to see from where you are but, as with other health insurers, a significant diminishing share of all Medicare dollars goes to cover hospital inpatient services.

In Medicare, however, we have been experiencing a particularly dramatic growth in home health services. Together with nursing facilities, those now account for more than 10 percent of total Medicare expenditures.

We continue to enjoy high levels of customer satisfaction. A recent study shows that the majority of beneficiaries are highly satisfied with their insurance and their care.

We also experienced increasing physician participation. About 65 percent of eligible providers are now participating in the system. And we continue to lead the health industry in the effective use of high technology for program administration. We continue to operate the system with administrative costs of less than 2 percent of program outlays.

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*The charts referred to appear in the appendix following Dr. Vladeck's prepared statement.

As you know from all the discussions last year, in the small group or individual sale market, private health insurance administrative costs can run as high as 25 percent. In the most efficient large groups in the commercial market, administrative retention runs 5 percent or more.

One of the reasons our costs are so low is because we have pioneered a program in fostering electronic claims submission. Ninety percent of our hospital and nursing facility bills, and 70 percent of our physician claims, are submitted electronically. That is significantly higher than for private insurers.

For 30 years, we have been insuring the nation's elderly and disabled. We know that beneficiaries feel a certain ownership of the program, and the feeling is justified. Through their payroll contributions, and those of their employers during their working lives, and their own premium payments, beneficiaries contribute a substantial fraction of the costs of the Medicare program.

Let me, without going into some of the specific experiences in cost containment, suggest that over the last decade, except for the last 18 months, our experience has been that, on a per-capita basis, despite the fact that our population has been getting sicker, while the privately-insured population has been getting less sick on average, Medicare costs per capita have grown less quickly than have costs in the private sector.

In 1994, there was a significant deceleration in private sector insurance costs, a greater deceleration than that which we experienced, although I would note that the major contributors to the difference between the growth in Medicare costs and the growth in private sector costs in 1994, were that we had very high cost increases for long-term care services, home care and nursing homes, which are not a major part of private insurance. Whereas private employers achieved significant savings in their coverage of prescription drugs which, of course, is not covered by the Medicare system.

Let me just add a few words in that regard, about the growth in managed care in the Medicare program. We are participating in the managed care revolution. Indeed, we are increasingly assuming a leadership position. We are working very closely with the industry to meet goals of expanded choice and quality of services. We are projecting a 20 percent growth in Medicare managed care enrollment this year, a clear signal that beneficiaries are changing the face of the program by their own choices.

At present, 75 percent of Medicare beneficiaries live in communities in which they have one or more managed care plans available to them. And 9 percent of beneficiaries have chosen to enroll in managed care. This is a period of impressive growth—that is Chart No. 10 in the package that you have. In 1994, total enrollment increased by better than 1 percent a month and the number of contracts increased by roughly 20 percent.

If you look at what is happening in the private sector, however, the greatest growth in managed care in the last 5 years has occurred not in traditional HMO's, but in so-called PPO's, Preferred Provider Organizations, and arrangements of that sort, in which individuals have lower cost-sharing if they stay within the network or within the plan, but higher cost-sharing if they go outside.

We do not currently have such an option in the Medicare program. We think it is increasingly the option of choice for folks in the private sector, and we would like to be able to offer such an option in Medicare. We will be suggesting working with you on legislation this year in order to establish of a Medicare PPO option.

In addition, we need to find better ways to pay for managed care plans. Our current methodology is not only inadequate in terms of the incentives it often provides in low-cost areas, and the instability it can produce in rates for HMO's from 1 year to another, but it is designed in such a way that it is almost impossible for the Medicare program itself to save money from growth in HMO enrollment under the current payment mechanisms.

We think there is a lot of promise in notions of competitive bidding within identified markets for Medicare contracts. I would like to work with the Committee and other members in the course of the year to develop a test of competitive bidding for Medicare HMO pricing.

We are also moving ahead very aggressively, in conjunction with the HMO industry and the National Committee on Quality Assurance and other private sector groups, in developing better performance and quality measures foi HMO's, which have been a longstanding issue, both for us and in the private sector as well. I hope that, within the next few weeks, we will be in a position to announce a project in which we will build on the private sector for plan accountability work under the so-called HEDIS system to adapt that to Medicare, while at the same time we are totally reorienting the way in which the peer review organizations review the quality of care and respond to customer complaints in HMO's.

Just a few final words by way of conclusion, if I may. While we strive to expand and change the ways in which we are doing business in the Medicare program, we have to acknowledge our financial realities.

The most recently available estimate from the 1994 Report of the Trustees of the Hospital Insurance Trust Fund, as you know, predicted an exhaustion date for the fund of the year 2001, under moderate assumptions.

Although that was 3 years better than the previous year's report, largely as a result of changes in 1993, especially the removal of the earnings cap on the HI tax, which had a significant effect on the overall status of the trust fund.

In addition, the 1993 provisions, which raised the maximum percentage of Social Security benefits subject to the income tax from 50 to 85 percent, and dedicated the additional revenues to the HI fund, contributed importantly to that improvement in the status of the fund.

Nonetheless, we have both short-term and long-term issues associated with the well-being of the fund. The trustees' report is due just a month from now. I cannot appropriately tell you everything that is in it. I can promise you, however, that we will address largely on the outlay side the issue of solvency of the fund over the next 10 or 15 years, and suggest that the long-term solvency of the fund after we baby-boomers become eligible after 2010 or so, and the ratio of workers to beneficiaries changes very dramatically, requires a much broader and longer-term look at the issues.

If I could just summarize, I think the Medicare program continues to be an extraordinary accomplishment, of which all Americans should be proud. Especially the Members of this Committee, who have played so central a role in its development and improvement over the years, have a special reason for pride.

The vision started 30 years ago has proven to create a revolutionary change in the well-being and the quality of life of the nation's elderly. Ironically, one of the other things it has done is contribute to increased availability of medical services for the elderly, which is probably not unrelated, although not the primary cause, of increasing life expectancy for persons 65 and older which, in turn, increases the expense of the trust fund as we provide services to people over a longer period of time.

The challenges we face in the years ahead because of demography, because of changes in the health care system, because of the growing needs for care in vulnerable populations, are quite formidable. We very much look forward to working with Members of the Committee to address these issues in the months and years ahead.

I thank you. I am happy to answer any questions. I am also happy for any changes in the plan of attack today.

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

The CHAIRMAN. Before the other Members got here, I explained the situation that we may have an objection to the Committee meeting, and I want the other witnesses to be able to testify.

So I am going to ask Karen Davis to come up now. Gail Wilensky is not here. Oh, there she is. All right. Then I will ask the two of you to testify. Then we will call Dr. Vladeck back for questions, and then the panel for questions.

So if you can wait, Dr. Vladeck, while Dr. Davis and Dr. Wilensky testify.

Senator D'AMATO. Mr. Chairman.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Inasmuch as I have a hearing at 10:00 o'clock, I would like permission to submit a statement for the record.

The CHAIRMAN. Without objection.

Senator D'AMATO. I thank the Chair.

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

The CHAIRMAN. Dr. Davis is the President of the Commonwealth Fund in New York. The work that you have done, Doctor, is well known.

And Dr. Gail Wilensky is well known to this Committee. How many times have you appeared before us over the years?

Dr. WILENSKY. Lots.

The CHAIRMAN. When she was HCFA Director. And we are delighted to have you both.

Dr. Davis.

STATEMENT OF DR. KAREN DAVIS, PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. DAVIS. Thank you, Mr. Chairman, Members of the Committee.

I too will submit my statement for the record, and just try to abstract a few points from some charts that appear at the back of my statement.

[Dr. Davis' prepared statement, charts referred to, and responses to questions subsuquently posed in writing by Senator Moseley-Braun appear in the appendix.]

I think it is particularly fitting to have this hearing on Medicare in 1995 because this is the 30th anniversary of the Medicare program. It has brought health and economic security to millions of our Nation's most vulnerable citizens.

Medicare faces a dilemma today. It is expensive for the program and, therefore, for taxpayers. And it is also expensive for Medicare beneficiaries who, even with Medicare, pay a high proportion of this own health care costs. In part, this dilemma is brought on by the success of Medicare.

Life expectancy at age 65 in the U.S. is now one of the best in the world. We now have cataract operations, hip replacements, control of hypertension that has contributed to plummeting stroke death rates. In short, people live longer and better. And, in part, Medicare deserves the credit for some of that record.

You will see at the back of my statement, on Chart 1, 37 million people are covered by Medicare. And, despite the popular impression that most older people are well to do, in fact, three-fourths of all Medicare beneficiaries have incomes under $25,000. While poverty rates for the elderly are below those of the nonelderly, many people have been lifted just above poverty by Social Security benefits.

In fact, as Dr. Vladeck indicated, only 3 percent of all Medicare outlays go to beneficiaries with incomes in excess of $50,000.

Chart 2 indicates that Medicare alone is not enough. Medicare, in fact, only covers 45 percent of the expenses of the elderly. Most buy Medigap coverage or get employer retiree health benefits to supplement Medicare.

But, for low-income individuals, Medicaid often is not there to supplement Medicare. Only half of Medicare beneficiaries with incomes under $5,000 are on Medicaid and one-fifth rely only on Medicare to pay their health care bills. In fact, most of those poor elderly are eligible for Medicaid to supplement Medicare's premiums and cost sharing, but simply do not know they are eligible, and do not find out about their benefits.

Chart 4 indicates that Medicare spending goes largely to the sickest beneficiaries. For the sickest 10 percent of Medicare beneficiaries, they account for 70 percent of all of the outlays. These are people with cancer, heart disease, diabetes, arthritis, hypertension, osteoporosis, people in nursing homes.

You see the implications of that in Chart 4. For the sickest 10 percent, the average outlays under Medicare average over $28,000 per person per year. For the healthiest 90 percent, Medicare spends an average about $1,300 per person per year.

This creates a major problem with managed care, since there is tremendous incentive to enroll the healthiest 90 percent and avoid the sickest 10 percent, if plans are paid the same price for covering both the healthy and the sick.

Chart 5 indicates that it is important to understand how much elderly pay out of pocket. They face large deductibles, premiums and expenditures for noncovered services, such as prescription drugs. With today's current premiums and deductibles, it is easy for a woman with $10,000 income who has Medicare only, to be spending over $2,000 a year if she winds up in the hospital and needs some prescription drugs.

Even with Medigap, where average premiums are over $840, a woman with a $10,000 income could easily be paying $1,500 out of pocket.

You will see on Chart 6 that, on average, the elderly spend 12 percent of their incomes out of pocket, compared with 3.7 percent for nonelderly households. But I would like to stress that these are averages, that there are even higher percentages of income that are taken for low-income Medicare beneficiaries and for those who are chronically ill, who are in the hospital frequently, or using prescription drugs.

Chart 7 indicates that Medicare spending has grown rapidly over the last 2 decades. There is, however, some good news. There has been moderation in the rates of growth of Medicare spending over the last decade and, in fact, hospital and physician Medicare spending per beneficiary over the last 10 years has been lower than the growth in private insurance outlays for hospital and physician services.

As you see in Chart 8, the major increases are coming for services such as home health, long-term care, and skilled nursing facility services, where the rates have in fact accelerated in recent years. And, as Dr. Vladeck indicated, it is those services that tend not to be covered by private health insurance plans.

Chart 9 indicates that Medicare beneficiaries in fact give Medicare quite high ratings for affording them quality medical care.

And Chart 10 reports on the results of a Kaiser/Commonwealth Fund survey of all adults, which found that 52 percent of Medicare beneficiaries are very satisfied with their health insurance. And that compares with 44 percent of workers covered under employer health plans. So Medicare beneficiaries, on average, are more satisfied with what they have than workers. Also, Medicare beneficiaries are more satisfied than those who are insured individually.

On the bottom line at the very end of the last chart, the last page, at the bottom of Chart 11, you see that only 8 percent of voters who voted in November of 1994 support decreased spending on Medicare for the elderly. There is more support for specific targeted measures, such as having the wealthier pay more or tighter provider payment rates, but those would generate relatively little in the way of savings.

Well, what can be done? Managed care is one alternative. But, with the current system of paying HMO's, it would in fact cost the Medicare program, not save the Medicare program money to expand it. Current studies show that the rates for managed care are about 6 percent higher than they are under fee for service.

One could deal with that by lowering what is called the adjusted average per-capita costs by 6 to 10 percent. But then you would have wide variations, so that still would be inequitable for some plans, and favorable for others.

Because the basic problem with managed care is the incentive to game the system by taking the healthier patients. In the long run what one is going to have to do is to readjust that formula to take better account of the health status of people who are enrolled. But good ways of doing that seem years away.

In the meantime, there are other things you could do, like penalize for inappropriate marketing or disenrollment practices, but there are still subtle ways for plans to keep healthier patients and avoid taking sicker ones. It depends upon what type of specialists are in the plan, where your facilities are located, that would affect the mix of patients that you get.

Another option is to cut benefits for beneficiaries. If you were to increase deductibles or copayments for services like hospital care or home health, I think you have to recognize that you would add to the financial burden, especially for the chronically ill and the sickest, who are already paying a lot of money out of pocket.

Another approach is to have modest premium increases that would be spread across all beneficiaries. That would be less burdensome, particularly if it were graduated with the wealthier paying more. But the problem from that early chart is that you are really not going to generate much savings from very high-income beneficiaries because there are not very many of them.

You could tighten provider payment rates. You have to recognize that physician payments under Medicare are already 58 percent of what private insurers pay physicians.

You could tighten hospital payments. But, again, I think you have to recognize that there are some rural hospitals, there are some teaching hospitals, that are in a very vulnerable, precarious situation. If they got a substantial hit from Medicare, a lot of those institutions would be in serious financial trouble.

There are other measures. Dr. Vladeck mentioned various demonstrations that could be pursued to test out possible ways of saving money. There are methods that employers have used, like high-cost case management and selective contracting.

But I think the bottom line is that there is no easy way to make substantial savings in the Medicare program. It is a popular program; It is an effective program. And I think the thing that is most important for the Committee to remember is that 37 million of our most vulnerable citizens rely upon it for their health insurance coverage.

We should not risk reversing the gains in health and economic security that Medicare has achieved, as we try to assure the fiscal solvency of the program for future generations.

Thank you.

The CHAIRMAN. Thank you very much.

Dr. Wilensky.

STATEMENT OF DR. GAIL R. WILENSKY, SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD

Dr. WILENSKY. Thank you. Mr. Chairman and Members of the Committee, thank you for inviting me to speak before you again. I am currently at Project HOPE. I do not speak for Project HOPE but, rather, am giving my own opinions.

I would like to make it clear that I am not interested in Medicare bashing. I was very proud to have been an administrator of the Medicare and Medicaid programs from 1990 to 1992, and worked long and hard to try to make these programs function effectively.

Medicare is the world's largest insurance program, and it has been one of our country's most popular programs.

There have been a number of changes to the program since it was started, but we need to understand that there is a reason that Medicare has been so popular. In the first place—and this is, of course important—it fulfilled its original mission well. That was to increase and extend access to care for the elderly.

Before 1965, the elderly had had trouble getting insurance, and also getting appropriate care. The intention of the Congress when it passed this law was to mimic the prevailing system of health care financing in 1965, represented by the reimbursement arrangements of the Blue Cross and Blue Shield plans. And it accomplished its objective exceedingly well. Some might even say too well.

Medicare is not only popular though because it fulfilled its mission, but also because it places few restraints on the elderly as consumers of health care. Payments are more or less open-ended, and come with minimal restraints, at least as far as the elderly are concerned, except if they are in the hospital for very long periods of time.

There is full choice about which physicians to use, which hospitals to seek, which home care providers to use, and with little reason to care about their cost. There is no evidence today that the elderly are having any systematic problems securing access to care under Medicare, even with the reductions in provider payments that have been made.

And there is little or no pressure on the elderly to seek cost-effective providers or cost-effective health plans under Medicare. Most have either private insurance or Medicaid supplementing Medicare. And that means, for the Medicare-covered services, there is little financial pressure.

The major weakness in the program has to do with its financing. In the short term, entitlement spending, in general and Medicare spending in particular, acts as a major drain on the budget, exacerbating the deficit.

But, in the longer term, Medicare is not financially viable, as you know only too well. Future fiscal insolvency raises serious questions about the nature and design of a program that will be sustainable in the 21st century.

The hospital portion, the HI portion, that is funded by the trust fund is due to go belly-up in the year 2001. Its current growth rate is estimated at 10.2 percent, with growth rates between 7-1/2 and 10 percent per year for the remainder of the decade.

As you know, the other parts of Part A, the skilled nursing facilities, the home care, and so forth, are projected to grow even faster in the current year, around 26 percent and, even by the end of the year, are still projected to be growing at 8 or 9 percent per year.

This trust fund is running out of money. And, by the year 2001, we expect it will be bankrupt, with the imbalance growing rapidly thereafter.

Part B, which is financed three-quarters by the general fund, has a much more direct impact on the deficit. Its growth has been projected at 10.9 percent per year, and with growth rates between 12 and 13 percent per year for the rest of the decade.

And, while physician spending is due to grow less this year, around 6 percent, it is expected to grow at 9 to 12 percent per year throughout the rest of the decade. And it is even higher every place else for Part B.

This is at a time when the private sector appears to have slowed its spending dramatically. Between 1983 and 1991, Medicare spending grew more slowly than did spending in the private sector. I have shown this in Chart 1. But, since 1991, this role has been reversed, and Medicare has grown substantially faster than the private sector, 50 percent higher in real terms per person.

The differential appears to be even greater in 1993–94. But our numbers are not as good. It appears that, according to CBO, spending has grown twice as fast in Medicare as in the private sector, and some suggestions are that the differential may be even greater. At least when we look at places like the Foster-Higgins National Survey of Employers, we see absolute reductions in spending being reported for premiums—not the Washington version of cuts, lower rates of increase—but real people's definition of the word "cut".

But we should not be surprised at this outcome. Medicare is primarily fee-for-service medicine, with Government-administered pricing and a volume control on physicians. Hospitals are encouraged to game the way inpatient admissions are coded, to increase the use of hospital outpatient procedures, and physicians are rewarded for doing more when less may be as good or better.

There are few incentives for the elderly to seek out cost-effective providers, or for their physicians and their suppliers to limit the spending to be more cost-effective in the services that they provide. And, when they do so, they rarely receive a reward.

In this third-party-financed, fee-for-service world, our cost containment efforts can only come from a combination of the following: reducing prices and watching out for volume increases; tying price changes to spending targets; increasing deductibles and co-pays; or trying to limit access to providers and technology.

We have mostly relied on the first three, and we should not be surprised that, while direct controls may moderate spending for a few years, after a while this moderating force dissipates.

In trying to reform Medicare, we should keep certain goals in mind. Having more consumer choice for the elderly, providing incentives for accessible, high quality, patient-oriented care, encouraging more cost-conscious decision making by the elderly, incorporating some of the innovative changes of the private sector, and laying the groundwork for a fiscally-solvent Medicare program.

Medicare, as I have indicated, remains a fee-for-service program, with only limited types of managed care available. And the projections are, even though there is rapid growth now, that we will see an enrollment of no more than 2½ million beneficiaries in HMO's in 1995.

There are several reasons that explain the low managed-care population. But probably the most significant deterrent of growth is the limited types of non-HMO managed care options that are

currently available to the Medicare population, and the lack of incentives for them to seek out cost-effective health care.

In order to effectively reform Medicare, therefore, we will need to change the basic incentive structure associated with Medicare, open up options available to the elderly, and provide them with the information needed to make choices appropriate for each of them.

I believe that the use of a better designed, average adjusted per-capita cost payment, the payment that now goes to the HMO's, could be come the basis for a voucher which would encourage such cost-effective choices.

We would need to make some changes in the design. We need to make it more stable, and to take better account—as both Dr. Karen Davis and Dr. Bruce Vladeck have indicated—of the risk selection that appears to occur, as well as to open up more choices toward which that payment can be made.

Ultimately, I believe it may be appropriate and desirable to vary the amount of the payment with the income and wealth of the elderly person. But that is not a decision that you need to make immediately.

Some specific changes I would recommend are on page 11. Let me just review some of them: Allow Medicare Select to be available everywhere; allow Point-of-Service plans to exist under Medicare; allow for partial capitation, or carve-outs.

Clearly, we need to revise the capitation rate. Break the link with fee-for-service spending. Try to use competitive bidding in some areas to set the right level for payment. Experiment with some alternative calculations of the capitation payment for areas that cannot support competitive bids. Move to make an annual open enrollment period, rather than the 30-day disenrollment period that now exists, which encourages churning, and find a better rule to have quality and get rid of the 50-50 rule, which limits growth and does not insure quality. And, perhaps most importantly, allow HMO's to price underneath the Medicare payments and rebate the savings to the elderly and share the savings with the Government.

To the extent that payment is set at a level of the lowest-cost plan in area, this would provide a powerful incentive for the elderly to choose cost-effective health care plans.

And, I would like to emphasize for Mr. Baucus' advantage, that it may or may not turn out to be that the lowest cost plan is a managed care plan. Some parts of the country may well not be able to support or have these.

In the short term, I recognize that Medicare changes may need to produce savings, and this may well need to dominate Congressional decision-making. But there are some changes that are consistent with the move to a more incentive-based choice structure, some which are neutral and some of which move in the wrong direction.

And so I plead with you, when you try to find short-term savings and long-term reform, be sure that you keep this in mind. For example, if you were to have an increased coinsurance for home health or a fixed copayment for rehab hospital admissions, this would raise some additional revenues, it may lower utilization in

these areas, and it would make managed care options that usually cover these additional costs more attractive.

Similarly, bundling post-acute care payments would encourage better management of this type of care.

Reducing payments to indirect medical education or direct medical education would be neutral with how it affects the choice structure for Medicare.

But reducing physician fees in a dramatic way may be harmful in that it may induce more volume changes, just the thing that you would like to avoid.

So I believe it is possible to accommodate the need for short-term revenue increases, while setting the stage for fundamental change in the incentives, information and options that characterize the Medicare program.

Since it will take some time to realize all the gains from restructuring Medicare, it is important that these reforms be started as soon as possible. And this session of Congress is none too soon.

Thank you.

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

The CHAIRMAN. Doctor, thank you very much.

Let me explain to the panel again, we may have an objection to the Committee meeting past 11:00 o'clock.

So Dr. Vladeck testified, and then Drs. Davis and Wilensky. And then I am going to ask Dr. Vladeck to come back. The Administration does not want to appear on a panel, and has not historically. We will ask him questions, and then when we get to about 10:30, I am going to ask these two to come back and at least finish up with them. If we get shut off at 11:00, we get shut off at 11:00.

Senator BAUCUS. Mr. Chairman.

The CHAIRMAN. Yes.

Senator BAUCUS. Mr. Chairman, I have some questions I would like to submit.

The CHAIRMAN. Absolutely.

[Responses received appear in the appendix with the witnesses prepared statement.

Senator BAUCUS. I cannot stay long, but just the main points of the questions have to do with HMO's in rural areas and managed care generally in rural areas. It is my deep concern that where we move to managed care, seniors in rural areas are going to have a harder time compared with others.

Second is the importance of the Montana Medical Assistance Facility Project. I would like to see them permanent. I will draw this out in the questions I would like to submit to the panel.

The CHAIRMAN. Without objection.

Senator BAUCUS. Thank you.

The CHAIRMAN. Now, Dr. Vladeck, if you can come back, I am going to ask to hold our questions to 4 minutes on the first round, and we will see how far we go. But I do want to let the other two witnesses get back for questions before we get shut off at 11:00 o'clock.

Doctor, let me start. And I will read the order we have here: Packwood, Moynihan, Grassley, D'Amato, Graham, Conrad, Moseley-Braun, Pressler, Baucus, Simpson.

Doctor, as you are well aware, every year since 1970—with a 2-year exception, 1973 and 1974—the trustees have indicated that the HI fund is going to go bankrupt. And each Congress and administration has always saved it somehow, and one way or another we have added more money.

We go negative next year. We go into the red the next year. We go bankrupt in 2001 in the HI fund. And yet the administration, as best I can tell, has no proposal for the moment for rectifying that immediate problem. Do you have suggestions as to how we do it?

Dr. VLADECK. Well again, Mr. Chairman, as I suggested in my statement, as the Secretary to the Trustees who are meeting just about 4 weeks from now, I think it would be inappropriate for me to go into any detail about what they are recommend, particularly because I do not know what that is.

But I would suggest, sir, that we have two problems with the HI fund; we have a short-term problem and a long-term problem. If I can work backwards——

The CHAIRMAN. You mean you have no suggestions for us as to how to do this?

Dr. VLADECK. The trustees' report will contain a number of suggestions.

The CHAIRMAN. Do you have any personal thoughts as to how to do it?

Dr. VLADECK. I have some personal thoughts. As I suggested in my testimony, we have to do something about the rate of increase in outlays for both home care and nursing facility services, which are growing much faster than the hospital inpatient services, which is the other part.

And I could not tell you precisely that there a set of changes in those programs that would produce savings sufficient to assure the solvency of the fund for a longer period of time. But I think that is the place to concentrate, and the place where we would like to work with you on proposals in this year to do something about both those programs.

I think those will address the problem of the short-term issues having to do with the fund. I think, once you get past 2010, the demography shifts so dramatically that, as with the OASDI funds, you need to re-look at the long-term shape of the financing of these programs over time.

And that is something where I believe it is appropriate for a mechanism similar to that which was put together in 1983 to try to take a systematic look and develop a long-term bipartisan approach to the issues associated with both of the funds after the baby boomers become so large a share of the beneficiaries.

Senator BAUCUS. I am sorry, Mr. Chairman, did you say 2020?

Dr. VLADECK. About 2010 when the first of us begin to shift in a considerable way.

The CHAIRMAN. Do you have any suggestions as to how we should face that problem?

Dr. VLADECK. Well, I think, if you look at what happens after 2010, Mr. Chairman, you have a substantial increase in the ratio of older persons to workers. At the same time, the demography predicts conversely that you will have a substantial reduction in the

proportion of young people below working age who are being dependent on the working population, so that the total dependency ratio in society, as economists call it, does not increase nearly as dramatically.

We pay a lot as a society, through a variety of tax and other mechanisms, to support educational and other services for children below working age. Those are primarily financed from radically different revenue sources than those from which we finance our two major programs for retirees. But if there will be less demand on those sources after 2010 because of these demographic shifts, while the demands are growing so substantially on the retirement age programs, then I think you have to look at the whole fiscal structure of financing benefits in society.

The CHAIRMAN. Do you have any suggestion, I will say again, as to what we should do?

You are saying that we are going to come out even on this? And because there are fewer children to take care of, we can take care of more of the elderly, and it is a wash financially.?

Dr. VLADECK. I believe, sir, it really has to do with one's assumptions about what happens to retirement age, how long older people stay in the work force, and what the shift in the age of the work force does for productivity and real output in the economy. And that is about the limit of my knowledge of the economics, but I think you have to do a systematic look at those broader macroeconomic shifts before you can talk about the long term balance in the trust fund.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

You know, much of the interest in managed care, and putting Medicare beneficiaries into it, I think comes from the point of view that it will achieve a lot of savings achieved in Medicare.

What do you think might be a realistic level of savings that could be achieved if Medicare beneficiaries were to move more extensively than at present into managed care? And let me also ask you, along the same lines, how long, if there would be savings, it would take to achieve them?

Dr. VLADECK. I think those are very good questions, sir. I think the best way to respond is to suggest—and I think both CBO and GAO have reported similar kinds of findings—that in the private sector, for younger, healthier populations, HMO's over time appear to achieve savings in the range of 5 to 10 percent, relative to traditional fee-for-service insurance.

We have never demonstrated such savings for the older and sicker population covered by Medicare. But I would hope, in the long term, savings in the range of 5 percent or so would be attainable. Without requiring people to enroll in HMO's, however, it would be quite a long time. And we will need to do some things in the interim before the penetration rates for HMO's in the Medicare population reach the level where you could talk about savings in that regard.

Let me just highlight three particular issues there. The first is, as Senator Baucus has already suggested, in the private sector, as well as in Medicare, real questions about how you do managed care effectively in rural areas. And, as you know, Senator, because of

the population issues, Medicare beneficiaries are somewhat more likely to reside in rural areas than are privately insured folks. So the issue of developing the right kind of systems for rural areas is even more important for Medicare.

Second, we do not have a payment method at the moment that permits us to achieve any savings. My testimony speaks that we are working on it.

Third, and perhaps most troubling long term, is that if you talk to private employers, as we do, about how they achieve savings in managed care, they are able in many local markets to negotiate for favorable deals. In a way, that is conditioned on two factors. First, they are not the Government. They do not have to obey rules about open competitive bidding, about some of the other process requirements we have to observe when we buy.

And, second, their market shares are 3, 4, 5, 6 percent in their local market, so they can make deals at the marginal price to the provider. We are too big a player in most markets to get discounts that substantial without putting the whole health care system in those communities in jeopardy.

So our ability to achieve the same savings, even if we had exactly the same programs and networks as the private sector in managed care, is certainly yet to be demonstrated. And we have some real concerns about how to do it.

The CHAIRMAN. So, in order to save a lot of money, it has got to be mandatory membership. And it takes mandatory membership to make the savings very quickly. Otherwise, there are very few savings, and they are really in the out years?

Dr. VLADECK. And, sir, I think if you were going to try to save money quickly through mandatory membership in the short term, our experience suggests you would have to be willing to restrict substantially some of the rules that now seek to assure quality and good access to services within Medicare managed care.

Senator GRASSLEY. I want to focus on the disabled and the frail or sick elderly. Some argue that they might fare better if they were in a managed care environment because of tighter management. And others think that they would do worse because health plans will either want to avoid treating them altogether, or will be tempted to skimp on necessary care.

Do we have any evidence from practical experience about how such patients fare in a managed care environment?

Dr. VLADECK. Very very little. Because, until very recently, very few such people were enrolled in managed care plans.

And there has been some growth among the disabled, but the numbers are still very small, so the amount of actual evidence we have is very small.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to use my time in this round to focus on the issue of fraud and abuse, which has been a long-time concern of mine.

Looking at a study by the General Accounting Office dated February of 1995, and I will just quote a few sentences of their statement of the problem. The GAO states that, "In our 1992 report, we noted two problems related to Medicare claims processing contrac-

tors, which are responsible for applying controls against fraud and abuse. First, funding of contractors' activities to control fraud and abuse has not been commensurate with the growing volume of claims." And the report states, "Today's Medicare pays more claims with less scrutiny than any other time in the last 5 years."

The second problem noted is, "Medicare claims administration is a complicated process, with some 80 contractors sharing responsibility for claims processing payment and review."

And then they state the third problem that, "HCFA is aware that flawed payment policies and abusive billing practices plague Medicare, but the exploitation of the program continues."

Do you agree with that assessment of the status of fraud and abuse within the Medicare program?

Dr. Vladeck. Senator, I would agree that, as of a year ago, it was a perfectly accurate assessment. As you know, we have been putting an awful lot of work and energy into addressing some of these problems. We have been working very intensively with our contractors, particularly in certain areas of the country, to change the ways in which they do business.

We have totally changed the way in which we pay for durable medical equipment, which is traditionally an area in which we have had a lot of abuse.

We have reviewed all DME suppliers in the entire Medicare program and discontinued payment to a significant number of them when there was no evidence of ability to develop quality services.

We have added senior-level staff people within HCFA with full-time responsibility for program integrity for the first time in more than a decade.

And we are working very intensively with the Department of Justice and the Inspector General, as well as with our contractors in many parts of the country, to start getting a better handle on these problems.

Your first point—or the GAO's point which you cited—which has to do with the restrictions on funds available for program integrity activities in the Medicare program continues to be a problem, since program administration is a discretionary budget outlay, not an entitlement outlay.

But we will be making a proposal, as part of the Vice President's REGO 2 initiative, for some innovative new ways to fund program integrity activities in Medicare and other HHS programs that we think, over time, should provide a much firmer and stronger financial base for these activities, and return to the Government several-fold for every dollar that is expended.

I would hope within the next month or 6 weeks, the Vice President will be making these proposals, and that we can come back to you with specific legislation very soon thereafter.

Senator GRAHAM. You mentioned as one of the changes that there has been a change in the billing practices. A criticism of the way in which the Medicare program has operated is that there has been insufficient examination of providers prior to receiving certificates.

In South Florida, we had testimony at a meeting of the Aging Committee that firms which only had a post office box, and where even that was found not to exist, had a Medicare provider number

and were billing Medicare for substantial numbers of services, assumedly unrendered.

What has happened on that front?

Dr. VLADECK. Senator, thanks in part to your leadership, we have totally revised the way in which we enroll new providers through the Florida intermediary and carriers in that regard. And, as I said, we have eliminated several thousand identified names from the list.

We are having a meeting in about two weeks, at which we are going to develop a plan to adopt those procedures throughout the nation, and completely change the way in which providers come into the program.

Senator GRAHAM. Mr. Chairman, if our time is cut short, I would like to request the opportunity to offer some written questions to pursue the issue.

The CHAIRMAN. Without objection.

[The questions and answers appear in the appendix with the respective witness' prepared statement.]

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman.

In this morning's Washington Post, our Chairman is quoted as saying in a speech that, in order to balance the budget by 2002, we would need some $400 billion in savings out of Medicare and Medicaid over the next 7 years.

I would like to know your opinion on what the impact would be of savings of that level on Medicare beneficiaries, Medicaid beneficiaries, as well as providers.

Dr. VLADECK. Senator, I do not think we could sustain either program in its current form with savings of that magnitude. I believe we are talking, over that period of time, of reductions so that by the year 2002, the programs would each be spending 25 or 30 percent less than is now projected for them.

This despite the fact that we are projecting for both of them under current law a significant increase in the number of people they will be serving over that period of time.

On the Medicaid side, the single biggest driver of cost increases over the balance of this decade is increased enrollment, not expenditures per enrollee.

On the Medicare side, it is not the single biggest contributor, but about 2 percent a year of increases in Medicare costs are just due to changes in increased number of enrollees and increased disability among enrollees.

So, if you are talking about numbers of that magnitude by the year 2002, you are talking about either major reductions in the benefits, major increases in the proportion of the costs of the program that are borne by the beneficiaries, or changes in provider payments of a magnitude that we have never talked about before.

Just to give you a couple of illustrations, on average, about 50 percent of the revenue of American hospitals is derived from Medicare and Medicaid. That is on average. In rural areas and inner-city areas and other communities, the dependency on the public programs is substantially greater than that. In rural areas in particular, again because of the demographics, Medicare and Medicaid

between them customarily can account for as much as 60 percent or even two-thirds of institutional revenues.

It is hard to put specifics underneath those numbers, but I do not think we would recognize the current programs in anything like their current form with numbers of that magnitude.

Senator CONRAD. I just specifically turn to rural areas. Obviously, I represent one of the most rural States in the country. It is not at all atypical for hospitals to have 60 to 70 percent of their patients Medicare-eligible in my State.

A significant number of those hospitals are vulnerable now. Can you give us some idea of what institutions like that would face if reductions on this order or magnitude were made?

Dr. VLADECK. I do not know how they would sustain themselves without major increases in either local or State taxation to support them, as has happened in some rural communities.

Senator CONRAD. Have you done any analysis on what would happen to institutions that are providers that especially have a high proportion of Medicare-eligible patients under a scenario like that outlined by the Chairman?

Dr. VLADECK. I can only give you that general answer at the moment, but we are performing such analyses of particular categories of hospitals. As soon as they are available, of course we will be happy to share them with you.

Senator CONRAD. Is it safe to say that rural hospitals with disproportionate levels of Medicare-eligible patients would be most vulnerable in a scenario like this one?

Dr. VLADECK. Well, sir, if you are talking about Medicaid at the same time, there would be sort of a race between the small rural hospitals and some of the inner-city teaching hospitals, in particular, as to who would run out of money faster.

If savings of that size were sought to a considerable extent through reductions in provider payments, both categories of institutions would be the most immediately affected in a dramatic way.

Senator GRAHAM. I thank the Chair.

The CHAIRMAN. Doctor, let me give you the figures, so you have them accurately. It is not 25 or 30 percent. We are scheduled to spend about $2.8 trillion on Medicare and Medicaid over the next 7 years. A $400 billion reduction from that would be about 14 percent, and it is a compounded increase every year of 5 percent.

Dr. VLADECK. I understand, sir. If I was misunderstood, forgive me. But my understanding is that, by the year 2002, expenditures in that year under such a scenario are 25 to 30 percent lower than is currently projected in the year 2002 because of the wedge effect.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. I think I would like to pick up a little bit from Senator Conrad, and with regard specifically to the Medicare Select program. I was just asking my staffer about that.

Illinois is one of the 15 States that is chosen as part of the demonstration project. But looking at the counties in my State that have participated in Medicare Select, none of them are the really rural counties, and we have quite a bit of rural area in Illinois. I am wondering whether or not, with regard to any of the 15 States,

is part of the experiment focusing in on the impact of this Medicare Select program in low-density or rural areas?

Dr. VLADECK. Well, Senator, I must say that one of the States where Medicare Select has been relatively successful is in North Dakota. And, while much of the activity is concentrated in the urban areas of North Dakota, it is very hard to have a significant insurance activity in North Dakota without some substantial rural participation. As a result, I believe that North Dakota is one of several States that offers Select in rural areas. However, our data show that in North Dakota Select is largely a program in which hospitals agree to waive the inpatient deductible for Select enrollees. Most of the savings have come from here. There is no real management of care in the North Dakota Select plans. This may be different than what is happening in parts of Illinois or Wisconsin.

Senator MOSELEY-BRAUN. I understand that the statistics, the data, are just being developed now. When do you expect to be able to report with regard to that experiment, and will it break out urban high-density from rural communities in terms of its analysis?

Dr. VLADECK. We have promised at least preliminary results of the quantitative evaluation on Medicare Select by the third quarter of this year, prior to Labor Day. And I can promise you that, while I do not know whether it was planned up until now, we will break it out by urban and rural.

Senator MOSELEY-BRAUN. Specifically with regard to home health care issues, the studies have shown that home health care can be a much more cost-efficient way of providing health services than inpatient care, for example. And yet, your testimony this morning indicated that the program has seen a 30 percent increase, which is larger than any other component part of the program.

To what do you attribute that disparity? Is it a function of enrollment? Is it a function of program administration, of overutilization, of what?

Dr. VLADECK. We have three or four explanations that we think are important. One is, over the last number of years, for a variety of technical reasons, the number of visits per beneficiary in the Medicare home health program has increased very dramatically, by more than 50 percent per case.

So the benefit has been transformed from a post-acute benefit into a real long-term care benefit. We are now averaging something like 80 visits per beneficiary who receives the service, which was clearly not the original intent of the statute, which was not the case prior to a consent decree we entered into with the court in 1988 or 1989. So there has been a transformation of the kinds of services being provided, the kind of people being served, that we are just beginning to get a look at.

We have also had particular problems with fraud and abuse in home care in some parts of the country that have contributed to some of the growth. In addition, we probably have inadequately stringent standards for certification of new home health agencies in many parts of the country.

So the only thing growing faster than the total number of Medicare home health claims is the number of certified agencies. That is an inefficient way to deliver services. It also raises questions about the economy associated with the services.

We have been working with the industry for more than a year on a comprehensive set of recommendations relative to the future of the Medicare home health benefit. We have a meeting, I believe, the 20th and 21st of March with the industry, after which we would hope to bring proposals through to the Congress, and to do some things ourselves.

The CHAIRMAN. I am going to have to stop you, Carol. We do have a notice. We are going to have to quit at 11:00, and I want to get the other two doctors back on. We have three more Senators on this round, and I am going to ask them to limit themselves to 3 minutes. I apologize, but we will never get the other people back on if we do not.

Senator Pressler.

Senator MOSELEY-BRAUN. Mr. Chairman, if it is all right, I would like to submit my remaining questions in writing.

The CHAIRMAN. Yes.

Senator MOSELEY-BRAUN. Thank you.

[The questions and answers appear in the appendix with the respective witness' prepared statement.]

Senator PRESSLER. Thank you, Mr. Chairman. I shall be a little bit parochial here, but I want to ask about small city hospitals. Now many of my hospitals located in small cities in South Dakota depend on Medicare to keep their doors open. In some instances, 80 percent of the hospital revenue is generated from Medicare.

If and when we proceed with Medicare reductions, what steps can be taken to protect those small hospitals?

Dr. VLADECK. Well, Senator, that is a difficult question. There has been a significant reallocation over the last 5 or 7 years in the total amount of money we pay the hospitals, to some degree at the initiative of the committees of jurisdiction in both Houses, away from smaller urban hospitals in the direction of both rural hospitals and inner-city academic institutions. This movement occurred in the belief that there were very important public purposes served by those institutions, which do less well in the private market.

That is to say, we have to some extent tilted the Medicare hospital payment system in the direction of academic institutions and in the direction of rural hospitals. But those hospitals, even with the additional benefit from Medicare, still do less well in toto than other hospitals elsewhere in the country.

If, within a fixed pot, you try to tilt back in the direction of some of the smaller urban hospitals, which have been disadvantaged by these changes over the last decade or so, it has to come from somewhere. And that has been the difficulty in trying to look at any significant future reductions in Medicare payments.

Senator PRESSLER. Now my providers in South Dakota expressed concern that their reimbursement rates are considerably less than the Medicare-approved rates in surrounding States. I realize that the approved fees are based on a complicated formula of average fees. However, my providers seem to be locked into these lower

rates. Historically they have done a good job of keeping their rates down. The Medicare payment system seems to penalize them for being cost-effective. That is, they will always be reimbursed at a lower rate. What can be done to fix this problem?

Dr. VLADECK. Well, if you are talking about hospitals, sir, the only adjustment that we really make on a geographical basis has to do with relative wage rates in both the health care and non-health-care sectors in those communities.

And, to the extent that rates are lower in your State, it is largely a reflection of relatively up-to-date comparative wage data with other States. If you are talking about physicians, there is a somewhat more complicated issue in terms of the phasing in of geographic adjustments.

But I think one of the things to tell physicians in historically low payment areas is that we are in the midst of a multi-year phase-in of the changes in the geographic adjustment, which will not totally address all those problems, but should shrink some of the differences between traditionally low-priced areas and higher-priced areas.

Senator PRESSLER. Now, without any changes in the Medicare Part A or B programming, meaning either a charge in covered benefits or increased premiums, how long do you project that the respective trust funds will be solvent?

Dr. VLADECK. Well, obviously sir, the Part B trust fund is solvent as long as Congress is prepared to appropriate each year adequate monies to pay it, since it is tied to annual appropriations.

Again, last year's report of the trustees of the HI fund, of the Part A fund, suggested an exhaustion date of 2001. I am optimistic that this year's report will stretch that out a little bit further because of the deceleration in health care costs that has occurred in the last year or so. But again, it is just a little premature for me to put a more precise fix on the latest estimates on the HI fund.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman, and Dr. Vladeck.

Could I just ask on a personal note. It is not the worst news that the new trustees' report is giving us another 3 years of solvency in the fund, if that is what you say. It could have been the other direction. And we did do some useful things in the Reconciliation Act of 1993.

I guess one question I wondered if you are dealing with right now is Part B. There is a question of direct appropriation, about three-quarters of that amount. We originally expected Part B to be a 50 percent payment by the individuals, by the beneficiaries. That is correct?

Dr. VLADECK. That is correct.

Senator MOYNIHAN. And then we let it drift around, through changes, and then we set it finally at 25 percent. Does the administration think we ought to proceed to move it back to 50? And what would you say would be the savings we could gather if we did?

Dr. VLADECK. I could not give you a savings estimate on that offhand——

Senator MOYNIHAN. Could you?

Dr. VLADECK [continuing]. Although I will certainly supply you with one. I will be happy to.

[The information referred to follows.]

Since 1983 the premium has been set as 25 percent of program costs and has adequately covered the costs of Part B services for Medicare beneficiaries and would continue to do so if the premium were permanently extended.

To answer your second question, if we assumed that beneficiaries paid 50 percent of Part B program costs from CY 96 to 2005, the savings are:

1996:	$14.02 billion	2001:	$36.14 billion
1997:	$19.58 billion	2002:	$41.98 billion
1998:	$22.87 billion	2003:	$48.79 billion
1999:	$26.57 billion	2004:	$56.71 billion
2000:	$31.05 billion	2005:	$65.93 billion

Dr. VLADECK. In terms of increasing the Part B premium, I hesitate to raise this issue with you gentlemen here, but there has been so much discussion over the last year or so of preserving and protecting the core of Social Security, of OASI benefits.

If you realize that 98 percent or more of Medicare beneficiaries are also Social Security beneficiaries, if you say we are going to protect Social Security entirely, but we are going to double Medicare premiums, it has the same disposable income effect, the same gross income effect, on every Social Security beneficiary as a reduction in Social Security benefits.

Senator MOYNIHAN. Well, may I just let you consider some different perspectives? Dr. Armey on the House side has said of Social Security that it is a fiduciary responsibility of the Federal Government.

And we are just now about to the point where people are going to get out what they put in, so it is in a sense their money. Part B is not.

Dr. VLADECK. That is correct.

Senator MOYNIHAN. Will you give us those estimates?

Dr. VLADECK. I certainly shall.

Senator MOYNIHAN. I appreciate it very much. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Mr. Chairman, I am amazed always at these figures. That comes from my work on the Entitlements Commission. I think, Doctor, that you would agree that total Medicare expenditures have gone from $34 billion in 1980 to $160 billion in 1994.

Dr. VLADECK. That is correct.

Senator SIMPSON. That is an increase of $11.7 billion per year. Is that correct?

[The following was subsequently supplied for the record by the witness:]

Yes, the amount of total expenditures is correct, however, under our estimates, which assume a different set of assumptions, it is an average increase of $9 billion per year.

Senator SIMPSON. So CBO projects that Medicare will grow from $176 billion in 1995 to $286 billion in 2000. That is an average annual growth rate of 10.2 percent over the next 5 years. Does that sound about right?

Dr. VLADECK. That is correct.

[The following was subsequently supplied for the record by the witness:]

Actually our projections are a little different. Our actuaries estimate that Medicare will grow from $174 billion in 1995 to $276 billion in the year 2000. This is an average growth rate of 9.7 percent.

Senator SIMPSON. Then how in the world can you talk about "cutting" Medicare, when all we are talking about is slowing the increase?

This is an absurd exercise in the English language. It is absurd to hear the AARP talk about a $200 billion cut in Medicare when it has gone by numbers that you see with your eyeballs from $34 billion in 1980 to $160 billion in 1994, and have the guts to tell their members that Medicare has been cut $200 billion. There is no sense in the English language that can fit.

And how in the world are you able to come here as a representative of our Government, and not talk about the fact that the HI trust fund is going to go broke in the year 2001—now not go broke until the year 2003—and recommend nothing to this group, and tell us that you are going to wait until the trustees' report comes in?

And you know what the demographics are. You know what the aging population is. You know that 1 in 8 is over 65, and in 20 years 1 in 5 will be over 65. And you know those things, and you sit here and tell us nothing. Why?

Dr. VLADECK. Well, Senator, if I may, I think we in the administration spent a lot of time over the last year and a half trying to point out that the growth in Medicare spending since the inception of the program, or over the last 10 years, or whatever, was very much of a piece of the growth in health care spending in general.

The reason one can speak of cuts in some instances is because the implicit contract between the American people and the Medicare program is one for an array of services, it is not for a dollar figure. It is a service benefit program, not an indemnity program. And so one often talks about cuts in terms of the value of the benefits.

And we believe that, over time, the long-term health of the Medicare program is inextricably tied to the long-term health of the health system in general.

We tried last year to make a whole array of suggestions about reform of the health care system. Congress did not support them. The President has written to the leadership, and has acknowledged publicly that we have to proceed incrementally, rather than in so systematic a form, and has expressed his willingness to work on health care reform, and to address the issue of Medicare outlays in that context.

Senator SIMPSON. You said the slower expected growth in the "complexity of the Medicare inpatient cases is what is going to make everything go down." Furnish me, please, what you mean by the word "complexity".

Dr. VLADECK. Yes, sir. I will be happy to.

[The following was subsequently supplied for the Record:].]

By using the term "complexity of cases," I was referring to the relative severity-of-illness/costliness of the mix of Medicare patients at a hospital, from one year to

the next. For example, particularly on the years immediately after the Prospective Payment System (PPS) for inpatient hospital care was implemented, hospitals began to treat certain types of cases in outpatient settings rather than in inpatient settings. These cases tended to be patients with illnesses that were less severe and less costly, leaving a more severely ill and more costly mix of patients in the inpatient setting. This trend toward a more severely ill mix of patients has continued over time. While it continues to occur, however, over the past year or two it has occurred at a lower rate than expected.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The line of questioning by Senator Simpson is interesting to me because it has great currency for those uninitiated in health care, because it is easy to say that you are talking about a cut, and actually we are just talking about slowing the rate of increase.

Is it not correct, Dr. Vladeck, that unless Senator Simpson has ways of controlling the cost of health care, that the cost of health care continues to go up? And there is not much seniors can do about that. So, in fact, what happens, no matter what phrases Senator Simpson chooses to use, people are going to have to get their benefits cut. Right?

Dr. VLADECK. Well we have, sir, been able to cut payments to providers.

Senator ROCKEFELLER. Yes.

Dr. VLADECK. This has, in some instances, reduced services indirectly.

Senator ROCKEFELLER. But I think this reduction in the rate of increase versus cut is kind of an old game. And it is a good one. I have used it a couple of times myself.

But I do not think it necessarily fools people who are going to have their benefits cut. Providers are going to have their rates cut, because Government spending has not kept up, and we have not done health care reform.

Everybody knows that we can pass the balanced budget amendment this afternoon, but until we do health care reform, and get health care costs under control, it is all a big joke.

Senator MOYNIHAN. We might pass it.

Dr. VLADECK. No, no, I said could. I was dealing only in the highly hypothetical.

Senator ROCKEFELLER. So I do not know. That is my 3 minutes worth right there. [Laughter.]

The CHAIRMAN. Doctor, I am going to have to excuse you, and let the other two doctors come back for just a moment. We have about 15 minutes left to quiz the two of them.

Dr. VLADECK. Thank you, sir.

Senator MOYNIHAN. Thank you, Doctor.

The CHAIRMAN. Dr. Davis, let me ask you a question. The last chart you have is voter support for 25 selected policies to reduce the deficit. And then in your statement, you say national opinion polls show little support for cutting Medicare, showing in Chart 11 that only 8 percent of the voters want to do that.

Assuming we wanted to balance the budget—forget whether or not we pass the balanced budget amendment—are you suggesting that we be guided by this chart?

Dr. DAVIS. No, sir. It is just information to show that Medicare is popular with voters. And I think what I pointed out at the bot-

tom of that chart, on the second page, that 8 percent of all of the voters supported decreased spending on Medicare for the elderly, that was a——

The CHAIRMAN. I understand what it shows, but this chart has strong to moderate support, for things the voters would vote for that would help narrow the deficit. Basically that is means testing Medicare, decreasing food stamps, decreasing farm support and decreasing defense spending. That would give $50 to $60 billion if we did the really tough stuff.

Then you have moderate opposition to a lot of things, and then strong opposition to decreasing or eliminating tax deductions for charitable giving, home mortgages, reducing the annual cost of Social Security, increasing the income tax, increasing gasoline and heating oil taxes, and opposition to decreased spending on Social Security, Medicaid, Medicare or veterans' benefits.

Let me ask you, if we wanted to balance the budget, how would we do it, and in any way comport with this poll?

Dr. DAVIS. I do not think they are consistent. I do not think you can balance the budget with measures that are popular with the American people.

There are ways to balance the budget. One can increase payroll taxes.

Senator MOYNIHAN. May I say, Mr. Chairman, we found that out in 1993. [Laughter.]

The CHAIRMAN. We found it out in 1985.

Dr. DAVIS. I did indicate at the bottom of my statement, on page 5, that there were some of those items, such as tighter provider payment rates, higher payments by very well-off beneficiaries, that do get higher support. The problem is that they are not going to yield much money.

The CHAIRMAN. But they do not produce a lot of money. There are not enough rich in this country, unfortunately.

Dr. DAVIS. And particularly not among the elderly,

The CHAIRMAN. If we means-test them, it will make us psychologically feel better, but it does not produce a lot of money.

Dr. DAVIS. Only 3 percent of all Medicare outlays go to families with incomes of over $50,000. So, even if you totally cut everybody off, you would only save 3 percent of the program.

The CHAIRMAN. Then let me ask you a specific question. If our goal was to limit Medicare growth to 5 percent a year, instead of 10.2, what would be your advice as to how to do it?

Dr. DAVIS. Well again, as Dr. Vladeck indicated, a 5 percent rate of growth is unprecedented in the health care system for privately-insured or Medicare beneficiaries over any period of time.

So I think it really is on the order of magnitude of cuts that are more than the 1990 and 1993——

The CHAIRMAN. I understand that. My question is, if we wanted to hit that target, what would be your advice as to how to do it?

Dr. DAVIS. I think you have to look at spreading that cost over as many people as possible. So my own preference is that the first thing, whether you could get that much or not, is to tighten provider payment rates. Medicare already pays physicians fees at 58 percent of what private insurers pay. But, on the other hand, most physicians are still willing to take Medicare beneficiaries. So

maybe you could tighten it a little bit more. You would still have physicians participating.

You could tighten payments for hospitals. I think Dr. Vladeck indicated that rural hospitals, inner-city teaching hospitals, are in a pretty precarious state. So you would want to be able to target that in a way that would not disproportionately affect those providers.

You could have modest increases in Part B premiums. Senator Moynihan raised the issue about the premium. If you spread a little bit of money over a lot of beneficiaries, that is less harmful than increasing the hospital deductible or the copayment for home health services.

But it is just very hard to achieve that magnitude of savings without inflicting pain on vulnerable beneficiaries, and without jeopardizing the financial stability of some pretty essential health care providers.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. I wonder if I could ask Dr. Wilensky a question. You must have thought about this Part B portion during your tenure. Would you have any suggestions for us?

Dr. WILENSKY. I think there are some short-term savings that you can do. But, fundamentally, if you are going to get anything like the kinds of savings that Senator Packwood or you have suggested, you are going to have to reform the structure and incentives of Medicare. Medicare is just like medicine was organized in the 1960's. There is a reason you are not seeing the kinds of changes that we see in the private sector going on there.

Senator MOYNIHAN. And you would look to HMO development?

Dr. WILENSKY. I would look to having a fixed payment per capita, which could be used to buy a fee-for-service plan. In some of the rural areas, that may be either all there is, or it may be, with case management, the most effectively organized health care for these areas.

In general, I expect to see managed care dominate. I do think that the issue about changing the premium share, especially if you have the Qualified Medicare Beneficiary program in place, and Medicaid in place, is reasonable. We, in fact, have moved from what had been the original bargain with the elderly, of a 50–50 sharing to a 25–75 sharing of the premium payment and, we ought to go back and rethink this. But, fundamentally, you are going to have to do much more change.

Senator MOYNIHAN. We do note in your testimony the Foster-Higgins survey which indicates that for all firms——

Dr. WILENSKY. Right.

Senator MOYNIHAN [continuing]. For non-retired persons, obviously, health care premiums declined 1.1 percent, with the decline being largest for large firms, 1.9 percent. We have not heard much testimony about health care premiums declining.

Dr. WILENSKY. In various parts of the country, it is now being reported that there are absolute declines in spending. Overall, the consumer price index went up about 4.9 percent for medical care. But a lot of that was driven by what was going on in the public sector market, Medicare and Medicaid, and what we are at least hearing anecdotally suggests tremendous changes. We do know

that between 1991 and 1993, Medicare per person was growing 50 percent faster than spending in the private sector.

Medicare is not taking advantage of how to restructure—re-engineer to use Vice President Gore's term—the way health care is being provided. And we are never going to get the kinds of savings we could get if we follow 1960-style organization. It is not going to happen.

Senator MOYNIHAN. Could I just say that, in our hearings in the last Congress on health care, we began picking up from Dr. Ellwood and others the fact that the age of 10 percent a year forever was past.

Dr. WILENSKY. You do not have to do that.

Senator MOYNIHAN. Exactly. You do not have to do that.

Dr. DAVIS. If I could add a caution to the interpretation of those figures. First of all, in any 1 year, numbers can jump around.

Second, when employer health plans cut benefits, increase deductibles, or drop children, premiums will go down. So you are not talking about comparing the same benefits in 1 year with another. So I would raise some cautions to see if that really holds over the longer term.

Senator MOYNIHAN. I thank you, Doctor.

The CHAIRMAN. I think what Dr. Ellwood said, as I recall, it was like that argument that within 20 years the entire gross national product of Sweden will go to the Government.

I think Dr. Ellwood just said that we will reach a certain level, it just is not going to happen. We just are not going to do it. And at that stage, if we are spending 10 or 11 percent, and we are moving up toward 19 or 20 or 21 percent of the gross national product going to health, we will not do it.

Senator GRAHAM. I would like to return to my interest in fraud and abuse. One of the areas that the GAO pointed to was the fact that there are 80 contractors sharing responsibilities for claim processing. Could you comment as to the efficacy of that system, and what its contribution might be to fraud and abuse?

Dr. WILENSKY. I spent a lot of time trying to see whether I could help reduce the number of carriers and contractors. I think, however, that you may not have to focus as much on reducing the actual numbers—which is a terribly political issue, akin to base closing—as much as you need to insist that all of the carriers and contractors use the same system.

So you do not have to pay for 10 or 15 different kinds of system updates, and it is less important whether or not they are technically local people doing some of the local field work and regional carriers and State carriers. If they are using the same systems for the basic Part A and Part B, you might be able to go after the fraud and abuse easier because you could look for things faster.

In durable medical equipment, the area that went to four carriers, which was something that was started when I was there, and is being implemented now, is very important. The reason the reduction in their numbers are important is that durable medical equipment, which seems to have had some of the worst scams of Medicare, is such a small part of the carrier's budget—on average 5 percent when all 34 Part B carriers did it—that even if there

were terrible things going on, the carriers might not notice it because it is only 5 percent of what they did.

Concentrating this work in 4 regional carriers gives Medicaid a chance to see any funny stuff that is going on, and putting in requirements about registering, about having certain kinds of identifiers, so that you cannot just use a post office or mailing address, can help too. But the worst part about going after fraud and abuse has to do with the structure of the U.S. Congress. And the worst problem for that is that the money to go after fraud and abuse comes out of the appropriations, and the savings goes to the entitlement.

This means that every penny that is spent for fraud and abuse has to compete with vaccine programs for kids and the LIHEAP program for the low-income elderly. Some payment safeguard money is always getting cut. The savings go, because of the nature of the structure, to the entitlement, to the Medicare trust fund. And it makes it very hard to get enough money to go after fraud abuse. Bruce Vladeck cannot say that; he is part of the administration. I have felt this frustration. I can say it.

Until those kinds of savings can offset expenditures, it will be difficult to get the kind of investment in fraud and abuse that we should have.

Senator GRAHAM. I am very pleased that you made that statement because I have long been an advocate that we ought to open up the trust funds to deal with these integrity issues because the trust funds are the ones who are at risk. They ought to be the ones who have the greatest interest in seeing that these practices are stopped.

And, in fact, at least in South Florida, which supposedly has one of the highest levels of Medicare abuse, we have seen enforcement going down in the face of these escalating conditions, rather than strengthening our capacity.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Mr. Chairman, I would share with the witnesses, and with all of us on this panel, you can see what is going to happen. We are not going to let Medicare go up 10.5 percent.

Dr. WILENSKY. We should not.

Senator SIMPSON. It would be cruel to do that because we are going to vote April 1 on a $1 trillion debt limit. A trillion bucks, one trillion bucks. And we are going to do that. And we should do that responsibly so we can pay our bills.

And so, let us say that we have got the ultimate remedy here, and maybe let Medicare go up only 5 percent. The headline will be, "Medicare cut in half." Medicare, the cherished thing for all seniors on earth, cut in half. And you know that.

So, instead of having a 10.5 or 10 percent increase in growth, we are going to let it go up only 5 percent. It will be described by all the haranguers as a 50 percent cut in Medicare.

And going out of sight, by your own figures, all the figures I am using today are coming from HCFA, the National Institute of Health Care Management, figures all over the place. So do all the polls you want. You know what they are going to say on Social Security, Medicaid. Why would the people of America who are on Medicare want to complain? You get the best health care in the

world the minute you want it, and somebody else is paying for it. So why would they not be quite content with that?

But you give us figures that are totally different, the two of you. Dr. Davis says that the Medicare rate of growth is lower than the private sector, and shows us that from 1984 to 1993, Medicare is 7.9 percent, private is 11.2 percent.

And Dr. Wilensky tells us that 1991 to 1993 Medicare growth is 6.5 percent, and the private health insurance growth is 4.7 percent. Where are we?

Dr. DAVIS. Well, we are obviously using the same data bases. It is a matter of whether we are focusing on a 10-year period, or a 1- or 3-year period, whether we are looking at the present or future projections that are coming from the actuaries.

And I think in any 1 year a lot of things could be going on, and it is better to take a look over a longer period of time. Over the last 10 years, as you saw in my Chart 7, Medicare outlays per beneficiary for hospital and physician services have gone up slower than private insurance outlays for hospital and physician services over that 10-year period.

Where Medicare is growing more rapidly is for home health and skilled nursing facility services, which are not typically covered by private health insurance.

Senator SIMPSON. How about durable goods, big ticket items?

Dr. WILENSKY. Big ticket items like durable medical equipment.

Dr. DAVIS. I think those parts of the Medicare benefit package that are not subject to prospective reimbursement the way we have done with Medicare hospital and physician payments, are more of a problem. Those new systems have changed hospitals and physicians and have, in fact, created this better performance of Medicare over the previous 10 years. We really ought to look more at extension of prospective payment methods to other benefits in the benefit package.

Dr. WILENSKY. Let me answer though why I think it is so important that you break at 1991. It is not by accident that you see this happening. Initially, in the period you had regulations that were taking hold before people figured out how to gain the system.

And what happens when you look from 1987 to 1991, Medicare is doing better than the private sector. That gave enough time for hospitals and for other people to figure out how to get around some of the new rules. And physicians, believe me, will also figure it out when they have had time to deal with the relative value scale.

But things changed in 1991. It is not only that some of the home health and rehab hospitals started skyrocketing in the early 1990's. But, at the same time, Medicare continued to go up in the areas outside of direct physician and hospital in particular. The private sector was responding to aggressive attempts to try to redo how health care was provided. So Medicare got around some of the restraints that had been put on, and the private sector was beginning to aggressively respond to the pressures it had. And in 1993 to 1994, it is even greater.

The CHAIRMAN. I apologize. I have got to apologize to Senators Conrad and Rockefeller. There is objection. We have got to quit at 11:00 o'clock. And so we will have to abruptly adjourn this meeting now.

Senator MOYNIHAN. We will return to the subject.

The CHAIRMAN. I am sure we will. I am sorry that it is so hurried and abbreviated but, under our rules, we have to quit.

Senator CONRAD. Mr. Chairman, could you just tell us, what was the nature of the objection?

The CHAIRMAN. To the Committee's meeting more than 2 hours past the start of the Senate.

Senator CONRAD. And was——

The CHAIRMAN. We asked for permission to meet, and an objection was raised on the floor to our going past the 2 hours when the Senate started.

Senator CONRAD. Do they have any reason for objecting?

Senator MOYNIHAN. It is that vague? [Laughter.]

Thank you, doctors.

[Whereupon, at 11:00 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR MAX BAUCUS

Good morning, Mr. Chairman. This hearing addresses an issue of critical importance for preserving Medicare services to senior citizens, and for controlling our budget in the coming decade. That is, finding ways to slow the growth in the cost of Medicare.

MANAGED CARE

One option is greater use of managed care. Managed care seems to be slowing the growth of health costs in the private sector. And many suggest that the government could use it to slow growth in Medicare.

One of today's witnesses will suggest that one way to encourage seniors to join managed care is by increasing copayments and deductibles for those who aren't in managed care. That is an interesting idea, but I have some serious concerns about it.

I believe managed care is part of the solution. But we have to remember that some states have very little managed care at the moment. One of them is Montana. We have very little managed care available to people under sixty-five. And there are absolutely no managed care options available to people on Medicare anywhere in the state.

So increasing Medicare copayments and deductibles for Montana seniors seems to me to be grossly unfair, considering that our state has not a single HMO for them to join. And low reimbursement rates discourage HMOs from Wanting to contract with Medicare in Montana. In effect, then, imposing a higher premium or copayment as a rigid national policy amounts to penalizing someone for living in Montana.

So, when we talk about encouraging managed care in Medicare, we need to be realistic. We need to be flexible. And we need to be fair to rural states like Montana.

MAKING THE MONTANA MAF PERMANENT

I also want to give particular mention to a small project that is one of Medicare's biggest success stories.

That is the Montana Medical Assistance Facility project. As a demonstration project, it has preserved health care in seven rural Montana communities. It has preserved health services for thousands of hard-working Montana farmers and ranchers in thinly populated counties like Carter, Garfield and Roosevelt.

Not only that, but—to get back to the subject of our hearing—the MAF also saves the Medicare program money. The savings have totalled half a million dollars so far. Not much compared to the budget deficit, but every little bit counts.

Unfortunately, the demonstration project is due to expire in a little over a year. That endangers the ability of Montanans in these counties to get even basic health care.

The time has come to make this Medicare success story permanent. I eagerly await Dr. Vladeck's views on this proposal, because it is a top priority for me.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR ALFONSE M. D'AMATO

Mr. Chairman, I am pleased to join you this morning to review the status of the Medicare program.

This is an important hearing because it concerns the future of a program that currently provides health insurance protection for one in every seven Americans. While Medicare now serves over 36 million aged and disabled beneficiaries, its future is a matter in which every American has an important stake.

Unfortunately, the costs of this program have been growing tremendously—so much so that the latest projections by Medicare's trustees indicate that the program will become insolvent by the year 2001. Our challenge is to assure the long-term solvency of this program while continuing to deliver quality health care coverage that America's seniors can depend upon. In short, we must keep this program secure for today's beneficiaries, while making sure it is still there tomorrow for our children and grandchildren.

To help us address that challenge, we are fortunate to have with us today the current and former Administrators of the Health Care Financing Administration (HCFA): Dr. Bruce Vladeck and Dr. Gail Wilenski—as well as Dr. Karen Davis, who is President of the Commonwealth Fund and former HHS Deputy Assistant Secretary for Health Policy.

I am pleased to welcome these distinguished witnesses, and I look forward to their insights as we work to safeguard the future of our nation's Medicare program.

PREPARED STATEMENT OF KAREN DAVIS

MEDICARE TURNS THIRTY

Thank you for this opportunity to testify on the importance of the Medicare program in financing health care for the elderly and disabled. This year marks the 30th anniversary of the Medicare program. When it was enacted thirty years ago, most elderly were uninsured. They lost their health insurance coverage when they retired. Medicare has brought health and economic security to some of the nation's most vulnerable citizens for three decades.

It is particularly fitting to take stock of Medicare's essential role as an insurer of elderly and disabled beneficiaries at this point in the program's history. Medicare is caught in a dilemma—brought on in part by its success. As the life expectancy of the elderly in the U.S. has increased to be among the best in the world and as modern technology has brought new ways of both extending and improving the quality of life, the cost of caring for older people has risen. Health care for the elderly and disabled is expensive for Medicare and it is expensive for beneficiaries. Understanding why this is the case is fundamental to any attempt to modify the program.

Who is Covered by Medicare?

It is particularly important to keep in mind an accurate picture of the people Medicare serves. Among the 37 million Medicare beneficiaries are those with limited financial resources, those with very serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. Even with Medicare and Medicaid which supplements Medicare for the poor, many aged and disabled persons face serious financial hardship and forego needed care because they cannot afford it.

Despite popular views that older Americans enjoy high incomes and standard of living, most elderly Americans have modest incomes. As shown in Chart 1, over three-fourths of Medicare beneficiaries have incomes below $25,000. Fewer than 5 percent have incomes exceeding $50,000. While poverty rates of older Americans are somewhat lower than for the non-elderly population, many elderly people have been lifted barely above the poverty level by Social Security benefits. For important subgroups, such as elderly people living alone poverty rates exceed 20 percent—comparable to poverty rates for children.

The high concentration of low-income elderly, and the fact that such elderly are more likely to be in poor health and need more health care services, means that Medicare outlays are concentrated on relatively low-income beneficiaries. Eighty-three percent of Medicare outlays go to beneficiaries with incomes of $25,000 or less. Only 3 percent goes to elderly individuals or couples with incomes in excess of $50,000.

Poor Medicare beneficiaries are eligible for Medicaid to help pay Medicare premiums and cost-sharing, as well as for other services such as prescription drugs. However, only about half of aged Medicare beneficiaries with incomes of under $5,000 are enrolled in Medicaid (see Chart 2). A Commonwealth Fund study in the late 1980s found that the most common reasons why elderly poor are not covered

by public benefit programs are that they are unfamiliar with the programs or do not think they are eligible. Better outreach to those who are qualified for Medicaid supplementation to Medicare is important.

FINANCIAL BURDEN OF HEALTH COSTS ON MEDICARE BENEFICIARIES

The financial burden of health care costs for Medicare beneficiaries is very unevenly distributed. Some elderly enjoy good health and rarely use health care services. Others are seriously disabled and require extensive treatment. Because Medicare beneficiaries have very different needs for health care, health expenditures are very skewed. In 1993, 10 percent of Medicare beneficiaries accounted for 70 percent of outlays (see Chart 3). One-fourth of beneficiaries accounted for 91 percent of outlays.

The average expenditure in 1993 for all Medicare beneficiaries was $4,020 (see Chart 4). For the ten percent of Medicare beneficiaries with the highest outlays, the average expenditure was $28,120. This is contrasted with $1,340 for the 90 percent of Medicare beneficiaries with the lowest outlays.

Understanding this variation in outlays is particularly important in any discussion of expanding capitated managed care coverage under Medicare. If capitation payments are not appropriately adjusted for health status, over or underpayments can be quite serious. Plans can make considerable profit at a capitated rate of $4,000 or even $3,000 if they can avoid enrolling those beneficiaries likely to be in the most costly 10 percent. The incentives to enroll only healthier enrollees or encourage less healthy enrollees to disenroll are formidable.

Even though Medicare outlays are concentrated on the most vulnerable—the poor and those with serious medical problems—out-of-pocket costs to these groups can pose a serious financial burden. About 12 percent of Medicare beneficiaries have no health insurance to supplement Medicare—either from Medicaid or from private coverage through a retiree health plan or through individually purchased Medi-Gap coverage. These beneficiaries are concentrated in incomes under $10,000 (see Chart 2).

As shown in Chart 5, the hospital deductible under Medicare is $716, the Part B deductible is $100 per year, and the Part B premium is $550 per year. Given non-covered services such as prescription drugs, out-of-pocket costs for Medicare beneficiaries who rely only on Medicare can easily exceed $2000 per year. For a elderly woman with an income of $10,000, this is clearly an excessive and burdensome cost. Even for those with Medi-Gap private coverage, costs can be high. The average Medi-Gap premium is now $840, which in combination with the Part B premium and even modest outlays for non-covered services, can run over $1500 a year.

It is not well understood that the elderly pay far more for their own health care than the non-elderly—even with important coverage from Medicare. This happens because Medicare pays only 45 percent of the health care bills of the elderly. As shown in Chart 6, on average elderly households spend 12 percent of their incomes directly out-of-pocket for health care, compared with 3.7 percent for nonelderly households.

Cost-sharing requirements by their very design mean that those who are ill and use services bear the burden. The chronically ill and other high utilizers of care are most likely to incur large individual liability for Medicare cost-sharing and uncovered services and charges. A Commonwealth Fund study, Medicare's Poor, found that thirty percent of Medicare beneficiaries rate their health as fair or poor. For those who are poor, members of minority groups, or over age 85 even higher numbers have poor health. For example, over 60 percent of poor elderly have arthritis. Half suffer from hypertension and need counseling about diet and exercise, and many require physician monitoring and prescription drugs to control their condition. Twelve percent of poor elderly people have diabetes and many require insulin treatment as well as medical care for the many conditions that arise as complications to diabetes.

For those elderly with long-term care needs, costs can be even higher. Medicare pays only 2 percent of all nursing home expenses; about half of all nursing home expenses are paid directly by patients and families. For those elderly with functional impairment living at home, costs can also be high. Over one-third of poor elderly people living at home report being restricted in one or more activities of daily living compared to 17 percent of those with moderate or high incomes.

Inadequate Medicare benefits not only mean financial burdens, but also barriers to needed care. The significant deductible and coinsurance provisions in Medicare deter some of the elderly poor and near poor from obtaining care. Low-income and minority elderly are less likely to get preventive services such as Pap smears and mammograms, in part because of the financial barrier posed by out-of-pocket costs.

Rates of ambulatory sensitive hospital admission rates are particularly high for poor and minority elderly—indicating inadequate access to primary care.

In sum, poor and near-poor elderly are more likely to be experiencing health problems that require medical services than elderly people who are economically better off. Yet, they are less able to afford needed care because of their lower incomes. For those who do get care large out-of-pocket medical expenses can lead to impoverishment.

Medicare Expenditures

At the same time Medicare leaves many elderly and disabled beneficiaries inadequately protected against high health care costs, the program's outlays have grown rapidly over time. Medicare outlays per enrollee exceed $4000 per person. While Medicare outlays have grown at unacceptably high rates over the last decade and a half, there is some good news.

Most significantly, Medicare outlays for hospital and physician services per enrollee have grown more slowly than private health insurance outlays for these services in the decade from 1984 to 1993 (see Chart 7). After two decades of increasing more rapidly than the private sector, Medicare's more recent performance is considerably better than that of the private sector. Spending on inpatient hospital and physician services have moderated considerably. In 1993, hospital inpatient outlays grew at 8.3 percent, and physician outlays at 4.5 percent, down from double-digit rates of growth in the 1980s (see Chart 8). Certainly the new methods of paying hospitals and physicians introduced in 1984 and 1992 respectively have had an impact. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches—particularly home health and skilled nursing facilities services.

Medicare has also had an excellent record of low administrative costs. Medicare's administrative costs average 2 percent of program outlays, compared with 15 percent in small group market plans and 5.5 percent in large group market plans.

Medicare has been criticized for not promoting aggressively enough managed care alternatives for its beneficiaries. Yet, Medicare is itself similar to a preferred provider plan. With the recent reforms in provider payment, Medicare sets prospective prices for hospitals and physicians at a substantial "discount" to usual charges. Medicare's physician payment fees, for example, average 58 percent of fees paid under private health insurance plans. All providers who are willing to participate at these rates are permitted to enroll. Physicians who agree to take "discounted" payments as payments in full become participating physicians and are listed in directories of preferred providers. This has worked remarkably well, to the extent that over 90 percent of all Medicare physician services are now on assignment.

In addition Medicare makes HMO options available to beneficiaries. Three-fourths of beneficiaries live in areas where managed care plans are available. Seventy percent of HMOs now offer or plan to offer shortly a Medicare product marketed to Medicare beneficiaries. Despite the reluctance of many elderly to give up their personal physician to join an HMO, HMO enrollment has increased from 1 million in 1985 to 3 million in 1995—about 9 percent of all beneficiaries.

Even if enrollment were to expand more markedly, it is unlikely that there would be savings to the program, and in fact might cost the Medicare program. Given the extreme variability in health outlays among beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. Focus groups of Medicare beneficiaries by the Henry J. Kaiser Family Foundation found reports of sicker Medicare beneficiaries being encouraged to disenroll to obtain needed specialty care. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries which they have very strong incentives to do, Medicare will be overpaying for those under managed care, and yet paying the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. The extent of managed care abuses could be curbed by tightening capitation payment rates and imposing penalties for high disenrollment rates, but the basic underlying incentives are unlikely to be substantially altered. A good method of setting capitation rates to adjust for differences in beneficiary health status seems years away. Nor has the long-term success of managed care in controlling costs (aside from getting provider price discounts) yet been demonstrated.

Why then is Medicare so costly? The simple answer is that Medicare is costly because it covers very sick people, and because health care costs for all Americans—whether privately insured or covered by Medicare or Medicaid—have risen rapidly over the last two decades. Until more effective approaches for containing health care costs in the health system as a whole are developed, the program is likely to be caught in the dilemma of high costs for both taxpayers and beneficiaries.

There are few attractive alternatives for reducing Medicare outlays. Cuts in benefits would add to the financial hardship on beneficiaries. This is particularly true of increases in deductibles or copayments on services such as hospital care or home health that are used by the sickest beneficiaries. Provider payment rates could be tightened further, but they are already considerably lower than private payers. Severe cuts would jeopardize the financial stability of hospitals serving older and seriously ill patients—such as rural hospitals and teaching hospitals. Some modest savings might be achieved through practices such as high cost case management and selective contracting for specialized services. Any changes to Medicare will need to be designed with care to avoid unintended consequences that are harmful either to vulnerable beneficiaries or to the health system that provides accessible, high quality care.

BENEFICIARY VIEWS OF MEDICARE

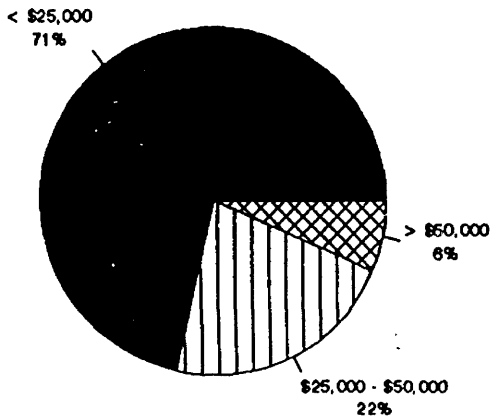
Medicare enjoys a high degree of support from both the elderly and non-elderly. Medicare beneficiaries report high rates of satisfaction with the plan. The Medicare Current Beneficiary Survey finds that 89 percent are satisfied or very satisfied with the overall quality of medical care (see Chart 9). A Kaiser-Commonwealth Fund 1993 health insurance survey found that 52 percent of Medicare beneficiaries are very satisfied with their insurance, compared with 44 percent of families covered by employer-provided private coverage, 39 percent of Medicaid beneficiaries, and 30 percent of those who purchase private health insurance individually (see Chart 10).

National opinion polls also show little support for cutting Medicare. As shown in Chart 11, a Kaiser Family Foundation/Harvard University voter exit survey in November 1994 found widespread support for Medicare. Only 8 percent of voters support decreased spending on Medicare for the elderly—even below the 17 percent who support decreased spending on Social Security. Some specific measures such as tighter provider payment rates or higher payments by very well off beneficiaries (the 5 percent with incomes over $50,000) muster more support but these are unlikely to yield substantial savings.

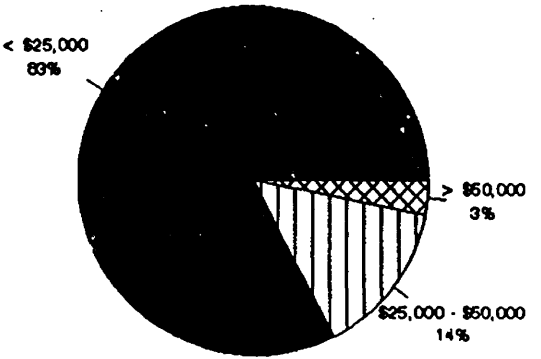
Medicare is an effective and popular program. But more importantly it is a program on which 37 million of the nation's sickest and most vulnerable Americans rely. Medicare was established in 1965 because private insurance was not accessible to older Americans. They were dropped as they reached retirement because they were bad risks. We should not risk reversing the important gain in health and economic security that Medicare has achieved as we look to assuring its fiscal solvency for future generations.

Thank you.

Income Distribution of Medicare Beneficiaries by Gender, 1992



Males



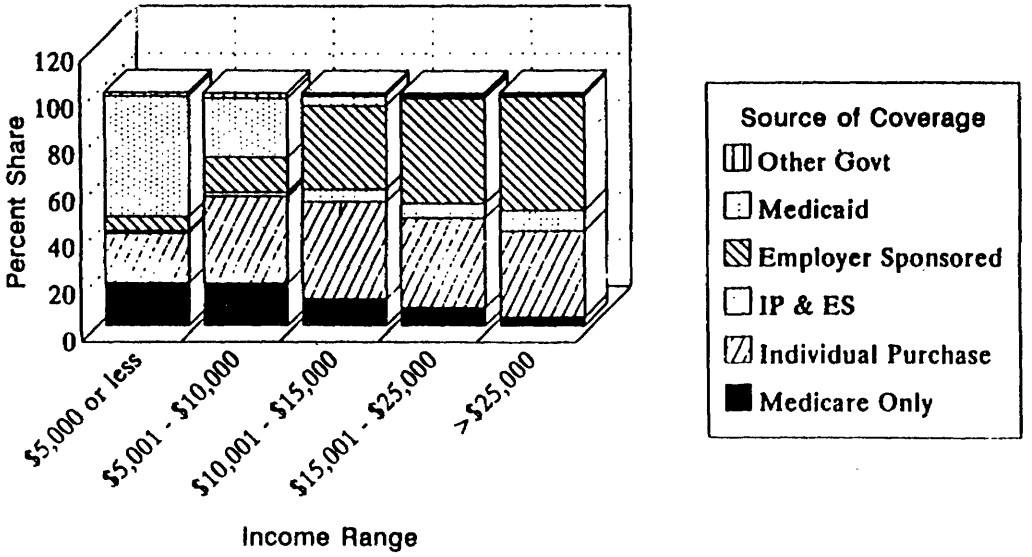
Females

Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart 1

Insurance Holdings of Aged Medicare Beneficiaries

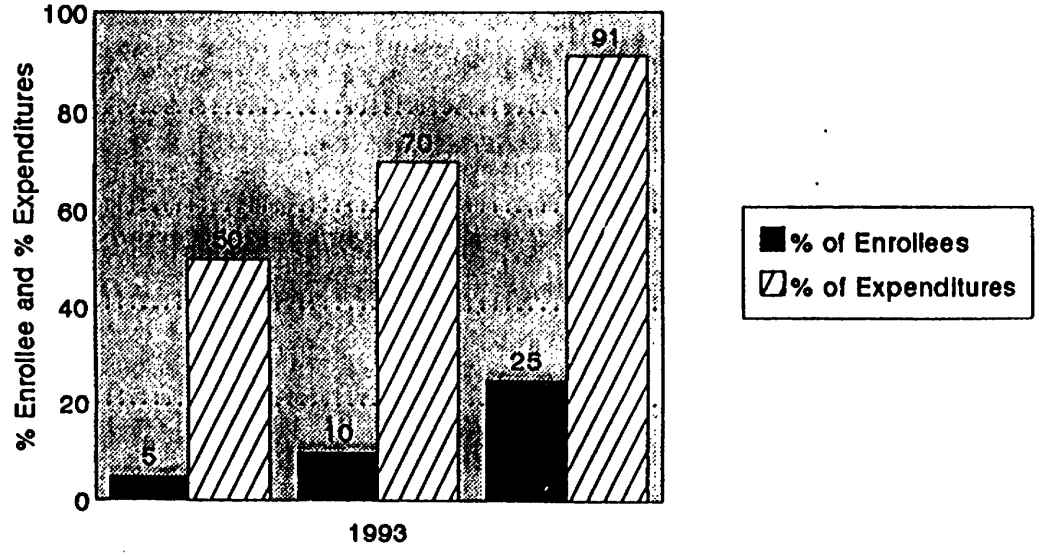
Percent Share By Income



Source: "Why More Cost-Sharing Won't Slow Medicare Spending"
Journal of American Health Policy, July/August 1993

Chart 2

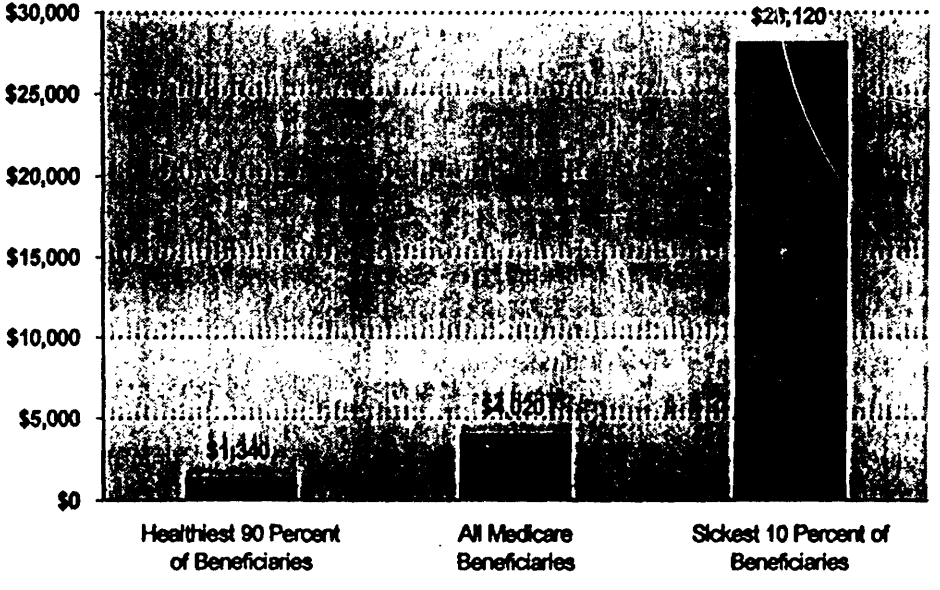
Distribution of Medicare Expenditures
by Top Percentiles of Enrollees



Source: HCFA/OACT

Chart 3

Average Medicare Outlays per Beneficiary by Health Status, 1993



Calculated by Karen Davis from HCFA's *Medicare: A Profile*, February 1995

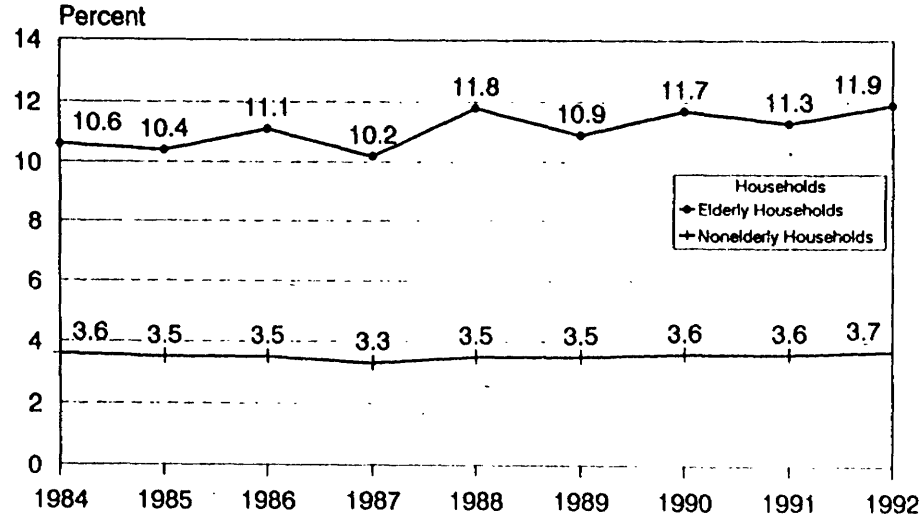
Chart 4

Medicare Cost Sharing
1995

- Inpatient Hospital Deductible = $716 per benefit period
- Part B Deductible = $100 per year
- Part B Premium = $46.10 per month
- In addition, beneficiaries pay copayments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier and hospital outpatient services.

Chart 5

Direct Household Spending for Health Care as Percentage of Household Income, 1984-1992



Source: Congressional Budget Office calculations based on data from the Consumer Expenditure Surveys of the Bureau of Labor Statistics, 1984-1992

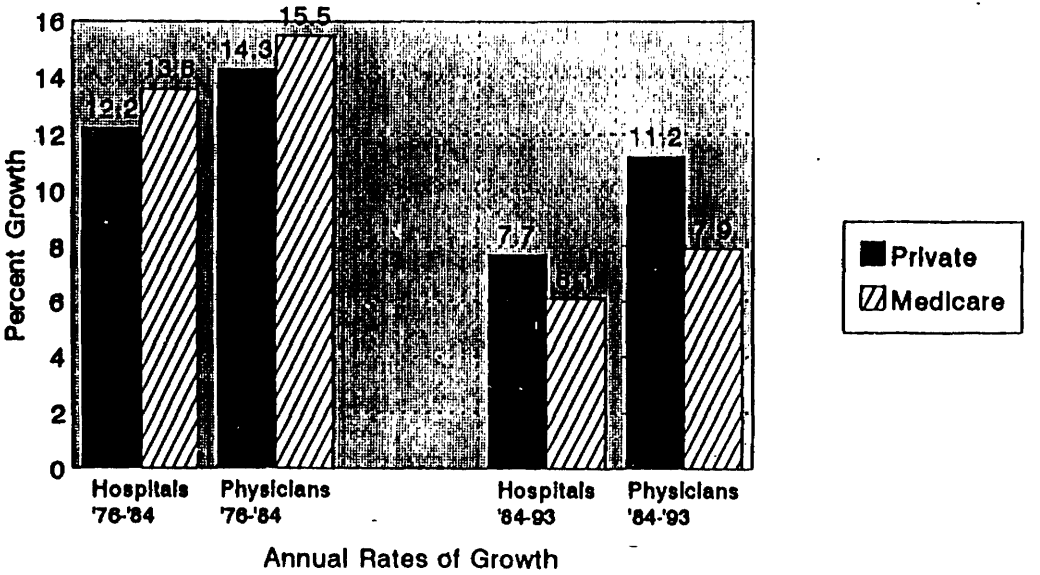
THE COMMONWEALTH FUND

Chart 6

Comparison of Growth in Hospital and Physician Expenditures

Per Enrollee

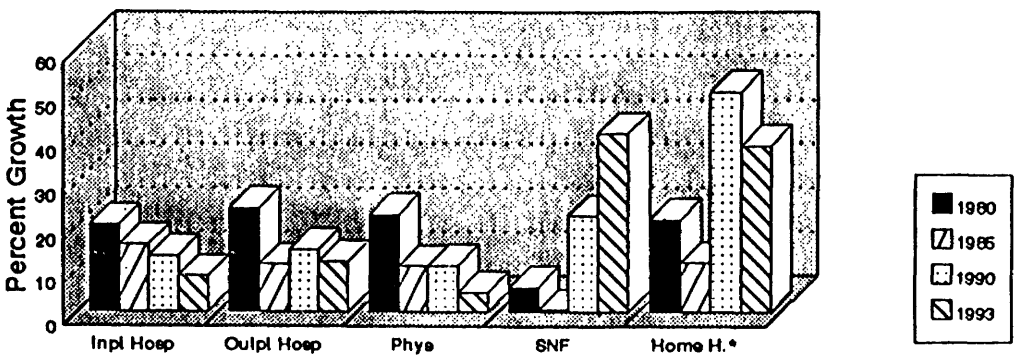
Private Health Insurance vs. Medicare



Source: HCFA/OACT

Chart 7

Annual Growth in Medicare Outlays
Select Years

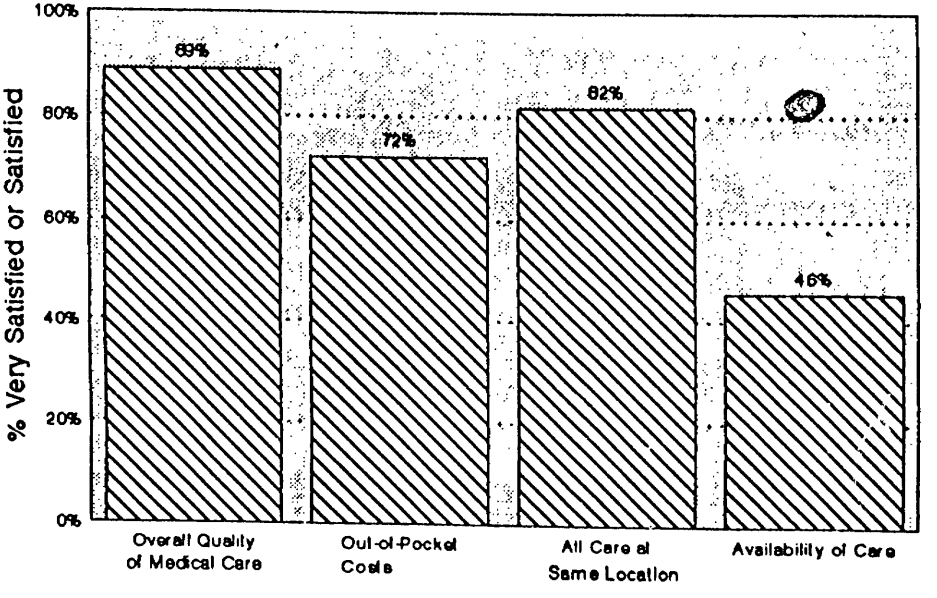


1980	19.9	23.7	22.2	5.7	21
1985	15.4	11	10.5	0.4	11.2
1990	12.9	14.3	10.6	21.9	50.1
1993	8.3	11.6	4.5	40.6	37.8

*Home Health includes Part A only
Source: HCFA/Division of Budget

Chart 8

Beneficiary Satisfaction



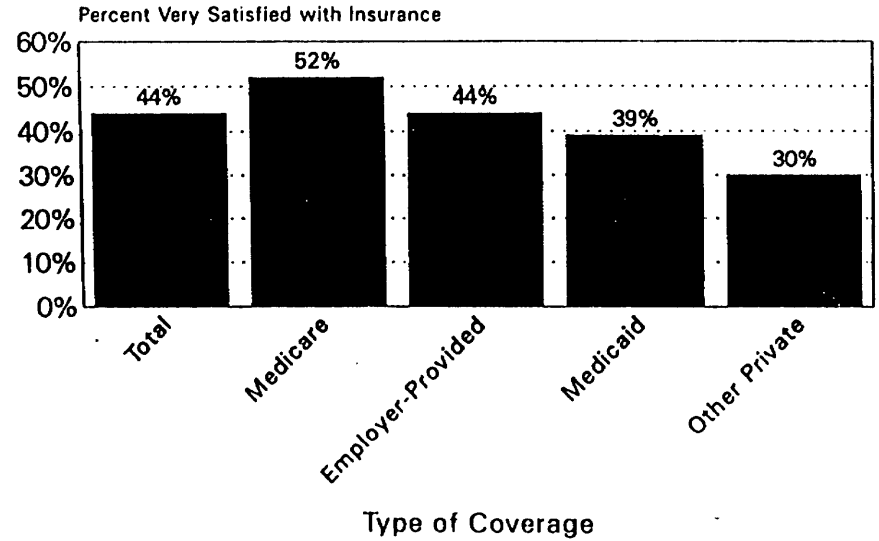
Elderly in the community.

Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart 9

Satisfaction with Health Insurance

Medicare Recipients Most Satisfied



Kaiser/Commonwealth Fund Health Insurance Survey, 1993
Louis Harris and Associates, Inc.

Chart 10

VOTER SUPPORT FOR 25 SELECTED POLICIES TO REDUCE THE FEDERAL DEFICIT

	% of voters who favor the proposal		
	Total Voters	Voted for Republican in House	Voted for Democrat in House
STRONG TO MODERATE SUPPORT			
Having people over age 65 who earn more than $50,000 a year pay more for Medicare than other seniors	71%	69%	73%
Decrease spending on food stamps	55%	60%	54%
Decrease agricultural price supports	53%	50%	56%
Decrease defense spending	53%	40%	64%
MODERATE OPPOSITION			
Paying doctors and hospitals less for the care they provide to seniors under Medicare	48%	44%	55%
Decrease spending on public housing	45%	50%	43%
Decrease spending on unemployment compensation	43%	44%	42%
Increase the proportion of Social Security benefits subject to federal income taxes	42%	40%	47%
Decrease federal aid to cities	39%	47%	33%
Decrease spending on AFDC	39%	49%	27%
Increase the retirement age for Social Security from 65 to 67	39%	44%	28%
Increase Social Security or employer taxes	35%	27%	44%
Limiting the tax deduction for employers' contributions to their employees' health insurance	32%	38%	27%
Requiring people to pay a larger share of nursing home costs before federal assistance begins	32%	38%	24%

(continued)

Source: Kaiser/Harvard Survey 1994

VOTER SUPPORT FOR 25 SELECTED POLICIES TO REDUCE THE FEDERAL DEFICIT (continued)

	% of voters who favor the proposal		
	Total Voters	Voted for Republican in House	Voted for Democrat in House
STRONG OPPOSITION			
Decrease or eliminate tax deduction for charitable giving	29%	29%	29%
Decrease or eliminate tax deduction for home mortgages	27%	32%	24%
Reduce the annual cost of living increase in Social Security	26%	34%	18%
Decrease federal aid for college student loans	24%	26%	22%
Increase the federal income tax	23%	20%	31%
Increase taxes on gasoline and heating oil	20%	15%	25%
Decrease federal aid to education	19%	18%	21%
Decrease spending on Social Security	17%	21%	13%
Decrease spending on Medicaid for the poor	17%	17%	15%
Decrease spending on Medicare for the elderly	8%	5%	10%
Decrease veterans' benefits	7%	8%	8%

Source: Kaiser/Harvard Survey 1994

RESPONSE OF KAREN DAVIS TO A QUESTION FROM SENATOR CAROL MOSELEY-BRAUN

Question. Your testimony discussed the burden of existing Medicare premiums, copays, and Medigap fees on many elderly Americans. Do you believe proposals to increase Part B premiums and/or increases in coinsurance and deductibles will adversely affect the majority of Medicare beneficiaries? If so, how would you structure reforms so that Medicare remains fiscally viable but does not become cost prohibitive for many elderly beneficiaries?

Answer. In my view making Medicare fiscally sound for future generations will require addressing the revenue base of Medicare. Part A is financed by a payroll tax of 1.45 percent of earnings by employers and by employees; Part B is financed 75 percent by general revenues and 25 percent by premiums. Increasing the payroll tax by 0.5 percent each on employers and employees would generate approximately $30 billion annually. Other longer run options include combining Part A and Part B, improving benefits so that beneficiaries do not need to purchase supplemental coverage and/or expanding coverage to additional groups (such as uninsured children, early retirees and disabled persons during their first two years of disability) and financing coverage for all Medicare beneficiaries with a value added tax.

In the short term any restructuring of Medicare should recognize both the economic vulnerability of Medicare beneficiaries as well as the institutions that provide them with health care. Of the options you cite, premium increases are the least burdensome since they are spread across all beneficiaries. If premium increases are combined with outreach efforts to enroll beneficiaries with incomes below 120 percent of the federal poverty level in the Medicaid Qualified Medicare Beneficiaries (QMB) program, low-income elderly would be protected from this increase. Or premiums could be increased only for those with incomes above the threshold for taxing Social Security benefits. Increasing the hospital deductible or co-pay for home health care are more likely to add to financial burdens on the most seriously and chronically ill, since they are the ones most likely to incur multiple hospitalizations and out-of-pocket costs for prescription drugs and other noncovered services. Some tightening of physician and hospital payment rates is possible, but could jeopardize the fiscal stability of hospitals that serve large numbers of Medicare patients. Prospec-

tive payment methods could be developed and instituted for a broader range of Medicare services including home health services and hospital outpatient care.

As I indicated in my testimony, I do not believe that Medicare managed care offers much prospect of Medicare savings. In fact as currently structured managed care costs the Medicare program money. Medicare beneficiaries should be given explicit choices of managed care plans, but for those beneficiaries preferring to keep their own physician there should be no financial penalty for selecting that option. The method of paying managed care plans under Medicare needs to be improved to adjust better for the health status of enrolled beneficiaries to avoid incentives for plans to avoid sicker patients or to encourage sicker patients to disenroll.

PREPARED STATEMENT OF BRUCE C. VLADECK, PH.D.

Mr. Chairman and Members of the Committee: I am pleased to be here today to discuss the Medicare program, its extraordinary success in providing health care to the elderly, and the challenges the program faces in controlling expenditures without jeopardizing the services Medicare offers its beneficiaries. Medicare has fulfilled its promise of providing access to basic health care for elderly and disabled Americans. As Medicare enters its thirtieth year, however, we face a world quite different from that in which the program began. We will face continuing challenges in assuring access to care, in assuring the quality of that care, in responding appropriately to technological advances in medicine, and in helping to reform the health-care delivery system.

BACKGROUND

Before Medicare was created, in 1965, over half of the elderly population had no health insurance. Now over 95 percent of the elderly are insured. In 1972, Congress expanded Medicare to include disabled individuals and those afflicted with end stage renal disease. Today, these individuals have basic health insurance and need no longer fear massive bills or having to do without basic care they need. We should not lose sight of the importance of this achievement: it justly ranks as one of America's major accomplishments of the past several decades.

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

While sustained by our program, many of our beneficiaries could be described as vulnerable.

- Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less than $25,000 (see Chart 1). Fifty-nine percent of senior citizens rely on Social Security for 50 percent or more of their income (see Chart 2).
- Currently, 20 percent of our beneficiaries are either seniors age 85 and older, most of whom are women, or persons with disabilities or end stage renal disease (see Chart 3).

In the first full year of operation, Medicare served 19.4 million elderly Americans, with Federal spending totalling approximately $4.5 billion. Today, Medicare meets the health care needs of approximately 36 million beneficiaries, with annual expenditures of approximately $160 billion in 1994.

Early projections of Medicare participation did not take into account the fact that access to medical care has helped contribute to the increased life expectancy for the elderly. However, access to care also translates into greater demand for services.

This growth in spending has resulted from a variety of factors, including improvements in benefits, expansions in eligibility, and increases in the costs of health care. Ironically, part of the growth may also be traced to Medicare itself: Medicare's case load has quietly risen because life expectancy has improved significantly, partly because of the improved medical care paid for by Medicare.

The Medicare program consists of two distinct parts.

- Part A covers services furnished by hospitals for inpatient care, home health agencies, skilled nursing facilities, and hospices. Medicare Part A services are primarily financed by the Medicare payroll tax, paid by both employees and employers.
- Medicare Part B is voluntary and is offered to all Medicare Part A beneficiaries, and individuals age 65 and over who might not qualify for Part A, for a monthly premium, now $46.10. The premiums collected are currently required by statute

to finance 25 percent of the Part B program; the rest is financed through general Federal revenues.

Part B covers a wide range of medical services and supplies including physician services, outpatient hospital services and some home health services. Part B services also include diagnostic laboratory tests, x-rays, and the purchase or rental of durable medical equipment.

- In recent years, Medicare has witnessed substantial increases in spending for home health services and outpatient procedures. In 1994, Medicare spent 15 percent of all outlays on these services (See Chart 4).

The Medicare program has helped the nation achieve a high standard for quality health care.

- Medicare pays almost 30 percent of the nation's hospital expenditures, and this solid base of support has had a major role in permitting the modernization of the nation's hospitals.
- The training of physicians at hospitals is extensively subsidized through Medicare's graduate medical education and indirect medical education payments.
- Medicare has also pioneered the expansion of at-home medical care through home health agencies.
- Medicare has improved access to medical treatments through special funding for rural and frontier areas.
- Lastly, Medicare, to help assure the quality of health care delivered to Medicare beneficiaries, pioneered the first utilization and quality review program, which served as a model for the rest of the country. Most importantly, all suppliers and providers that serve Medicare beneficiaries, must meet the HCFA standards for health and safety. In addition, I will later describe our Health Care Quality Improvement Program, under which the Medicare Peer Review Organization (PROs) program is setting the standard for modern quality assurance activities.

MEDICARE'S STRENGTHS

Medicare continues to have high levels of customer satisfaction and physician participation. Recent studies have shown that the majority of Medicare beneficiaries are highly satisfied with their medical care and coverage.

Medicare also boasts a high participation rate among physicians and other providers of health care services, which helps assure access to medical treatment and services for Medicare beneficiaries. Over 578,000 physicians (including limited license practitioners), or approximately 65 percent of those physicians who bill Medicare, have signed up to be participating physicians, meaning they forgo extra billing on all claims for Medicare beneficiaries. In addition, 6,473 hospitals participate in Medicare.

Medicare continues to lead the health insurance industry in the effective use of high technology for program administration. We operate the Medicare system with administrative costs of less than two percent of program outlays (see Chart 5). In contrast, private insurance administrative expenses are about 25 percent in the small group market and about five percent in the large group market.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission. Ninety percent of Medicare's hospital and skilled nursing home facility claims and 70 percent of its physician claims are submitted electronically (see Chart 6). In contrast, 60 percent of Blue Cross's hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is ten percent for all claims.

We have also focused attention on reducing the paperwork burden on health care providers, working closely with the health care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, skilled nursing facilities and home health agencies. Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

For thirty years, Medicare has been insuring the nation's elderly and disabled. We know that beneficiaries feel a certain ownership of the program. This feeling is justified. Through their payroll contributions and those of their employers during their working lives, beneficiaries directly contribute a significant fraction of their insurance costs. The average worker turning 65 and becoming eligible for Medicare today will contribute, along with their employers, about 40 percent, on average, of what Medicare Part A will eventually pay.

MEDICARE SUCCESSES IN CONTROLLING COSTS

Medicare has been successful in slowing the growth of expenditures for hospitals and physicians. From 1984 to 1993 Medicare's annual rates of expenditure growth were 6.1 percent for hospitals and 7.9 percent for physicians. In the same time period, private insurance experienced rates of 7.7 percent for hospitals and 11.2 percent for physicians (see Chart 7).

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's Fiscal Year 1996 Budget, the projected annual average rate of growth for 1996-2000 is 9.1 percent. In contrast, six months ago in the Mid-Session Review the projected annual average rate of growth for the same period was 10.3 percent. The primary contribution to lower Medicare projections is slower projected growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower expected growth in the complexity of Medicare inpatient cases (see Chart 8).

Medicare has generally experienced a slower growth rate of expenditures per enrollee than private health insurance: from the mid 1980's to the early 1990's, Medicare per enrollee expenditures grew at 7.2 percent versus 10.3 percent for private insurance. While there was a temporary reversal of this relationship from 1992 to 1994 (see Chart 9), our actuaries project the per enrollee growth rate of Medicare and private health insurance to grow at roughly the same rate beginning in 1996 and continuing into the 21st century.

This record has been due, in part, to Medicare's prospective payment system (PPS) for hospitals and the physician payment reform, both of which have helped slow the rate of expenditure growth.

The Prospective Payment System

In 1984, Medicare began paying hospitals on a prospective basis for inpatient care of beneficiaries. Prior to PPS, hospitals were paid on a reasonable cost basis for all charges in treating a patient on an inpatient basis. Under PPS, each patient stay is categorized into a Diagnosis Related Group or DRG. The DRG payment is calculated to represent all the costs associated for treating a patient with a given diagnosis and is made as one bundled payment for the hospital.

This prospective payment gives the hospital the incentive to provide cost-effective treatment and reduce waste while providing quality care to the patient. The system has worked largely as intended: cost increases have been curbed and the quality of patient care has been maintained. Hospitals have played a significant role in helping the prospective payment system work as envisioned.

In addition, in 1992 we extended the prospective payment system to incorporate Medicare's share of capital expenses of hospitals. Until 1991, Medicare was making payments to hospitals on a reasonable cost basis. This cost-based system did not provide incentives for hospitals to make prudent capital investments. Under the old cost-based system hospitals were engaged in a race for technology, often competing for high technology pieces of equipment, such as MRIs and CAT scans, that cost the Medicare program millions of dollars. Under PPS, hospitals now have the incentive to make prudent investment decisions without burdening the Medicare program with paying for excessive purchases of unnecessary medical equipment.

Physician Payment Reform

Medicare physician payment reform also provides better incentives for appropriate use of health care services. The reform package in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) had three key elements. First, the law set a goal for the rate of Medicare physician expenditure growth, called the Medicare Volume Performance Standard (MVPS). Second, a resource-based fee schedule replaced Medicare's antiquated customary, prevailing, and reasonable charge system. The last element included provisions for financial protection for Medicare beneficiaries by establishing uniform limits on extra billing by nonparticipating physicians.

The fee schedule refocuses current incentives by generally increasing payment for primary care and reducing payment for surgery and other procedures. At the same time, the Medicare Volume Performance Standards could with further refinement help restrain overall spending for Medicare physicians' services. Further, beneficiaries are protected from extra billing charges under the fee schedule.

Since implementation of the fee schedule in 1992, we have seen a slower rate of growth in physician expenditures.

Other Areas for Payment Reform

Medicare currently covers four major services that are not paid prospectively: skilled nursing facilities (SNFs), home health agencies, hospital outpatient depart-

ments and PPS-exempt hospitals. We are working on developing prospective payment systems for all of these services.

RECENT DEVELOPMENTS

Over the past few years, HCFA has improved the oversight and efficiency of Medicare claims processing; strengthened prevention and detection of fraud and abuse; simplified paperwork; expanded beneficiary outreach efforts; assured improved quality of health care; strengthened managed care options; and enhanced the coordination and integration of health care.

Simplifying Program Administration

As I mentioned earlier, Medicare is a leader in streamlining program administration and fostering the use of electronic claims. We are continuing our efforts in this area by increasing our use of electronic technology for all phases of claims processing to reduce administrative costs. In fact, Medicare has experienced a significant reduction in administrative costs for processing both Part A and Part B claims. For example, Medicare's bottom line cost to process claims has been reduced by 24.6 percent per physician claim and by 21.1 percent per Part A claim since Fiscal Year 1990.

In order to continue efforts at streamlining our current claims processing systems, we recently signed a contract with GTE to develop the Medicare Transaction System (MTS). MTS will improve communication, data capabilities, and information sharing among our contractors.

MTS will replace 11 automated systems currently operated by over 65 insurance companies under contract to Medicare at 62 sites. The new system will be able to process over 1 billion claims per year as projected by the turn of the century. MTS will be phased-in over two years, starting in 1997.

In partnership with suppliers, providers, and Medicare beneficiaries, HCFA has sought to re-engineer our business processes. For example, in the durable medical equipment (DME) area, we concluded that we should concentrate all processing for durable medical equipment and supplies in a small number of specialized carriers. This step was intended to achieve more sophisticated and uniform coverage policies, to improve claims processing, and to help prevent fraud and abuse. Greater efficiency would be achieved because each carrier would have a trained pool of experienced personnel able to handle the DME claims more effectively and to process claims more quickly and accurately.

Starting in October 1993, we have gradually transferred the processing and monitoring of durable medical equipment and supplies from 34 Part B carriers to four durable medical equipment regional carriers (DMERCs).

This consolidation also allowed for standardized submission of electronic claims. All suppliers are now able to use a single format to submit their claims to Medicare. This format results from a major redesign of the previous process, which had well over 30 different electronic formats.

Combatting Fraud and Abuse

As I mentioned earlier, Medicare is administered largely by private contractors under our supervision. Medicare has agreements with over 65 contractors to process beneficiary claims. In 1994, over 750 million claims were processed and Medicare paid more than $159 billion for medical services, treatment and equipment. With such a vast network in place the potential for fraud is very real. Although the majority of our providers and suppliers are legitimate, a few disreputable actors are responsible for a significant amount of fraud and abuse.

HCFA is expanding and strengthening efforts to root out fraud and abuse and to vigorously pursue those who commit such illegal activities.

- We have taken an active lead on establishing separate fraud units in 22 Medicare intermediary and carrier sites.
- HCFA has strengthened relationships not only with the DHHS Office of the Inspector General, but also with the Department of Justice (including the FBI), State and local law enforcement agencies, and our contractors.
- We are increasingly exercising our authority to suspend payments to suppliers or providers when we discover reliable evidence of fraud.
- We are also working with State Medicaid offices to share new technology and approaches to detect fraudulent activities. Some states have state of the art technology available and are quite willing to provide assistance in determining approaches that will benefit our present and future needs.

To better monitor fraud and abuse in a particularly problematic area, HCFA has changed the way durable medical equipment claims are handled. Suppliers no longer can game the system by sending claims to the carrier that paid the highest

amount or subjected them to the least scrutiny. They must now bill the regional carrier that services the area where the beneficiary lives.

The consolidation of claims processing for durable medical equipment mentioned above has significantly increased our ability to deal with fraud and abuse in this area. We now have much improved ability to track specific providers and suppliers, to check on questionable claims, and to stop payment on claims that are not legitimate.

The Statistical Analysis DMERC (or SADMERC) has the added function of conducting statistical analyses of data provided by all four carriers. This arrangement provides a quick and efficient way to detect aberrant patterns of claims that could not have been easily discovered and investigated in the past.

HCFA has also moved to eliminate the use of multiple billing numbers by DME suppliers. Starting in October 1993 we established a new supplier number application process for 120,000 DME suppliers through a National Supplier Clearinghouse (NSC). The NSC maintains a national file on DME suppliers.

In order to be able to obtain a new supplier number and bill the Medicare program each supplier must complete a uniform supplier number application which must be approved by the NSC. Through this process, we are able, for the first time, to have comprehensive information about our supplies that can be used to reliably detect abusive suppliers who attempt to relocate their operations under a different name. For example, the NSC can provide information to carriers about aberrant suppliers and those who do not have valid supplier numbers. The carriers can then stop payment on falsely billed claims and suspend billing numbers.

Upon signing the application, the supplier attests that it will comply with the Medicare Supplier Standards. Any failure to comply with these Standards is grounds for termination from the Medicare program.

Beneficiary/Provider Outreach

We have made great strides in improving beneficiary and provider relations by listening to them and identifying their needs. After identifying the problems, we went to work to create solutions. In 1994, HCFA provided simplified forms to both beneficiaries and providers in order to reduce the amount of paperwork hassle. The revised "Explanation of Medicare Part B Benefits" made it easier for Medicare's elderly and disabled populations to understand what was happening to their claims. The form is also being further refined to consolidate Part A and Part B benefits information into one form. Medicare now requires physicians to sign only one form at the time admitting privileges are granted rather than signing a form each year. This one action simplified participation in Medicare for some 300,000 physicians and over 6,000 hospitals.

Part of our responsibility to beneficiaries and the general public is to provide public education on specific health issues. Accordingly, HCFA has created and developed a Consumer Information Strategy. This initiative is coordinated with internal and external partners, including the Public Health Service, National Institutes of Health and varied consumer and advocacy groups. We have alerted Medicare beneficiaries about our coverage of the influenza and pneumococcal vaccines, and mammography. We are currently developing future campaigns on breast and prostate cancers. We strongly encourage beneficiaries to become better educated health care consumers.

Growth in Managed Care

Medicare is participating in the managed care revolution, and indeed HCFA is increasingly assuming a leadership position. Our managed care agenda has two priorities: (1) to ensure the provision of quality services by contracting with HMOs that put the beneficiary first; and (2) to expand our beneficiaries' choices of managed care products by providing options—similar to those available in the private sector. We are working with HMOs as partners to. meet our goals of expanded choice and quality services. We expect as much as 20 percent growth in Medicare managed care enrollment this year—a clear signal that beneficiaries are changing the face of the Medicare program by their own choice.

At present, 74 percent of Medicare beneficiaries have access to a managed care plan, and nine percent of all Medicare beneficiaries have chosen to enroll in a managed care option (see Chart 10). 1994 was a year of impressive growth in Medicare managed care: we experienced double digit growth both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent (See Chart 11). Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. For example, in our Philadelphia region, the number of contracts increased from 6 to 16 and in the New York region contracts increased from 11 to 14.

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

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

We also want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, beneficiaries would face nominal copayments if they stayed in plan but have the option to go to any physician at any tune, if they were willing to pay increased cost-sharing. A PPO option represents the ideal choice for those beneficiaries torn between staying in the fee-for-service program and joining a Medicare risk plan. We look forward to working with this Committee on the PPO option in the months ahead.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must ensure the provision of quality health care to beneficiaries, in partnership with managed care leaders. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive health needs of the Medicare population. A challenge we face as more and more beneficiaries enroll in HMOs is one of monitoring, data collection and plan accountability. Like any other health care purchaser, we want a quality product.

Payment/Competitive Bidding

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

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

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

Quality

Insuring high quality care for Medicare beneficiaries is a high priority for HCFA. The cornerstone of Medicare's quality assurance efforts rests with peer review organizations (PROs). PROs are charged with assuring that care is appropriate, provided in the correct care setting, and meets professionally recognized standards of quality. PROs, along with our program to inspect health care providers and to monitor their compliance with Federal requirements, provide an assurance that care meets quality standards.

Our knowledge and expertise in measuring and improving quality of care has evolved rapidly in the last decade, and we have been making corresponding changes in the Medicare Peer Review Organizations (PROs) and End Stage Renal Disease Networks. Two years ago we announced the Health Care Quality Improvement Program (HCQIP) to bring modern principles of quality management to PRO activities, particularly the focus on patterns of care rather than individual cases of questionable care. The HCQIP forms the heart of our efforts to improve quality of care for Medicare beneficiaries over the next decade.

HCQIP embodies the major quality themes: development of quality indicators or measures, support for continuous quality improvement, development of information to promote informed consumer choice, and increased consumer protection. The most important achievement of the HCQIP is redirecting our attention from individual cases to improving quality in the mainstream of care. The HCQIP seeks to stimulate the proactive involvement of plans, providers and practitioners in quality improvement activities.

Our programs for inspecting and monitoring providers have been enhanced to improve their effectiveness at assuring the delivery of quality health services. We are reassessing and revising our standards of performance to make the focus one that is primarily directed at improving patient outcomes, and reducing process and structure requirements for facilities. Our demonstration to develop quality indicators for home health agencies and skilled nursing facilities is nearing completion. These indicators will improve the health care industry's ability to continuously improve the quality care provided and enhance our ability to assure quality of care for all patients in the care of a skilled nursing facility or home health agency.

MANAGED CARE QUALITY

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

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

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

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

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

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

In Medicare, we are beginning to pilot test a new, performance based approach to Peer Review Organization (PRO) review of HMOs developed under contract with the Delmarva Foundation. These measures reflect the special health needs of an elderly and disabled population, for example, in management of chronic conditions. These measures will them be considered in conjunction with the broader HEDIS effort.

Coordination and Integration of Health Care

HCFA is constantly looking for new approaches to providing high quality care at a lower cost than traditional approaches to medical care. Starting in 1990, a demonstration project, the Program of All-inclusive Care for the Elderly (PACE), was developed to provide an integrated system of care for frail elderly beneficiaries.

PACE is the congressionally authorized replication of the health care delivery system pioneered by On Lok, Inc. PACE provides integrated acute and long-term care financed through capitation. The program provides community-based care that integrates comprehensive medical, restorative, social and supportive services to address the client's multiple, interrelated needs. Preliminary data seem to indicate that this integrated care approach is successful in providing high quality, cost-effective health care to the frail elderly population.

Another demonstration that is now undergoing a second phase of operation is the Social HMO demonstration. The Social HMO offers Medicare beneficiaries the opportunity to receive a wide range of services to meet both acute and long-term care needs. This model of care combines the features of HMOs with those of long-term care in demonstration projects.

The first Social HMO demonstration enrolled a cross section of the elderly populations, including the functionally-impaired and the well elderly, and used a coordinated case management system to provide a range of services to enrollees. The financing methodology was prepaid capitation from Medicare and member premiums.

The second generation Social HMOs will focus on refining the targeting and financing methodologies and benefit design, with an emphasis on geriatric care and the extension of the model to special populations. Six provider organizations from across the country have been selected to participate in the second phase of the demonstration.

I am optimistic that through demonstrations such as these, new models of care can be tested and successfully implemented to serve the long-term health care needs of Medicare beneficiaries.

ADDITIONAL CHALLENGES FACING THE MEDICARE PROGRAM

As we continue to work with tighter budgets and growing needs, the Medicare program seeks to serve its beneficiaries in the best possible ways. The aging of our population, changes in morbidity and mortality, and technological advances in medicine will continue to contribute to the changing needs of the people Medicare serves.

Access and Quality Concerns

HCFA is committed to finding new ways to assure quality health care and access to medical services in more efficient ways. We are developing enhanced performance standards and quality indicators to assure that the quality of service and treatment of Medicare beneficiaries continues to improve.

We have funded grant programs to provide access to health care in rural areas, and we support the availability of managed care options across the country. We strongly encourage beneficiaries to make educated decisions about their health care by providing choices. Despite these efforts access to quality health care is sometimes difficult for those beneficiaries living in rural, frontier or inner-city areas. Our goal is make basic quality health care easy to receive.

Improved Beneficiary Outreach

In addition to cost containment and quality goals, we are committed to improving communication with beneficiaries. HCFA is striving to make Medicare more understandable for beneficiaries. We have been working to create new channels to extend our beneficiary outreach efforts. One project is 1-800-MEDICARE, a national toll-free service that will provide immediate on-line assistance for beneficiary inquiries. We are currently working with various industry, private sector, consumer, and beneficiary groups to accomplish this ambitious task. I am confident that this effort will provide a new level of beneficiary service and access to information never seen before.

Medicare's Trust Funds

While we strive to expand and change the way we do business, we must acknowledge financial realities. The most recently available estimate of the Trust Fund exhaustion date from the April 1994 Trustees report, indicate that the Hospital Insurance (HI) Trust Fund would be solvent until 2001 under 11moderate" assumptions. Changes made by OBRA 93 had the effect of extending the date of solvency reported in the April 1993 report by about three years.

While OBRA 93 made various cuts in provider payments, the largest part of this effect resulted from revenue provisions. The HI tax of 1.45 percent is now applied to all earnings; previously earnings above $135,000 escaped this tax. In addition, the maximum percentage of Social Security benefits subject to the income tax was raised from 50 percent to 85 percent. The additional revenues generated by these provisions were dedicated to the HI Trust Fund.

The Board of Trustees will be issuing its report in April 1995. I will be happy to discuss these issues with the Committee in greater detail once the report is released.

Medicare's Benefit Package

As I mentioned earlier, through better access to medical services, improved medical care and advanced technology our beneficiaries' quality of life has increased and they are living longer. These factors have made more obvious what many consider

gaps in our health care system. The long-term care or prescription drug needs of the elderly are not addressed in our current Medicare program.

While Medicare does cover temporary stays in skilled nursing facilities and provides limited coverage for home health care these benefits were not designed to address needs for long-term care. In 1987, Medicare covered only 2 percent of all nursing home expenditures (for short-term stays), while 58 percent was financed through private sources, which include direct out-of-pocket expenditures by the elderly (see Chart 12). A limited number of Medicare beneficiaries have any private insurance coverage for nursing home services. All of these challenges facing Medicare will continue to grow as our "baby boom" population reaches age 65 shortly after the turn of the century.

CONCLUSION

Although there are many approaches and views on how to provide cost effective accessible health care, the effect will be keenly felt by Medicare beneficiaries. The move towards better coordination and cooperation with our partners both in the private and public sectors will help make Medicare a stronger and more responsive program.

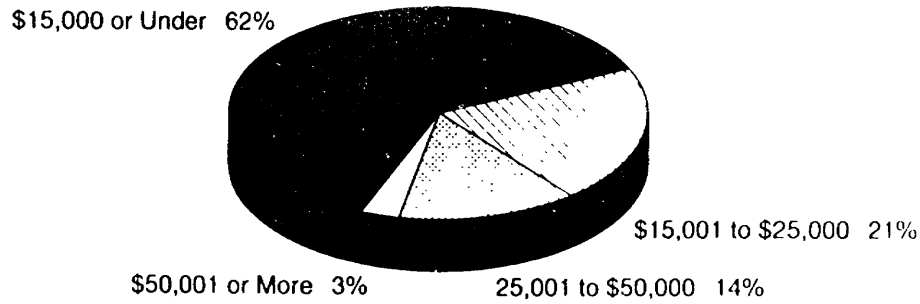
The Medicare program continues to be an extraordinary accomplishment. The vision started thirty years ago has proven to be revolutionary and has helped make the quality of life for the nation's elderly better. The steps taken by this Committee have helped provide more comprehensive health benefit for millions of Medicare beneficiaries. In turn, the steps taken by Medicare have often provided the leadership for private insurance companies to offer the same types of benefits and coverage for medical treatments for all Americans.

However, this Committee or HCFA's responsibilities are not completed, they are just beginning. The challenges that we face to provide basic health care to the vulnerable populations in this country, in addition to all Americans, is formidable. I look forward to working with the members of this Committee to address these issues.

I would be happy to answer any question you may have.

Share of Program Expenditures by Income

Of Medicare Individuals or Couples, 1992

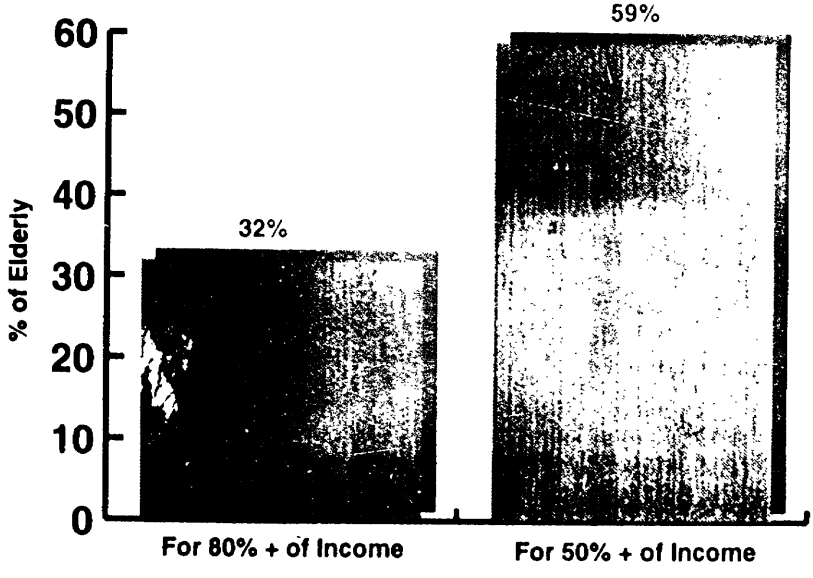


83% of Expenditures: Annual Income of $25,000 or Less

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

Chart 1

Percent of Elderly Relying on Social Security
1992

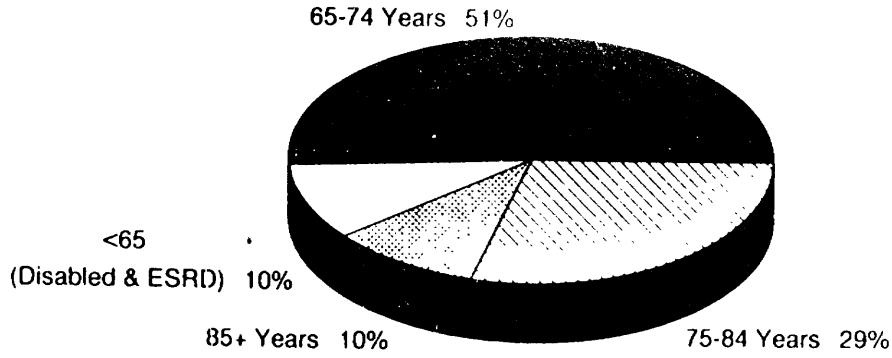


Source: Income of the Population, 55 Years or Older, 1992, SSA, Office of Research & Statistics

Chart 2

The Composition of the Medicare Population, 1992

Elderly, Disabled and ESRD



Total Beneficiaries=35.6 Million

Source HCFA/BDMS

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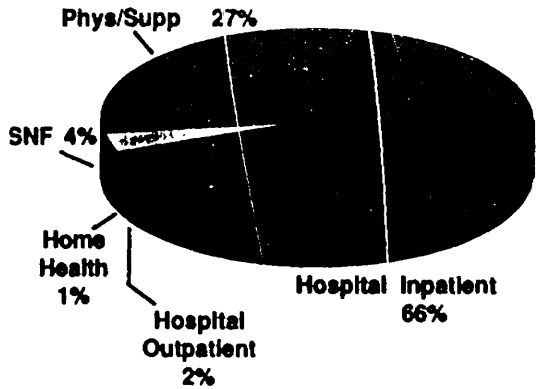
Chart 3

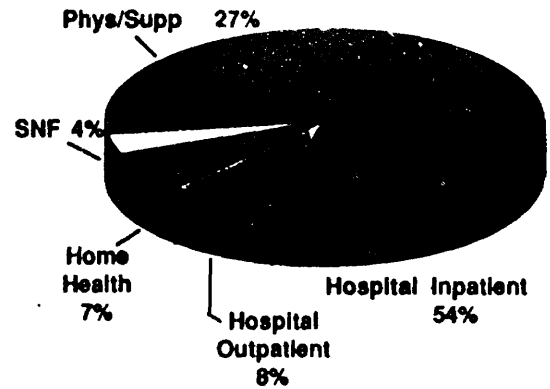
Where the Medicare Dollar Goes

1980



1980 Total = $33.9 B

1993



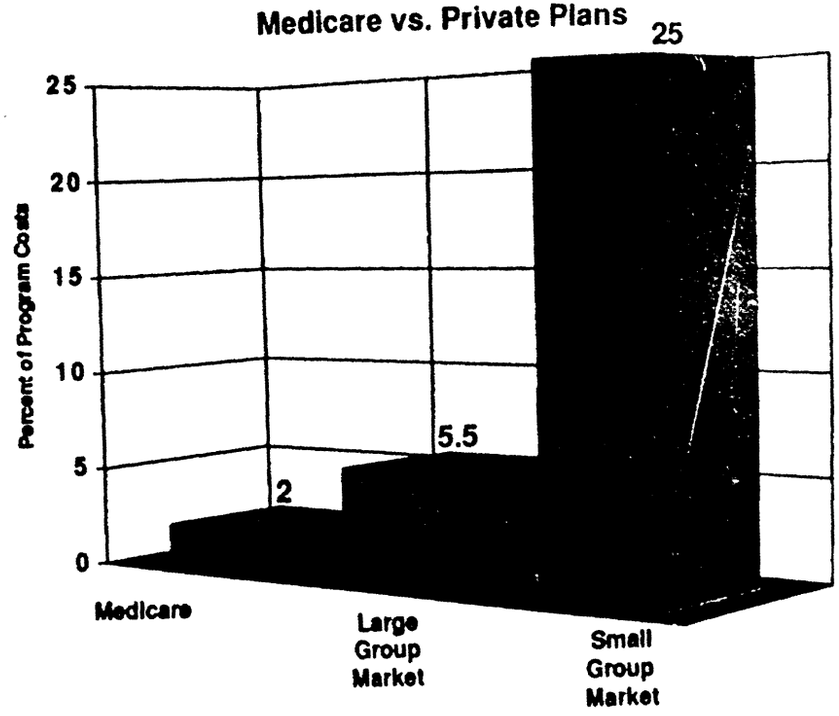
1993 Total = $142.9 B

Source: HCFA/OACT

Chart 4

Administrative Costs

Medicare vs. Private Plans

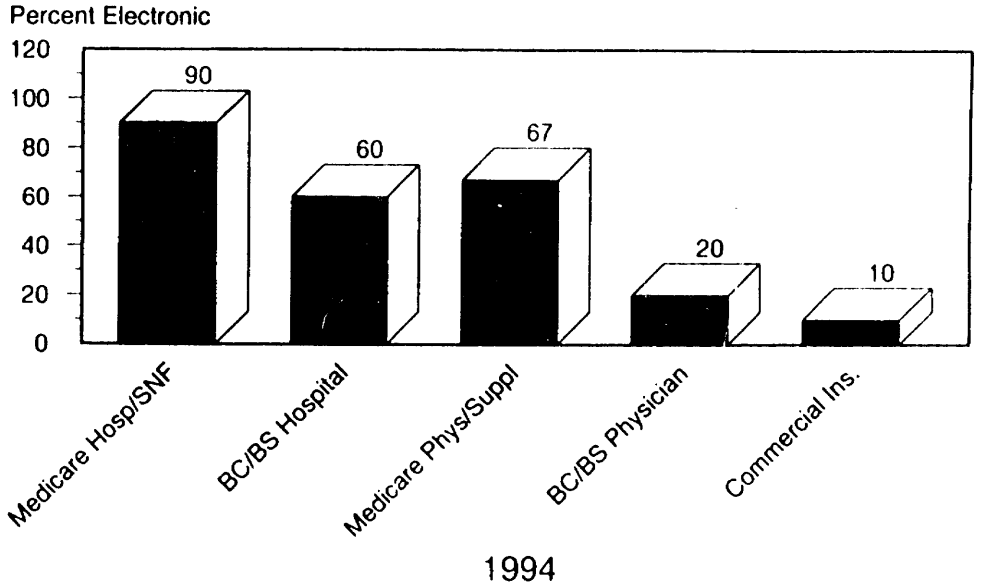


Small group market = firms<50 employees; Large group market = firms 10,000+ employees
Sources: HCFA/OACT and CRS, "Costs and Effects of Extending Health Insurance Coverage," 1988
Note: Administrative activities in the two sectors differ; e.g., private costs include marketing and profit

Chart 5

Electronic Submission of Claims

Medicare vs. Private Insurance



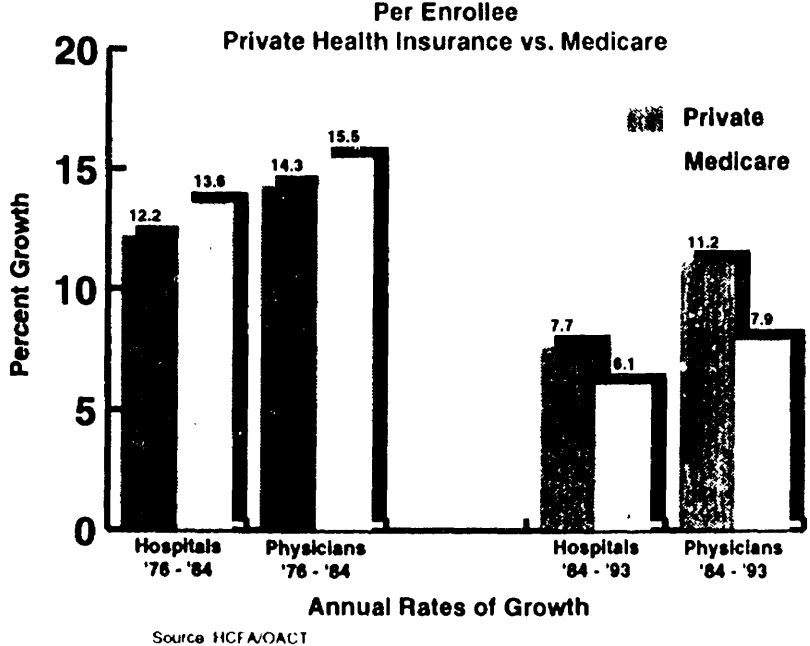
1994

Source HCFA/BPO, Blue Cross Assoc

P78 HCFACHT2

Chart 6

Comparison of Growth in Hospital and Physician Expenditures



Source: HCFA/OACT

Chart 7

Medicare and Medicaid Growth Slows Under the Clinton Administration

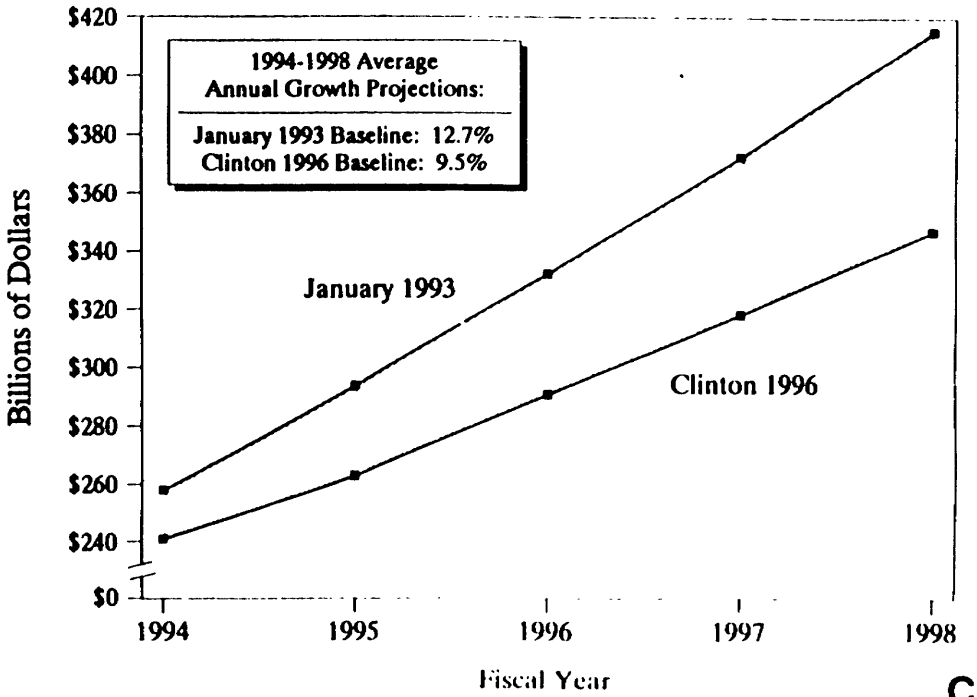
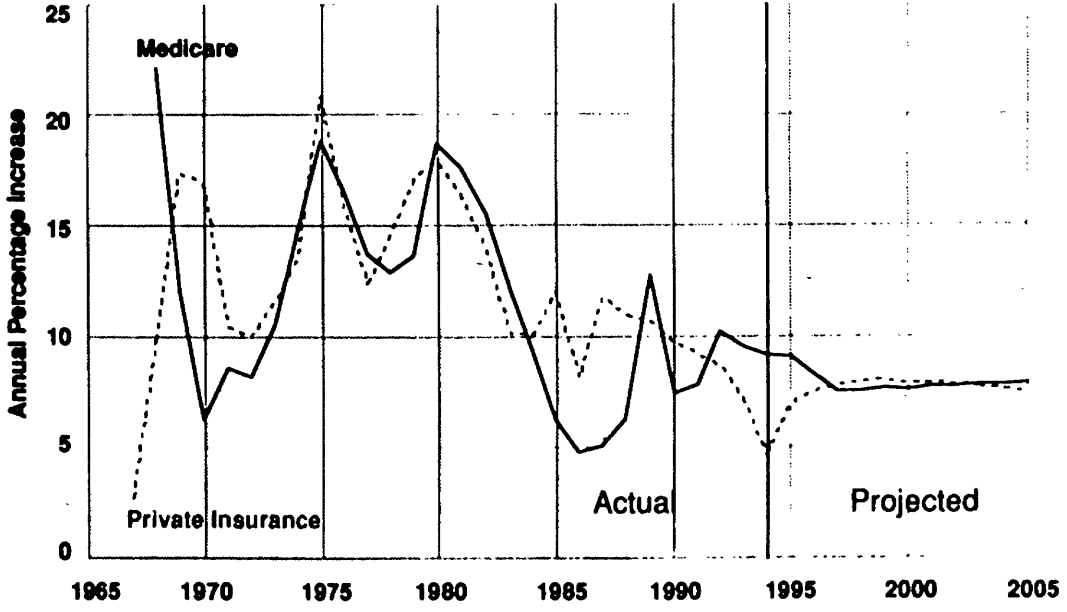


Chart 8

Annual Percentage Increase in Medicare Expenditures per Enrollee Versus Private Health Insurance Expenditures per Insured Person



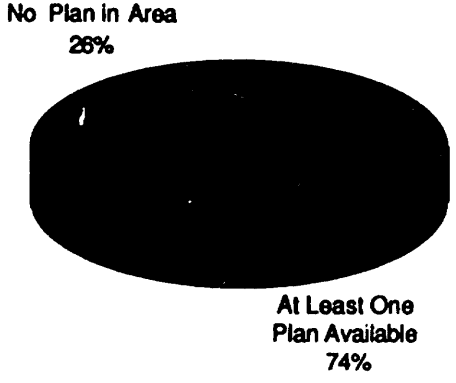
Source: HCFA/OACT

Notes: Historical Data Shown for Private Health Insurance are Estimates based on Limited Data on the Number of Insured Persons.
Values Shown for 1994 are Preliminary Estimates.

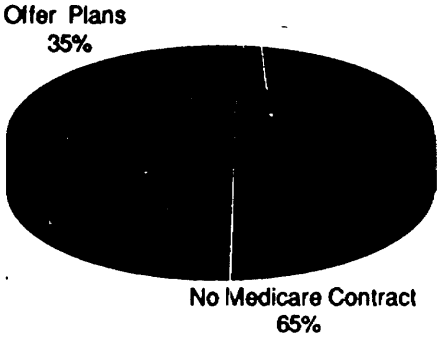
Chart 9

Availability of Medicare Managed Care Products

Percent of Beneficiaries
With Plans Available (1994)



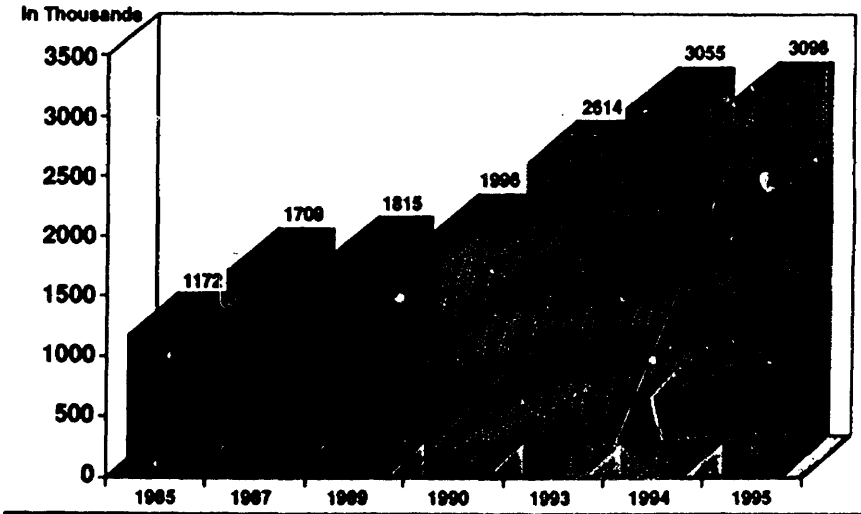
HMOs Participating as
Medicare Risk or Cost Contractors*



Source: HCFA: Office of Managed Care
*Excludes HMOs contracting as health care prepayment plans.

Chart 10

Medicare HMO Enrollment, 1985 to Present
(In Thousands)



Cost HMO Enrollment	731	706	681	732	799	787	758
Risk HMO Enrollment	441	1003	1134	1264	1815	2268	2340

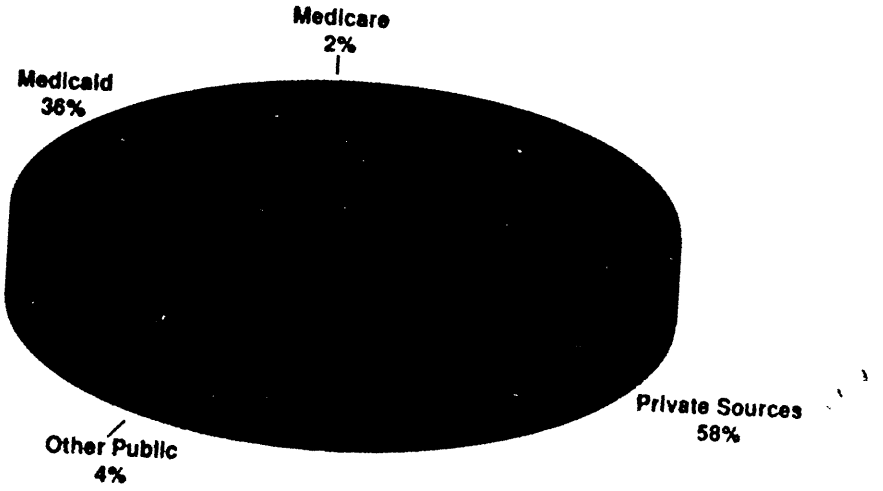
Risk HMO Enrollment Cost HMO Enrollment

Cost HMO Enrollment Numbers Include Cost HMOs and Health Care Prepayment Plans
Source: HCFA: OMC

Chart 11

What Share Do the Elderly Pay?

Nursing Home Expenses



1987

Source: HCFA/OACT

RESPONSES OF DR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR MAX BAUCUS

Question. Dr. Vladeck, do you support making the Montana MAF program permanent? Should it be an open program so that other States have an opportunity to participate?

Answer. The Medical Assistance Facility (MAF) Demonstration has successfully provided an opportunity for small rural communities that can no longer support a full service hospital to maintain access to primary care, emergency services, and limited acute care services. HCFA also operates another limited service hospital project, the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program in conjunction with the States of California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia. Unlike the MAF Demonstration, the EACH/RPCH program is a permanent Medicare operating program in these seven States.

While similar in most respects, some provisions of the MAF and EACH/RPCH programs are different. HCFA supports utilizing the best aspects of both programs in a single limited service hospital program that could be expanded nationwide. HCFA staff have had discussions with Congressional staff on this issue and will continue to provide technical assistance to develop an effective program to help maintain access to health care services in rural areas.

Question. In your opinion, are further Medicare cuts likely to start reducing access?

Answer. HCFA is concerned that further Medicare cuts may reduce beneficiaries' access to care. As the Secretary reported to the Congress in her fourth annual report "Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access" (September 12, 1994), vulnerable groups—such as beneficiaries living under the poverty line and those without supplemental health insurance already exhibit patterns of utilization that suggest they face barriers to Medicare services.

We believe that the only way to successfully cut Medicare expenditures without compromising access is to do so in the context of broad-based health care reform. As the number-of uninsured continues to grow, and providers face tougher negotiation of rates with private payers, Medicare cuts will have an increasingly greater effect on their overall financial condition. Only through broad-based reform will we be able to balance the effects of Medicare cuts with greater financial support from the broader marketplace.

RESPONSES OF DR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR GRAHAM

Question. With the passage of the 1990 Budget Enforcement Act, Congress placed a rigid limit or cap on discretionary spending that includes the cost of Medicare fraud and abuse controls. Benefit payments, however, are not subject to those caps.

According to the General Accounting Office in its February 1995 High-Risk Series report *Medicare Claims,* "This creates a dual problem. Any increase in spending for Medicare's fraud and abuse controls would required cuts in funding for other programs, such as education or welfare. A decline in benefit costs, however, cannot be used as an offset. In fact, funding for fraud and abuse activities is in continual jeopardy, since cutting this funding could free up money for other programs. Reduced antifraud and antiabuse funding, however, translates to greater Medicare costs."

For some time, I have argued that the Congress should address the problems raised by GAO by opening up the Trust Fund for fraud prevention and reduction activities. For every $1 spent on effective antifraud investigations, audits and prosecutions, it is estimated the Medicare program is saved $11-14. Would the Administration consider or support legislation opening up the Trust Fund for the purpose of fraud reduction activities?

Answer. We share your concerns about fraud and abuse control. The Department of Health and Human Services is developing proposals for improving the funding of fraud and abuse activities. We hope to forward these proposals to Congress shortly.

RESPONSES OF DR. VLADECK TO QUESTIONS SUBMITTED BY SENATOR CAROL MOSELEY-BRAUN

Question. Last year, the Trustees reported that the hospital trust fund would run out of money in 2001. Although changes in OBRA 93 may modify that dire prediction, it is clear that hospital trust fund outlays will most likely continue to outpace revenues. This scenario coupled with double digit growth in Part B costs have clear implications to our federal budget. What proposals or combination of proposals do you believe are most viable to reign in spiraling Medicare costs?

Answer. The financial problems faced by the Medicare HI Trust Fund reflect the problems affecting the entire health care system. Whether the strategy to maintain the solvency of the fund includes changes in financing, changes in eligibility, or specific controls on expenditures, the only solutions which will be effective in reigning in Medicare costs must be accompanied by broad-based health care reform.

Medicare cuts on the order of magnitude necessary to balance the trust fund without broader reforms will create market distortions and additional problems for the rest of our health care system. For example, as the number of uninsured continues to grow, significant cuts in provider payments could severely strain many fragile health care delivery systems in rural areas in inner cities. Large cuts could also lead to decreased access for Medicare beneficiaries and the uninsured.

Therefore, we cannot recommend specific proposals in the absence of broader health care reform measures. However, the Administration looks forward to working with Congress to pass a broad-based health care reform package.

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

Mr. Chairman and members of the committee, thank you for inviting me to speak before you today. My name is Gail Wilensky. I am a Senior Fellow at Project HOPE, an international health education foundation, and a former Administrator of the Health Care Financing Administration during the Bush Administration. However, I am here today representing only my own views on Medicare and my testimony should not be regarded as representing an official position of Project HOPE.

STRENGTHS OF THE MEDICARE PROGRAM

I would like to make it clear that I am not interested in "Medicare bashing." I was very proud to have been the Administrator of the Medicare and Medicaid programs from 1990—1992, and worked long and hard to make these programs function effectively. It was a great honor and privilege to have had that opportunity.

Medicare is the world's largest insurance program, and has been one of this country's most popular programs. It was enacted in 1965 to provide coverage for the aged, and was later expanded to provide coverage for the disabled as well as the end stage renal disease (ESRD) program. There are currently 32 million beneficiaries who are aged, 3.5 million who are disabled, and about 75,000 who are on the ESRD program.

In 1965 the program was enacted for the aged only. It was enacted as a compromise between a social insurance program and a voluntary means tested program. Part A, the Hospital Insurance (HI) program, covers inpatient hospital care, short-term skilled nursing care, home health and hospice care. It is a mandatory program financed by a portion of the payroll tax used for Social Security funding. Part B, Supplementary Medical Insurance (SMI), covers physician services, diagnostic x-ray and lab tests, ambulatory services, outpatient hospital services, physical therapy, and durable medical equipment. It is a voluntary program, but since three-fourths of the program's cost is funded by general revenue, participation is almost universal among the Medicare population.

Although there have been numerous changes to the program since its inception in 1965, the most significant legislation has concerned the following. In 1972, coverage of the disabled and ESRD program was added to the original program, which had covered only the aged. In 1983, the prospective payment system (PPS) was introduced for inpatient hospital operating services. Capital payments were brought under a PPS payment system in 1991. In 1988, the Medicare Catastrophic Coverage Act, which limited beneficiaries out-of-pocket liability and added a outpatient prescription drug benefit, was passed but was subsequently repealed in 1989. In 1989, the relative value scale physician fee payment system was adopted, effective 1992.

Medicare has been a very popular program for several reasons. First and foremost, it fulfilled its original mission well. The reason Medicare was enacted was to increase and extend access to care for the elderly. Prior to 1965, the elderly had experienced great difficulties in purchasing insurance, and in receiving what was regarded as adequate and appropriate amounts of health care. Partly, this was a problem of low income, but even those elderly who were not low income had difficulties purchasing insurance. The intention of the Congress had been to make the system mimic the prevailing system of health care financing in 1965, which was represented by the reimbursement arrangements of the Blue Cross and Blue Shield plans. Medicare accomplished its basic objective exceedingly well, some might even say too well.

Medicare is not only popular because it fulfilled its mission, but also because it places few restraints on the elderly as consumers of health care. Aside from a few

exceptions, mostly regarding hospital care after 90 days of care, payments under Medicare are open-ended and come with minimal restraints, at least as far as the elderly are concerned. There is full choice about which physicians to use, which hospitals to seek, which home care providers to use, with little reason to care about their cost. Although some concerns have been raised about potential future problems of access to physicians as a result of Medicare payment changes, there is basically no evidence to date that the elderly are having any systematic problems securing access to care under Medicare. There is little or no pressure on the elderly to seek cost-effective providers or cost-efficient health care plans under Medicare. Since more than 80% of the elderly have either private insurance or Medicaid supplementing their Medicare benefits, there is also not much financial pressure concerning the deductibles or coinsurance requirements for Medicare covered services that Medicare does not pay for.

WEAKNESSES AND PROBLEMS

Medicare has some major weakness, and is in serious need of reform. The most overwhelming weaknesses of Medicare concern its financing, which represent both short term and long term problems for the program. In the short term, entitlement spending in general and Medicare spending in particular acts as a major drain on the budget, and therefore exacerbates the deficit. In the longer term, Medicare is not financially viable, and its future fiscal insolvency raises serious questions about the nature and design of a program that will be sustainable for the 21st century.

The Hospital Insurance portion of Medicare, Part A, is funded by the HI trust fund. According the Congressional Budget Office baseline estimates, Part A growth for fiscal year 1995 is 10.2%, with growth rates between 7.5% and almost 10% projected for the remainder of the decade. Hospitals are projected to grow between 6-7% per year, but the other components of Part A are expected to grow at much faster rates. Home health, which is projected to grow at 26% from 1994 to 1995, is projected to gradually slow to 9% annual growth at the end of the decade; skill nursing facilities, which is also projected to grow at 26% between 1994 and 1995, is projected to slow down to 8% growth by the end of the decade.

The HI trust fund is running out of money. According to intermediate actuarial assumptions, which some consider optimistic, the latest HI Board of Trustee report projects that the trust fund will be bankrupt in the year 2001 and that the imbalance between revenues and cost will grow rapidly thereafter. Under current projections, for example, by the year 2020 the cost rate, or out-go, of the program would be more than double the income rate, or in-flow, of the program. Thus, while Part A does not have the immediate impact on the deficit of Part B, because of its Trust Fund financing, the need for change is clear and unmistakable.

Part B, which is financed approximately three quarters by the general fund, and one quarter by premium payments from the elderly, poses a different set of problems. It is not a trust fund that is being drained of resources, but rather the federal budget that is being adversely effected. According to the Congressional Budget Office baseline estimates, Part B growth projected for fiscal year 1995 is 10.9%, with growth rates between 12-13% annually for the remainder of the decade. Even growth rates in spending for the physician component, which in this fiscal year is projected to grow slightly less than 6%, are projected to grow between 9-12% per year throughout the rest of the decade. Growth rates for durable medical equipment, laboratories, outpatient hospital spending, and other Part B spending are projected to grow even more rapidly.

At a time when spending in the private sector appears to have slowed dramatically, the increases in spending for Medicare continues in double digits. Between 1983 and 1991, Medicare spending grew more slowly than spending did in the private sector. (See Chart 1). But since 1991, Medicare has grown substantially faster than spending in the private sector, 6.5% versus 4.7% growth in real spending, per capita. The differential spending appears to be even more dramatic for 1993-1994, although most of the data for this period remains preliminary. According to the latest CBO estimates, spending for private expenditures grew at about a 5% rate in 1994, while those of Medicare exceeded 10%. There are some indications, however, that spending in the private sector, or at least some segments of the private sector may have slowed down even more dramatically than the CBO projections suggest. A recent Foster-Higgins National Survey of Employers study indicated, for example, that for all firms, health care premiums declined 1.1%, with the decline being largest for large firms, −1.9%. Another indication comes from the changes in the Consumer Price Index. The rise in the medical component of the Consumer Price Index was 4.9% as opposed to a 2.7% overall increase in the CPI. What this means is that for the first time in a long while the MCPI is less than twice the overall

CPI, and a substantial proportion of the upward pressure is coming from the Medicare and Medicaid programs.

We shouldn't be surprised at this outcome. Medicare is primarily fee-for-service medicine with government-administered pricing and a volume control on physicians. Hospitals are encouraged to game the way inpatient admissions are coded, and to increase use of hospital admissions. Physicians are rewarded for doing more rather than less when less may be as good or better. There are few incentives for the elderly to seek cost-effective providers or for their physicians or medical suppliers to limit the spending on services provided to the elderly. Increased spending has been particularly a problem for hospital outpatient spending, clinical lab procedures, home health care and skilled nursing facilities, but it has also been a problem in efforts to moderate physician spending. An individual physician's behavior has little bearing on the change in fees for that individual physician. Rather, the fees are determined by the aggregate behavior of all physicians, differentiated only according to whether they are primary care, specialty physicians (excluding surgeons), or surgeons. This, combined with the cost-increasing incentives inherent in a la carte fee-for-service medicine, means that there are few incentive for physicians to practice cost-efficient and prudent medicine, and no rewards for those that do.

In this third-party-financed, fee-for-service world, our cost-containment efforts can only come from a combination of the following:

- reducing prices (and guarding against volume increases);
- tying price changes to spending targets;
- increasing deductibles and co-pays;
- controlling access to providers and technology.

We have primarily relied on the first three, and have shown little interest in invoking the fourth. Our history is one of a direct control strategy, and perhaps we should not be surprised that while direct controls can moderate spending for a few years (particularly when compared to a passive private sector), it appears that this moderating force dissipates after a short period of time.

THE GOALS OF MEDICARE REFORM

The goals of reforming Medicare should include at least the following:

- increasing consumer choice for the elderly;
- providing incentives for accessible, high-quality, patient-oriented care;
- encouraging cost-conscious decision-making by the elderly;
- incorporating the innovative, cost-reducing delivery system reforms from the private sector into the Medicare program;
- laying the ground work for a fiscally solvent Medicare program.

PRESENT STRUCTURE OF MEDICARE

Despite all of the changes occurring in the private sector, Medicare remains a fee-for-service program with only limited types of managed care available. The projections for 1995 indicate an expected enrollment of 2.5 million beneficiaries in HMOs, representing 6.6% of all enrollees (See Chart 2). The enrollment in HMOs has grown rapidly over the last few years relative to the non-Medicare population (Chart 3), but that is because the base was so small.

There are several reasons that explain the low managed care population in Medicare. First, Medicare subsidizes the main competitors to HMOs. Fee-for-service Medigap is implicitly subsidized, since most of the increased use in health services that comes from eliminating Medicare's cost-sharing is paid for by Medicare. Employer provided supplemental insurance is also subsidized because it is provided tax-free to the beneficiary. In addition, there have been problems with Medicare's payments to HMOs. Inadequate adjustment for risk appears to have produced overpayments to some HMOs, and probably underpayments to other HMOs as well. However, this is more of a problem for HCFA, and explains why to date there appears to have been little savings associated with the HMO growth, although that finding has been subject to some dispute. Of greater relevance is the substantial variation in payment levels between counties and the substantial variation in payment levels from year to year. In addition, questions have been raised about the accuracy of HMO payments in terms of its component measurements, and about the effects of a potential "spillover" on Medicare from having a large HMO enrollment in the non-Medicare population.

What is probably the most significant deterrent to managed care growth, however, is the limited types of non-HMO managed care options that are currently available to the Medicare population, the very population that most needs and probably most desires flexibility. Medicare Select, a PPO offering, was limited to offerings 15 states, with a three year sunset provision. That authority is in the process of being

renegotiated, but its need for reauthorization reflects the difficulty that managed care plans have had within the Medicare framework. Point-of-service plans, which allow patients to opt out of their network and choose other physicians or facilities, are not currently allowed. Risk based "carve-outs," like the package price heart bypass demonstration, are also not allowed except on a demonstration basis. And HMO group-only contracts, which would permit employers to establish an HMO/CMP plan which enrolls only their own retirees who are Medicare beneficiaries, are also not allowed.

If the Medicare program is to significantly increase its managed care enrollment, the first requirement must be to make available the more varied and flexible options that have been and are in the process of being developed in the private sector. But availability will probably not be sufficient. In order to see substantial growth in managed care, it will also be necessary to change the incentives facing the elderly.

STRATEGIES FOR REFORMING MEDICARE

In order to effectively reform Medicare, it will be necessary to change the basic incentive structure associated with Medicare, open up the options available to the elderly and provide them with the information needed to make choices appropriate for each individual. Currently there is little incentive for an elderly person to seek out cost-effective physicians or hospitals, or to use lower cost durable medical equipment, laboratories, or outpatient hospitals. Similarly, hospitals are encouraged to increase the use of outpatient admissions and procedures, and physicians are only rewarded for doing more and have reason to fear litigation repercussions if they do less than they used to and have an adverse outcome. Ultimately we would need to reward the elderly for choosing more cost-effective health care, provide incentives for physicians and hospitals to order prescribe cost-effective medicine, and be willing to share the savings which an aggressive reorganization of health care can produce.

I believe that the use of a better designed Adjusted Average Per Capita Cost (AAPCC) payment, the payment currently used for HMOs, could become the basis of a voucher which would encourage such cost-effective choices. In order to make this transformation, it would be necessary to redesign the determinants of the AAPCC to make it more stable and to take better account of the risk selection that appears to occur, as well as open up more choices toward which that payment can be made. Ultimately, it may be appropriate or desirable to vary the amount of the payment with the income and/or wealth of the elderly person, thus transforming Medicare into an income-related voucher or payment, but that is a decision that need not be made in 1995. Some specific changes that I would recommend would include the following:

- Allow Medicare Select to be available everywhere.
- Allow Point of Service plans.
- Allow partial capitation or risk-based "carve-out" plans.
- Refine/Revise the capitation rate.
  - —Break the link to fee-for-service spending;
  - —Experiment with basing Medicare's contribution to the premium on a competitively bid level; use this amount for Medicare's contribution for fee-for-service plans as well.
  - —Experiment with alternative calculations of the capitation payment for areas that can't support competitive bids.
- Move to annual open enrollment period for all changes in Medicare related policies; discontinue 30 day disenrollment policy for HMOs.
- Remove 50/50 rule for HMOs serving Medicare beneficiaries; require outcomes based reports plus consumer satisfaction measures to be available to all potential enrollees.
- Allow HMOs to price underneath the Medicare payment and rebate savings to the elderly (and share savings with the government).

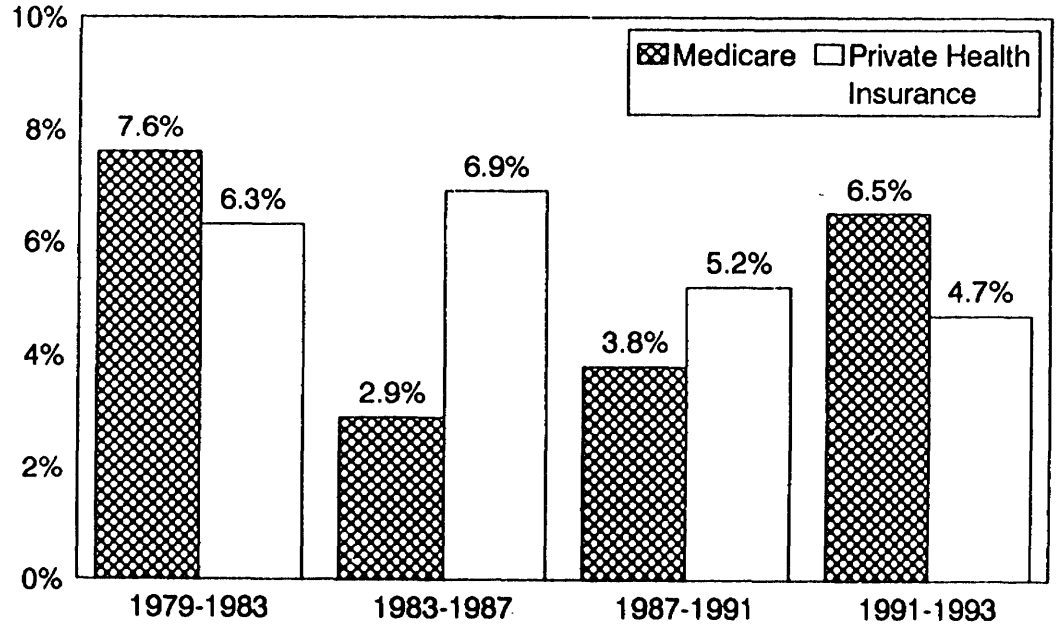
The above changes would substantially increase the availability of managed care to the elderly, remove provisions which inhibit managed care growth and where appropriate, replace with more direct measurements and provide some incentives to choose the more cost-effective health care plans. To the extent that the payment is set at the level of the "lowest cost plan" in the area, this would provide a strong incentive for the elderly to choose cost-effective health care plans, which may or may not turn out to be managed care plans.

In the short term, the need to realize savings from Medicare changes may dominate Congressional decision making. But because there are some changes which are consistent with the move to a more incentive based choice structure, some which are neutral, and some changes which would move the system in the wrong direction, what changes are adopted will have important ramifications for the long run. For example, adding a 10% co-insurance for home health, or a fixed copayment for rehab hospital admissions would raise some additional revenues, lower utilization in these area, and make managed care options more attractive. Similarly, "bundling" post-acute care services, capitating those areas of Part A, which have been growing very rapidly over the last several years and will continue to grow more rapidly than the remainder of Part A for the rest of the decade, will also make managed care plans that tend to cover these components more attractive and discourage their utilization in the fee-for-service world. Reducing payments to indirect medical education or direct medical education would be neutral with respect to its effect on the choice of the elderly regarding cost-effective health care plans. But reducing overall physician fees may lead physicians to compensate with additional volume increases which would not be helpful, either in terms of moderating spending or in moving the system to a more cost-effective basis.

Thus, it is possible to accommodate the need for short-term revenue increases while setting the stage for a fundamental change in the incentives, information and options that characterize the Medicare program. Since it will take some time to realize all the gains from restructuring Medicare, it is important that these reforms be started as soon as possible. This session of Congress is none too soon to start.

Chart 1

Real Change In Medicare Expenditures Per Enrollee and Private Health Insurance Per Member, 1979-1993 (In Percent).

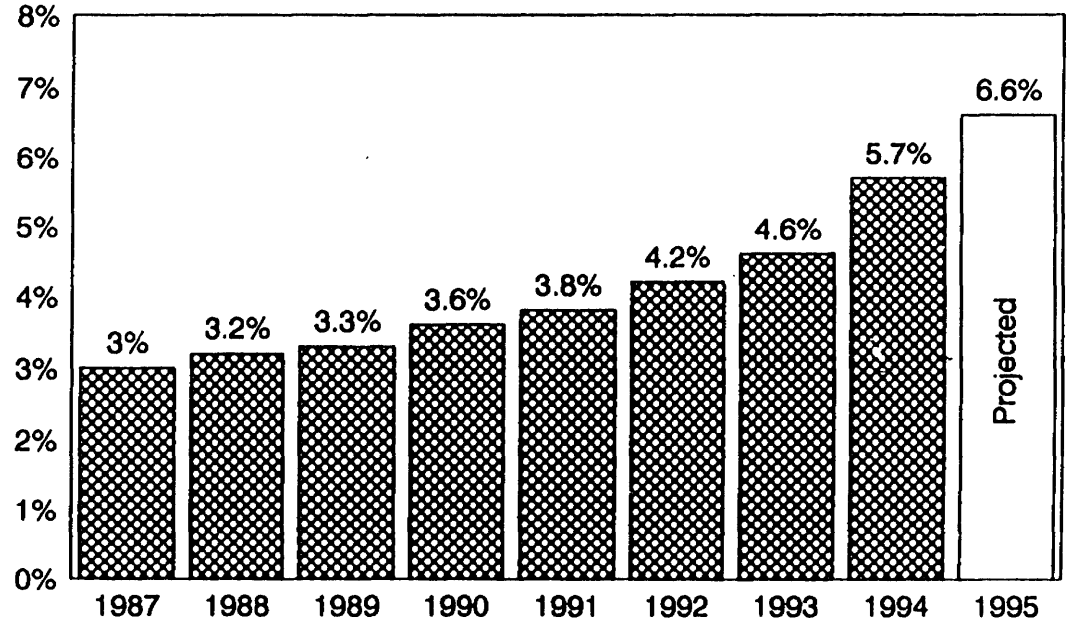


Source: ProPAC analysis of data from HCFA, Office of the Actuary.

Chart 2

HMO Growth

Percentage of People Eligible for Medicare Enrolled in HMOs

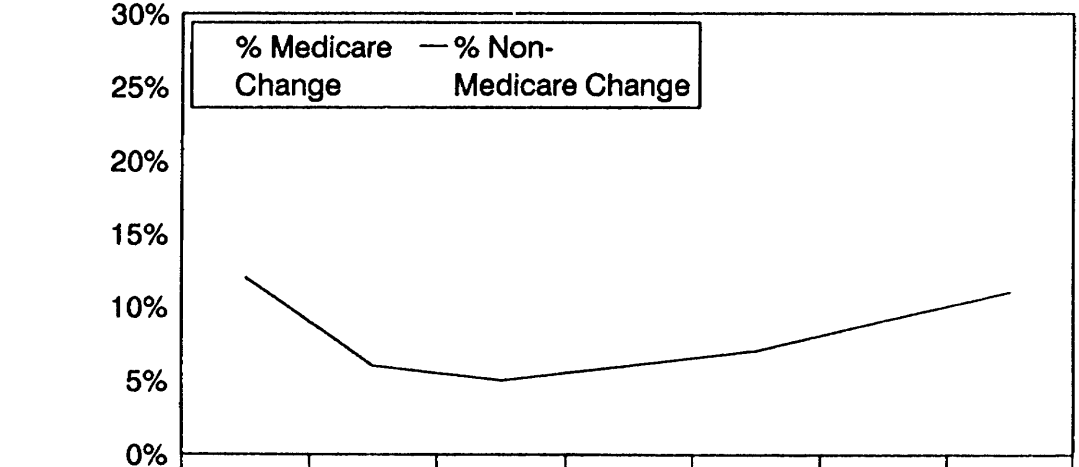


Source: New York Times.

Chart 3

Relative Growth In HMO Enrollment

Medicare (Risk HMOs) and Non-Medicare Populations



	1988	1989	1990	1991	1992	1993	1994
% Medicare Change	6%	7%	11%	10%	13%	16%	25%
% Non-Medicare Change	12%	6%	5%	6%	7%	9%	11%

Source: HCFA OMC; Group Health Association of America.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

(BY ALLAN D. JENSEN, MD, SECRETARY FOR FEDERAL AFFAIRS)

Mr. Chairman and members of the Committee: My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore, Maryland and the Secretary for Federal Affairs for the American Academy of Ophthalmology.

Ophthalmologists are physicians who provide primary and comprehensive medical and surgical eye care. The Academy is made up of nearly 20,000 ophthalmologists—over 90-percent of the ophthalmologists in the United States.

My statement will focus on trends in Medicare spending reductions, the Medicare Select Demonstration program, proposals creating so-called "centers of excellence" and the need for significant reform of the Medicare program. I am pleased to have the opportunity to present this statement on the Academy's behalf.

The American Academy of Ophthalmology believes that all Americans should have access to quality health care including appropriate and affordable eye care. We believe that an appropriate level of eye care is necessary in order to promote general well-being, independent daily functioning, enhanced quality of life and meaningful economic productivity.

As we grow older, our bodies undergo significant changes. The visual system is no exception. Many disorders of the eye are associated with the aging process. In fact, its is not uncommon for Americans age 65 and older to experience significant vision problems. Consequently, ophthalmologists and our patients have a strong interest in maintaining the strength and integrity of the Medicare program—the nation's most important provider of health care services for older Americans.

MEDICARE TRENDS

The Academy is concerned about reports suggesting Congress is considering cutting the Medicare program by $20-$40 billion over the next five years.

Regrettably, the Medicare program is, historically, one of the first programs to be targeted when Congress seeks budgetary savings. Since as far back as the Reconciliation Act of 1986 and including the budget acts of 1987,1989, 1990 and most recently 1993, the physicians who treat Medicare patients—the nation's oldest and most ill—have had reductions in their reimbursements.

To date, these reductions have not had a significant effect upon the accessibility or quality of Medicare services. The concern remains, however, that if arbitrary budget goals continue to drive payment policies, the level of care provided under Medicare may eventually erode. We urge Congress to be mindful of this trend and its implication for the well-being of the nation's senior citizens.

MEDICARE SELECT DEMONSTRATION PROGRAM

Recently, as a means of securing Medicare savings, many in Congress are considering expanding the Medicare Select demonstration program. The Academy believes this step should be taken cautiously.

Congress should carefully scrutinize Medicare Select before granting the program permanent nationwide status. Specifically, expansion should be approved only after information has been presented certifying the program's effectiveness. The Academy believes that Congress should be assured that the Medicare beneficiaries who choose the program are guaranteed access to appropriate quality health care services over the long-term.

"CENTERS OF EXCELLENCE"

The Academy is also concerned about the creation of HCFA-administered schemes to achieve additional budgetary savings. To date, some of these schemes have been thwarted by Congress. However, the Academy continues to be concerned about one proposal, in particular, the so-called "centers of excellence."

Under the typical "centers of excellence" proposal, the Federal government would centralize with a select group of urban providers and their facilities much of the cataract surgery, coronary artery bypass graft (CABG) and other selected surgical procedures performed in an area. The Federal government would make "rebate" payments to the "center's" patients as a means of drawing the patients into the facility and creating high-volume for the selected providers.

The Academy strongly supports patient access to providers and facilities of superior quality such as academic medical centers, teaching hospitals and other similar facilities. The "centers of excellence" should not be confused with such facilities. The "centers" result from the Federal government intervening in the health care market place in an effort to secure additional budget savings. Instead of ensuring patient access to high quality care, these "centers" represent a threat to quality care, market-based competition, and rural health care.

The Academy strongly opposes the concept of "centers of excellence."

Quality Problems

Despite being called "centers of excellence," the proposal typically includes no mention of quality standards or standards for "excellence." The "centers" are selected on the basis of cost—through a competitive low-bidder process—not on the basis of quality. Patients could be misled into believing that their surgical outcomes would be improved because their surgery took place in a marketed "center of excellence" instead of in a community-based facility.

In truth, "excellence" is already widespread in procedures such as cataract surgery. The Agency for Health Care Policy and Research (AHCPR), an arm of the Department of Health and Human Services, has determined that the success rate for the procedure is 95-percent. It is highly unlikely that centralization in low-bidder facilities with no quality oversight would improve on this success.

Today's community-based ophthalmologists follow their patients over the patient's lifetime. These ophthalmologists are aware of the patient's medical history and are aware of conditions such as diabetes and other systemic problems. This knowledge allows the physician to make appropriate clinical decisions that ensure quality patient care.

The government's intrusion in the health care market place will splinter this long-term physician-patient relationship. As a result of misleading marketing as a provider of "excellence," patients will be drawn out of their long-term relationship at a time when appropriate clinical decision-making is most critical—when surgery is necessary. The quality of care will suffer needlessly as a result of this disruption.

Competition and Access Problems

Typically, the "centers" proposal excludes rural providers from competing to be "centers of excellence." The language setting up the "centers" specifies that in order to be a designated facility, the "center" must be in an urban area as defined by the Social Security Act. As a result of this language, rural providers, regardless of the quality of care they provide, are excluded from even competing for the designation.

Moreover, by locating these "centers" only in urban areas, the Federal government would create access problems for patients in rural and other underserved areas. Through the marketing of a facility as a "center of excellence" and the Federal government's "rebate" payment, patients would be encouraged and, in effect, paid to leave their community-based providers in rural and underserved areas and travel to an urban "center" for care. The exodus of patients from providers in rural and underserved areas could force many providers to relocate in order to maintain their practices. Patients remaining in the underserved areas could be left with limited access to providers.

Necessity of Care Problems

The "centers of excellence" could result in significant necessity of care problems.

The community-based ophthalmologists, providing comprehensive eye care over the long-term have assessed the patient's visual functions and understand the patient's visual needs, i.e., the patient may read extensively or drive a truck for a living. With this knowledge, the physician can work with the patient to decide if surgery is necessary. Surgery is offered as an alternative only when it is in the patient's best interest. There is little incentive to perform a procedure prematurely.

By contrast, the providers at the "centers of excellence" do not have long-term relationships with their patients. The "centers" can succeed only if their low-bidder fee is offset by an increase in surgical procedures performed. In effect, this requirement for volume creates a government-endorsed incentive to perform surgery.

The threat of inappropriate care is further exacerbated by the rebate payment provided to patients who undergo surgery in the "centers." The Academy questions whether the Federal government should be paying individuals to receive surgical care.

Ethical Problems

Through the "centers," the Federal government would make a "rebate" payment to the patients who received care at the facility. It is our understanding that the purpose of the payment is to entice additional patients to receive care from the Federally selected providers and their facilities. Currently, such "rebate" payments or "kickbacks" are illegal under the Medicare program because the government feels they may induce unnecessary care. We urge Congress to consider the implications of allowing patients to be paid to use government-endorsed provider.

REFORM OF MEDICARE

The Academy is very concerned about discussions in Congress regarding significant reductions to the Medicare programs. We are equally concerned about schemes such as the "centers of excellence" whose proposed existence is veiled in quality terms, yet, in truth, is only another attempt at reducing Medicare spending.

The issue Congress must address is what approach should be pursued to ensure that the Medicare program is able to respond to the needs of current and future beneficiaries. While there are many approaches which can be taken, history should tell us that there is one which has proven to be ineffective—reducing Medicare spending through physician payment cuts. Despite recurring physician payment cuts, Congress still finds itself wrestling with the Medicare program. It should be clear that the continued targeting of physician payments will not cure the fundamental problems which ail the Medicare program. In fact, it has been argued that just the opposite may occur. The Physician Payment Review Commission (PPRC) has expressed concerns about targeting physician payments. The PPRC stated the following in its Annual Report to Congress 1994:

Although the growing disparity between Medicare and private payment rates has not yet caused measurable reductions in access, further divergence in those rates would increase the risk of adverse effects on access. The Congress should be cautious about policies that will further widen the gap through additional constraints on Medicare payment rates.

The Academy urges Congress to look beyond physician payments and examine the Medicare program in its entirety. Already, some members of the Senate and House have proposed innovative changes to the structure and function of the program. Similarly, the American Medical Association has made some recommendation regarding a "transformation" of Medicare. We encourage Congress to vigorously examine these proposals. These recommendations may represent an important first step toward ensuring a viable Medicare program.

Thank you for your attention to these issues. We appreciate this opportunity to comment on the Medicare program.

STATEMENT OF THE AMERICAN ASSOCIATION OF PPOS

March 7, 1995

Hon. ROBERT PACKWOOD, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC

Dear Mr. Chairman: The American Association of Preferred Provider Organizations (AAPPO) appreciates the opportunity to comment on the issue of managed care and Medicare, the subject of your February 28 hearing. We respectfully request that this letter be made part of the official hearing record.

As you know, managed care plans have become the norm in the private sector. Sponsors of both commercially-insured and self-insured health plans increasingly offer managed care options to their employees, a trend driven by employee preference as well as cost savings. The Medicare program, in its continuing reliance on a fee-for-service model, is out of step with the rest of the health care market. Medicare beneficiaries, like the privately-insured population, should have a choice among

plan options. In many cases, they may prefer a plan that involves less paperwork and ensures that care is coordinated among physicians and other providers.

Recent testimony by the Congressional Budget Office reflects AAPPO members' experience: managed care plans can achieve significant cost-containment success. Corroboration can be found in the annual Foster-Higgins survey, which found PPOs the lowest-cost health plan model in 1994. We strongly urge you to incorporate this success in Medicare through increased use of managed care. PPOs deserve particular attention in that they already have a proven record of reducing expenses without restricting patient choice. Since much of the opposition to managed care in Medicare stems from fear of being coerced into consulting only specified providers, serious consideration should be given to a model that can address this concern without sacrificing either efficiency or quality.

PPOs are network-based managed care organizations created to facilitate a working relationship between physicians, hospitals, and other providers and health care purchasers or their administrators. Providers agree to deliver their services at competitively negotiated rates and prices and to comply with utilization management and quality assessment controls. A PPO is marketed as a product to employers and employees, as well as directly to insurance companies, which in turn market the network to their employer clients. Employees enrolled in a PPO plan retain the freedom to select their provider, but are given financial incentives to choose to receive care within the managed network.

PPOs have grown in prevalence and popularity in recent years. The consulting firm Hay/Huggins reports that a majority of employers with health insurance plans now offer a PPO option; a significant development in 1994 was the increased incidence of PPOs and other managed care models serving as the employer's primary health plan. In other surveys, employers report increasing use of managed care networks in their retiree and even in their international benefit plans.

AAPPO supports efforts to extend the Medicare Select program to all 50 states, and to make it permanent. Medicare Select allows beneficiaries to enroll in private health plans that compete to provide low-cost, high-quality care. It offers a low-commitment, low-threat introduction to managed care for beneficiaries without previous experience, and in time may provide a comfortable transition to choosing managed care for basic as well as supplemental Medicare benefits. Medicare Select can deliver high quality care at a lower premium cost to beneficiaries, and produce savings to the government at the same time.

Beyond the specifics of Medicare Select, AAPPO would like to work with the Committee and the Administration to revise the regulations and payment methodologies that currently restrict the use of managed care in Medicare, and to develop a real, workable PPO option for Medicare beneficiaries nationwide. Thank you for your attention, and for including our views in the hearing record.

Sincerely,

GORDON B. WHEELER, *President & Chief Operating Officer.*

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